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/2021/ca**. 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**?	$1,500 individual / $3,000 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** and 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**?	$8,300 individual / $16,600 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 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** 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**?	No.	You can see the **specialist** you choose without a **referral**.

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	$50 **copay**/visit **Deductible** does not apply	Not Covered	——————none——————
	Specialist visit	$75 **copay**/visit **Deductible** does not apply	Not Covered	——————none——————
	Preventive care/ **screening**/ immunization	No charge	Not Covered	If you receive non-preventive services during a preventive visit, the applicable cost share will apply to those non-preventive services.
If you have a test	**Diagnostic test** (x-ray, blood work)	$75 **copay**/visit **Deductible** does not apply (x-ray/lab work)	Not Covered	**Preauthorization** may be required.
	Imaging (CT/PET scans, MRIs)	50% **coinsurance** subject to **deductible**	Not Covered	**Preauthorization** may be required. If you don't get **preauthorization**, payment for care may be denied.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.hioscar.com/search/CA/drugs?year=2021**	Generic drugs (Tier 1)	$25 **copay**/prescription **Deductible** does not apply (preferred generic, retail), $62.50 **copay**/prescription **Deductible** does not apply (preferred generic, mail order)	Not Covered	**Preauthorization**/step therapy may be required. If you don't get **preauthorization** payment for care may be denied.
	Preferred brand drugs (Tier 2)	$55 **copay**/30 day supply **Deductible** does not apply (retail), $137.50 **copay**/90 day supply **Deductible** does not apply (mail order)	Not Covered	
	Non-preferred brand drugs (Tier 3)	$125 **copay**/30 day supply **Deductible** does not apply (retail), $312.50 **copay**/90 day supply **Deductible** does not apply (mail order)	Not Covered	

*For more information about limitations and exceptions, see the plan or policy document at https://www.hioscar.com/forms/2021/ca.

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/CA/drugs?year=2021**	**Specialty drugs** (Tier 4)	50% **coinsurance** subject to **deductible** (retail/mail order)	Not Covered	Up to $250 per script after prescription drug **deductible**. **Preauthorization**/step therapy may be required. If you don't get **preauthorization** payment for care may be denied.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% **coinsurance** subject to **deductible**	Not Covered	**Preauthorization** may be required.
	Physician/surgeon fees	50% **coinsurance** subject to **deductible**	Not Covered	**Preauthorization** may be required.
If you need immediate medical attention	**Emergency room care**	$750 **copay**/visit **Deductible** does not apply (ER Facility Fee), No charge (ER Physician Fee)	$750 **copay**/visit **Deductible** does not apply (ER Facility Fee), No charge (ER Physician Fee)	**Emergency Room care** by an **Out-of-Network provider** is covered if the services are for an emergency condition. Cost-share waived if admitted.
	Emergency medical transportation	$750 **copay**/transport **Deductible** does not apply	$750 **copay**/transport **Deductible** does not apply	**Preauthorization** is required for non-emergency transportation. If you don't get **preauthorization**, payment for care may be denied.
	Urgent care	$75 **copay**/visit **Deductible** does not apply	Covered at **in-network** level	**Urgent Care** is covered out of **network**.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% **coinsurance** subject to **deductible**	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. However, **preauthorization** is not required for emergency admissions.
	Physician/surgeon fees	50% **coinsurance** subject to **deductible**	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. However, **preauthorization** is not required for emergency admissions.

*For more information about limitations and exceptions, see the plan or policy document at https://www.hioscar.com/forms/2021/ca.

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 mental health, behavioral health, or substance abuse services	Outpatient services	$50 **copay**/visit **Deductible** does not apply (office visit), 50% **coinsurance** subject to **deductible** (for other outpatient services)	Not Covered	——————none——————
	Inpatient services	50% **coinsurance** subject to **deductible**	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied. However, **preauthorization** is not required for emergency admissions.
If you are pregnant	Office Visits	No charge	Not Covered	Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply.
	Childbirth/delivery professional services	50% **coinsurance** subject to **deductible**	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	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 caesarean section. **Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
If you need help recovering or have other special health needs	**Home health care**	$75 **copay**/visit **Deductible** does not apply	Not Covered	100 visits per benefit period. **Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	Rehabilitation services	$75 **copay**/visit **Deductible** does not apply	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	Habilitation services	$75 **copay**/visit **Deductible** does not apply	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.

*For more information about limitations and exceptions, see the plan or policy document at https://www.hioscar.com/forms/2021/ca.

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	**Skilled nursing care**	50% **coinsurance** subject to **deductible**	Not Covered	100 days per benefit period. **Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	Durable medical equipment	50% **coinsurance** subject to **deductible**	Not Covered	**Preauthorization** may be required.
	Hospice services	50% **coinsurance** subject to **deductible**	Not Covered	**Preauthorization** may be required.
If your child needs dental or eye care	Children's eye exam	No charge	Not Covered	One (1) exam per benefit period.
	Children's glasses	50% **coinsurance** **Deductible** does not apply	Not Covered	One (1) prescribed lenses and frames per Benefit Period. $150 allowance for Lenses and Frames, or Contact Lenses.
	Children's dental check-up	No charge	Not Covered	One (1) preventive 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**.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your **plan** document.)

- Abortion
- Acupuncture
- Bariatric surgery
- Private-duty nursing - 100 visits/year combined with home health care
- Routine foot care

*For more information about limitations and exceptions, see the plan or policy document at https://www.hioscar.com/forms/2021/ca.

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: Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or **www.dol.gov/ebsa/healthreform**. Other coverage options may be available to you too, including buying individual insurance coverage through the **Health Insurance** **Marketplace** Covered California. For more information about Covered California, visit www.coveredca.com or call 1-800-300-1506.

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:

Oscar Health **Plan** of California, Attn: Member Services, 12777 W. Jefferson Blvd., Bldg. D, Suite 100, Los Angeles, CA 90066, (855) 672-2755.

Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814-2725, (888) 466-2219, www.dmhc.ca.gov

California Consumer Assistance Program, Operated by California Department of Managed Health Care, 980 9th St., Suite 500, Sacramento, CA 95814, (888) 466-2219, www.dmhc.ca.gov

Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or **www.dol.gov/ebsa/healthreform**.

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? Yes.

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, kwiijigo holne' **1-855-OSCAR-55**.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

*For more information about limitations and exceptions, see the plan or policy document at https://www.hioscar.com/forms/2021/ca.

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 copay	$75
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	$1,500
Copayments	$400
Coinsurance	$4,200
What isn't covered	
Limits or exclusions	$50
The total Peg would pay:	**$6,150**

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 copay	$75
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	$1,000
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay:	**$2,320**

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

The plan's overall deductible	$1,500
Specialist copay	$75
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	$400
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay:	**$2,000**

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.

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 פאראן פאר אייך שפראך היילף סערוויסעס פריי פון אפצאל. רופט 1-855-OSCAR-55.

বাংলা (Bengali): লক্ষ্য করুন: 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–558.

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.

Ελληνικά (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): સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. કૉલ 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៖ បើអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាគឺមានសំរាប់បំរើអ្នកដោយឥតគិតថ្លៃ ។ 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 คุ ณพู ดภาษาไทยคุณสามารถใช้ 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.

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, koji' hódíílnih **1-855-OSCAR-55** (TTY: 711.)

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-OSCAR-55

An Exclusive Provider Organization (EPO) Plan

2021 Subscriber Agreement and Combined Evidence of Coverage and Disclosure Form

Oscar Health Plan of California
12777 West Jefferson Blvd, 1st Floor
Suite 100, Building D
Los Angeles, CA, 90066

Effective January 1, 2021

For Questions, call Member Services at 1-855-672-2755 or login at www.hioscar.com. Por favor contáctenos al 1-855-672-2755 para obtener una versión en Español.

[XXXXX]

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INTRODUCTION

READ THIS ENTIRE AGREEMENT CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP POLICY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS AGREEMENT.

This Combined Evidence of Coverage and Disclosure Form ("Agreement") explains the benefits available to You under a Group Health Plan contract between Oscar Health Plan of California (hereinafter referred to as "We", "Us" or "Our") and the Group listed in the Group Policy.

This Agreement is governed by the laws of California. As a health care service plan, Oscar is subject to the California Knox-Keene Health Care Service Plan Act of 1975, as amended, and the regulations promulgated thereunder ("Knox-Keene Act"). Any provision required in this Agreement by the Knox-Keene Act will bind Oscar whether or not that provision is provided in this Agreement.

Throughout this Agreement, You will find key terms that appear with the first letter of each word capitalized. When You see these capitalized words, You should refer to the section titled **DEFINITIONS** where the meanings of these terms or words are defined. Some key terms may be defined within a specific benefit description.

Choice of Physicians and Providers
This is an Exclusive Provider Organization ("EPO") plan.

Services must be performed or supplies furnished by an In-Network Provider in order for benefits to be payable. Typically, there are no Benefits provided when using an Out-of-Network Provider and You may be responsible for the total amount billed by an Out-of-Network Provider. The only exceptions are:

- Covered Services received from an Out-of-Network provider as a result of a medical Emergency, Urgent Care Visit or an Authorized Service as defined in the **DEFINITIONS** section; and
- Covered Services received at an In-Network Facility, at which, or as a result of which, the Member receives Covered Services from an Out-of-Network Provider.

Covered Services received from an Out-of-Network Provider under these exceptions are provided at In-Network Cost Sharing.

To maximize Your benefits, be sure to confirm that the Provider (e.g. a Physician or Hospital) You wish to see is an In-Network Hospital or an In-Network Provider (for Providers other than Hospitals) under Your Plan. Services must be performed or supplies furnished by an In-Network Provider in order for benefits to be payable, unless one of the exceptions listed above apply.

You do not need to get a referral to see a specialist for services, including dental services. Please call 888-902-0403 for a listing of facilities, providers and how to change your provider.

Your Network of Providers

Providers that have a contract with Oscar agree to provide Covered Services to Oscar members. Information about Your Network can be accessed by calling member services at 1-855-672-2755 or on Our website www.hioscar.com.

How to Find a Provider in the Network

There are three (3) ways You can find out if a Provider or Facility is in the network for this Agreement. You can also find out where they are located and details about their license or training.

- See Our directory of In-Network Providers at www.hioscar.com, which lists the Physicians, Providers and Facilities that participate in Our network.
- Call member services at 1-855-672-2755 or access Our website at www.hioscar.com for a list of Physicians, Providers and Facilities that participate in Our network, based on specialty and geographic area.
- Check with Your Physician or Provider to determine if they are an In-Network Oscar Provider.

Choosing a Primary Care Physician or a Primary Care Provider (PCP)

Under this Plan, a Member does not have to select a PCP, but is encouraged to do so. You may choose an internist, general practitioner, family practitioner, or OB-GYN as Your PCP. The PCP is available to supervise and coordinate the Member 's health care in Oscar's Network, and Oscar may assign each Member to a PCP at their discretion. This is an "open Referral" Plan. You do not need a Referral from a PCP to obtain treatment for covered benefits before receiving Specialist care from an In- Network Specialist.

How to Get Language Assistance

Oscar offers a Language Assistance Program to assist Members with limited English proficiency understand the health coverage provided under this Agreement at no additional cost. We provide oral interpretation services, as well as written translation for written materials vital to understanding Your health coverage.

This service also allows You and Your Physician to talk about Your medical or behavioral health concerns in a way You both can understand. We have representatives that speak Spanish and have medical interpreters to assist with other languages.

Requesting language assistance is easy. Just contact Member Services by calling 1- 855-672-2755 to update Your language preference, to receive future translated documents, or to request interpretation assistance. Oscar also sends/receives TDD/TTY messages by using the National Relay Service through calling 711 or a number listed below. A special operator will get in touch with Us to help with Your needs.

To reach CA Relay, please use the numbers below:

Type of Call	Language	Toll-free 800 Number
TTY/VCO/HCO to Voice	**English** **Spanish**	**1-800-735-2929** **1-800-855-3000**
Voice to TTY/VCO/HCO	**English** **Spanish**	**1-800-735-2922** **1-800-855-3000**
From or to Speech-to-Speech	**English** **Spanish**	**1-800-854-7784**

Written materials available for translation include Grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the following languages:

- Spanish
- Any threshold language

Oral interpretation services are available in additional languages.

Triage or Screening Services
If You believe Your medical or dental condition is an Emergency, call 911 or go to the nearest Emergency room.

If You have questions about a particular health condition and You don't believe it is an Emergency, or if You need someone to help You determine whether or not care is needed, You can request a call from our Doctor on Call service. These Physicians can speak with you over the phone to evaluate your health and give recommendations on your care.

We can forward you to this service if you call Us at 1-855-672-2755, or you can request a call in the Oscar app, twenty-four (24) hours a day, seven (7) days a week.

Anti-Discrimination Policy
Oscar Health Plan of California does not discriminate based on race, color, national origin, ancestry, religion, sex, marital status, sexual orientation or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from that contract as a subscriber, enrollee, member, or otherwise.

Your Privacy
You have the right to receive a copy of the Notice of Privacy Practices. You may obtain a copy by calling Our member services department at 1-855-672-2755 or by accessing Our website at www.hioscar.com.

Our Notice of Privacy Practices describes how We use and disclose protected health information. You can access Oscar's Notice of Privacy Practices on Our website at www.hioscar.com. You can also request a paper copy, at no cost to you, by calling Member Services at the number listed on the back of Your Oscar ID card.

- Mario Schlosser (CEO)

HOW TO CONTACT US

If You have any questions about the information provided, please feel free to contact us. We are available 8 AM – 8 PM , Monday through Friday and 8 AM – 6 PM on Saturday.

For information about...	Contact	Email	Phone Number
Enrollment	Member Services	help@ hioscar.com	1-855-672-2755
Medical Benefits & Claims	Member Services	help@ hioscar.com	1-855-672-2755
Hearing and Speech Impaired Customer	Member Services	help@ hioscar.com	Via the National Relay Service by dialing 711 or CA Relay-See below
Precertification	Member Services	help@ hioscar.com	1-855-672-2755

Please also feel free reach out to us by mail, at our address:

Oscar Health Plan of California
Attn: Member Services
12777 West Jefferson Blvd, 1st Floor
Suite 100, Building D
Los Angeles, CA, 90066

Visit Oscar's website at www.hioscar.com to shop for a doctor and pick one You like. Or just click to talk with a doctor right away. Then see all Your visits, prescriptions, and lab work in an intuitive timeline. We keep track of Your care so you don't have to.

Need help with something along the way? Our trusted team of nurses and healthcare experts work hard to answer Your questions and save You money. We want to keep You happy and healthy, so just ask when You have questions. We're like a doctor in the family.

This Agreement is subject to all the definitions, limitations, exclusions and conditions as stated herein. Authorized officers of Oscar have approved this Agreement.

Should You need to contact the Department of Managed Health Care, please call (1- 888-446-2219); DMHC also has a TDD line (1-877-688-9891) for the hearing and speech impaired.

To reach CA Relay, please use the numbers below:

Type of Call	Language	Toll-free 800 Number
TTY/VCO/HCO to Voice	**English Spanish**	**1-800-735-2929 1-800-855-3000**
Voice to TTY/VCO/HCO	**English Spanish**	**1-800-735-2922 1-800-855-3000**
From or to Speech-to-Speech	**English Spanish**	**1-800-854-7784**

DEFINITIONS

Listed below are the definitions that contain the meaning of key terms used in this Agreement. Throughout the Agreement, the terms printed in bold face below will appear with the first letter of each word in capital letters.

Accidental Injury is physical harm or disability which is the result of a specific, unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental Injury does not include illness or infection, except infection of an accidental cut or wound.

Act means the Knox-Keene Health Care Service Plan Act of 1975.

Active Labor means a labor at a time at which either of the following would occur:

- There is inadequate time to effect safe transfer to another hospital prior to delivery.
- A transfer may pose a threat to the health and safety of the patient or the unborn child

Adopted Child and Adoptive Child is a child whose birth parent or appropriate legal authority has signed a written document granting the Subscriber, enrolled Spouse or enrolled Domestic Partner the right to control health care for or, absent this document, other evidence exists of this right.

Agreement means this Oscar Subscriber Agreement and Combined Evidence of Coverage and Disclosure Form, including any endorsements, attached paper, or Schedule of Benefits issued to You by Oscar.

Ambulatory Surgical Center is a freestanding outpatient surgical Facility. It must be licensed as an outpatient clinic according to State and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations or the Accreditation Association of Ambulatory Health Care.

Ancillary Provider means an independent clinical laboratory, durable/home medical equipment supplier, and/or Specialty Pharmacy.

Authorized Referral occurs when a Member, because of his or her medical needs, requires the services of a specialist who is an Out-of-Network Provider, or requires special services

or Facilities not available at a Contracting Hospital, but only when the. Referral has been authorized by Oscar before services are rendered, taking into consideration whether:

- There is no In-Network Provider with the appropriate training and experience who practices in the appropriate specialty or there is no Contracting Hospital which provides the required services or has the necessary Facilities; and
- The Member is referred by an Oscar In-Network Provider to a Hospital or Provider that does not have an agreement with Oscar for a Covered Service.

If there is a shortage of one or more types of Providers to ensure timely access to Covered Services, Oscar will also assist covered individuals to locate available and accessible contracted Providers in neighboring Service Areas for obtaining health care services in a timely manner appropriate to the Member's health needs. Approvals of authorizations to Out-of-Network Providers (i.e. certifications) will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Out-of-Network Provider You requested. If We approve the authorization, all services performed by the Out-of-Network Provider are subject to a treatment plan approved in consultation with You, Your PCP, and the Out-of-Network Provider.

For additional information on how to obtain an Authorized Referral, see the section titled **HOW YOUR COVERAGE WORKS**.

Authorized Service(s) means a Covered Service You get from an Out-of-Network Provider that We have agreed to cover at the In-Network level through an Authorized Referral. Oscar may authorize such service(s) when a service is not available from an In- Network Provider within the Plan's applicable access standards.

You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply. Please see Your Schedule of Benefits and the section titled **CLAIMS AND PAYMENTS** for more details.

Benefit Period means a calendar Year (January 1 through December 31) for which a health benefit plan provides coverage for health benefits.

Case Management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs. The programs are confidential and voluntary and are made available at no extra cost to You.

Chronic Health Conditions is a medical condition due to a disease, illness, or other medical problem or medical disorder that persists without full cure, worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration.

Clinical Ecology means the inpatient or outpatient diagnosis or treatment of allergic symptoms by cytotoxicity testing (testing the result of food or inhalant by whether or not it reduces or kills white blood cells); urine auto injection; skin irritation by Rinkel method; subcutaneous provocative and neutralization testing (injecting the patient with allergen); or sublingual provocative testing (droplets of allergenic extracts are placed in mouth).

Clinical Trial means an organized, systematic, and scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer or disabling or life- threatening chronic disease in human beings.

Code means the California Health and Safety Code.

Coinsurance is Your share of the costs of a covered health care service or prescription, calculated as a percentage (for example, 20%) of the allowed amount for the service as stated in the Schedule of Benefits. You pay Coinsurance after any Deductible You owe. For example, if the Agreement's allowed amount for an Office Visit is $100 and You have met Your Deductible, Your Coinsurance payment of 20% would be $20. Your Coinsurance does not apply to charges for services which are not covered and will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Compounded (combination) Medications, when one or more ingredients are FDA-approved, require a prescription to dispense, and are not essentially the same as an FDA-approved product from a drug manufacturer.

Copayment is a fixed amount (for example $15) You pay for a covered health care service or prescription, usually when You receive the service. The amount can vary by the type of covered health care service. Copayments are outlined in the Schedule of Benefits.

Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

Cost Share means the amount which the Member is required to pay for Covered Services. Where applicable, Cost-Shares can be in the form of Copayments, Coinsurance and/or Deductibles.

Covered Individual means a person for whom the Planholder has submitted an Enrollment Application Form and the required Premium, and whom Oscar has accepted for coverage under this Plan.

Covered Services are health care services that are Medically Necessary services, Drugs, or supplies for which You are entitled to receive benefits and that are listed in the **WHAT IS COVERED – MEDICAL and WHAT IS COVERED – PRESCRIPTION DRUGS** sections.

Custodial Care is care provided primarily to meet Your personal needs that does not require the regular services of trained medical or Health Professionals, including, but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets and supervision of medications which are ordinarily self administered.

Deductible: The term Deductible means the amount of charges You must pay for any Covered Services and Prescription Drugs before any benefits are available to You under this Agreement. Your Deductible is stated in Your Schedule of Benefits. The Prescription Drug Deductible may be separate from the Medical Deductible and may or may not accumulate towards satisfying the Medical In-Network or Out-of- Network Provider Deductibles. Additional information is available in the **CLAIMS AND PAYMENTS** and **WHAT IS COVERED – PRESCRIPTION DRUGS** sections.

Dental Services are diagnostic, preventive, or corrective procedures on or to the teeth or gums, regardless of why the services are provided and whether in treatment of a medical, dental or any other type of condition.

Department means the California Department of Managed Health Care.

Dependents are members of the Subscriber's family who are eligible and accepted under this Agreement as stated in the **YOUR ELIGIBILITY** section.

Diabetes Equipment and Supplies means the following items for the treatment of diabetes (insulin or non-insulin and gestational) as Medically Necessary:

- blood glucose monitors
- blood glucose monitors designed to assist the visually impaired
- blood glucose testing strips
- blood glucose calibration solution
- ketone urine testing strips
- insulin pumps and related necessary supplies
- lancets and lancet puncture devices
- pen delivery systems for the administration of insulin
- insulin syringes
- visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin

Diabetes Outpatient Self-Management Training Program includes services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a Member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the Member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.

Domestic Partner or Domestic Partnership are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. Further, they must have either filed a Declaration of Domestic Partnership with the Secretary of State of the State of California in accordance with Section 298.5 of the Family Code, or have been issued an equivalent document by a local agency of California, another state, or a local agency of another state under which the partnership was created. A Domestic Partner must meet the eligibility requirements for Domestic Partners outlined under the **YOUR ELIGIBILITY** section.

Drugs means Prescription Drugs.

Effective Date is the date on which Your coverage under this Agreement begins.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably expect one or more of the following to result:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

An Emergency Medical Condition includes a Psychiatric Emergency Medical Condition, which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others, or
- immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Emergency Services and Care will not be covered if You did not require emergency services and care and You reasonably should have known that an emergency did not exist.

Emergency Services means, with respect to an Emergency Medical Condition or a Psychiatric Emergency Medical Condition:

- A medical screening, examination, and evaluation by a physician and surgeon, or by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or Active Labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.
- An additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.
- The care and treatment to relieve or eliminate a Psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general acute care hospital, or to an acute psychiatric hospital.

Emergency Services and Care will not be covered if You did not require emergency services and care and You reasonably should have known that an emergency did not exist.

Experimental, Investigational, and Unproven Services mean any health care service, treatment, procedure, facility, equipment, drug, device, or supply that:

- Is not accepted as Standard Medical Treatment of the condition; or
- Has not been approved by the U.S. Food and Drug Administration (FDA) to be lawfully used; or
- Has not been identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or

- Requires review and approval by any Institutional Review Board (IRB) for the proposed use or are subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations; or
- Requires any Federal or other governmental agency approval not listed above that has not been and will not be granted at the time services will be provided.

Facility means any premises owned, leased, used or operated directly or indirectly by or for the benefit of a plan or any affiliate thereof, and any premises maintained by a provider to provide services on behalf of a plan. Facility includes, but is not limited to, a Hospital, Ambulatory Surgical Center, Mental Health / Substance Abuse Facility, or Skilled Nursing Facility, as defined in this Agreement and other approved Facilities.
The Facility must be licensed, registered or approved by the Joint Commission on Accreditation of Hospitals or meet specific rules set by Us.

Family Plan means a Plan in which the Subscriber is enrolled with one (1) or more Dependents. For additional information on Newborns during the first sixty (60) days from birth and Adopted Children during first sixty (60) days from the date the Subscriber, enrolled spouse, or enrolled Domestic Partner is granted the right to control health care for an Adopted Child, refer to the **YOUR ELIGIBILITY** section.

Formulary means a listing of Prescription Drugs that are designated as Covered Drugs. The list of approved Prescription Drugs developed by Oscar in consultation with Physicians and pharmacists has been reviewed for their quality and cost effectiveness. This Formulary contains a limited number of Prescription Drugs and may be different than the Formulary for other Oscar products. Generally, it includes select Generic Drugs with limited Brand Prescription Drugs coverage. This list is subject to periodic review and modification by Oscar. We may add or delete Prescription Drugs from this Formulary from time to time. A description of the Prescription Drugs that are listed on this Formulary is available upon request and at www.hioscar.com. Oscar's formulary does not apply to or include certain physician-administered pharmaceuticals that are covered under your medical benefits.

Gender Identity Disorder (Gender Dysphoria) (GID) is defined as is in the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Edition. It is a formal diagnosis used by psychologists and Physicians to describe people who experience significant dysphoria (discontent) with the sex they were assigned at birth and/or the gender roles associated with that sex.

Gender Reassignment (Confirmation) Services means a collection of Medically Necessary drugs and services that are used to treat gender dysphoria, including hormone treatment, counseling and psychiatric services, excluding drugs or services Oscar considers to be Cosmetic or Experimental or Investigational.

Gender Transition is the process of changing one's outward appearance, including physical sex characteristics, to accord with his or her actual gender identity.

Grievance means a written or oral expression of dissatisfaction to the plan or the Director regarding the plan and/or provider, including a written or oral expression of dissatisfaction by You, if You believe Your plan contract, enrollment or subscription has been or will be improperly cancelled, rescinded or not renewed. Grievances to the Director may be made electronically, verbally, or in writing signed by You (or Your legal representative). You are not required to use a specific form to submit a written grievance to the Director. If You submit a Grievance before the effective date of a cancellation, rescission, or nonrenewal for reasons other than nonpayment of premiums, We shall continue to provide coverage.

Home Health Agencies and Visiting Nurse Associations are home health care Providers which are licensed according to State and local laws to provide skilled nursing and other services on a visiting basis in Your home or which are approved as home health care Providers under Medicare and the Joint Commission on Accreditation of Healthcare Organizations.

Hospice Care is a coordinated plan of home, inpatient and outpatient care that provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available twenty-four (24) hours a day, seven (7) days a week. The hospice must meet the licensing requirements of the State or locality in which it operates.

Hospital is a health Facility which provides diagnosis, treatment and care of persons who need acute inpatient Hospital care under the supervision of Physicians, and it must be licensed to provide general acute inpatient and outpatient services according to State and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations.

For the purpose of Serious Emotional Disturbance of a Child, Severe Mental Illness, and mental health conditions identified as a "mental disorder" in the Diagnostic and Statistical

Manual of Mental Disorders (DSM), Fourth Edition, the term "Hospital" includes an acute psychiatric Facility which is a Hospital specializing in psychiatric treatment or a designated psychiatric unit of a Hospital licensed by the state to provide twenty-four (24) hour acute inpatient care for persons with psychiatric disorders. For the purpose of this Plan, the term acute psychiatric Facility also includes a psychiatric health Facility which is an acute twenty-four (24) hour Facility as defined in California Health and Safety code 1250.2. It must be:

- Licensed by the California Department of Health Services,
- Qualified to provide short-term inpatient treatment according to State law,
- Accredited by the Joint Commission on Accreditation of Healthcare Organizations,
- Staffed by an organized medical and professional staff which includes a Physician as medical director, and
- Actually providing an acute level of care.

Infertility means either:

- the presence of a demonstrated condition recognized by a licensed physician and surgeon as a cause of infertility; or,
- the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

Treatment for infertility means procedures consistent with established medical practices in the treatment of infertility by licensed physicians and surgeons including, but not limited to, diagnosis, diagnostic tests, medication, surgery, and gamete intrafallopian transfer.

In vitro fertilization means the laboratory medical procedures involving the actual in vitro fertilization process.

Infusion Therapy is the administration of Drugs or Prescription substances by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin) and intrathecal (into the spinal canal) routes. For the purpose of this Plan, it shall also include Drugs administered by aerosol (into the lungs) and by a feeding tube.

In-Network Hospital is a Hospital that has a contract, either directly or indirectly, with Oscar, or another organization, to give Covered Services to Members through negotiated payment arrangements under this Plan. To find an In-Network Hospital near You, call member services at **1-855-672-2755** or access Our website at www.hioscar.com.

In-Network Pharmacy is a Pharmacy that has an In-Network Pharmacy agreement in effect with or for the benefit of Oscar at the time services are rendered. To find an In- Network

Pharmacy near You call member services at **1-855-672-2755** or access Our website at www.hioscar.com.

In-Network Provider is a Provider that has a contract, either directly or indirectly, with Oscar, or another organization, to give Covered Services to Member through negotiated payment arrangements under this Plan. To find an In-Network Provider near You call member services at **1-855-672-2755** or access Our website at www.hioscar.com.

Investigational and Investigational Procedures are those that have progressed to limited use on humans but which are not widely accepted as proven and effective procedures within the organized medical community.

Material: A factor is "material" with respect to a matter if it is one to which a reasonable person would attach importance in determining the action to be taken upon the matter.

Maintenance Medication is a Drug You take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If You are not sure if the Prescription Drug You are taking is a Maintenance Medication, please call member services at 1-855-672-2755 or check Our website at www.hioscar.com for more details.

Medically Necessary and Medical Necessity Services that a Physician (Medical Doctor (MD), Doctor of Osteopathy (DO), or similarly trained professional) would provide to a person in their care for the purpose of evaluating, diagnosing or treating an illness, injury or disease, or associated symptoms, while exercising prudent clinical judgment.

Prudent clinical judgment shall reflect:

- Generally accepted standards of medical practice in the United States;
- Specificity of clinical appropriateness unique to individual or circumstance (type, frequency and dosage of proposed intervention);
- Knowledge of scientifically-established effectiveness of proposed intervention

Generally accepted standards of medical practice shall reflect:

- Evidence-based guidelines, including MCG (formerly Milliman Care Guidelines), that have been established in the scientific literature via their inclusion in peer-reviewed medical (or similar) journals.
- Expert opinions based on experiential history of Physicians practicing in relevant clinical area;
- Clinical guidelines established by Physician Specialty Societies, such as National Comprehensive Cancer Network [NCCN], and similar;

- Clinical guidelines that are established to Oscar physicians with input from licensed participating providers in Oscar's network
- Any other relevant factors.

Medically Necessary services shall not be:

- Primarily for the convenience of the patient, physician, or other health care provider
- More costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

Member shall mean the Subscriber, any Dependents, and any Covered Individuals who are enrolled or automatically enrolled for coverage under this Agreement.

Mental Health and Substance Abuse (including Severe Mental Illness, Serious Emotional Disturbances of a Child, Mental Health Conditions, and Chemical Dependency)

Severe Mental Illness includes:

- Schizophrenia,
- Schizoaffective disorder,
- Bipolar disorder (manic-depressive illness),
- Major depressive disorders,
- Panic disorder,
- Obsessive-compulsive disorder,
- Pervasive developmental disorder or autism,
- Anorexia nervosa, and
- Bulimia nervosa.

Serious Emotional Disturbances of a Child means a child under the age of eighteen (18) years, who:

- Has one (1) or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and
- Meets one (1) or more of the following criteria:
    a. As a result of the mental disorder:

- the child has substantial impairment in at least two (2) of the following areas:
    1. Self-care,
    2. School functioning,
    3. Family relationships, or
    4. Ability to function in the community;
- And either of the following occur:
    1. The child is at risk of removal from home or has already been removed from the home.
    2. The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

- The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder.
- The child has been assessed pursuant to Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of Division 4 of Title 2 of the Education Code and determined to have an emotional disturbance, as defined in paragraph (4) of subdivision © of Section 300.8 of Title 34 of the Code of Federal Regulations.

Mental Health Condition includes any mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM IV).

Minimum Essential Coverage means any of the following: Government sponsored programs Medicare, Medicaid, CHIP, TRICARE for Life, veteran's health care program; coverage under an eligible employer-sponsored plan; coverage under a health plan offered in the individual market within a State; coverage under a grandfathered health plan, and such other health benefits coverage, such as a State health benefits risk pool, or as the Secretary of Health and Human Services (HHS) recognizes.

Monthly Premium Due Date is the first day of the Agreement period for which the Premium is paid.

Negotiated Fee Rate is the amount of payment that Oscar has negotiated with the In-Network Provider.

Newborn is a recently born infant within thirty-one (31) days of birth.

Office Visit is when You go to a Physician's office and have one (1) or more of ONLY the following three (3) services provided:

- History-Gathering of information on an illness or injury.
- Examination.
- Physician's medical decision regarding the diagnosis and treatment plan.

For purposes of this definition, Office Visit will not include any other services while at the office of a Physician (e.g., any surgery, Infusion Therapy, diagnostic X-ray, laboratory, pathology and radiology) or any services performed other than the three (3) services specifically listed above.

Oscar means Oscar Health Plan of California. In this agreement, Oscar is referred to as "WE", "US", "OUR".

Optional or Optional Treatment means a service outside of what the plan covers. Unless specified, a Member will be responsible for the full payment for any "optional" treatment the Member chooses. Member payment for an "optional treatment" will not count towards the Member's Deductible or Out-of-Pocket Maximum.

Other Eligible Provider means nurse anesthetists and blood banks that do not enter into agreements with Us, but Covered Services provided by Other Eligible Providers are available at the In-Network Cost-Sharing.

Out-of-Network Pharmacy is a Pharmacy that does not have an In-Network Pharmacy agreement in effect with or for the benefit of Oscar at the time services are rendered. There are no benefits provided at the time of service when using an Out-of-Network Pharmacy and You will be responsible for the total amount billed. You have the option of submitting a paper claim to Us after services are rendered for reimbursement, however, We will only reimburse based upon any In-Network benefit specified in this Agreement and You will still be responsible for the difference in any amount paid to the Out-of-Network Pharmacy.

Out-of-Network Provider is a Provider that does not have an agreement or contract with Us, or Our subcontractor(s) to provide services to Our Member through negotiated payment arrangements under this Plan. There are no benefits provided when using an Out-of-Network Provider and You may be responsible for the total amount billed by an Out-of-Network Provider. The only exceptions are (1) Covered Services received from an Out-of-Network Provider as a result of a medical Emergency, Urgent Care Visit, or an Authorized Service as defined in this section; and (2) Covered Services received at an In-Network Facility, at which, or as a result of which, the Member receives Covered Services from an Out-of-Network Provider.

Covered Services received from an Out-of-Network Provider under these exceptions are provided at In-Network Cost Sharing.

Out of Pocket Maximum is a specified dollar amount of expense incurred for Covered Services in a Benefit Period as listed in the Schedule of Benefits. Such expense does not include charges for any non-Covered Services.

When the Out-of-Pocket Maximum is reached, no additional Deductible, Copayment or Coinsurance is required unless otherwise specified in this Agreement. In coverage, other than self-only coverage, an individual's payment toward a Deductible, if required, is limited to the individual annual deductible amount. In coverage, other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual Out-of-Pocket Maximum. After a family satisfies the family Out-of-Pocket Maximum, the carrier pays all costs for Covered Services for all family members.

Pharmacy means a licensed retail or home delivery (mail order) Pharmacy.

Physical and/or Occupational Therapy/Medicine is the therapeutic use of physical agents other than Drugs. It comprises the use of physical, chemical and other properties of heat, light, water, electricity, massage, exercise and radiation.

Physician means:

- A doctor of medicine (M.D.) or a doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided.

Plan is the set of benefits, conditions, exclusions and limitations described in this document.

Precertification is a required review of a service, treatment or admission for a benefit coverage determination that must be done before the service, treatment or admission start date. For Emergency admissions, Your authorized representative or Physician must tell Us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time. For the purposes of this document, the term "Precertification" is considered to be synonymous with "pre-authorization" or "prior authorization."

For additional information on Precertification, see the section titled **GETTING APPROVAL FOR BENEFITS.**

Predetermination is an optional, voluntary Prospective or Concurrent Review request for a benefit coverage determination for a service or treatment. We will check Your Agreement to determine if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Agreement or is Experimental/Investigative as that term is defined in this Agreement.

For additional information on Predetermination, see the section titled **GETTING APPROVAL FOR BENEFITS.**

Planholder means the person to whom Oscar has issued this Plan for the benefit of the Covered Individual(s). The Planholder is legally responsible for payment of Premium and any Copayments, Coinsurance and Deductible amounts required under this Plan. The Planholder is not covered under this Plan.

Premium is the monthly charge the Group Health Plan contract holder must pay Oscar to establish and maintain coverage under this Agreement. Premium may also be referred to as Subscription Charge.

Premium Payment(s) means monthly Premium received by Oscar.

Prescription means a written order issued by a Physician.

Prescription Drug (also referred to as legend) means a medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on their original packing label that says, "Caution: Federal law prohibits dispensing without a prescription." This includes the following:

- Compounded (combination) medications, when the ingredients are FDA-approved and require a prescription to dispense, and is not essentially the same as an FDA-approved product from a Drug manufacturer.

A Prescription Drug will be classified by a tier.

- Tier 1 consists of most generic drugs and low cost preferred brand name drugs.
- Tier 2 consists of non-preferred generic drugs, preferred brand drugs and any other drugs recommended by Our pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
- Tier 3 consists of non-preferred brand name drugs or drugs recommended by Our P&T committee based on drug safety, efficacy and cost, that generally have a preferred and often less costly therapeutic alternative at a lower tier.

- Tier 4 consists of drugs that are biologics, drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self- administration, or drugs that cost the health plan more than six hundred dollars ($600) net of rebates for a one-month supply

We also offer coverage from Preventive Prescription Drugs at $0.

Primary Care Physician (PCP) means a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, or for initiating referral for specialist care. A primary care physician may be either a physician who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner. The Physician may work in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other practice allowed by the Plan.

Provider is a professional or Facility licensed by law that provides health care services within the scope of that license and is approved by Us. This includes any Provider that provides You with services that State law requires Us to cover. Providers that deliver Covered Services are described throughout this Agreement. If You have a question about a Provider not described in this Agreement, please call member services at **1- 855-672-2755**.

A Provider is

- Licensed to practice where the care is provided;
- Rendering a service within the scope of that license and such license is required to render the service; and
- Providing a service for which benefits are specified in this Plan.

A Provider includes, but is not limited to, the following:

- Dentist (D.D.S.)
- Optometrist (O.D.)
- Dispensing optician
- Podiatrist (D.P.M.)
- Clinical psychologist
- Certified registered nurse anesthetist (C.R.N.A.)
- Clinical social worker (C.S.W. or L.C.S.W.)
- Marriage, family and child therapist (M.F.C.T.)
- Physical therapist (P.T. or R.P.T.)
- Speech pathologist
- Speech therapist

- Audiologist
- Occupational therapist (O.T.R.)
- Respiratory therapist
- Registered nurse practitioner (R.N.P.)
- Certified nurse midwife
- Psychiatric Mental Health Nurse
- Acupuncturist

Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity such that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others, or
- Immediately unable to provide for, or utilize, food, shelter or clothing, due to the mental disorder.

Qualified Individual means, with respect to Oscar, an individual who has been determined eligible to enroll in a Plan. This individual may be a resident, which means a person whose domicile is in California, or who is present in California for other than a temporary or transitory purpose. We will require a person to provide proof that his or her domicile is California, or that he/she is present in California for other than a temporary or transitory purpose.

Reconstructive Surgery is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to create a normal appearance, to the extent possible.

Residential Treatment Center is an inpatient treatment Facility where the Member resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a Mental Health or Substance Abuse condition. The Facility must be licensed to provide psychiatric treatment of Mental Health and Nervous conditions or rehabilitative treatment of Substance Abuse according to State and local laws.

Self Administered Injectable Drugs means Drugs that are injected which do not require a medical professional to administer.

Service Area is the geographic area within the State of California within which this Agreement is offered and issued. Oscar's Service Area for its small group business includes Los Angeles County and Orange County. Please refer to the **SERVICE AREA** section for a

full list of the zip codes which make up the Service Area. Below are the specific zip codes which make up the Service Area:

Skilled Nursing Facility is a Facility that provides continuous nursing services. It must be licensed according to State and local laws and be recognized as a Skilled Nursing Facility under Medicare.

For purposes of Serious Emotional Disturbances of a Child, Severe Mental Illness, and mental health conditions identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Edition, a Skilled Nursing Facility will also include a Residential Treatment Center, although different Cost-Sharing and no day limits apply.

Specialist (Specialty Care Physician/Provider or SCP) is a Physician who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drugs means high-cost, injectable, infused, oral or inhaled Drugs that generally require close supervision and monitoring of their effect on the patient's Drug therapy by a medical professional. These Drugs often require special handling, such as temperature-controlled packaging and overnight delivery, and are often unavailable at retail Pharmacies. Specialty Drugs can be Tier 1, 2, 3, or 4 drugs.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a Facility. With respect to a pregnant woman who is having contractions, the term "stabilize" also means to deliver (including the placenta), if there is inadequate time to affect a safe transfer to another Hospital before delivery or transfer may pose a threat to the health or safety of the woman or the unborn child.

Standard Medical Treatment refers to any healthcare service, treatment, procedure, facility, equipment, drug, device, or supply that is in general use in the medical community in the United States, and:

- Has been demonstrated through reliable evidence in peer reviewed medical literature to have scientifically established medical value for diagnosing, curing or alleviating the condition being treated; and
- Is appropriate for the hospital or other facility provider in which it is performed; and

- The performing physician or other professional provider has had the appropriate training and experience to provide the service, treatment or procedure.

State means the State of California.

Subscriber is the eligible Employee covered under the Group Health Plan contract.

Tax Dependent has the same meaning as the term Dependent under the Internal Revenue Code.

Tax Filer means an individual, or a married couple, who indicates that he, she or they expect:

- To file an income tax return for the Benefit Year
- If married, per IRS guidelines, to file a joint tax return for the Benefit Year;
- That no other taxpayer will be able to claim him, her, or them as a Tax Dependent for the Benefit Year; and
- That he, she, or they expects to claim a personal exemption deduction on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse or Domestic Partner.

Telehealth shall have the same definition assigned to it as Cal. Bus. & Prof. Code Section 2290.5.

Urgent Care means those services necessary to prevent serious deterioration of Your health resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy. In the case of pregnancy, this would include services necessary to prevent serious deterioration of the health of a woman or her unborn child.

Year and Yearly is a twelve (12) month period starting each January 1 at 12:01 a.m. Pacific Time.

You and Your means the Subscriber/Planholder and any Dependents covered under this Agreement.

YOUR ELIGIBILITY

Who is Covered Under this Agreement
You, the Subscriber to whom this Agreement is issued, are covered under this Agreement. You must work, live, or reside in Our Service Area to be covered under this Agreement. If You are enrolled in Medicare, You are not eligible to purchase this Agreement. Members of Your family may also be covered depending on the type of coverage You selected.

Types of Coverage
We offer the following types of coverage:

- Individual. If You selected individual coverage, then You are covered.
- Individual and Spouse. If You selected individual and Spouse coverage, then You and Your Spouse or Registered Domestic Partner are covered. (Domestic Partner means a person who has established a domestic partnership under California law. For purposes of this Agreement, a Registered Domestic Partner shall be treated the same as a Spouse.)
- Parent and Child/Children. If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.
- Family. If You selected family coverage, then You, Your Spouse or Registered Domestic Partner, and Your Child or Children, as described below are covered.

Children Covered Under this Agreement
If You selected parent and child/children or family coverage, Children covered under this Agreement include Children who are Your natural Children, legally adopted Children, step Children, or newborn children. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You or Your Spouse have been appointed the legal guardian by a court order. Foster Children and grandchildren are not covered.

The attainment of age 26 shall not operate to terminate the coverage of a Dependent child while the child is and continues to be (1) incapable of self-sustaining employment by reason of physically or mentally disabling injury, illness, or condition; and (2) chiefly dependent upon the Subscriber for support and maintenance. In other words, eligibility will continue past the age limit only for those already enrolled Dependent Children who cannot work to support themselves by reason of an intellectual or physical disability. A Dependent Child's coverage will terminate upon attainment of the limiting age unless You submit proof that the Dependent Child is incapable of self sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; or that the Dependent Child is chiefly

dependent upon You for support and maintenance, to the plan within 60 days of receiving such a request from Us. We will send this notice at least 90 days prior to the date the Child attains the limiting age.

Newborn and Adopted Child(ren) of the Subscriber or Subscriber's Spouse will be covered for an initial period of thirty-one (31) days from the date of birth or adoption.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Agreement at any time.

When Coverage Begins

Coverage under this Agreement will begin as follows:

- If You, the Subscriber, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group.
- If You, the Subscriber, do not elect coverage upon becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.
- If You, the Subscriber, marry or enter into a domestic partnership while covered, and We receive notice of such marriage within 60 days thereafter, coverage for Your Spouse and Child starts on the first day of the month following such marriage. If We do not receive notice within 60 days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse or Child.
- Immediate coverage under this Group Health Plan is provided from and after the moment of birth, to each newborn infant of Yours or Your Covered Spouse's.
- Immediate coverage under this Group Health Plan is provided to each minor Child placed for adoption from and after the date on which the adoptive Child's birth parent or other appropriate legal authority signs a written document, including, but not limited to, a health facility minor release report, a medical authorization form, or a relinquishment form, granting Your or Your Spouse the right to control health care for the adoptive Child or, absent this written document, on the date there exists evidence of You or Your Spouse's right to control the health care of the Child placed for adoption.

Special Enrollment Periods

A special enrollment period is a period during which a Qualified Individual or enrollee who previously did not enroll at initial enrollment or annual open enrollment, experiences certain qualifying events or changes in eligibility and due to those events may enroll in, or change enrollment in, their health plan outside of the annual open enrollment period.

Unless specifically stated otherwise, a Qualified Individual or enrollee has sixty (60) calendar days from the date of a triggering event or sixty (60) calendar days of the date of loss of other coverage to enroll in a new plan if the triggering event is one listed below:

- Loss of minimum essential coverage
- An Employee or Dependent has lost or will lose coverage under another employer health benefit plan as a result of
    - termination of his or her employment;
    - termination of employment of the individual through whom he or she was covered as a Dependent;
    - change in his or her employment status or of the individual through whom he or she was covered as a Dependent,
    - termination of the other plan's coverage exhaustion of COBRA or Cal-COBRA continuation coverage,
      cessation of an Employer's contribution toward his or her coverage,
    - death of the individual through whom he or she was covered as a Dependent, or
    - legal separation, divorce or termination of a Domestic Partnership.
- You gain or become a dependent, through birth, marriage, adoption, placement for adoption, entry into a domestic partnership, placement in foster care, or through a child support order or other court order, or other eligible child Dependent status is attained
- Coverage is mandated pursuant to a valid state or federal court order
- Health coverage issuer substantially violated a material provision of the health coverage contract
- Employee or Dependent gains access to new health benefit plans as a result of a permanent move
- An individual has been released from incarceration
- An Employee or Dependent are receiving services from a contracting provider for one of the conditions described in subdivision (c) of California Health & Safety Section 1373.96, and that provider is no longer participating in the prior benefit plan
- An Employee or Dependent is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service
- An individual, not previously a citizen, national, or lawfully present, gains such status
- An Employee or Dependent loses eligibility for Medicaid (Medi-Cal) or a state child health plan

- An Employee or Dependent becomes eligible for Medicaid (Medi-Cal) or a state child health plan

We must receive notice and Premium payment within 60 days of one of these events. The effective date of Your coverage will begin on the first day of the following month, except in the case of birth, adoption, or placement for adoption. See “When Coverage Begins” for details.

TERMINATION

Termination of Coverage

Prior to Termination of Coverage, Plan will provide written Notice describing the circumstances of Termination or impending termination. Coverage under this Agreement will automatically be terminated on the first of the following to apply:

- The Group and/or Subscriber has failed to pay Premiums, and the Grace Period has been exhausted.
- Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.
- For Spouses in cases of divorce, the date of the divorce.
- For Children, until the end of the month in which the Child turns 26 years of age. (See "Children Covered Under this Agreement" for exceptions.)
- For all other Dependents, the end of the month in which the Dependent ceases to be eligible.
- The end of the month during which the Group or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.
- If We can demonstrate fraud or an intentional misrepresentation of material fact under the terms of the Group Health Plan contract by an individual contract holder or Your employer.
- The date that the Group Health Plan Contract is terminated. If We terminate and/or decide to stop offering a particular class of group policies, without regard to claims experience or health related status, to which this Agreement belongs, We will provide the Group and Subscribers at least 90 days' prior written notice. In this case, we will make available to the Group Health Plan contract holder or employer all health benefit plans that it makes available to new group business.
- If We elect to terminate or cease to provide or arrange for the provision of health benefits for new health care service plan contracts in the small group market in this state, We will provide written notice to the Group and Subscriber at least 180 days prior to when the coverage will cease.
- The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
- The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.
- The date there is no longer any enrollee who lives, resides, or works in Our Service Area.
- The Member dies.

"Grace period" refers to a:

- A thirty one (31) day grace period. In this case, the last day of coverage will be 30 consecutive days beginning the day the Notice of Start of Grace Period is dated.

If You have overlapping coverage, and can provide us with proof of this, Oscar may refund up to one (1) month of premium payment.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination. You must pay all outstanding premiums before reinstatement.

If You believe your plan coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a Request for Review. You have the options of coming to Us and/or the Department of Managed Health Care if you do not agree with the plan decision to cancel, rescind or not renew your plan coverage.

You may submit a Request for Review to Oscar by calling 1-855-672-2755, or submitting a request at hioscar.com, or by mailing your written Request for Review to:

Oscar Health Plan of California
12777 West Jefferson Blvd, 1st Floor
Suite 100, Building D
Los Angeles, CA, 90066

Alternatively, You may submit a Request for Review to the Department of Managed Health Care. Requests for Review by the Department of Managed Health Care may be submitted by calling 1-888-466-2219, or online at healthhelp.ca.gov, or by mail to:

Help Center
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, California 95814-2725

Notices Provided During the Grace Period

Oscar may terminate this Agreement in the event the Subscriber fails to remit premiums in full by the due date to Oscar. Oscar will duly notify the Subscriber and send a Notice of Start of Grace Period and provide at least a 30 day grace period in accordance with Section 1365 of the California Health and Safety Code. Nonpayment of premiums includes without limitation payments returned due to insufficient funds and checks post-dated beyond the

30 day grace period. If We terminate this Agreement for nonpayment of premium, We will first give the Subscriber 30 days prior written notice of cancellation. The notice of cancellation will state that this Agreement will not be terminated if the Subscriber makes appropriate payment in full before the end of the 30 day grace period.

Rescission

If within twenty-four (24) months after the effective date of this agreement, we discover any act, practice or omission that constitutes fraud or an intentional misrepresentation of material facts that you or your dependents knew, but did not disclose on your application, we may terminate or rescind this agreement as of the original effective date.

By signing the enrollment application, every Member age eighteen (18) or older acknowledges that they provided true and complete answers to all questions in the application to the best of their knowledge and understood that all answers were important and would be considered in the acceptance or denial of the application. Every Member age eighteen (18) or older further acknowledges that all information responsive to a question on the application was required to be provided in their answers consistent with California law. If Oscar discovers that You committed an act, practice, or omission that constitutes fraud or intentional misrepresentation of material fact is found in the application, Oscar may rescind this Agreement within the first twenty-four (24) months from Your Effective Date. This means that Oscar will revoke Your Agreement as if it never existed back to the original Effective Date.

By signing the application, You additionally acknowledge that all of Your Dependents listed on the application who were eighteen (18) years of age or older read the application and provided true and complete information on the application to the best of Your knowledge. You further acknowledge that to the best of Your knowledge and belief, that You have done everything necessary to be able to assure Oscar that all information about all applicants, including Your children under the age of eighteen (18) listed on the application, was true and complete. Oscar may rescind the entire Agreement, within the first twenty-four (24) months from Your Effective Date, if it discovers that You committed an act, practice or omission that constitutes fraud or intentional misrepresentation of material fact is found in the application. Members other than the individual whose information led to the rescission may be able to obtain coverage as set forth below in Eligibility following Rescission.

This Agreement may also be terminated if You knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this Agreement. Termination for any act, practice or omission that constitutes fraud or any intentional

misrepresentation of material fact will be effective as of the Effective Date of coverage in the case of rescission. We will give You at least thirty (30) days written notice prior to rescission of this Agreement. After the first twenty-four (24) months following Your Effective Date, We may only rescind or terminate Your coverage on the basis of any act, practice or omission that constitutes fraud.

If rescinded, You, consistent with California law, will be required to pay for any services Oscar paid on Your behalf and Oscar will refund any Premium paid by You, less Your medical and Pharmacy expenses that Oscar paid.

If Your Agreement is rescinded, You will be sent a written notice within thirty (30) days that will explain the basis for the decision and Your appeal rights, including the right to request review by Us or the Department of Managed Health Care.

HOW YOUR COVERAGE WORKS

Your Agreement provides a wide range of coverage for health care services. The information contained in this section is designed to explain how You can access Your benefits. Oscar will cover up to the maximum described below for a Covered Service or supply. Review the Schedule of Benefits and the **WHAT IS COVERED – MEDICAL** and **WHAT IS COVERED – PRESCRIPTION DRUGS** sections for information on Deductibles, Out of Pocket Maximums, Copayments/Coinsurance and any per day, Year or visit limits that may be applied to a particular benefit.

Any limits on the number of visits or days covered are listed in the Schedule of Benefits. These benefits are subject to all other provisions of this Agreement as well, which may also limit benefits or result in benefits not being payable.

This is an Exclusive Provider Organization (EPO) Plan. SERVICES MUST BE PERFORMED OR SUPPLIES FURNISHED BY AN IN-NETWORK PROVIDER IN ORDER FOR BENEFITS TO BE PAYABLE UNLESS AN EXCEPTION APPLIES. There are no benefits provided when using an Out-of-Network Provider and You may be responsible for the total amount billed by an Out-of-Network Provider. The only exceptions are (1) Covered Services received from an Out-of-Network Provider as a result of a medical Emergency, Urgent Care, or as an Authorized Service as defined in the **DEFINITIONS** section; and (2) Covered Services received at an In-Network Facility, at which, or as a result of which, the Member receives Covered Services from an Out-of- Network Provider. Covered Services received from an Out-of-Network Provider under these exceptions are provided at In-Network Cost Sharing.

You are responsible for confirming that the Provider You are seeing or have been referred to see is an In-Network Hospital or an In-Network Provider for this Plan. Any claims incurred from a Provider who is not an In-Network Provider under this Plan are considered Out-of-Network services and are not covered. You may be responsible for the total amount billed by an Out-of-Network Provider, even if You have been referred by another Oscar In-Network Provider, unless one of the exceptions listed above applies.

Oscar can help You find an In-Network Hospital or In-Network Provider specific to Your Plan by calling member services at 1-855-672-2755 or access Our website at www.hioscar.com.

Services offered by providers
Some Hospitals and other Providers do not provide one or more of the following services that may be covered under Your Agreement and that You or Your family member might need:

- Family planning;
- Contraceptive services, including Emergency contraception;
- Sterilization, including tubal ligation at the time of labor and delivery;
- Infertility treatments; or
- Abortion

You should obtain more information before You become a Subscriber or select a network Provider. Call Your prospective doctor or clinic, or call Oscar at 1-855-672- 2755 or access Our website at www.hioscar.com to ensure that You can obtain the health care services that You need.

Providers are independent contractors. Oscar is not responsible for any claim for damages or injuries suffered by the Member while receiving care from any Provider.

In-Network Providers include Primary Care Physicians / Providers (PCPs), Specialists (Specialty Care Physicians / Providers (SCPs)), other professional Providers, Hospitals, and other Facilities who contract with Us to care for You. Referrals are never needed to visit an In-Network Specialist or a non-physician who provides mental health/substance abuse services.

To see a Provider, call their office:

- Have Your Identification Card handy. The Provider's office may ask You for Your ID number,
- Tell them You are an Oscar Member,
- Tell them the reason for Your visit.

When You go to the office, be sure to bring Your Identification Card with You.

Provider Status
The Negotiated Fee Rate may vary depending upon whether the Provider is an In- Network Hospital, an In-Network Provider (for Providers other than Hospitals), or Other Eligible Provider, and may vary between Providers within the same category.

In-Network Providers: For Covered Services performed by an In-Network Provider, the Negotiated Fee Rate for Your Agreement is the rate the Provider has agreed with Oscar to accept as reimbursement for the Covered Services. Because In-Network

Providers have agreed to accept the Negotiated Fee Rate as payment in full for those Covered Services, they should not send You a bill or collect amounts above the Negotiated Fee Rate. However, You may receive a bill or be asked to pay all or a portion of the Negotiated Fee Rate to the extent You have a Deductible, Copayment, or Coinsurance. If You receive a bill in excess of Your Cost Share amount, please call Us at 1-855-672-2755 or write to Us at:

Oscar Health Plan of California
12777 West Jefferson Blvd, 1st Floor
Suite 100, Building D
Los Angeles, CA, 90066

Other Eligible Providers: These Providers do not enter into agreements with Us. However, You will be charged In-Network Cost-Sharing for the Covered Services received from these Providers.

Please see the section titled **WHAT IS COVERED - MEDICAL** for additional information.

Note: If You utilize an In-Network Provider, the Provider will send Us a claim on Your behalf. If You utilize an Out-of-Network Provider or Other Eligible Provider, the Provider may or may not file a claim on Your behalf.

Member Cost Share
For certain Covered Services, You may be required to pay all or a part of the Negotiated Fee Rate as Your Cost Share amount (Deductible, Copayment, and/or Coinsurance). See the Schedule of Benefits and the **WHAT IS COVERED – MEDICAL** section for Your Cost Share responsibilities and limitations, or call Us at **1-855-672-2755** to learn how this Plan's benefits or Cost Share amounts may vary by the type of Provider You use.

Oscar will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by Your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network Provider or Other Eligible Provider.

Network Providers are prohibited by their contract with Us from billing or collecting from You for any services that are provided but denied because they are not Medically necessary unless they obtain a written agreement from You wherein You agree to pay for such services. Out-of-Network Providers do not have a contract with Us and You will be

responsible for the total amount billed by an Out-of-Network Provider for services that are denied because they are not Medically Necessary.

Timely Access to Care

We offer timely access for scheduling appointments with an In-Network physician, mental health professional and specialist for medical/surgical services, per state law.

- Urgent care appointments not requiring authorization may be obtained within forty- eight (48) hours of the request for an appointment
- Urgent care appointments requiring authorization may be obtained within ninety-six (96) hours of the request for an appointment
- Non-urgent appointments for primary care may be obtained within ten (10) business days of the request for an appointment
- Non-urgent appointments with specialist physicians may be obtained within fifteen (15) business days of the request for appointment
- Non-urgent appointments with a non- physician mental health care provider may be obtained within ten (10) business days of the request for an appointment
- Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness or other health conditions may be obtained within fifteen (15) business days of the request for an appointment
- Telephone triage or screening service wait time shall not exceed thirty (30) minutes

The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with the professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Members.

Preventive care services, and periodic follow up care, including but not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice.

Oscar provides interpretation services, as described in the **INTRODUCTION** section titled "How to Get Language Assistance." Please see this section for complete instructions and phone numbers to request assistance.

Authorized Referrals
In some circumstances, We may authorize In-Network Provider Cost Share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstance, You or Your Physician or Provider must request Precertification and contact Us in advance of obtaining the Covered Service and obtain Our written approval to have the services provided by Out-of-Network Provider. It is Your responsibility to ensure that We have been contacted. If We certify an In-Network Provider Cost Share amount to apply to a Covered Service received from an Out-of-Network Provider, You will only be responsible for any Copayments, Coinsurance, and/or Deductibles stated in this Agreement. Please contact Us at **1-855-672-2755** for Authorized Referral information or to request authorization. Approvals of authorizations to Out-of-Network Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Out-of-Network Provider You requested. The written authorization (the certification letter) will indicate the specific service that is approved and the specific provider that is approved to provide it. If We approve the authorization, all services performed by the Out-of-Network Provider are subject to a treatment plan approved by Us in consultation with Your In-Network Provider, the Out-of-Network Provider and You.

Out-of-Area Services and Out-of-Network Providers Outside Oscar's Service Area
Outside of Our Service area, Oscar covers only Emergency or Urgent Care services. If You need to go to an Out-of-Network out-of-area Provider for an Emergency or Urgent Care, the charges for that care are covered. Additionally, subject to Our prior approval, We may cover transplant services, or other highly specialized services through an Oscar designated Provider which is Out-of-Area. To the extent that the services of Out-of-Network or out-of-area Providers are covered, You are liable for the applicable Copayments, Coinsurance and/or Deductibles stated in this Agreement.

Travel outside the United States
When You are traveling abroad and need medical care You can call the Oscar Service Center at 1-855-672-2755. They are available 8am-8pm PST, Monday through Friday and 8am-6pm PST on Saturday.

If You need inpatient Hospital care, Your Provider should contact Us for Precertification. If You need Emergency medical care, go to the nearest Hospital. There is no need to call before You receive Emergency care.

Refer to the section titled **GETTING APPROVAL FOR BENEFITS** to learn how to get Authorization when You need to be admitted to the Hospital for non-Emergency care.

For care obtained when You are traveling outside of the United States, You may need to pay for the following services up front:

- Doctor services;
- Inpatient Hospital care; and
- Outpatient services.

You will need to file a claim form for any payments made up front. You can obtain filing forms as well as further information by calling member services at 1-855-672- 2755 or by visiting **www.hioscar.com.**

Additional information on claims for services received while traveling abroad:

- You are responsible, at Your expense, for obtaining an English language translation of foreign country Provider claims and medical records.
- The exchange rate utilized for:
    - Inpatient Hospital care is based on the date of admission.
    - Outpatient and professional services are based on the date of service.
    - You will find the address for mailing the claim on the form.

CLAIMS AND PAYMENTS

A claim is incurred on the date the service is provided to You. This is important because You must be enrolled and eligible to receive benefits on the date the service is provided. A claim must be submitted in order for Us to record the services and consider them for benefits. We will record claims in Our records in the order in which Your claims are processed, not necessarily in the order in which You receive the service or supply.

We only provide benefits for Covered Services that are Medically Necessary. Benefits and benefit limits are described in **WHAT IS COVERED – MEDICAL** and in the Schedule of Benefits.

Claims
Oscar is not liable under this Plan unless proper notice is furnished by You (or someone acting on Your behalf) to Us that Covered Services have been rendered to a Member.

Network Provider Claims
The Network Provider is responsible for filing all Claims in a timely manner. You will not be responsible for any Claim which is not filed on a timely basis by the Network Provider.

Oscar follows all Department of Managed Health Care regulations when it comes to the payment of claims. Please submit Your claims as soon as possible in order to expedite payments. Any benefits determined to be due under this Agreement shall be paid within thirty (30) working days after We receive a complete written proof of loss and determination that benefits are payable.

When using an In-Network Provider they will bill Oscar directly for services rendered to You. In order for the Provider to submit a claim on Your behalf, You must give the Provider information necessary for the claim to be filed, such as Your Oscar ID card.

Contracted providers must submit claims within one hundred eighty (180) calendar days following the dates of service, unless otherwise mandated by law or in the provider contract. A claim received after the one hundred eighty (180) days billing time limit may be subject to a denial.

Out-of-Network Provider Claims
You are required to give notice of any Claim for any services rendered by an Out-of-Network Provider. No payment will be made for any Claims filed by a Member for services

rendered by an Out-of-Network Provider unless You give written notice of such Claim to Oscar within 180 days of the date of service or as soon as reasonably possible.

To give notice of a Claim, please call Us at the phone number listed on Your Identification Card to obtain a Claim form. You must sign the Claim form before Oscar will issue payment to a Provider or reimburse You for services received under this Plan. You must complete a Claim form for services rendered by an Out-of-Network Provider and submit it, together with an itemized bill, to the following address:

Oscar Health Plan of California
P.O. Box 52146
Phoenix AZ, 85072–2146

If You do not receive a Claim form within 15 days after You gave Us notice of the Claim, You shall meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss Section. Such information shall be submitted to the following address:

Oscar Health Plan of California
P.O. Box 52146
Phoenix AZ, 85072–2146

For periodic payment, written proof of loss must be given to Us within 90 days after the end of each period for which Oscar is liable. For any other loss, proof must be given within 90 days after the loss. If You do not furnish such proof of loss within the time required, Your Claim will not be invalidated or reduced, as long as it was not reasonably possible to give proof of loss within the required time, and as long as such proof of loss is furnished as soon as reasonably possible, and in no event, except in the absence of legal capacity, later than one year from the time proof of loss is required.

Payment to Providers and Provider Reimbursement
Benefits for In-Network Providers are based on the Negotiated Fee Rate. In-Network Providers have an agreement in effect with Us and have agreed to accept the Negotiated Fee Rate as payment in full. You will not be required to pay any In- Network Provider for amounts owed to that Provider by Us (excluding Deductible, Copayments/Coinsurance, and services or supplies that are not a covered benefit of the Plan), even in the unlikely event that We fail to pay the Provider. We pay the benefits of this Plan directly to Contracting Hospitals or In-Network Hospitals, In- Network Physicians, medical

transportation Providers, certified nurse midwives, registered nurse practitioners and other In-Network Providers, whether You have authorized assignment of benefits or not.

This is an Exclusive Provider Organization ("EPO") plan. Services from an Out-of-Network Provider are not covered. The only exceptions are (1) Covered Services received from an Out-of-Network Provider as a result of a medical Emergency, Urgent care visit or an Authorized Service as defined in **DEFINITIONS** section; and (2) Covered Services received at an In-Network Facility, at which, or as a result of which, the Member receives Covered Services from an Out-of-Network Provider. Covered Services received from an Out-of-Network Provider under these exceptions are provided at In-Network Cost Sharing.

You will be responsible for any charges for Out-of-Network Providers. You should read the section titled **WHAT IS COVERED – MEDICAL** carefully to determine those differences. Any assignment of benefits, even if assignment includes the Provider's right to receive payment, will not be effective unless an Authorized Referral has been approved by us. In all cases, We will pay Providers directly when Emergency Services and care are provided to You. We will continue such direct payment until the Emergency Care results in stabilization.

Oscar has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Members seeking Emergency Services, Urgent Care services or other services authorized by Us in accordance with this Agreement from Out-of-Network Providers could be balance billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

To maximize Your benefits, be sure to confirm that the Provider (e.g. a Physician or Hospital) You wish to see is an In-Network Provider (for Providers other than Hospitals) under Your Plan (see "Your Network of Providers" in the **INTRODUCTION**). SERVICES MUST BE PERFORMED OR SUPPLIES FURNISHED BY AN IN-NETWORK PROVIDER IN ORDER FOR BENEFITS TO BE PAYABLE. There are no benefits provided when using an Out-of-Network Provider and You may be responsible for the total amount billed by an Out-of-Network Provider. The only exceptions are (1) Covered Services received from an Out-of-Network Provider as a result of a medical Emergency, urgent care or an Authorized Referral as defined in the **DEFINITIONS** section and (2) Covered Services received at an In-Network Facility, at which, or as a result of which, the member receives Covered Services from an Out-of-Network Provider. Covered

Services received from an Out-of-Network Provider under these exceptions are provided at In-Network Cost Sharing.

Reimbursement
In the event You are required to make payment other than a required Copayment, Deductible or Coinsurance amount at the time Covered Services are rendered, We will reimburse You by check. Reimbursement will be made only for Covered Services received in accordance with the provisions of this Plan.

Claim Forms
When We receive the notice of claim, We will send You forms for filing proof of loss. If these forms are not given to You within 15 days after the giving of such notice, You shall meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss Section.

Time of Payment of Claim
Any benefits determined to be due under this Agreement shall be paid and delivered within forty-five (45) working days after We receive a complete written proof of loss and determination that benefits are payable. A claim together with all additional information reasonably necessary to determine Our obligation under this Agreement and reasonable access to information concerning Provider services is required.

Information necessary to determine Our obligation under this Agreement claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for Us to determine the Medical Necessity for the health care services provided.

Submission of Claims
Either the Subscriber or Provider of service must claim benefits by sending Oscar properly completed claims forms itemizing the services or supplies received and the charges. These claim forms must be received by Oscar within one hundred eighty (180) from the date of services or supplies are received. If the claim is for an Out-of- Network Emergency Center or Urgent Care Center, these claim forms must be received by Oscar within one hundred eighty (180) days from the date of services. Oscar will not be liable for benefits if a completed claim form is not furnished to Oscar within this time period, except in the absence of legal capacity. Claims forms must be used, canceled checks or receipts are not acceptable.

Liability of Subscriber to Pay Providers
In accordance with Oscar's In-Network Provider agreements and applicable statutes, Members will not be required to pay any In-Network Provider for amounts owed to that Provider by Oscar (other than Copayments/Coinsurance), even in the unlikely event that Oscar fails to pay the Provider.

Members are liable, however, to pay Out-of-Network Providers for any amounts not paid to those Providers by Oscar.

Note: For Emergency Care rendered within California by an Out-of-Network Provider You will not be responsible for any amount in excess of the applicable cost-sharing set forth in the Schedule of Benefits.

Other Charges
Copayments and Coinsurance are outlined in the Schedule of Benefits. Your Copayment and Coinsurance may be a fixed dollar amount per day, per visit, and/or it may be a percentage of the Negotiated Fee Rate.

Note: You are responsible for confirming that the Provider You are seeing or have been referred to see is an In-Network Provider under Your Plan. Unless an exception (listed in the **HOW YOUR COVERAGE WORKS** section) applies, any claims incurred with a Provider who is not a part of Your Plan's In-Network Providers, will not be covered.

Oscar can help you find an In-Network Provider specific to Your Plan by calling member services at 1-855-672-2755 or visit Us at www.hioscar.com.

These amounts are Your financial responsibility. After Your Deductible is satisfied, Copayments are normally paid by You at the time services are performed. If Your Plan contains a Deductible, You must satisfy the In-Network medical Deductible before We will make payment for services You receive, except for certain services as stated in the sections below. Additionally, the medical Deductible is explained in the Schedule of Benefits. While Your Coinsurance financial responsibility may also be collected by the Provider at the time services are performed, the Provider may choose to bill You for these services after they have submitted the claim to Us. Cost sharing for services with Copayments is the lesser of the Copayment amount or Negotiated Fee Rate.

If You replace Your health care coverage from another health insurance carrier with this Agreement, We will **NOT** apply Deductible or Out-of-Pocket amounts to this Agreement. However, if You replace an Oscar product with another Oscar product, the level of Deductible(s) and Out-of-Pocket Maximum(s) which You satisfied will be transferred to Your new Oscar product.

Described below are Your Coinsurance and Out of Pocket Maximums.

You may be required to pay Coinsurance for services received while You are covered under this Plan. Coinsurance is the percentage amount of the Negotiated Fee Rate that You are responsible for as stated in the Schedule of Benefits.

Out of Pocket Maximum

The Out of Pocket Maximum includes all payments, including Deductibles, Coinsurance and Copayments, which You pay during a Benefit Period for all Essential Health Benefits, medical services, child dental and vision services and Prescription Drug services combined. It does not include amounts You pay for non-Covered Services or Premium Payments.

Your Out of Pocket Maximum is determined by the number of Members enrolled in this Plan. If only one (1) Member is enrolled in this Plan, then only the Individual Out of Pocket Maximum applies. If more than one (1) Member is enrolled in this Plan, then both the Individual Out of Pocket Maximum and the Family Out of Pocket Maximum are applicable.

- Individual Out of Pocket Maximum for one (1) Member
    - Once the total allowable charges applying to the Individual Out of Pocket Maximum have been met, Oscar will provide coverage for 100% of the Negotiated Fee Rate for Covered Services for the remainder of that Benefit Period.
- Family Out of Pocket Maximum for two (2) or more Members
    - If You are a Member in a Family of two (2) or more Members, You reach the Plan Out of Pocket Maximum either when You reach the maximum for any one Member, or when Your Family reaches the Family Out of Pocket Maximum. Once the Out of Pocket Maximum has been met for one (1) Member, Oscar will provide coverage at 100% of the Negotiated Fee Rate for Covered Services for the remainder of that Benefit Period for that Member. In coverage, other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum, and the individual's payments toward a deductible is limited to the individual annual deductible amount. The Member's Individual Out of Pocket Maximum will contribute towards the Family Out of Pocket Maximum.
- All other family Members will be subject to the remainder of the Out of Pocket Maximum until the Family Out of Pocket Maximum is satisfied. All Cost Shares paid for Covered Services by each additional individual Member in a family during a Benefit Period will contribute to the

remainder of the Family Out of Pocket Maximum. Once the total allowable charges applying to the Family Out of Pocket Maximum have been met, Oscar will provide coverage at 100% of the Negotiated Fee Rate for Covered Services for all family members for the remainder of that Benefit Period.

- The Out of Pocket Maximum will be tracked and calculated by Us and You will be informed by Us when You have reached the Out of Pocket Maximum. You should consider retaining receipts for the purpose of verifying the calculation of Your Out of Pocket Maximum.

The Out of Pocket Maximum amounts are listed in the Schedule of Benefits.

The automatic enrollment of a Newborn or Adopted Children may cause the applicable Out of Pocket Maximum to automatically change from the Individual Out of Pocket Maximum to a Family Out of Pocket Maximum. Additional information on Newborn or Adopted Children is explained in the **YOUR ELIGIBILITY** section.

WHAT IS COVERED – MEDICAL

This part describes the Covered Services available under Your Agreement. Covered Services are subject to all the terms and conditions listed in this Agreement, including, but not limited to, Deductibles, Copayments, Coinsurance, exclusions and Medical Necessity requirements. Please read the Schedule of Benefits for details on the amounts You must pay for Covered Services. Also be sure to read the **HOW YOUR COVERAGE WORKS** section for more information on Your Agreement's rules.

Your benefits are described below. Benefits are listed alphabetically to make them easy to find. Services must be performed or supplies furnished by an In-Network Provider in order for benefits to be payable. The only exceptions are (1) Covered Services received from an Out-of-Network provider as a result of a medical Emergency, Urgent Care, or an Authorized Referral as defined in DEFINITIONS; and (2) Covered Services received at an In-Network Facility, at which, or as a result of which, the Member receives Covered Services from an Out-of-Network Provider. Covered Services received from an Out-of-Network Provider under these exceptions are provided at in-network Cost-Sharing.

For a list of services and supplies that are not covered by this Agreement, and important details on excluded services, please refer to **WHAT IS NOT COVERED (EXCLUSIONS) – MEDICAL** and **WHAT IS NOT COVERED (EXCLUSIONS) – PRESCRIPTION DRUGS**.

You should also know that many Covered Services can be received in several settings, including a Physician's office, an Urgent Care setting, an outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where You choose to get Covered Services, and this can result in a change in the amount You need to pay.

Please see the Schedule of Benefits for more details on how benefits vary in each setting.

This agreement only covers services and supplies that are medically necessary. Oscar reserves the right to review services and/or supplies to determine if they are medically necessary prior to those services being rendered (precertification), while services are being rendered (admission review or concurrent review), or after services have been provided (retrospective review). Please refer to the **DEFINITIONS** section for a definition of medically necessary. Additional information on the review process is available in the section titled **GETTING APPROVAL FOR BENEFITS** or call member services.

Eligibility for coverage cannot be based on health status-related factors, such as health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, or any other health status-related factor determined appropriate by the United States Secretary of Health and Human Services. This Agreement does not discriminate against an individual based on any of the following factors: age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

Acupuncture
Please see "Therapy Services" later in this section.

Allergy Services
Please see "Office Visits" and "Office Visits – Additional Services in an Office Setting" later in this section.

Ambulance and Transport Services (Air, Ground and Water)
Precertification is required for all non-Emergency transportation (see the section titled **GETTING APPROVAL FOR BENEFITS** for details).

Medically Necessary ambulance and transport services are a Covered Service when all of the following criteria are met:

- You are transported by a State licensed vehicle that is designed, equipped and used only to transport the sick and/or injured and staffed by Emergency Medical Technicians (EMT), paramedics or other certified medical professionals. Ambulance services include medical and mental health Medically Necessary non-Emergency ambulance transportation, including psychiatric transportation for safety issues. This includes ground, fixed wing, rotary wing or water transportation.
- Any of the following:
    - For ground transportation, You are taken:
        - From Your home, scene of an accident or medical Emergency to a Hospital;
        - Between Hospitals, including when We require You to move from an Out-of-Network Hospital to an In-Network Hospital; or
        - Between a Hospital and a Skilled Nursing Facility (ground transportation) or other approved Facility.
    - For air or water transportation, You are taken:
        - From the scene of an accident or medical Emergency to a Hospital;
        - Between Hospitals, including when We require You to move from an Out-of-Network Hospital to an In-Network Hospital; or
        - Between a Hospital and an approved Facility.
    - Transportation is approved by Oscar.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases We may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or injury by medical professionals during an ambulance service, even if You are not taken to a Facility. If requested through a 911 call, ambulance charges are covered if it is reasonably believed that a medical Emergency existed even if You are not transported to a Hospital. Payment of benefits for ambulance services may be made directly to the Provider of service unless proof of payment is received by Us prior to the benefits being paid.

If you reasonably believe that you are experiencing an emergency, you should call 911 or go directly to the nearest hospital emergency room.

Ground Ambulance
Services are subject to Medical Necessity review by Oscar. All scheduled ground ambulance service for non- Emergency transports, not including acute Facility to acute Facility transport, requires Precertification.

Air and Water Ambulance
Air Ambulance Services are subject to Medical Necessity review by Oscar. We retain the right to select the Air Ambulance Provider. This includes fixed wing, rotary wing or water transportation. Air ambulance services for non- Emergency Hospital to Hospital transports require Precertification. Emergency Air Ambulance Services and appropriately Precertified non-emergency Air Ambulance Services will be paid at the In-Network level of benefits. An Out-of-Network Provider located in California cannot bill You for covered Air Ambulance Services any amounts greater than Your applicable In-Network copayment, coinsurance and deductible. For Emergency Air Ambulance Services and appropriately Precertified non-emergency Air Ambulance Services, You will not pay more than the applicable In-Network copayment, coinsurance and deductible.

Hospital to Hospital Air Ambulance Transport
Air ambulance transport is for purposes of transferring from one Hospital to another Hospital and is a Covered Service if such air ambulance transport is Medically Necessary, for example if transportation by ground ambulance would endanger Your health and the transferring Hospital does not have adequate Facilities to provide the medical services needed. Examples of such specialized medical services that are generally not available at all types of Facilities may include, but are not limited to: burn care, cardiac care, trauma care,

and critical care. Transport from one Hospital to another Hospital is covered only if the Hospital to which the patient is transferred is the nearest one with medically appropriate Facilities, unless otherwise Authorized by Us. Air Ambulance service for non-Emergency Hospital to Hospital transports require Precertification.

Fixed and Rotary Wing Air Ambulance
Fixed wing or rotary wing air ambulance is furnished when Your medical condition is such that transport by ground ambulance, in whole or in part, is not appropriate.
Generally, transport by fixed wing or rotary wing air ambulance may be necessary because Your condition requires rapid transport to a treatment Facility, and either great distances or other obstacles preclude such rapid delivery to the nearest appropriate Facility. Transport by fixed wing or rotary wing air ambulance may also be necessary because You are located in a place that is inaccessible to a ground or water ambulance Provider. Fixed and Rotary Wing Air Ambulance services that are not provided through the 911 emergency response system require Precertification.

Autism
Benefits for Covered Services for the treatment of Autism are provided on the same basis as any other medical condition. Please see "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" later in this part.

Behavioral Health Treatment for Pervasive Developmental Disorder or Autism Benefits for Covered Services and supplies provided for Behavioral Health Treatment for Pervasive Developmental Disorder or Autism are subject to the same cost-sharing provisions as other medical services or Prescription Drugs covered by this Plan, except as specifically stated in this section. These benefits are subject to all other terms, conditions, limitations and exclusions, including **WHAT IS COVERED – MEDICAL.**

Our Provider network will be limited to certain Qualified Autism Service Providers who may supervise and employ Qualified Autism Service Professionals or Paraprofessionals who provide and administer Behavioral Health Treatment for a Provider that has contracted with Oscar.

For purposes of this section Behavioral Health Treatment means professional services and treatment programs, including Applied Behavior Analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with Pervasive Developmental Disorder or Autism and that meet all of the following criteria:

- The treatment is prescribed by a licensed Physician or is developed by a licensed psychologist.
- The treatment is provided under a treatment plan prescribed by a Qualified Autism Service Provider and is administered by one of the following:
    - A Qualified Autism Service Provider.
    - A Qualified Autism Service Professional supervised by the Qualified Autism Service Provider.
    - A Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional.
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six (6) months by the Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with applicable State law that imposes requirements on the provision of Behavioral Health Treatment services. The Qualified Autism Service Provider is required to meet all the requirements listed below in order to serve members who are eligible to receive treatment for Pervasive Developmental Disorder or Autism:
    - Describes the patient's behavioral health impairments or developmental challenges that are to be treated.
    - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
    - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or Autism; and
    - Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate.
- The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to Oscar upon request.

For purposes of this section Applied Behavior Analysis means the design, implementation, and evaluation of systematic instructional and environmental modifications to promote positive social behaviors and reduce or ameliorate behaviors which interfere with learning and social interaction.

For purposes of this section Intensive Behavioral Intervention means any form of Applied Behavioral Analysis that is comprehensive, designed to address all domains of functioning and across all settings, depending on the individual's needs and progress. Interventions can be delivered in a one-to-one ratio or small group format, as appropriate.

For purposes of this section Pervasive Developmental Disorder or Autism includes the following, in accordance with the DSM IV, and as amended in the most recent edition of the DSM:

- Autistic Disorder
- Rett's Disorder
- Childhood Disintegrative Disorder
- Asperger's Disorder
- Pervasive Developmental Disorder Not Otherwise Specified (including Atypical Autism).

For purposes of this section Participating Qualified Autism Service Provider is either of the following:

- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or Autism, provided the services are within the experience and competence of the person who is nationally certified; or
- A person licensed as a Physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to State law, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or Autism, provided the services are within the experience and competence of the licensee.

For purposes of this section Participating Qualified Autism Service Professional is a Provider who meets all of the following requirements:

- Provides Behavioral Health Treatment, which may include clinical case management and case supervision under the direction and supervision of a Participating Qualified Autism Service Provider,
- Is supervised by a Participating Qualified Autism Service Provider,
- Provides treatment pursuant to a treatment plan developed and approved by the Participating Qualified Autism Service Provider,
- Is a behavioral service Provider who meets the education and experience qualifications for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program, as defined in State regulation,
- Has training and experience in providing services for Pervasive Developmental Disorder or Autism pursuant to applicable State law, and Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

For purposes of this section Participating Qualified Autism Service Paraprofessional is an unlicensed and uncertified individual who meets all of the following criteria:

- Is supervised by a qualified autism service provider or qualified autism service professional at a level of clinical supervision that meets professionally recognized standards of practice.

- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Participating Qualified Autism Service Provider.
- Meets the education and training qualifications described in Section 54342 of Title 17 of California Code of Regulations.
- Has adequate education, training, and experience, as certified by a qualified autism service provider or an entity or group that employs qualified autism service providers.
- Is employed by the qualified autism service provider or an entity or group that employs qualified autism service providers responsible for the autism treatment plan.

Coverage is not provided for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to Oscar upon request.

Breast Cancer
Benefits for Covered Services in relation to Breast Cancer are provided, including, screening and diagnosis of breast cancer, consistent with generally accepted medical practice and scientific evidence. Treatment for breast cancer includes coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. See "Prosthetics and Devices," as well as "Inpatient Facility Services," and "Preventive Services" for additional details.

Clinical Trials
Benefits include coverage for services given to You as a participant in an Approved Clinical Trial if the services are Covered Services under this Plan, including routine patient care costs.

Routine Patient Care Costs include Drugs, items, devices, and Health Care Services provided consistent with coverage under the Plan for a Member who is not enrolled in an Approved Clinical Trial, including:

- Drugs, items, devices, and Health Care Services typically provided, absent a Clinical Trial.
- Drugs, items, devices, and Health Care Services required solely for the provision of the investigational Drug, item, device, or Health Care Service.
- Drugs, items, devices, and Health Care Services required for the clinically appropriate monitoring of the investigational Drugs, items, devices, and Health Care Services
- Drugs, items, devices, and Health Care Services provided for the prevention of complications arising from the provision of the investigational Drug, item, device, or Health Care Service.
- Drugs, items, devices, and Health Care Services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include the following:

- The investigational Drug, item, device, or Health Care Service itself
- Drugs, items, devices, and Health Care Services Services provided solely to satisfy data collection and analysis needs that are not used in the clinical management of the Member.
- Drugs, items, devices, and Health Care Services specifically excluded from coverage under this Plan, except for Drugs, items, devices, and Health Care Services Services required to be covered pursuant to the Clinical Trials section of this Plan, or applicable law.
- Drugs, items, devices, and Health Care Services customarily provided free of charge by the research sponsor to a clinical trial participant.

Eligibility to participate in the Clinical Trial will be determined :

- You are eligible to participate in an Approved Clinical Trial, according to the Clinical Trial protocol, for the treatment of cancer or another life-threatening disease or condition (a "life-threatening disease or condition" is a condition from which the likelihood of death is probable unless the course of the condition is interrupted); and either:
  - the referring health care professional is an In-Network Provider and has concluded that Your participation in the Clinical Trial would be appropriate because You meet the conditions of paragraph (i); *or*
  - You provide medical and scientific information establishing that Your participation in the Clinical Trial would be appropriate because You meet the conditions of paragraph (i).

We reserve the right to restrict coverage to an Approved Clinical Trial in California, unless the Clinical Trial is not offered or available through an In-Network Provider in California. If one or more In-Network Providers is conducting a Clinical Trial, We may require You to participate in the Clinical Trial through a specific In-Network Provider if that In-Network Provider accepts You as a Clinical Trial participant.

An "Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life- threatening condition and it meets one of the following requirements:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following: :
  - The National Institutes of Health
  - The federal Centers for Disease Control and Prevention
  - The Agency for Health Care Research and Quality
  - The federal Centers for Medicare & Medicaid Services
  - The United States Department of Veterans Affairs or the United States Department of Defense or the United States Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the

Secretary of the United States Department of Health and Human Services determines meets all of the following requirements:
    - it is comparable to the National Institutes of Health system of peer review of studies and investigations; and,
    - it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.
  - A group or center of any of the following entities, inclusive, the Department of Defense or the Department of Veterans Affairs: the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the federal Centers for Medicare & Medicaid Services.. or
  - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- Studies or investigations done as part of an Investigational new Drug application reviewed by the United States Food and Drug Administration;
- Studies or investigations done for Drug trials which are exempt from the Investigational new Drug application review by the United States Food and Drug Administration.

We may require You to use an In-Network Provider to utilize or maximize Your benefits.

All other requests for Clinical Trials services that are not part of Approved Clinical Trials will be reviewed according to Our Clinical Coverage Guidelines, and any related policies and procedures.

Oscar is not required to provide benefits for the following services. We reserve Our right to exclude any of the following services:

- Services that are given only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- Services that are customarily provided by the research sponsors free of charge to enrollees in the Clinical Trial.

Dental Services

Medically Necessary dental or orthodontic services are covered if they are for direct treatment of cancer or integral to Reconstructive Surgery for cleft palate procedures. Cleft palate is a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Preparing the Mouth for Medical Treatments

Your Agreement includes coverage for Dental Services to prepare the mouth for medical services and treatments such as radiation therapy to treat cancer, preparation for transplants, or initiation of immunosuppressives. Covered Services include:

- Evaluation

- Orthognathic (jawbone) surgery
- Dental X-rays
- Anesthesia

Dental Anesthesia
General anesthesia and associated facility and physician charges for dental procedures rendered in a Hospital or Ambulatory Surgery Center setting is a Covered Service for Members who, as determined by their Provider, meet any of the following conditions:

- Is under nine years of age,
- Is developmentally or physically disabled, or has a serious mental illness or
- Has compromised health or a medical or behavioral condition for which general anesthesia is Medically Necessary; or
- Has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation insurance
- Has a medical condition and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment

We may require Prior Authorization for Dental Anesthesia.

Note: If You decide to receive Dental Services that are not covered under this Agreement, an In-Network Provider who is a dentist may charge You his or her usual and customary rate for those services. Prior to providing You with Dental Services that are not a Covered Service, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about the Dental Services that are covered under this Agreement please call member services at 1-855-672-2755.

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- Has compromised health or a medical or behavioral condition for which general anesthesia is Medically Necessary; or
- Has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation insurance
- Has a medical condition and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment

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Dental Services - Child
The dental benefits only apply to Members until the end of the month in which he/she turns nineteen (19) years old. For Members up to age 19, we cover medically necessary dental services including, but not limited to, diagnostic services, preventive services, restorative services, oral surgery, etc. Dental Services must be found to be medically necessary based on standard dental practices.

This Agreement covers medically necessary dental services, when performed by a Dental Provider (licensed dentist) who is contracted with the Plan. Services performed by a Dental Provider who is not contracted with Us, are not covered, unless you receive prior approval from Us or in the event of a true dental emergency.

We do not provide any incentive or rewards to clinical reviewers for issuing denials for coverage, care or decisions that would result in underutilization. We ensure that all clinical decisions are made only by licensed staff reviewers (license dentist) and are based solely on medical necessity and appropriateness of care, services and the dental plan benefits outlined in this Agreement. We use written clinical criteria and considers the individual members needs when making any decision for medical necessity.

Covered Services
We only cover the procedures and services listed in "Section 1, Covered Services." Requests for benefits beyond what is stated in "Section 1, Covered Services" and the "Limitations and Exclusions", will be considered under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) when found to be medically necessary based on supporting documentation.

Any procedure or service determined to be beyond our medical necessity guidelines or is not found to meet medically necessary based on the supporting documentation, will not be covered under EPSDT or this Agreement. Members will be financially responsible for any charges associated with the procedures or services that exceed their dental benefits and are found not to be dentally necessary.

Oscar covers five categories of pediatric dental services, 1) Diagnostic and Preventative, Routine/Basic Services, 3) Major Services, 4) Medically Necessary Orthodontics and 5) Emergency treatment all subject to annual limitations. Each is subject to a different cost-share as noted in the Schedule of Benefits.

Please reference the table on the following page for procedure codes, descriptions, limitations, and exclusions for the covered services under this Agreement:

Diagnostic and Preventive	Limitations
Periodic Exam (D0120)	One time every six (6) months, per provider
Comprehensive Oral Exam (D0150)	One time per patient, per provider for initial evaluation
Limited and Problem Focused Oral Exam (D0140/D0160)	One time per patient, per provider
Bitewing x-rays (D0270 through D0277)	One (1) (D0270) per date of service Two (2) (billed once as D0272) per six (6) months per provider Three (3) (billed once as D0270 and D0272) per date of service

	Four (4) (billed once as D0274) per six (6) months per provider (age 10+)
Full mouth or Panoramic x-rays (D0210/D0330)	Full Mouth (D0210): One (1) time in any thirty-six (36) months per provider; or Panoramic (D0330): One (1) time in any thirty-six (36) months per provider
Cleanings (D1110/D1120/D4346)	One (1) time, per six (6) months
Fluoride (D1206/D1208)	One (1) time, per six (6) months
Space maintainers (D1510 through D1527) Recement or Rebond (D1551 through D1553)	One (1) appliance, per quad (section) per patient, under 18. Recement or rebond: One (1) time per quad (section) every twelve (12) months, under 18
Sealants (D1351/D1352)	One (1) time, every 36 month on permanent first, second, and third molars
Emergency "Palliative" Treatment (D9110)	One (1) time, per date of service

Routine/Basic Services	**Limitations**
Fillings (Amalgam D2140 through D2161) (Composite D2330 through D2394)	Primary (baby) teeth: One (1) time, per surface, per tooth every twelve (12) months Permanent teeth: One (1) time, per surface, per tooth every thirty-six (36) months
Prefabricated crowns (stainless steel and resin) (D2929 through D2399)	Primary (baby) teeth: One (1) time, per surface, per tooth every twelve (12) months Permanent teeth: One (1) per surface per tooth every thirty-six (36) months
Crown repair (D2980)	Covered after twelve (12) month from initial crown placement with, same provider
Deep cleanings (D4341/D4342)	One (1) time, per quad (section) in any twenty-four (24) month period, ages 13+
Periodontal maintenance	One (1) time, every three (3) months (after a Deep Cleaning)

Major Services	Limitations
Crowns (D2710 through D2791)	One (1) time, per tooth, every five (5) years, ages 13+
Gingivectomy (D4210/D4211) and Osseous Surgery (D4260/D4261)	One (1) time, per quad (section) every thirty-six (36) months, ages 13+
Extractions (D7110 through D7250)	Subject to evidence of medical necessity
All other major Oral Surgery (D7260 through D7999)	Subject to evidence of medical necessity
Anesthesia: Deep Sedation (D9222/D9223) Nitrous Oxide (D9230) IV Conscious Sedation (D9239/D9243) Non-IV Conscious Sedation (D9248) (Covered in conjunction with approved oral surgery services)	Covered when documented local anesthesia is not possible, such as severe mental or physical handicap, extensive surgical procedures, an uncooperative child, an acute infection at the injection site, or a failure of local anesthetic to control pain. Covered when dispensed in a dental office by a practitioner acting within scope of his/her licensure. *Not covered for treatment of patient nervousness/apprehension.

Endodontics

We cover procedures for treatment of diseased pulp chambers, pulp canals, as follows: 1) therapeutic pulpotomy, 2)canal procedures, 3) apexification/recalcification and 4) apicoectomy, where Hospitalization is not required. Therapeutic pulpotomy is included with cost of a root canal procedure if the root canal procedure was complete within forty-five (45) days of pulpotomy.

Endodontic Service	Limitation
Therapeutic pulpotomy (D3220)	One (1) time, per primary (baby) tooth
Pulpal debridement (D3221) Partial pulpotomy (D3222) Pulpal therapy (D3230/D3240	One (1) time, per tooth
Root canal procedures: Anterior (front) tooth (D3310) Pre-molar (middle) tooth (D3320)	One (1) time, per tooth

Molar (back) tooth (D3330)	
Root canal retreatments: Anterior (front) tooth (D3346) Pre-molar (middle) tooth (D3347) Molar (back) tooth (D3348)	One (1) time, per tooth, after twelve (12) months of initial treatment
Apexification (D3351/D3352)	One time, per tooth
Apicoectomy(D3410 through D3426)	Subject to evidence of medical necessity

Prosthodontics:

We cover removable completed and partial dentures. Fixed dentures bridges are covered only when the specific dental criteria is met.

Prosthodontic Service	Limitation
Full/Completes (D5110/D5120)	One (1) appliance, per arch every five (5) Year period, from a previous complete, immediate or overdenture
Partial Dentures (D5211 through D5214)	One (1) appliance, per arch every five (5) Year period, from a previous complete, immediate or overdenture
Full/Complete Immediate Dentures (D5130/D5140)	One (1) appliance, per patient. Subsequent complete dentures are not a benefit within a five (5) year period of an immediate denture.
Partial Immediate Dentures (D5221 through D5224)	One (1) appliance, per ach, per patient. Subsequent complete dentures are not a benefit within a five (5) year period of an immediate denture.
Denture Adjustments (D5410 through D5422)	Two (2) per arch, every twelve (12) months, one (1) per arch per date of service per provider
Full/Complete Denture Replacement of missing or broken teeth (D5520)	Four (4) per arch per provider, limited to twice (2) every twelve (12) months per provider
Denture repairs (D5511through D6630)	One (1) time, per date of service, per provider, two (2) every twelve (12) months per provider

Replace broken teeth, per tooth (D5640)	Four (4) teeth, per arch, per date of service per provider, two (2) per arch every twelve (12) months per provider
Add tooth to existing partial denture (D5650)	Three (3) teeth, per arch per, date of service per provider, once (1) per tooth
Add clasp to existing partial denture, per tooth (D5660)	Three (3) teeth, per date of service per provider, once (1) per tooth
Denture Relines (D5730 through D5761)	One (1) per appliance, every twelve (12) months, covered six (6) months after initial placement of denture if extractions were required, twelve (12) months after initial placement of denture if extractions were not required
Tissue conditioning (D5850/D5851)	Two (2) every thirty-six (36) months
Overdentures (D5863 through D5866)	One (1) appliance, per arch every five (5) Year period, from a previous complete, immediate or overdenture

Fixed Bridge Criteria

1. Fixed bridges – made of cast, porcelain fused to metal, or resin with predominantly base metal are covered once, per tooth every five (5) year period, age 13+ as follows:

- When it is necessary to replace a single missing permanent tooth on one side of an arch and the patient's oral condition allows for supporting (abutment) teeth on each side of the missing tooth.
- When a patient has medical condition that prevents the use of a removable partial denture. If a fixed bridge is used when a partial denture could satisfactorily restore the case, it is considered an Optional Treatment
- Fixed bridges are not covered in the presence of untreated moderate to severe periodontal disease or when a proposed supporting tooth/teeth has a poor outcome.
- Fixed bridges used to replace missing posterior (back) teeth are considered Optional Treatment when the supporting teeth would only be crowned only for the purpose of supporting a pontic (fake tooth).
- Fixed bridges are considered Optional Treatment when provided in connection with a
- partial denture on the same arch
- Replacement of a fixed bridge is covered only if the existing bridge cannot be made satisfactory by repair
- A cantilever bridge (supported on one end only) is not covered for the replacement of missing posterior teeth.

Denture Criteria

1. Dentures, including full/partial maxillary (upper) and full/partial mandibular (lower) with clasps, stress breakers and prosthetics are covered as follows:
    - When it is necessary to replace posterior teeth on both side of an arch and the patient's oral condition allows for supporting (abutment) teeth to hold the denture in place
    - Partial dentures are not covered in the presence of untreated moderate to severe periodontal disease or when a proposed supporting tooth/teeth has a poor outcome.
    - Full and partial dentures are not be covered for replacement if an existing appliance can be made satisfactory by a denture relining or repair
    - Immediate dentures are inserted directly after the removal of teeth and are used during the healing process. Replacement of immediate dentures with a complete denture is not covered, see the limitation listed above.

Implants:

We only cover implants and implant related services when exceptional medical conditions are present. Implants are not covered for replacement of teeth due to decay, periodontal disease or to restore occlusion (bite) due to tooth loss or due to normal aging of the patient.

Implants	Limitations
Implants and implant related services (D6010 through 6199)	Only a benefit when an exceptional medical conditions are met

Implants Exception Medical Conditions:

- Exception medical conditions that may be considered for implants services are as follows:
    - Cancer of the oral cavity requiring surgery and/or radiation leading to destruction of alveolar bone, where the missing osseous structures are unable to support removable denture.
    - Severe deterioration of the gums on the upper and/or lower arches that cannot be corrected with oral surgery procedures, and the patient is unable to function with a removable denture.
    - Skeletal deformities that prevents the use of removable dentures (such as arthrogryposis, ectodermal dysplasia, partial anodontia and cleidocranial dysplasia).
    - Traumatic destruction of jaw, face, or head where the remaining structures are unable to support a removable denture.
    - Special Needs patients may qualify for implant services. Special Needs Patients are defined as those patients who have a physical, behavioral, developmental, or emotional condition that prohibits them from adequately responding to a provider's attempts to perform an examination.

Orthodontics
We cover medically necessary orthodontia. Medically Necessary Orthodontia is defined when a member has "handicapping malocclusion". An orthodontic (HLD) score of 26 points of higher is required for medically necessary orthodontia. All orthodontic treatment must be prior authorized by Us before treatment and banding are completed. If for any reason orthodontic services are terminated or coverage is terminated before completion of the approved orthodontic treatment, Our responsibility will cease with payment through the month of termination.

Medically Necessary Orthodontia	Limitations
Orthodontic services (D8080 through D8704)	One (1) per course of treatment, regardless of plan year, as long as member remains eligible for dental benefits

Orthodontic Criteria
The determination of Medical Necessity will be made by the Provider in accordance with guidelines established by Us. When there is a conflict of opinion on whether or not a service or procedure is Medically Necessary between the Provider and Us, Our opinion will be final. You or Your orthodontist should send Your treatment plan to Us to find out if it will be covered under this Agreement.

Orthodontia procedures will only be approved, as follows:

- When a patient has dentofacial abnormalities that severely compromise the patient's physical health
- When serious handicapping malocclusion is present. The presence of a serious handicapping malocclusion is determined by the severity of the following:
    - Degree of malalignment;
    - Missing teeth;
    - Angle classification;
    - Overjet and overbite;
    - Open bite and crossbite.

Emergency Dental
We Cover emergency dental care. Emergency treatment is covered when there is an serious threat to the patient's health and treatment is needed to relieve severe pain and suffering and to protect the patient's ability to maintain and/or regain life or health. Emergency dental care is not subject to Our Preauthorization.

Dental Exclusions

We do not cover the following:

- Any dental procedures not specially listed as covered under this Agreement, Policy or Rider.
- Dental procedures provided to patients by a Provider who is not contracted with Us, except when immediate dental treatment is required as a result of a Dental Emergency occurring more than 50 miles from the Member's home.
- Dental procedures or services performed solely for Cosmetic purposes
- Dental procedures, in which in the opinion of the attending dentist, are not necessary to
- the patient's dental health.
- Any dental services, or appliances, determined not to be medically necessary and/or reasonable for maintaining or improving the patient's health, as determined by Us.
- Dental services that are received as Emergency Care, in which in Our opinion are not to treat a true dental emergency.
- Experimental or investigational procedures, including any treatment, therapy, procedure or drug, facility, equipment, devise, or supply which is not recognized as being in accordance with general accepted dental standards.
- Additional treatment costs incurred because a dental procedure cannot be performed in
- the dentist's office due to the general health and physical limitations of the patient
- Services of a Pedodontist (pediatric dentist), except when the Member is unable to be treated by his/her contracted provider, or treatment by a Pedodontist is medically necessary, or his/her contracted provider is a Pedodontist.
- Dental expenses incurred after termination of coverage or prior to the date of eligibility
- Hospital charges of any kind. Refer to your Health Plan for benefit information.
- Major surgery for fracture or dislocations
- Elective procedures, including prophylactic (preventive) extractions of third molars (wisdom teeth).
- The replacement of Dentures, Crowns, Fixed Bridges, or other appliances that have been lost, stolen or damaged.
- Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a Covered Service in this Agreement, Policy or Rider.
- Any services related to pathology laboratory fees
- Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or another public program other than Medicaid or Medicare.
- Treatment required due to an accident from an external force or are intentionally self-inflicted, unless otherwise listed as Covered Service.
- Services that restore tooth structure due to attrition, erosion, or abrasion
- Broken appointment fees
- Prescription or nonprescription drugs, home care items, vitamins, or dietary supplements and/or dispensing of drugs not normally supplied in a dental office.
- The following are not included as Orthodontic benefits:
    - Repair or replacement of lost or broken appliances;

- Retreatment of Orthodontic cases;
- Treatment involving: Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia; Hormonal imbalances or other factors affecting growth or developmental abnormalities, unless specifically covered as medically necessary orthodontia;
- Treatment related to temporomandibular joint disorders, unless specifically covered as medically necessary orthodontia;
- Composite or ceramic brackets, lingual adaptation of Orthodontic bands and other specialized or Cosmetic alternatives to standard fixed and removable Orthodontic appliances.
- Invisalign services are excluded.

Appeals

You have the right to file an appeal. An appeal is a request by a patient, a provider acting on behalf of the patient, or other authorized individual to review an action by Us to delay, modify or deny dental services, in whole or in part.

If you are not satisfied with Our determination, you have 180 calendar days from the date listed on the notice of determination to file an appeal. An appeal allows you to submit additional information that is relevant to your claim and to ask Us to review it. You may include documents, records, or other written information with your appeal. You can also request, free of charges, copies of all relevant documents used by Us and used in the review of your appeal.

You can send your written appeal to:

LIBERTY Dental Plan of California, Inc.
Attn: Grievances and Appeals
Quality Management Department
P.O. Box 26110, Santa Ana, CA 92799-6110
Fax: 833-250-1814
Online: www.libertydentalplan.com

Or you can contact Our Member Services Department by telephone at 1-855-672-2755.

If your situation meets the definition of urgent under the law, LIBERTY will complete and expedited review of your appeal. Generally, an urgent situation is one in which your health may be in serious jeopardy, or you are experiencing severe pain that cannot be adequately controlled while waiting for the standard review process. Upon review that your case does qualify as urgent and for expedited review, We will resolved your appeal within three (3) calendar days of receipt, or sooner, based on your condition.

IMPORTANT: You are not required to wait for a determination from LIBERTY, before contacting the DMHC for urgent cases. You can contact the DMHC as noted below, at any time.

Durable Medical Equipment and Medical Devices

Your Agreement includes benefits for durable medical equipment and medical devices when the equipment meets the following criteria:

- Can withstand repeated use and is not disposable
- Generally is not useful to a person in the absence of illness or injury
- Is appropriate for use in an individual's home or may be necessary for use at other locations or in the community to allow basic activities of daily living (ADLs)
- Is only for the use of the patient
- Is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience
- Is ordered by a Physician

Benefits include purchase-only equipment and devices (e.g., crutches), purchase or rent to purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be approved. We may limit the amount of coverage for ongoing rental of equipment as medically appropriate. We may not cover more in rental costs than the cost of purchasing the equipment.

We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment. We do not Cover over-the-counter durable medical equipment.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and We select the vendor. You must return rental equipment to the vendor from whom it was obtained. We cover the following durable medical equipment for use in your home (or another location used as Your home):

- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies
- Dry pressure pad for a mattress
- IV pole
- Enteral pump and supplies
- Bone stimulator
- Cervical traction (over door) equipment

- Phototherapy blankets for treatment of jaundice in Newborns
- Non-segmental home model pneumatic compressor for the lower extremities
- Nebulizer and supplies
- Peakflow meters
- Traecheostomy tube and supplies

We retain the right to determine if DME items shall be leased or purchased.

Custom equipment is only covered when:

- appropriate conventional or pre-fabricated equipment is not available (e.g. contracture or deformity interferes with fitting) or
- pre-fabricated equipment is not expected to result in a clinically equivalent outcome.

Orthotics and Special Footwear

When Medically Necessary, benefits are available for:

- Orthotics (braces, boots, splints) for foot disfigurements resulting from bone deformity, motor impairment, paralysis, or amputation. This includes but is not limited to, disfigurement caused by cerebral palsy, arthritis, polio, spina bifida, diabetes, accident, injury, or developmental disability, and
- Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent or treat diabetes-related complications

Covered Services include determining if You need the device, initial purchase, fitting, adjustment, and repair.

Prosthetics and Devices

Your Agreement includes benefits for prosthetics, which are artificial substitutes for body parts for functional or therapeutic purposes, when they are Medically Necessary for activities of daily living.

Benefits include the purchase, fitting, adjustments, repairs and replacements. Covered Services may include, but are not limited to:

- Artificial limbs and accessories
- One pair of glasses or contact lenses used after surgical removal of the lens(es) of the eyes
- Breast prosthesis (whether internal or external) after a Medically Necessary mastectomy, as required by the Women's Health and Cancer Rights Act. Custom-made prostheses when Medically Necessary and up to three (3) brassieres required to hold a prosthesis every twelve (12) months and adhesive skin support attachment for use with external breast prosthesis
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines

- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury or congenital defect
- Colostomy supplies
- Restoration prosthesis (composite facial prosthesis)
- Prosthetic devices (except electronic voice producing machines) to restore a method of speaking after laryngectomy
- Cochlear implants

Medical and Surgical Supplies

Your Agreement includes coverage for medical and surgical supplies that serve only a medical purpose, are used once, and are purchased (not rented). Covered supplies include syringes, needles, surgical dressings, splints, and other similar items that serve only a medical purpose. Covered Services do not include items often stocked in the home for general use like bandages, thermometers, and petroleum jelly.

Blood and Blood Products

Your Agreement includes coverage for the administration of blood. Benefits include Hospital services for blood, blood plasma, blood derivatives and blood factors, and blood transfusions, including blood processing and storage costs.

Ostomy and Urological Supplies

We cover ostomy and urological supplies in Our Service Area when Medically Necessary and distributed by an In-Network Provider. Coverage is limited to the standard supply that adequately meets Your medical needs, which may include:

- Ostomy supplies: adhesives (liquid, brush, tube, disc or pad); adhesive removers; ostomy belts; hernia belts; catheters; skin wash/cleaner; drainage bags and bottles (bedside and leg); gauze pads; irrigation supplies (faceplate, sleeve, bag, cone, catheter); lubricants; urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; stoma caps; colostomy plugs; ostomy inserts; urinary, drainable ostomy pouches; barriers; pouch closures; ostomy rings; ostomy face plates; skin barriers; skin sealants; waterproof and non-waterproof tape; catheter insertion trays; and gloves.
- Urological supplies: adhesive catheter skin attachments; catheter insertion trays with and without catheter and bag; male and female external collecting devices; male external catheter with integral collection chamber; irrigation tubing sets; indwelling catheters; foley catheters; intermittent catheters; cleaners; skin sealants; bedside and leg drainage bags; bedside bag drainage bottles; catheter leg straps and anchoring devices; irrigation trays; irrigation syringes; bulbs and pistons; lubricating gels; sterile individual packets; tubing and connectors; catheter clamp or plug; penile clamp; urethral clamp or compression device; waterproof and non-waterproof tape; and catheter anchoring device.

Diabetic Equipment and Supplies
Diabetic equipment and supplies for the treatment of diabetes are covered. Please see the "Diabetes Equipment, Education and Supplies" section.

Asthma Treatment Equipment and Supplies
Benefits are available for inhaler spacers, nebulizers (including face masks and tubing), and peak flow meters when Medically Necessary for the management and treatment of asthma, including education to enable the Member to properly use the device(s).

Emergency Care
Medically Necessary services will be covered whether You get care from an In- Network or Out-of-Network Provider. For information on Your Cost Shares for Emergency Services, please see the Schedule of Benefits, **HOW YOUR COVERAGE WORKS** section and the "Ambulance Services" provision above.

Emergency Services
Benefits are available for services and supplies to treat the onset of symptoms for an Emergency, which is defined below.

Emergency (Emergency Medical Condition)
"Emergency" or "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably expect one or more of the following to result:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Such conditions include but are not limited to, chest pain, stroke, poisoning, serious breathing problems, unconsciousness, severe burns or cuts, uncontrolled bleeding, or seizures.

Emergency Dental Service (covered by your LIBERTY Dental Plan) is defined in the California Health & Safety Code, to include a dental screening, examination, evaluation by dentist or Specialist to determine if an Emergency Dental Condition exists, and to provide care that would be acknowledged as within professionally recognized standards of dental care and in order to alleviate any emergency symptoms in a dental office/clinic setting and emergency department in a hospital. Emergency medical services may be an allowable

benefit, in accordance with the Schedule of Benefits. LIBERTY shall provide benefits for such emergency dental services and shall ensure the availability of a provider in the event that an on-call network provider is unavailable in a dental setting or hospital. LIBERTY does not cover services that LIBERTY determines were not dental in nature.

Emergency Dental Services shall also include coverage for urgently needed services outside of the service area to prevent serious deterioration of Your health resulting from unforeseen illness or injury for which treatment cannot be delayed until You return to the plan's service area.

Emergency includes being in Active Labor when there is inadequate time for a safe transfer to another Hospital prior to delivery, or when such a transfer would pose a threat to the health and safety of the Member or unborn child.

Emergency Medical Condition includes a Psychiatric Emergency Medical Condition, which is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or herself or to others, or
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Emergency Care

With respect to an Emergency Medical Condition or a Psychiatric Emergency Medical Condition:

- A medical screening, examination, and evaluation by a physician and surgeon, or by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or Active Labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.
- An additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

The care and treatment to relieve or eliminate a Psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a general acute care hospital, or to an acute psychiatric hospital.

If You are experiencing an Emergency please call 911 or visit the nearest Hospital for treatment.

Medically Necessary Emergency services will be covered whether You get care from an In-Network or Out-of-Network Provider. Emergency Care You get from an Out-of- Network Provider will be covered as an In-Network service.

If You are admitted to an Out-of-Network Hospital from the Emergency room, be sure that You or Your Physician calls Us as soon as possible for ongoing (concurrent) medical necessity review. See the section titled **GETTING APPROVAL FOR BENEFITS** for more details. If You or Your Physician do not call Us, You may have to pay for services that are not Medically Necessary.

Treatment that You get after Your condition has stabilized is not Emergency Care. If You continue to get care from an Out-of-Network Provider, You may have to pay for services unless We agree to cover it as an Authorized Service.

Family Planning Services

Covered Services include:

- Family planning counseling and education (see "Health Education" and "Preventive Care" later in this section)
- Over the counter FDA approved contraceptive methods as prescribed by a health care Provider (see "Preventive Care" later in this section)
- Women's contraceptives and sterilization procedures (see "Preventive Care" later in this section)
- Abortions

Foot Care

Coverage is provided for:

- Routine foot care (including the cutting or removal of corns and calluses).
- Nail trimming, cutting or debriding.
- Hygienic and preventive maintenance foot care.
- Cleaning and soaking the feet.
- Applying skin creams in order to maintain skin tone.
- Other services that are performed when there is not a localized illness, injury or symptom involving the foot.

Habilitation Services

Please see "Rehabilitation and Habilitation Services" later in this section.

Health Education
Health education counseling, programs and material to help You take an active role in protecting and improving Your health, including programs for tobacco cessation, chronic conditions (such as diabetes and asthma) and stress management.

Home Care Services
Precertification is required for Home Care Services (see the section titled **GETTING APPROVAL FOR BENEFITS** for details).

Benefits are available for Covered Services performed by a Home Health Care Agency or other professional Provider in Your home. To be eligible for benefits, You must essentially be confined to the home, as an alternative to a Hospital stay, and be physically unable to get needed medical services on an outpatient basis. Services must be prescribed by a Physician and the services must be so inherently complex that they can be safely and effectively performed only by qualified, technical, or professional health staff. Covered Services include but are not limited to:

- A registered nurse
- A medical social service worker
- Diagnostic services
- Nutritional guidance
- Training of the patient and/or family/caregiver
- A health aide who is employed by, or under arrangement with, a Home Health Agency or Visiting Nurse Association. A health aide is covered only if You are also receiving the services of a registered nurse or licensed therapist employed by the same organization and the registered nurse is supervising the services
- A licensed therapist for Physical Therapy, Occupational Therapy, speech or respiratory therapy
- Necessary medical supplies provided by the Home Health Agency or Visiting Nurse Association

Limitations:
- Up to 100 visits per Calendar Year.
- The ordering Physician must be treating the illness or injury necessitating the Home Health Care and renew the order for these services once every thirty (30) days.
- Providers in California must be a California licensed Home Health Agency or Visiting Nurse Association.
- We will not cover personal comfort items.

Hospice Care

Precertification is required for Hospice Care (see the section titled **GETTING APPROVAL FOR BENEFITS** for details). The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care. An interdisciplinary team includes, but is not limited to, the enrollee and the patient's family, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.
- Short-term inpatient Hospital care when needed in periods of crisis.
- Short-term inpatient Hospital care as respite care. Inpatient respite care is limited to a maximum of five (5) consecutive days per admission.
- Skilled nursing services, which shall be available on a 24-hour on-call basis, home health aide services and homemaker services given by or under the supervision of a registered nurse.
- Social services and counseling services provided by a licensed social worker.
- Nutritional support such as intravenous feeding and feeding tubes or hyperalimentation
- Physical Therapy, Occupational Therapy, speech therapy and respiratory therapy given by a licensed therapist.
- Pharmaceuticals, medical equipment and supplies needed for the palliative care of Your condition, including oxygen, related respiratory therapy supplies and incontinence supplies.
- Bereavement (grief) services for the Member and the Member's direct family members.

Your Physician and Hospice medical director must certify that You are terminally ill and likely have less than six (6) months to live. Your Physician must agree to care by the Hospice and must be consulted in the development of Your care plan. The Hospice must keep a written care plan on file and provide it to Us upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care are available to the Member in Hospice. These additional Covered Services will be covered under other sections of this document.

Limitations:

The following services, supplies or care are not covered:

- Services or supplies for personal comfort or convenience, including homemaker services that are not under the supervision of a registered nurse
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition

- Services not directly related to the medical care of the Member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services
- Services provided by volunteers

Human Organ and Tissue Transplant (Bone Marrow/Stem Cell) Services
Please see "Transplant Services" later in this part.

Infertility
We will standardly cover fertility preservation services as basic healthcare services in the case that You receive a covered treatment that directly or indirectly causes iatrogenic infertility.

We cover diagnostic and exploratory procedures to determine infertility, including surgical procedures to correct diagnosed diseases or conditions.

Limitations: Procedures such as artificial insemination, IVF, GIFT and ZIFT, which are not essential to the protection of an individual's health, are not covered. Coverage does not include: services for procurement and storage of donor semen/eggs and drugs for infertility treatment.

Inpatient Facility Services
We may authorize a lower level setting of services for coverage under this Plan in lieu of a Hospital. Members must seek Prior Authorization from Oscar before obtaining services (except Emergency care or Emergency ambulance services). If You do not get Prior Authorization, You may have to pay for services completely out of pocket.

Precertification is required for all inpatient Facility admissions and stays. Precertification is NOT required for emergency admissions and the length of Hospital stays associated with mastectomy and lymph node dissections. For emergency admissions, You, Your authorized representative or Physician must tell Us within forty- eight (48) hours of the admission or as soon as possible within a reasonable period of time (see the section titled **GETTING APPROVAL FOR BENEFITS** for details).

Inpatient Facility Care
Covered Services include acute care in a Hospital or Residential Treatment Center setting. Benefits for room, board, and nursing services include:
- A room with two or more beds.
- An approved room in a Special Care Unit. The unit must have Facilities, equipment, and supportive services for intensive care or critically ill patients.

- A private room, if medically necessary
- Meals, special diets.
- General nursing services.
-

Benefits for ancillary services include:

- Operating, childbirth, and treatment rooms and equipment.
- Prescribed Drugs.
- Anesthesia and oxygen supplies and services given by the Hospital.
- Medical and surgical dressings and supplies, casts, and splints.
- Diagnostic services.
- Therapy services.

Inpatient Professional Services

Covered Services include:

- Medical care visits.
- Intensive medical care when Your condition requires it.
- Benefits include treatment by two or more Physicians during one Hospital stay when the nature or severity of Your health problem calls for the skill of separate Physicians.
- A personal bedside exam by another Physician when requested by Your Physician. Benefits are not available for staff consultations required by the Hospital, consultations asked for by the patient, routine consultations, phone consultations, or EKG transmittals by phone.
- Surgery and general anesthesia.
- Newborn exam. A Physician other than the one who delivered the child must perform the exam.
  Professional charges to interpret diagnostic tests such as imaging, pathology reports, and cardiology.

Maternity Care

Maternity Services

If You would like to participate in Our Maternity Care program, please call Us at 1-855-672-2755 to notify Us of Your estimated date of delivery, Your Physician's name, and the name of the Hospital You have chosen for delivery of Your child. The Maternity Care program is a no-cost program which helps expectant women establish a healthy lifestyle for a healthy pregnancy. Participation in the Maternity Care program is not required nor does it impact eventual coverage of Your maternity services.

Covered Services include services needed during a normal or complicated pregnancy and services needed for a miscarriage including:

- Professional and Facility services for childbirth in a Facility or the home including the services of an appropriately licensed nurse midwife;
- Planned deliveries at home are covered with Prior Authorization;

- Routine nursery care for the Newborn during the mother's normal Hospital stay, including circumcision of a covered male Dependent and screening of a Newborn for genetic diseases provided through a program established by law or regulation;
- Prenatal and postnatal services;
- Fetal screenings, which are genetic or chromosomal tests of the fetus.
- Prenatal genetic testing for specific genetic disorders for which genetic counseling is available;
- Prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy and
- Participation in the Expanded Alpha Feto Protein Program, a statewide prenatal testing program administered by California's State Department of Health Services.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on these benefits, call Us at the number on the back of Your Oscar ID card.

Maternal Mental Health

We cover a Maternity Health program that includes education of Maternity Care benefits (see above). You may contact Oscar's Member Services team and elect to enroll in Oscar's Maternity Health Program. The Oscar Maternity Health Program will provide the following:

- Education of maternity benefits, including mental health benefits.
- An initial medical and mental health assessment
- The opportunity to collaborate with an Oscar nurse to establish an optional care plan including outreach cadence
- A post-delivery communication within 21-56 days to assist with post-partum medical service planning, as well as an additional mental health assessment.

Oscar ensures You are aware of mental health services and how to receive them. Post-delivery communication includes support in scheduling a visit with a mental health provider through Oscar's behavioral health services partner, Optum, if You choose to pursue such services.

Note: Under Federal law, We may not limit benefits for any Hospital length of stay for childbirth for the mother or Newborn to less than forty-eight (48) hours after vaginal birth, or less than ninety-six (96) hours after a cesarean section (C-section). However, Federal law as a rule does not stop the mother's or Newborn's attending Provider, after consulting with the mother, from discharging the mother or her Newborn earlier than forty-eight (48) or ninety-six (96) hours, as applicable. In any case, as provided by Federal law, We may not require a Provider to get Precertification from Us before prescribing a length of stay which is not more than forty-eight (48) hours for a vaginal birth or ninety-six (96) hours after a C-section. If the inpatient care is for a time less than forty-eight (48) or ninety-six (96) as applicable, a post-discharge follow up visit for the mother and Newborn within forty-eight (48) hours of discharge is covered when prescribed by the treating Physician. This visit shall include, at a minimum, parent education, assistance and training in breast or bottle feeding and the performance of any necessary maternal or neonatal physical assessments. Stays longer than forty-eight (48) or ninety-six (96) hours will be covered if medically necessary.

Mental Health and Substance Abuse (Chemical Dependency) Services
Precertification is required for certain Mental Health and Substance Abuse services except in an Emergency (for a list of services that require Precertification, see the section titled **GETTING APPROVAL FOR BENEFITS**).

Covered Services include services for Mental Health and Substance Abuse, including the diagnosis and Medically Necessary treatment of Substance Abuse Conditions, Severe Mental Illness (SMI) of a person of any age, and Serious Emotional Disturbances (SED) of a child as defined by the most recent edition of the DSM and all Mental Conditions identified as "Mental Disorders" in the DSM, Fourth Edition.

Mental Health Covered Services include the following:

- Inpatient Services in a Hospital, Residential Treatment Center, or any Facility that We must cover per State law. Inpatient benefits include:
    - Inpatient facility services for acute Mental Health Conditions, including Physician Services;
    - Inpatient psychiatric observation for acute psychiatric crisis, including Physician Services;

    - Short-term Mental Health crisis Residential Treatment.
- Outpatient Office Visits
    - Individual and group mental health evaluation and treatment;
    - Outpatient services for monitoring drug therapy;
    - Behavioral Health Treatment Office Visit for Pervasive Developmental Disorder or Autism (See also "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" earlier in this section for a description of additional Covered Services.
- Outpatient Items and Services
    - Short-term partial hospitalization;
    - Short-term intensive outpatient psychiatric treatment;
    - Outpatient psychiatric observation for an acute psychiatric crisis;
    - Psychological testing to evaluate a mental condition;
    - Behavioral Health Therapy Home Visit for Pervasive Developmental Disorder or Autism (See also "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" earlier in this section for a description of additional Covered Services); and
    - Non-emergency psychiatric transportation.

Substance Abuse (Chemical Dependency) Services include the following:

- Inpatient Services in a Hospital, Residential Treatment Center or any Facility that We must cover per State law. Inpatient benefits include:
    - Services for detoxification, including physician services
    - Transitional residential recovery services
- Outpatient Office Visits including Office Visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as:
    - Individual and group chemical dependency counseling; and
    - Medical treatment for withdrawal symptoms.
- Outpatient Items and Services
    - Day treatment program for substance use disorder
    - Intensive outpatient treatment for substance use disorder
    - Non-emergency psychiatric transportation

For a list of conditions covered under Mental Health and Substance Abuse, please see the **DEFINITIONS** section. Providers who can provide Covered Services include, but are not limited to:

- Primary Care Physician (when acting within the scope of his/her license and expertise),
- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental health clinical nurse specialist,
- Licensed marriage and family therapist (L.M.F.T.),

- Licensed professional counselor (L.P.C)

We offer certain Medically Necessary Outpatient Office Visits for Mental Health Covered Services and Substance Abuse (Chemical Dependency) through Telehealth. To obtain a list of Mental Health and Substance Use Providers within Our network please contact Us at 1-1-855-672-2755 or access Our website at www.hioscar.com.

Office Visits

An Office Visit is when You go to a Physician's office and have one or more of ONLY the following three services provided:

- History-Gathering of information on an illness or injury.
- Examination
- Physician's medical decision regarding the diagnosis and treatment plan.

Office Visit will not include any other services while at the office of a Physician (e.g., any surgery, Infusion Therapy, diagnostic X-ray, laboratory, pathology and radiology) or any services performed other than the three services specifically listed above.

Covered Services include:

- Office Visits with Primary care Physicians and Providers (PCP) and Specialty Care Physicians and Providers
- Urgent Care as described in "Urgent Care" later in this section
- After Hours Care. If You need care after normal business hours, Your Physician may have several options for You. You should call Your Physician's office for instructions if You need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If You have an Emergency, call 911 or go to the nearest Emergency room (see the section titled **WHAT IS NOT COVERED (EXCLUSIONS) – MEDICAL**).
- We cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. Second Surgical Opinion. We cover a second surgical opinion by a qualified Physician on the need for surgery. Required Second Surgical Opinion. We may require a second opinion before We preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
    - The second opinion must be given by a board certified Specialist who personally examines You.
    - If the first and second opinions do not agree, You may obtain a third opinion.
    - The second and third opinion consultants may not perform the surgery on You.
    - Second Opinion services must be obtained by an in network provider. In cases where there is not an in network provider with the appropriate

specialization to conduct the second opinion, We may authorize Your to obtain a second opinion from an out of network provider.

Office Visits – Additional Services in an Office Setting
Certain diagnostic procedures, including advance imaging procedures, wherever performed, require Precertification (see the section titled **GETTING APPROVAL FOR BENEFITS** for details).

Certain Reconstructive services, wherever performed, require Precertification (see the section titled **GETTING APPROVAL FOR BENEFITS** for details).

Additional services received during an Office Visit include, but are not limited to:

- Injection administration, including allergy serum
- Diagnostic laboratory and pathology services
- Diagnostic imaging services and electronic diagnostic tests
- Advanced diagnostic imaging services
- Office surgery
- Prescription Drugs for the Drug itself dispensed in the office through infusion or injection

Additional services provided during an Office Visit may be subject to a separate cost share if a service is sent to a third party, for example an independent lab.

Orthotics
Please see "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies" earlier in this section.

Osteoporosis
Coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis including, but not limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed Medically Necessary.

Outpatient Facility Services
Precertification may be required for all outpatient Facility admissions and specific outpatient services, including diagnostic treatment and other services (see the section titled **GETTING APPROVAL FOR BENEFITS** for details).

Certain Reconstructive services, wherever performed, require Precertification (see the section titled GETTING APPROVAL FOR BENEFITS for details).

Your Agreement includes Covered Services in an:

- Outpatient Hospital, including ambulatory care and Physician services,
- Ambulatory Surgical Center,
- Mental Health / Substance Abuse Facility, or
- Other approved Facilities

Benefits include Facility and related (ancillary) charges, when Medically Necessary, such as:

- Surgical rooms and equipment,
- Prescription Drugs, including Specialty Drugs dispensed through the Facility,
- Anesthesia and anesthesia supplies and services given by the Hospital or other Facility,
- Medical and surgical dressings and supplies, casts, and splints,
- Diagnostic services, and
- Therapy services including Physical, Speech and Occupational Therapy

Phenylketonuria (PKU)

Benefits for the testing and treatment of phenylketonuria (PKU) are paid on the same basis as any other medical condition. Coverage for treatment of PKU shall include those formulas and special food products that are part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is authorized by Oscar. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

The cost of the necessary formulas and special food products is covered only as it exceeds the cost of a normal diet. "Formula" means an enteral product or products for use at home. The formula must be prescribed by a Physician or nurse practitioner, or ordered by a registered dietician upon Referral by a health care Provider authorized to prescribe dietary treatments, and is Medically Necessary for the treatment of PKU. Formulas and special food products used in the treatment of PKU that are obtained from a Pharmacy are covered under Your Plan's Prescription Drug benefits. Formulas and special food products that are not obtained from a Pharmacy are covered under this benefit.

"Special food product" means a food product that is all of the following:

- Prescribed by a Physician or nurse practitioner for the treatment of PKU, and
- Consistent with the recommendations and best practices of qualified Health Professionals with expertise in the treatment and care of PKU, and
- Used in place of normal food products, such as grocery store foods, used by the general population.

- It does not include a food that is natural low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

Preventive Care

Preventive care can be given during an Office Visit or in the non-Office setting. Screenings and other services are covered for adults and children with no current symptoms or history of a health problem

Members who have current symptoms or a diagnosed health problem will get benefits under the "Diagnostic Services" benefit, not this benefit.

Preventive care services will meet the requirements of federal and State law. Preventive care services stated below are covered by this Agreement with no Deductible, Copayments or Coinsurance when You use an In-Network Provider. That means We cover 100% of the Negotiated Fee Rate. Covered Services fall under four broad categories as described below:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendation of the United States Preventive Services Task Force
- Immunizations for routine use in children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration, including:
    - The American Academy of Pediatrics Bright Futures Recommendations for Preventive Pediatric Health Care and
- Additional preventive care and screening for women provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, including:
    - FDA-approved contraceptive drugs, devices, and other products for women, including FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the enrollee's provider.
        - Oscar will not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this subdivision, unless
            - The FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product. In that case, Oscar will cover at least one without cost sharing.
            - If a covered therapeutic equivalent of a drug, device, or product is not available, or is deemed medically inadvisable by Your Provider, Oscar will provide coverage, subject to Our utilization management procedures, for the prescribed contraceptive drug, device, or product

without cost sharing. (See the section titled **GETTING APPROVAL FOR BENEFITS**.)

- Oscar will cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed or furnished by an In-Network Provider or pharmacist, or location licensed or otherwise authorized to dispense drugs or supplies.

- Voluntary sterilization procedures
- Injectable contraceptives and patches,
- Contraceptive devices such as diaphragms, intra-uterine devices (IUDs), cervical caps and implants,
- Family planning counseling and education,
- Follow up services related to the drugs, devices, products, and procedures covered under this subdivision, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.
- Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one (1) pump per pregnancy. Breast pumps are covered under Your Agreement's medical benefits,
- Gestational diabetes screening,
- Well woman visits that are age and developmentally appropriate, including preconception and prenatal care,
- Screening and counseling for sexually transmitted infections,
- Screening and counseling for Human Immunodeficiency Virus (HIV),
- Screening and counseling for interpersonal and domestic violence and
- Testing for Human Papillomavirus (HPV).
- BRCA testing

Examples of Preventive care Covered Services are provided below.

Well Baby and Well Child Preventive Care

- Office Visits.
- Routine physical exam including medically appropriate preventive laboratory tests, procedures and radiology services in connection with the exam.
- Screenings including blood lead levels for children at risk for lead poisoning; vision (eye chart only); and hearing screening in connection with the routine physical exam.
- Immunizations including those recommended by the American Academy of Pediatrics and the Advisory Committee on Immunization Practices.
- Hepatitis B and varicella zoster (chicken pox) injectable vaccines and other age appropriate injectable vaccinations as recommended by the American Academy of Pediatrics and the Office Visit associated with administering the injectable vaccination when ordered by Your Physician.
- Human papillomavirus (HPV) test for cervical cancer.

Adult Preventive Care

- Routine physical exams.
- Medically appropriate preventive laboratory tests and radiology procedures in connection with the routine physical exam.
- Cholesterol, osteoporosis (periodic bone density screening for menopausal or post-menopausal women), and routine eye and hearing screenings in connection with the routine physical exam.
- Immunizations including those recommended by the Advisory Committee on Immunization Practices for Members age nineteen (19) and above.
- Preventive counseling and risk factor reduction intervention services in connection with tobacco use and tobacco use-related diseases and smoking cessation programs. We offer smoking cessation products at no- cost sharing and without any limitations. Please contact Us or refer to Our Drug Formulary for a list of qualifying products.
- FDA-approved cancer screenings including pap examinations; breast exams; mammography testing; appropriate screening for breast cancer; ovarian, colorectal and cervical cancer screening tests, including the human papillomavirus (HPV) test for cervical cancer; prostate cancer screenings, including digital rectal exam and prostate specific antigen (PSA) test; Medically Necessary colonoscopy consultations; and the Office Visit related to these services.

You may call member services at **1-855-672-2755** for more details about these services or view the federal government's websites: https://www.healthcare.gov/preventive-care-benefits/, http://www.ahrq.gov/clinic/uspstfix.htm, and http://www.cdc.gov/vaccines/recs/acip/.

Prosthetics

Please see "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies" earlier in this section.

Rehabilitation and Habilitation Services

Benefits include services in a Hospital, free-standing Facility, Skilled Nursing Facility, or in an outpatient day rehabilitation program.

Covered Services involve a coordinated team approach and several types of treatment, including skilled nursing care, physical, occupational, and speech therapy, and services of a social worker or psychologist.

Habilitation services means health care services and health care devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a

child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient individual or group settings, or both. Examples of health care services that are not habilitation services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care or education services of any kind, including, but not limited to, vocational training. Habilitation services shall be covered under the same terms and conditions applied to rehabilitation services under the Agreement. Benefit limits for rehabilitative and habilitative services shall not be combined.

Residential Treatment Center
Please see "Inpatient Facility" in this section.

Skilled Nursing Facility
Precertification is required for Skilled Nursing Facility admissions and services (see the section titled **GETTING APPROVAL FOR BENEFITS** for details).

When You require inpatient skilled nursing and related services for convalescent and Rehabilitative Care, Covered Services are available if the Facility is licensed or certified under State law as a Skilled Nursing Facility. Custodial Care is not a Covered Service.

We cover the following services:

- Physician and nursing services
- Room and board
- Drugs prescribed by a Physician as part of Your plan of care in the Skilled Nursing Facility
- Durable Medical Equipment if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide
- Medical Social Services
- Blood, blood products and their administration
- Medical Supplies
- Behavioral Health Treatment for Pervasive Developmental Disorder or Autism
- Respiratory therapy

You must be under the active supervision of a Physician treating Your illness or injury.

Surgery
Surgical procedures, wherever performed, may require Precertification (see the section titled **GETTING APPROVAL FOR BENEFITS** for details).

Your Agreement covers surgical services on an Inpatient or outpatient basis, including office surgeries. Covered Services include:

- Medically Necessary operative and cutting procedures;
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of brain or spine;
- Endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy;
- Treatment of fractures and dislocations;
- Anesthesia and surgical support when Medically Necessary; and
- Medically Necessary pre-operative and post-operative care.

Bariatric Surgery

Precertification is required for all services related to Bariatric Surgery (see the section titled **GETTING APPROVAL FOR BENEFITS** for details). Precertification can be obtained by calling Us toll free at 1-855-672-2755.

Services and supplies will be provided in connection with Medically Necessary surgery for weight loss, only for morbid obesity and only when performed at a Covered Inpatient Facility. Your Physician must obtain Precertification for all bariatric surgical procedures.

Oral Surgery

Benefits are limited to certain oral surgeries including:

- Treatment of medically diagnosed cleft lip, cleft palate, ectodermal dysplasia, or other craniofacial anomalies associated with cleft palate;
- Orthognathic (jawbone) surgery for a medical condition or injury which improves function of the joint or bone that is Medically Necessary to gain functional capacity of the joint or bone.
- Oral / surgical correction of Accidental Injuries.
- Treatment of lesions, removal of tumors and biopsies.
- Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses.

Please see "Dental Services" earlier in the section for more information

Note: Although this Agreement covers certain oral surgeries, many oral surgeries (e.g. removal of wisdom teeth) are not covered. Oral surgery must be related to a medical condition and not be for dental or cosmetic purposes.

Reconstructive Surgery

Benefits include Reconstructive Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection,

tumors, or disease in order to improve function or to create a normal appearance, to the extent possible. Benefits also include Medically Necessary dental or orthodontic service that are an integral part of reconstructive surgery for cleft palate procedures and surgery performed to restore symmetry after a mastectomy.

Mastectomy and Lymph Node Dissections
Members who are getting benefits for a mastectomy or for Follow-up Care for a mastectomy and who choose breast reconstruction, will also get coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to give a symmetrical appearance; and
- Prostheses and treatment of physical problems of all stages of mastectomy, including lymphedemas.

Members will have to pay the same Deductible, Coinsurance, and/or Copayments that normally apply to surgeries in this Agreement.

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call Us at the number on the back of Your Oscar ID card.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services
Temporomandibular Joint (TMJ) and Craniomandibular Joint Services Precertification is required for certain diagnostic procedures and tests (see the section titled **GETTING APPROVAL FOR BENEFITS** for details).

Benefits are available to treat temporomandibular and craniomandibular disorders. The temporomandibular joint connects the lower jaw to the temporal bone at the side of the head and the craniomandibular joint involves the head and neck muscles.

Covered Services include removable appliances for TMJ repositioning and related surgery, medical care, and diagnostic services. Covered Services do not include fixed or removable appliances that involve movement or repositioning of the teeth, repair of teeth (fillings), or prosthetics (crowns, bridges, dentures), unless specifically covered. Please see "Dental Services" earlier in this section for more information.

Therapy Services
Precertification is required for Infusion Therapy and Other Therapy Services (in all settings) (see the section titled **GETTING APPROVAL FOR BENEFITS** for details).

Physical Medicine Therapy Services
Your Plan includes coverage for therapy services. Some Physical Therapy services may also be habilitative services. Habilitation services are covered under the same terms and conditions applied to rehabilitation services under the Agreement (see the "Rehabilitation and Habilitation Services" section above for details). To be a Covered Service, the therapy must be Medically Necessary. Treatment is covered when provided by a physical, occupational or speech therapist who acts within the scope of their license. Covered Services include:

- Physical Therapy – The treatment by a physical method to ease pain, restore health, and to avoid disability after an illness, injury, or loss of an arm or a leg. It also includes services related to Pervasive Development Disorder or Autism. It includes the use of heat, cold, exercise, electricity, ultraviolet, massage and aquatic therapy (as part of a Physician Therapy treatment plan) to improve circulation, strengthen muscles and encourage return of motion.
- Speech therapy and speech-language pathology (SLP) services – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct speech impairment. It also includes services related to Pervasive Development Disorder or Autism.
- Occupational Therapy – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes services related to Pervasive Development Disorder and Autism.
- Acupuncture – Typically provided only for limited conditions outlined in Oscar's coverage criteria, such as treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.

Infusion Therapy
Physician prescribed Infusion Therapy (each course of therapy must be Medically Necessary).

- If services are performed in the home, those services must be billed by and performed by a Provider licensed by State and local laws.
- Drugs and other substances used in Infusion Therapy.

- Professional services to order, prepare, dispense, deliver, administer, train or monitor, including clinical Pharmacy support and any Drugs or other substances used in a Course of Therapy.
- Durable, reusable supplies, and durable medical equipment including, but not limited to, pump, pole and electric monitor.
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products.

Infusion Therapy benefits will not be provided for:

- Compounding fees such as charges for mixing or diluting Drugs, medicines or solutions or incidental supplies including disposable items such as cotton swabs, tubing, syringes and needles for Drugs, adhesive bandages and intravenous starter kits.
- Drugs and medicines not requiring a Prescription.
- Drugs labeled "Caution, limited by federal law to Investigational use" or Drugs prescribed for Experimental use.
    - If Oscar determines that the requested Drug, device, procedure, or therapy is not covered because it is Investigational or prescribed for Experimental indications, the Member may request an independent medical review. Refer to the section titled **INDEPENDENT MEDICAL REVIEW**.
- Drugs or other substances obtained outside the United States.
- Non-FDA approved homeopathic medications or other herbal medications.
- Charges, including the preparation of the finished product, by an Out-of-Network Provider that exceeds the Prescription Drug Maximum Allowed Amount.
- Medical Supplies and Equipment used in Infusion Therapy will not be reimbursed under any other benefit of this Plan.

Other Therapy Services

Benefits are available for:

- Cardiac Rehabilitation – Medical evaluation, training, supervised exercise, and psychosocial support to care for You after a cardiac event (heart problem).
- Chemotherapy – Treatment of an illness by chemical or biological antineoplastic agents.
- Dialysis – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home Hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for You and the person who will help You with home self-dialysis. We also cover equipment and medical supplies required for home Hemodialysis and home peritoneal dialysis. Coverage is limited to the standard item of equipment of supplies that adequately meets Your medical needs. Covered Services include treatment by an Out- of-Network Provider subject to all the following conditions:

- The Out-of-Network Provider is duly licensed to practice and authorized to provide such treatment.
- The Out-of-Network Provider is located outside Our Service Area.
- The In-Network Provider who is treating You has issued a written order indicating that dialysis treatment by the Out-of-Network Provider is necessary.
- You notify Us in writing at least thirty (30) days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- We will provide benefits for no more than ten (10) dialysis treatments by an Out-of-Network Provider per Member per calendar year, unless Medically Necessary.
- Benefits for services of an Out-of-Network Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider.

- Pulmonary Rehabilitation – Includes outpatient short-term respiratory care to restore Your health after an illness or injury.
- Radiation Therapy – Treatment of an illness by X-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, and treatment planning.
- Respiratory Therapy – Includes the use of dry or moist gases in the lungs, non- pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or Drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; broncho-pulmonary drainage and breathing exercises.

Gender Reassignment Services
Precertification is required for certain Gender Reassignment (see the section titled **GETTING APPROVAL FOR BENEFITS** for details).

Benefits are provided for services and supplies in connection with Gender Reassignment when a Physician has diagnosed You with Gender Identity Disorder or Gender Dysphoria. Benefits are provided according to the terms and conditions of this Agreement that apply to all other medical conditions, including Medical Necessity requirements, Precertification and exclusions for Cosmetic Services.

Coverage includes, but is not limited to, Medically Necessary services related to Gender Reassignment such as transgender surgery, hormone therapy, psychotherapy, and vocal training. Coverage is provided for specific services according to benefits under this

Agreement that apply to that type of service generally, if the Agreement includes coverage for the service in question. For example, transgender surgery would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under this Agreement's Prescription Drug benefits.

Some services are subject to authorization in order for coverage to be provided. Please refer to the section titled **GETTING APPROVAL FOR BENEFITS** for information on how to obtain the proper reviews and authorization.

Telehealth
We cover Medically Necessary Covered Services offered through Telehealth by an In-Network Provider subject to the terms and conditions of the Our contracts with In-Network Providers. Telehealth Visits from certain Oscar-designated Telehealth Providers are covered in full. These Telehealth Visits can be requested through Oscar's website, mobile application, and our customer service line. Call customer service at 1-855-672-2755 or contact them via Our website at www.hioscar.com for additional information.

Transplant Services
Precertification is required for all services related to Human Organ and Tissue Transplants (see the section titled **GETTING APPROVAL FOR BENEFITS** for details).

We provide coverage for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. This may include harvesting the organ, tissue or bone marrow and for treatment of complications.

These procedures are covered only when performed at an Oscar designated centers For further information, please contact member services at 1-855-672-2755.

Transplants (requires Precertification): Your Physician must obtain Precertification for all services including, but not limited to preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart lung, kidney, pancreas, simultaneous pancreas kidney, bone marrow/stem cell and similar procedures. Charges for services provided for or in connection with a specified transplant performed at a Facility other than the designated facility will not be considered covered expense. Precertification can be obtained by calling Us toll free at **1-855-672-2755**.

Coverage will not be denied, if otherwise available under this Agreement, for the costs of transplantation services based upon HIV status.

The services and supplies are provided to You in connection with a covered non-investigative organ or tissue transplant, if You are:

- the recipient;
- the donor; or
- an individual identified by the Provider as a potential donor.

If You are the recipient, an organ or tissue donor who is not an enrolled Member is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage.

Transplant Travel Expense

Certain travel expenses incurred by the Member, up to a maximum of $10,000 Oscar payment per transplant will be covered for the recipient or donor in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated facility, provided the expenses are authorized by Us in advance. All travel expenses are limited up to the maximum set forth in the Internal Revenue Code at the time services are rendered and must be approved by Us in advance. Travel expenses include the following for the recipient (and one (1) companion) or the donor:

- Ground transportation to and from the facility when the designated facility is seventy-five (75) miles or more from the recipient's or donor's place of residence.
- Coach airfare to and from the facility when the designated facility is three-hundred (300) miles or more from the recipient's or donor's place of residence.
- Lodging, limited to one (1) room, double occupancy.
- Meals, tobacco, alcohol, Drug expenses and other non-food items are excluded.

When the Member recipient is under eighteen (18) years of age, this benefit will apply to the recipient and two (2) companions or caregivers.

When You request reimbursement of covered travel expenses, You must submit an itemized list of expenses and legible copies of all applicable receipts. Credit card slips are not acceptable. Covered travel expenses are not subject to Deductibles or Copayments/Coinsurance. Please call Member Services at 1-855-672-2755 for further information and/or to obtain the travel reimbursement form.
to Deductibles or Copayments/Coinsurance. Please call member services at 1-855-672-2755 for further information and/or to obtain the travel reimbursement form.

Travel expenses that are not covered include, but are not limited to: meals, alcohol, tobacco, or any other non- food items; child care; mileage within the city where the facility is located, rental cars, buses, taxis or shuttle services, except as specifically approved by Us; frequent flyer miles, coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related, or a direct result, of the transplant; telephone calls; laundry; postage; entertainment; travel expenses for a donor companion/caregiver (except as specified above); or return visits for the donor for a treatment of a condition found during the evaluation.

Unrelated Donor Searches
For unrelated donor searches for covered bone marrow/stem cell transplants, coverage will not exceed $30,000 per transplant. Travel expenses and hotel accommodations associated with organ, tissue and stem cell donations are not covered.

Anyone who is eighteen (18) years of age or older and of sound mind may become a donor when he or she dies. Minors may become donors with a parent or guardian's consent. Organ and tissue donation may be used for transplants and research. If You decide to become a donor, talk it over with Your family. Let Your Physician know Your intentions as well. Obtain a donor card from the Department of Motor Vehicles. Be sure to sign the donor card and keep it with Your driver's license or identification card. For more information, visit the Health and Human Services donation website at www.organdonor.gov.

Urgent Care Services
Urgent Care benefits are for those services necessary to prevent serious deterioration of Your health resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy. In the case of pregnancy, this would include services necessary to prevent serious deterioration of the health of a mother or her unborn child.

Vision Services
Benefits include medical and surgical treatment of injuries and illnesses of the eye.

We cover special contact lenses for aniridia and aphakia when prescribed by an In- Network Physician or In-Network Optometrist. We cover Up to six (6) Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year and up to two (2) Medically Necessary aniridia contact lenses per eye (including fitting and dispensing) in any Benefit Period at no charge.

Vision screenings required by Federal law are covered under the **WHAT IS COVERED – MEDICAL** section, under the "Preventive Care" provision.

Vision Services – Child

Vision Care that is Covered:

The following vision care benefits are available to Members until the end of the month in which the Member turns nineteen (19) years of age. We will cover vision care that is listed in this section. See Your Schedule of Benefits for Your Cost Share amounts and any limitations for covered vision care. We will not pay for vision care listed in the section titled **WHAT IS NOT COVERED (EXCLUSIONS) – MEDICAL** under "Vision Care."

Routine Eye Exam

Your Agreement covers a complete eye exam with refraction. The exam is a general evaluation of the complete visual system, including the structure of the eyes and how well they work together. The eye exam will evaluate the eye for diseases of the visual system and We will cover dilation as needed.

Eyeglass Lenses

You have a choice in Your eyeglass lenses. Lenses include factory scratch coating, UV coating, polycarbonate and photochromic lenses at no cost when received from an In-Network Provider.

Covered eyeglass lenses include standard plastic (CR39), polycarbonate, or glass lenses up to 55mm in:

- Single vision
- Bifocal
- Trifocal (FT 25-28)
- Progressive

Frames

- We offer a selection of frames that are covered under this Agreement
- Frames are limited to one (1) every Benefit Period

Elective Contact Lenses

- Elective contact lenses are contacts that You choose instead of eyeglasses for comfort or appearance. You may choose elective contact lenses in lieu of Your eyeglass lenses benefit. We offer a selection of contact lenses that are covered under this Agreement.

A one (1) Year supply of elective contact lenses is covered every Benefit Period (applicable to certain contact lenses within the formulary).

Non-Elective Contact Lenses

- Non-elective contacts are provided for the following medical conditions:
    - Aniridia
    - Aphakia
    - Keratoconus
    - Anisometropia
    - Corneal Disorders
    - Pathological Myopia
    - Aniseikonia
    - Post-Traumatic Disorders
    - Irregular Astigmatism
- Medically Necessary contact lenses may be prescribed in lieu of eyeglasses, when it will result in significantly better visual acuity and/or improved binocular function, including avoidance of diplopia or suppression.

If You receive elective or non-elective contact lenses then no benefits will be available for eyeglass lenses until You satisfy the benefit frequency listed in the **SUMMARY OF BENEFITS.**

Low Vision

Low vision is a significant loss of vision, but not total blindness. Providers specializing in low vision care can evaluate and prescribe optical devices and provide training instruction to maximize the remaining usable vision for Our Members with low vision.

Low vision benefits include:

- Comprehensive Low Vision Exam
- Optical/Non-optical aids
- Supplemental testing

Please submit appeals regarding Your vision coverage to the following address:

Oscar Health Plan of California
Attn: Oscar Vision
12777 West Jefferson Blvd, 1st Floor

Suite 100, Building D
Los Angeles, CA, 90066

Wellness Program
The purpose of the wellness program is to encourage You to take a more active role in managing Your health and well-being. Throughout the course of the year, We provide incentives in connection with the use of or participation in our step and sleep tracking program.

Using a step tracker (compatible phone or wearable fitness tracker), adult Members can track their steps and earn rewards when they hit personalized daily goals. When the Member opens the Oscar app and syncs their steps, they can see how far they've walked and whether they hit their goal for the day or not. For each day the Member hits their goal, they earn $1, up to their yearly max of $100. Members are able to qualify for this reward at least once per year, and the size of the reward does not exceed the applicable percentage set by federal regulation. Members can redeem their rewards for an Amazon gift card anytime by clicking a button in the app. Within minutes of redeeming their reward, the Member will receive an email with the gift card code and instructions to redeem. While Oscar encourages a member to use the reward to purchase health products (e.g., cookbooks , exercise equipment), a Member may use a reward towards any item on Amazon.com.

If a Member may also use any iOS or Android app to track his or her sleep. For each night of sleep tracked, a Member is eligible to earn $1 up to their yearly max of $100. Members can redeem their rewards for an Amazon gift card by submitting documentation in the form of screenshots of their sleep history as displayed in their sleep app. A Member may submit documentation directly to a specified email address at Oscar. Once the Member submits documentation of one or more nights of sleep, the documentation will be reviewed by Oscar, and then Oscar will send the Member an email with their reward. While Oscar encourages a Member to use the reward to purchase health products (e.g., cookbooks, exercise equipment), a Member may use a reward towards any item on Amazon.com.

Members who are unable to track their steps or their sleep may be eligible to complete another reasonable alternative. Eligible Members can submit a form requesting an alternative to a specified email address at Oscar or can call Member Services for additional support or information on how to submit the form by mail. The following Members are eligible for a waiver:

- Members who are physically unable to participate
- Members who do not own a smartphone
- Members who can no longer participate in either the step tracking or sleep monitoring programs

A Member must provide evidence of an inability to participate in the form of a signed document attesting that the Member does not own a smartphone or cannot participate in either the step tracking or sleep monitoring programs for another reason. When proper documentation is received, these Members will receive a $100 Amazon gift card reward by email or mail with the gift card code and instructions to redeem. If a Member had previously participated in the step tracking or sleep monitoring programs and can no longer participate in one of these programs, the Member will receive any unpaid amount up to $100 in an Amazon gift card (e.g., $70 in an Amazon gift card if the member had previously earned $30 in rewards while participating in the sleep monitoring program). While Oscar encourages a Member to use the reward to purchase healthy products (e.g., cookbooks, exercise equipment), a Member may use a reward towards any item on Amazon.com.

Members are responsible for any taxes related to the redemption of rewards. For more information, visit Our website at www.hioscar.com or call Us at 1-855-672-2788. Oscar is committed to helping you achieve your best health. If you think you might be unable to participate in this program, you might qualify for an opportunity to earn the same reward in a different way. Contact Your Member Services team at 1-855-672-2788 and We will work with you (and, if you'd like, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. Our wellness program and any products and services available under this program are not Covered Services under the Plan.

WHAT IS COVERED – PRESCRIPTION DRUGS

What Do We Cover?

Formulary Drugs
The Oscar Formulary is a list of Drugs We typically cover.

Oscar maintains a list of medications, typically a portion of those approved by FDA, that Oscar will cover. This list, referred to as the Oscar Formulary, is reviewed and updated by Oscar on a regular cycle. Oscar's Pharmaceutical and Therapeutics Committee oversees the review process to ensure clinical, quality and cost considerations are appropriately considered. The Oscar Formulary includes medications in almost all classes of medications, but does not necessarily include all forms of a given Prescription Drug (e.g. oral tablets, liquids, topical etc..).

We regularly update the Oscar Formulary.

Oscar updates the Oscar Formulary on an ongoing basis, but when modifying always ensures it is effective uniformly among all individuals in a given plan type. When changes are made, Oscar will notify both you and the Insurance Commissioner in accordance with federal and state specific law. To receive coverage for an Oscar Formulary medication, you must have a health care provider prescribe you the medication and the medication must be determined by Oscar to be medically necessary, (see Section: 'How Does Your Coverage Work').

To request coverage for a medication not listed on the Oscar Formulary, you or your health care provider can submit a request (see 'What if I disagree') section. If You have a question regarding whether a Drug is on the Formulary, please visit Our website at www.hioscar.com or call Us at 1-855-672-2755.

For Cost-sharing information see section 'How Does Your Coverage Work'.

Diabetes Supplies
We cover appropriate diabetic supplies.

Your Oscar Plan covers Medically Necessary diabetic supplies, but as with all covered medications, You are responsible for Cost-Sharing amount as applicable.

Common supplies Your Plan covers include (but are not limited to):

- Test strips specified for use with a corresponding covered blood glucose monitor
- Lancets and lancet devices
- Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein
- Insulin and insulin analog preparations
- Injection aids, including devices used to assist with insulin injection and needleless systems
- Insulin syringes
- Biohazard disposable containers
- Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
- Glucagon emergency kits

Vaccinations and Administration
We cover vaccines. Most Pharmacists will also administer them.

Your Oscar plan covers medically necessary vaccinations and annual flu shots. These can be administered by any health care provider, including in most states, pharmacists.

However, not all pharmacists provide vaccinations, and so we encourage you to contact them in advance. All vaccinations and flu shots, when administered per ACIP (Advisory Committee on Immunization Practices) guidelines, will not be subject to copayments, coinsurances, or deductible. Some pharmacists may charge an administration fee, which is not always reimbursable under Your plan. Annual Flu shots are covered in full.

Drugs used in the Treatment of Cancer
We cover appropriate cancer medications.

Your Oscar plan covers medically necessary medications for the treatment of cancer. Oscar requires the drug to either be approved by the FDA or to have been studied in scientific literature as safe and effective for your specific type of cancer such as the National Comprehensive Cancer Network Guidelines or other Nationally recognized clinical guidelines. If You have a question regarding whether a Drug is covered call Us at 1-855-672-2755.

We cover medications for pain related to cancer.

Oscar covers medications used for treating cancer-related pain even if the dosage administered exceeds the standard FDA approved amount, if deemed Medically Necessary by your Healthcare Provider.

Orally Administered Cancer Medication
We cover appropriate oral cancer medications.

Your Oscar plan covers Medically Necessary orally administered anticancer medication. This Coverage will be equal to or better than intravenously administered or injected cancer medications that are covered as under the medical benefit portion of Your Oscar Plan.

Per State law, the Cost Share for oral anti-cancer Drugs shall not exceed $200 per month, per thirty (30) day supply.

Injectable Drugs
We cover appropriate injectable drugs.

Your Oscar plan covers medically necessary injectable drugs. Injectable drugs are pharmaceuticals administered by needle or syringe via the skin (typically intravenously or intramuscularly). As part of this benefit, the necessary disposable needles or syringes are also covered.

Physician Administered Medications – Preferred Drug List
If your doctor is directly administering a medication, we prefer they use certain ones first.

Your Oscar plan covers medically necessary medications supplied and administered directly by a physician. These medications are commonly referred to as 'Physician Administered Medications' and are applied towards the medical benefit portion of your Oscar plan.

Oscar designates a subset of these Physician Administered Medications as preferred medications. The designation is developed using guidelines from the American Medical Association, Academy of Managed Care Pharmacies, and other clinical organizations, describing clinical outcomes, efficacy, and side-effects. The list of preferred medications is available on www.hioscar.com/forms and is periodically reviewed, and updated by Oscar as the status of existing medications changes and new drugs enter the market.

Medications designated as preferred by Oscar may still require prior authorization. (see section: 'How Does Your Coverage Work' for additional Information).

Oral Contraceptives
We Cover Oral Contraceptives.

Your Oscar plan covers contraceptives as part of Family Planning services, see our formulary for a list of covered oral contraceptives. If you do not see your medication listed see our 'What if I Disagree' section.

Smoking Cessation
We cover multiple types of treatment for smoking cessation.

Your Oscar plan covers medically necessary pharmaceuticals to aid Smoking Cessation, in accordance with "A" or "B" recommendations of the U.S. Preventive Services Task Force. This includes nicotine replacement therapy such as nicotine patches, gum, and lozenges.

We also cover screenings, intervention, and behavioral services for Smoking Cessation, as in accordance with "A" and "B" recommendations of the U.S. Preventive Task Force. You may also call the National Quitline at 1-800-QUIT-NOW at any time to assist with Smoking Cessation Attempts.

Medical Foods
We cover appropriate Medical Foods

Your Oscar Plan covers Medical Foods and any Medically Necessary services associated administration. Coverage may be subject to utilization review, including periodic review, of the continued medical necessity of the product. Medical foods includes but is not limited therapeutic food, formulas, amino acid-based elemental formula, or low-protein modified food products that are indicated for the therapeutic treatment of inborn errors of metabolism or genetic conditions and are administered under the direction of a physician.

How Does Your Coverage Work?
Cost-Sharing Amounts

The Formulary tier determines how much You pay.

The cost-sharing amount for your medications is determined by the Formulary tier of the drug being dispensed. Please see your Schedule of Benefits for more details about your plan's specific cost-sharing amounts.

In the event the negotiated amount for your medication is less than your applicable cost-sharing amount, you will pay only the negotiated amount.

If the retail or mail order price of a drug is lower than Your Copayment or Coinsurance, You will pay the lower of the two prices. Your Pharmacy will let You know that You may pay the lower price, unless Your Pharmacy automatically charges You the lower price. If You pay the cheaper retail price:

- Your Pharmacy will submit the Claim to Us in the same manner it would if You had paid Your Copayment or Coinsurance.
- Your payment will constitute an acceptable Copayment or Coinsurance amount, and will apply towards your Deductible and/or Out-of-Pocket Maximum.

How Do You Get it?
Day Supply

Some drugs have limits on the day supply dispensed.

Covered Drugs are provided up to the maximum day supply limit as indicated on Your Schedule of Benefits and/or Formulary. Oscar has the right to determine the day supply and refill thresholds. Payment for medications covered under this Plan may be denied if they are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing the stated maximum day supply limitation.

You may be able to fill Your medication early if travelling.

This Plan allows members to receive an early refill of certain medications in anticipation of extended travel – also known as a vacation override. A vacation override may not exceed members' eligibility expiration with Oscar.

Your Oscar plan does not cover the replacement of drugs or supplies that have been lost, stolen, or destroyed.

Quantity and Time Limits
Some drugs have limits on the quantity dispensed.

Some medications have limits, placed by Oscar, on the quantity that your pharmacist can supply to you at a given time. These limits are based on clinical data from the FDA and from nationally recognized clinical guidelines. The limits apply regardless of the quantity prescribed by your Healthcare Provider.

You or Your doctor can request an exception.

If you or your Health Care Provider believes you require a higher quantity of medication than the limit, your Health Care Provider can submit a request to Oscar for an exception. An Oscar clinician will review the request based on the submitted information. Any drugs dispensed by your pharmacist in a manner intended to change or circumvent the maximum limits set by Oscar will be denied.

Pain Management and Schedule II Prescription Drugs
Partial Fill of Controlled Medications

A prescription for a Schedule II controlled substance may be partially filled if:
(1) The prescription is for an inpatient of a skilled nursing facility; or
(2) The prescription is for a terminally ill patient.

A partially filled prescription is a prescription from which only a portion of the amount it was written for is filled at any one time; provided that regardless of how many times the prescription is partially filled, the total amount dispensed shall not exceed the original quantity it was written for.

When partially filling a prescription, all of the following conditions must be met:
(1) The prescription must be at least partially filled within seven to fourteen days from the date it was written;
(2) The pharmacist records the date and amount of each partial filling according to State Law;
(3) No portion of the prescription is dispensed more than 30 days from the date written; and
(4) The original triplicate prescription is forwarded to the Department of Justice in conformity with Health and Safety Code section 11164(a) at the end of the month in which the prescription has been completely filled or in which the prescription has been canceled by death of the patient or otherwise, whichever comes first.

Brand Name vs. Generic Drug Pricing Difference
Requiring a brand name drug may cost additional.

If you or your healthcare provider request a pharmacy to fill the branded version of a medication when a generic version is available, you will pay a higher cost-sharing amount. The higher cost-sharing amount will be the applicable cost-sharing of the branded medication plus the difference in the allowed amount between the branded and generic versions.

Drug Coupons, Rebates, or Other Drug Discounts
You must pay Oscar the difference if a coupon exceeds the cost of a medication.

Drug Manufacturers may offer coupons, rebates or other drug discounts to Members, which may impact the benefits provided under this Plan. The total benefits payable will not exceed the balance of the Allowed Amount remaining after all drug coupons, rebates, or other drug discounts have been applied.

The Member agrees to reimburse Oscar any excess amounts for benefits that We have paid You and for which You are not eligible due to the application of drug coupons, rebates or other drug discounts.

Some coupons will not count towards your out-of-pocket maximum or deductible.

Some specialty medications may qualify for third party Copayment assistance programs which could lower Your out of pocket costs for those products, subject to Our prior approval. For any such specialty medication where third party Copayment assistance is used, You shall not receive credit toward their Maximum Out-of-Pocket or Deductible for any Copayment or Coinsurance amounts that are applied to a manufacturer coupon or rebate.

Medication Synchronization Plan
You can pick up all Your drugs at the same time.

If you are filling more than one prescribed medication on an ongoing basis, you have the option to coordinate the refilling of your medications to a single pharmacy visit.

To use this program, notify your pharmacist at your next visit that Oscar supports this program and you'd like to coordinate your refills. Your pharmacist may refer to this option as a 'medication synchronization program'. The pharmacist will immediately submit the necessary 'early refill' requests to Oscar and if approved, your pharmacist will then fill your prescribed medications.

We will prorate on a per day basis, any Cost-Sharing amounts for a quantity that is less than a 30 days' supply when dispensed as part of a Medication Synchronization.

Selecting a Participating Pharmacy
Our website has a list of Pharmacies You can go to.

As an Oscar member, you have two methods to fill a prescription: (1) Visiting your local Retail Pharmacy, (2) Using a Mail-Order Pharmacy (see section on Mail-Order).

If using a Retail Pharmacy, first check on our website (www.hioscar.com) or contact Member Services at 1-855-672-2755 to confirm the pharmacy is in the Oscar Network, as some large chains and smaller independents are excluded depending on your plan type. Additionally, certain drugs are not available at standard retail pharmacies (see section: 'Specialty Pharmacy').

At the pharmacy you will be required to present your Oscar Insurance Card and your prescription (if not already sent electronically by your Healthcare provider). The pharmacy may also require additional information to fill your prescription and process the claim. At the time of pickup, you will be required to pay any cost-sharing amounts (deductibles, coinsurance, or copayments) and pricing differences (if applicable).

Mail Order Program
Your drugs can be delivered by mail.

Mail Order Pharmacies are an alternative way you can get your medications. Certain eligible covered drugs, such as maintenance medications can be delivered to your home. Not all Medications listed on our formulary can be filled at Mail Order. You can find more information and our Drug Formulary by going to www.hioscar.com or if You have any questions or need assistance in determining the amount of Your payment, or need to obtain the mail-order prescription form, You may contact Member Services at 1-855-672-2755.

If your In-Network Retail Pharmacy offers you a delivery option, this is not the same as our Mail Order Program. Oscar will not prohibit your Pharmacy from offering this as an extra service. Your pharmacy will let You know of any fees associated with the delivery, including any fees not reimbursable by Us.

Benefits for Specialty Drugs
Some Drugs have unique clinical requirements and must be filled at a Specialty Pharmacy.

Drugs that require specialized patient education prior to use and ongoing patient assistance while under treatment are called 'Specialty Drugs'.

These 'Specialty Drugs' must be dispensed through an Oscar contracted Specialty Pharmacy. Please visit our website at www.hioscar.com or call Member Services at 1-855-672-2755 to find out if your medication is considered a Specialty Drug and/or identify the best Specialty Pharmacy option for you.

Selecting a non-Participating Pharmacy
Pharmacies not listed in our directory will cost You more.

If you choose to visit a pharmacy not in the Oscar Network (a non-participating pharmacy), you will pay the full amount for the medication.

If the non-participating pharmacy is willing to accept reimbursement at the same rates as a participating pharmacy, they can submit a request for reimbursement to Oscar. Contact us at 1-855-672-2755 if you and your pharmacy wish to pursue this option.

Prior Authorization
Our clinicians review some prescriptions to confirm they are appropriate.

Some medications, despite being prescribed by your Healthcare Provider, require an additional review by a Clinician before you can fill the prescription. This process is called Prior Authorization. A Clinician performs a Prior Authorization review to ensure the prescribed drug is safe, effective, and appropriate for your specific treatment plan. A list of the medications which require a Prior Authorization and the required forms are available on our website at www.hioscar.com or by contacting member services at 1-855-672-2755.

We will review all Prior Authorization requests and make a decision to approve or deny coverage for the requested medication based on established clinical criteria. A decision will be made within the time limits specified by State or NCQA Regulations. If you or

Your Health Care Provider do not agree with the decision made by Oscar, you have the ability to contest the decision (see "When you disagree').

If your health care provider does not obtain a Prior Authorization, the pharmacy will be alerted when they are attempting to submit a claim to Oscar and you will not be able to receive your medication.

In certain cases at Oscar's discretion, Oscar may review medicines for medical necessity even though they are not subject to our Prior Authorization requirements. If so, your prescribing doctor will be asked for clinical information to support the medical necessity of your use of the drug. If the determination is unfavorable, future claims for this medication will be denied; in such an event that determination will be eligible for an appeal or exception processes.

Step Therapy

We sometimes require you to try an alternate drug before taking the one you were prescribed.

Some medications, despite being prescribed by your Healthcare Provider, are covered by Oscar only after you have first tried a clinically appropriate alternative. Your pharmacist or Health Care Provider may refer to this as a 'Step Therapy Requirement'. Oscar uses our history of your previous prescriptions (via submitted pharmaceutical claims) to automatically confirm if you have already tried the necessary alternative.

You or Your doctor can request an exception.

If you or your Health Care Provider believe the alternative medication is not safe or appropriate to try, your Healthcare Provider can submit a request for an exception. An request for an exception should also be submitted if you have previously tried the necessary alternative but while at another Health Plan.

If your health care provider does not obtain an exception or if we cannot confirm you have already tried the necessary alternative, the pharmacy will be alerted when attempting to submit a claim to Oscar and you will not receive coverage for your medication.

Drug Switching Incentive Programs
We may offer an incentive if You switch medications.

As an Oscar member you may be eligible for incentives for switching from a higher-cost to a lower-cost, clinically similar prescribed medication. Oscar will notify you of these recommendations via mail, phone, or messaging. If you are not notified of a specific switching recommendation, you will not be eligible for the applicable incentives.

Medical vs. Pharmacy Benefit Coverage
Some drugs are available only through the Pharmacy or Medical benefit.

Certain medications are designated to be received only as a Pharmacy or Medical Benefit drug. Typically, medications received under the Medical Benefit are administered by a physician and a list of these medications and the benefit they are designated to are available on our website.

When medications are billed under Your Oscar plan's medical benefit, they will not be provided as a Pharmacy Benefit Drug.

What if You Disagree?
Right of Appeal

You can request Oscar to reconsider a clinical decision.

Certain medications have requirements or restrictions placed by Oscar (see section: 'How Do You Get It'). In the event your Health Care Provider requests us to review these requirements or restrictions placed on Your Medication and the request is denied by Oscar, you have the right to appeal the decision.

The **GRIEVANCES** section of this plan outlines this in more detail.

Prescription Drug Formulary Exception Request
You can request Oscar to cover a drug that isn't listed on our Formulary.

If you or your health care provider believe your treatment needs require a medication not on the Oscar Formulary, your health care provider can submit an exception request.

The necessary form can be found on our website at www.hioscar.com. Once submitted, the exception request will be reviewed by a Clinician in accordance with state specific timeframes.

External Exception Request for Denial of Standard or Expedited Formulary Exceptions

You can request Oscar to have an independent clinical organization to review our clinical decision.

If Oscar denies the Formulary exception, reviewed in either a Standard or Expedited manner, a request for a review by the Independent Review Organization can be initiated by You, Your designee, or Your Healthcare Provider. These requests, also called an external exception, will be reviewed in the timeframes set forth by the Independent Review Organization and State regulations.

A Request for external exception review does not eliminate Your right to request an Appeal through Our Member Appeal procedures. The **GRIEVANCES** section of this plan outlines this in more detail.

If the review is approved by the Independent Review Organization, Oscar will cover the medication for the duration determined by the Independent Review Organization. Any drug covered through the exception process will count towards Your satisfaction of the annual limitation on Cost Sharing, also known as Your Maximum Out Of Pocket amount.

What do We Not Cover?

Limitations and Exclusions

- Your Oscar plan does not cover vitamins or dietary supplements for which there is a clinically equivalent non-prescription over-the-counter alternative. This does not apply to USPSTF endorsed preventive treatments such as prenatal vitamins and fluoride preparations.
- Your Oscar plan does not cover prescription drugs prescribed for the treatment of obesity or for use in any weight reduction, weight loss, or dietary control. Non-pharmacological healthy diet counseling and obesity screening, as endorsed by the USPSTF remain covered.
- Your Oscar plan does not cover prescription drugs used to enhance cosmetic appearance or performance. This includes, but is not limited to anti-aging, athletic performance (anabolic steroids, androgens or related), hair loss (rogaine, minoxidil or related), sweating (botox or related) and treatments for scarring.
- Your Oscar plan does not cover prescription drugs used to treat sexual dysfunction, including, but not limited to: sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form. These drugs are covered if prescribed to treat a medically necessary indication other than sexual dysfunction. Your Oscar plan does not cover prescription drugs used to treat sexual dysfunction unrelated to organic

disease, including, but not limited to: sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form. These drugs are covered if prescribed to treat sexual dysfunction related to organic disease or a medically necessary indication other than sexual dysfunction.

- Your Oscar plan does not cover prescription drugs prescribed or administered by a Dentist or Dental Specialist used to support the non-medical, dental procedures such as extractions, root canals, or periodontal treatments. This includes locally applied dental antibiotics such as Arestin+ or similar.
- Your Oscar plan does not cover growth hormone therapy used to treat familial short stature. This exclusion does not apply to growth hormone therapy when determined Medically necessary to treat a medical condition other than familial short stature.
- Your Oscar plan does not cover oral and injectable infertility/fertility medications unless specifically mandated by State law.
- Your Oscar plan does not cover vaccinations necessary solely for the purpose of travel to a region outside of the United States
- Your Oscar plan does not cover prescription drugs, devices or supplies available in an over-the-counter form or comprised of components that are available in a clinically equivalent over-the-counter form. This does not apply to over-the-counter products that Oscar is required to cover under federal or state laws or as a USPSTF endorsed preventive service.
- Your Oscar plan does not cover drugs, vaccines, and supplements which are not approved by the FDA or are labeled as "Investigational / Experimental" use only
- Your Oscar plan does not cover drugs obtained in an unauthorized manner (e.g. fraudulent identification) or drugs for which the intended use would be illegal, unethical, or otherwise improper. This includes drugs that have been repackaged by anyone other than the original manufacturer.
- Your Oscar plan does not cover the replacement of lost or stolen drugs
- Your Oscar plan does not cover prescriptions written as a result of 'self-prescribing' or prescriptions filled at a pharmacy owned by you or an immediate family member.
- Your Oscar plan does not cover compounded drugs unless it contains at least one ingredient that has been approved by the United States Food and Drug Administration (FDA). We will also not cover compounded drugs that are available as a similar commercially available Prescription Drug unless medically necessary. All compounds are subject to a Medical Necessity review.
- Your Oscar plan does not cover drugs dispensed in a Medical Office, Hospital, Acute Care, or Long Term Facility for which the Office or Facility is also seeking reimbursement from Your Medical Benefit or for which they receive a Standard Daily Rate for inclusive services.
- Your Oscar plan does not cover prescription drugs, supplies or devices provided in connection with an occupational sickness or an injury sustained in the scope of employment.

WHAT IS NOT COVERED (EXCLUSIONS) – MEDICAL

This list of services and supplies are excluded from Your medical coverage under this Plan and will not be covered in any case. Your Prescription Drug benefits are explained in the section titled **WHAT IS COVERED – PRESCRIPTION DRUGS**. Exclusions for Prescription Drugs are explained in the section titled **WHAT IS NOT COVERED (EXCLUSIONS) – PRESCRIPTION DRUGS**.

Note: The exclusions and limitations listed below do not apply to Medically Necessary services to treat severe mental illness (SMI) or serious emotional disturbances of a child (SED).

Acts of War, Disasters, or Nuclear Accidents: In the event of a major disaster, epidemic, war, or other event beyond Our control, We will make a good faith effort to provide You with Covered Services. Additionally, Your access to Medically Necessary Health Care Services will continue if You have been displaced by a declared state of emergency. We will coordinate benefits with other entities that may offer You coverage, such as coverage offered through the United States military to those on active military duty.

Administrative Charges

- Charges to complete claim forms,
- Charges to get medical records or reports,
- Membership, administrative, or access fees charged by Physicians or other Providers.

After Hours or Holiday Charges: Coverage is not provided for additional charges beyond the Negotiated Fee Rate for basic and primary services for services requested after normal Provider service hours or on holidays. This exclusion does not apply to Emergency Services.

Any federal, state or local taxes due on benefits, goods or services, shipping and handling charges, services required while incarcerated.

Alternative/Complementary Medicine: Coverage is not provided for (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy (unless part of a Physical Therapy treatment plan), reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic

therapy, and neurofeedback. This exclusion does not apply to Medically Necessary biofeedback.

Before Effective Date or After Termination Date: Charges for care You get before Your Effective Date or after Your coverage ends, except as written in this Agreement.

Chiropractic Services: Coverage is not provided for chiropractic services.

Clinical ecology

Coma stimulation

Cosmetic Services: Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance. This exclusion does not apply to Reconstructive Surgery for breast symmetry after a mastectomy, surgery to correct birth defects and birth abnormalities, or any surgery to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomology or creating a normal appearance.

Counseling Services: Religious counseling, marital/relationship counseling, vocational or employment counseling, and sex therapy, except for Medically Necessary treatment of a Mental Health Condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Edition, which includes treatment of SMI or SED.

Court Ordered Care: Include testing or care, unless Medically Necessary and Precertified (see the section titled **GETTING APPROVAL FOR BENEFITS** for details).

Custodial Care, Services/Care Other Facilities: Coverage is not provided for assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine). This exclusion does not apply to assistance with activities of daily living that is provided as part of covered Hospice Care, Skilled Nursing Facility or inpatient Hospital care.

Dental implants for Member age nineteen (19) and over: Material implanted into or on bone or soft tissue or any associated procedure as part of the implantation or removal of implants unless specifically stated as a Covered Service.

Dental Services and Dental Services - Child: Coverage is not provided for:

- Dental care for Members age nineteen (19) and older except as provided for in the section titled **WHAT IS COVERED – MEDICAL**, in the section "Dental Services."
- Services which, in the opinion of the attending dentist, are not necessary to Your dental health.
- Procedures, appliances, or restoration to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
- Cosmetic dental care.
- Experimental procedures or investigational services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficiency have not been determined for use in the treatment for which the item in service in question is recommended or prescribed.
- Services that were provided without cost to You by State government or an agency thereof, or any municipality, county or other subdivisions.
- Hospital charges of any kind are not covered by the Dental Plan.
- Major surgery for fractures and dislocations.
- Loss or theft of dentures or bridgework.
- Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date You became eligible for such services.
- Any service that is not specifically listed as a covered benefit.
- Malignancies.
- Dispensing of drugs not normally supplied in a dental office.
- Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the patient.
- Services of a pedodontist/ pediatric dentist, except when You are unable to be treated by Your panel provider, or treatment by a pedodontist/ pediatric dentist is Medically Necessary, or Your plan provider is a pedodontist/ pediatric dentist.
- Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonably should have known that an Emergency Care situation did not exist.

Please refer to Your Benefit Schedule to see a full description of the limitation and exclusions.

Dental X Rays, Supplies & Appliances: All associated expenses, including hospitalization and anesthesia, except as required by law or specifically stated as a Covered Service above, such as under the "Dental Services" section.

Devices that are:

- Not generally accepted under professional medical standards as being safe or effective even though they are approved by the federal Food and Drug Administration.
- Not approved by the federal Food and Drug Administration.

Diagnostic Admissions: Inpatient room and board or any charges in connection with a Hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

Disposable Supplies for home use: Bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies. This exclusion shall not apply to disposable supplies covered in **WHAT IS COVERED – MEDICAL** in the sections "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies," "Home Care Services" and "Hospice Care," and **WHAT IS COVERED – PRESCRIPTION DRUGS**.

Note: Your Prescription Drug benefits are also subject to exclusions. For additional information, refer to the section titled **WHAT IS NOT COVERED (EXCLUSIONS) – PRESCRIPTION DRUGS**.

Durable Medical Equipment, except as specifically stated in the section **titled WHAT IS COVERED – MEDICAL** under "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies":

- Orthopedic shoes or shoe inserts (except as specifically stated in the section titled **WHAT IS COVERED – MEDICAL** under "Diabetes Equipment, Education and Supplies" and "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies")
- Equipment primarily for comfort or convenience, including but not limited to, scooters and wheelchair add ons which do not serve a medical purpose
- Air purifiers, air conditioners, humidifiers
- Exercise equipment, treadmills
- Pools and spas
- Elevators
- Supplies for comfort, hygiene or beautification
- Correction appliances or support appliances and supplies such as stockings.

Educational Services: Services or supplies for teaching, vocational, or self-training purposes, except as listed in this Agreement. This exclusion does not apply to the Medically Necessary treatment of Pervasive Developmental Disorder or Autism, to the extent stated under the section titled **WHAT IS COVERED – MEDICAL** under "Behavioral

Health Treatment for Pervasive Developmental Disorder or Autism or to diabetes education as stated in the section titled **WHAT IS COVERED – MEDICAL** under "Diabetes Equipment, Education and Supplies."

Exams: Related to research screenings that are part of a voluntary research program or testing where the screening or exam would be paid for by the research program.

Expenses related to repatriation and medical evacuation to the United States and from outside the United States.

Experimental or Investigational Services: Services or supplies that are considered to be for Experimental, Investigational, or Unproven Procedures, and their complications, except for Clinical Trial costs required to be covered under law.

Eyeglasses/Contact Lenses: Prescription, fitting, or purchase of eyeglasses or contact lenses unless specifically stated as a Covered Service in this Agreement or as required by law. Items and services such as eye surgery or contact lenses to reshape the eye for purposes of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism. This exclusion does not apply for initial prosthetic lenses or sclera shells following intra- ocular surgery, or for soft contact lenses due to a medical condition. This exclusion does not apply to Member under age nineteen (19).

Eye Surgery: Corrective eye surgery to correct errors of refraction. Surgery includes without limitation nearsightedness (myopia), astigmatism and/or farsightedness (presbyopia), LASIK, radial keratotomy or keratomileusis, or excimer laser refractive keratectomy.

Fees for no shows and late cancellation. We do not cover fees Your Provider charges for no shows or late cancellations of appointments.

Foreign Travel: Except for Preventive Care Services, this plan does not cover physical examinations, immunizations and vaccinations required for foreign travel or employment purposes.

Government Coverage: To the extent that they are provided or eligible to be provided as benefits by any governmental unit, unless otherwise required by law or regulation.

Hair loss or growth treatment: Items and services for the promotion, prevention, or other treatment of hair loss or hair growth except as covered in the section "Transgender Services" in the section titled **WHAT IS COVERED - MEDICAL**.

Hearing Aids: Hearing aids and hearing tests to determine their efficacy and hearing tests to determine an appropriate hearing aid, except for as stated in **WHAT IS COVERED – MEDICAL** in the section "Preventive Care." This exclusion does not apply to cochlear implants.

Home Care:

- Services given by registered nurses and other health workers who are not employees of or working under an approved arrangement with a Home Health Care Provider, except for Hospice Care (see the section titled **WHAT IS COVERED – MEDICAL** under "Hospice Care."
- Service for Pervasive Developmental Disorder or Autism may be provided in the home.
- Food, housing, homemaker services and home delivered meals with the exception of Medically Necessary enteral and parenteral formulas.

Home delivery of childbirth unless Prior Authorized by Us

Human Growth Hormone: For long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion, unless Medically Necessary.

Hypnotherapy, except for hypnotherapy that is an element of outpatient evaluation and treatment for chemical dependency or a mental disorder, as identified in the DSM IV and provided by a licensed health care professional acting within the scope of his/her license.

Incarceration: Coverage is not provided for care required while incarcerated in a Federal, State or local penal institution or required while in custody of Federal, State or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation.

Infertility treatment: For treatment related to fertilization or Infertility such as any service billed with an Infertility related diagnosis, except as stated under "**WHAT IS COVERED – MEDICAL**."

Massage therapy

Missed or Canceled Appointments.

Non-Duplication of Medicare: We will not provide benefits that duplicate any benefits You would be entitled to receive under Medicare. This exclusion applies to all Parts of Medicare in which You enroll without paying additional Premium. However, if You have to pay an additional Premium to enroll in Part A, B, or C or D of Medicare, this exclusion will apply to the particular Part(s) of Medicare for which You must pay only if You have enrolled in the Part(s).

However, if You have Medicare, Your Medicare coverage will not affect the Covered Services covered under this Agreement, except as follows:

- Your Medicare coverage will be applied first (primary) to any services covered byboth Medicare and this Agreement.
- If You receive a service that is covered both by Medicare and this Agreement, Our coverage will apply only to the Medicare Deductibles, Coinsurance and other charges for Covered Services that You must pay above what is payable by Your Medicare coverage.

For a particular claim, the combination of Medicare benefits and the benefits We will provide under this Agreement for that claim will not be more than the billed charge for the Covered Service You received.

We will apply any expenses paid by Medicare for Covered Services covered under this Agreement toward Your Deductible, except expenses paid by Medicare Part D.

Non-Emergency Care Received in an Emergency Room: Coverage is not provided for care received in an Emergency room that is not Emergency Care, except as specified in this Agreement. This includes, but is not limited to, suture removal in an Emergency room.

Non-Licensed Providers: Treatment or services provided:

- by a non-licensed Provider under the supervision of a licensed Physician, except as stated in the section titled **WHAT IS COVERED – MEDICAL** under "Behavioral Health Treatment for Pervasive Developmental Disorders or Autism."
- for which a health care Provider license is not required.
- This exclusion does not apply to the Medically Necessary treatment for SMI or SED.

Not Medically Necessary: Any services or supplies which are not Medically Necessary.

Nutritional or Dietary Supplements and Nutritional Counseling: Nutritional and/or dietary supplements, except as described in this Agreement or that We must cover by law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that You can buy over the counter and those You can get without a written Prescription or from a licensed pharmacist.

Orthodontic Services: This exclusion does not apply to Members under age nineteen (19) or with cleft palate conditions. This includes dental braces, other orthodontic appliances and any related service unless specifically stated as a Covered Service.

Optional accessories or devices primarily for the Member's comfort or convenience, elastic support stockings (unless covered under the "Diabetes Equipment, Education and Supplies" section), foot pads, bunion covers, customization of vehicles, vehicle lifts for wheelchairs and/or scooters, modifications of the member's home (e.g. ramp installation), comfort/convenience items (e.g. home UV therapy unit, home monitoring devices),

Outdoor Treatment Programs and/or Wilderness Programs, except for medically necessary treatment of a Mental Health Condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Edition, or severe mental illness or serious emotional disturbance of a child.

Out-of-Network Providers: Services from an Out-of-Network Provider except as specifically stated under the benefit sections of this Agreement.

Over-the-Counter: Coverage is not provided for Drugs, devices, products, or supplies with over-the-counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over-the-counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Agreement or as required by law. See the section titled **WHAT IS COVERED – MEDICAL** under "Family Planning Services" and "Preventive Care." Also see the section titled **WHAT IS COVERED – PRESCRIPTION DRUGS**.

Personal Hygiene, Environmental Control or Convenience Items: Coverage is not provided for personal hygiene, environmental control, or convenience items including but not limited to:

- Air conditioners, humidifiers, air purifiers;
- Physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, even if ordered by a Physician. This exclusion also applies to spas.
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
- Charges from a health spa or similar facility;

- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
- Charges for non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Infant helmets to treat positional plagiocephaly;
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

Physical Exams: Physical exams to sign up for insurance, as a term of employment, for licensing, or for school activities.

Physician/Other Providers' Charges including:

- Physician or Other Providers' charges are otherwise excluded from coverage for Telehealth except as otherwise specified in the "**WHAT IS COVERED - MEDICAL**" section of this Certificate.

Private Duty Nursing: Inpatient or outpatient services of a private duty nurse unless provided by a Home Health Care Provider or a Hospice Provider.

Prosthetics: Prosthetics for sports or cosmetic purposes, unless specifically stated as a Covered Service in this Agreement or as required by law. This includes wigs and scalp hair prosthetics. We also do not cover replacement of prosthetics due to misuse.

Providers Services: You get from a non-covered Provider, as defined in this Agreement. Examples of non- covered Providers include, but are not limited to, masseurs or masseuses (massage therapists) and physical therapist technicians.

Reversal of Voluntary Sterilization: Reversal of voluntary sterilization or costs associated with the storage of sperm, eggs, embryos and ovarian tissue.

Self-Help Training/Care: For self-help training and other forms of non-medical self care, except as specifically stated in the section titled **WHAT IS COVERED – MEDICAL** under "Diabetes Equipment, Education and Supplies," or as required by law.

Services, care or treatment for medical complications resulting from or associated with non-covered services,

Services not approved by the Federal Food and Drug Administration: Drugs, supplements, tests, vaccines, devices, radioactive materials and any other services that by

law require federal Food and Drug Administration (FDA) approval in order to be sold in the United States but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside the United States.

This exclusion does not apply to any of the following:

- Services covered under the "Emergency Care" sections of the section titled **WHAT IS COVERED - MEDICAL** that you receive outside the United States.
- Experimental or investigational services when an investigational application has been filed with the FDA and the manufacturer or the other source makes the services available to You or Oscar through an FDA-authorized procedure, except that We do not cover services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol.
- Services covered under "Clinical Trials" in the section titled **WHAT IS COVERED – MEDICAL**.

Services or Supplies from Family Members: Services prescribed, ordered, referred by or given by a member of Your immediate family, including Your spouse, Domestic Partner, child, brother, sister, parent, in-law, or self.

Services You Receive for Which You Have No Legal Obligation to Pay: Services You actually receive for which You have no legal obligation to pay or for which no charge would be made if You did not have health plan or insurance coverage, except services received at a non-governmental charitable research Hospital. Such a Hospital must meet the following guidelines: a) it must be internationally known as being devoted mainly to medical research, and b) at least ten percent of its Yearly budget must be spent on research not directly related to patient care, and c) at least one-third of its gross income must come from donations or grants other than gifts or payments for patient care, and d) it must accept patients who are unable to pay, and e) two-thirds of its patients must have conditions directly related to the Hospital research.

Shipping and Handling

Surrogacy: Services or supplies provided to a person not covered under this Agreement in connection with a surrogate pregnancy including, but not limited to, the bearing of a child by another woman for an infertile couple.

Teeth (Congenital Anomaly): Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Agreement under the part **WHAT IS COVERED – MEDICAL** in the sections "Dental Services" or

"Dental Services – Pediatric" or as required by law. This exclusion does not apply to Members under the age nineteen (19).

Teeth, Jawbone, Gums: For treatment of the teeth, jawbone or gums that is required as a result of a medical condition except as expressly required by law or specifically stated as a Covered Service under the section titled **WHAT IS COVERED – MEDICAL** under "Dental Services" and "Dental Services – Pediatric."

Temporomandibular or Craniomandibular Joint Treatment: Fixed or removable appliances which move or reposition the teeth, fillings, or prosthetics (crowns, bridges, dentures)

Therapy: Coverage is not provided for services, supplies, and equipment for the following, (unless medically necessary treatment of a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Edition, or severe mental illness or serious emotional disturbance of a child):

- Gastric electrical stimulation.
- Hippotherapy.
- Intestinal rehabilitation therapy.
- Prolotherapy.
- Recreational therapy.
- Sensory integration therapy (SIT).

Travel expenses: We do not pay for travel expenses related to the provision of medical services (such as mileage, lodging and meals costs), except as authorized by Us or specifically stated in the section titled **WHAT IS COVERED – MEDICAL**.

Non-Covered (excluded) services: Services specifically designated in this Agreement as not Covered, or excluded, Services.

Vein Treatment: Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) for cosmetic purposes.

Vision care: We will not pay for services incurred for, or in connection with, any of the items below:

- Vision care for Member age nineteen (19) and older, unless covered by the medical benefits of this Agreement.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if the Member receives the benefits in whole or in part. This

exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.

- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, Domestic Partner, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this booklet or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes, except as otherwise specified herein.
- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a network Provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient Hospital vision care, unless covered by the medical benefits of this Agreement.
- For orthoptics or vision training and any associated supplemental testing.
- For two (2) pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Agreement.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- Oversize lenses.
- For sunglasses.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- No benefit is available for frames purchased outside of our formulary.
- For vision care received Out-of-Network.

Vocational rehab

Waived Copayment, Coinsurance or Deductible: For any service for which You are responsible under the terms of this Agreement to pay a Copayment, Coinsurance or Deductible and the Copayment, Coinsurance or Deductible is waived by an Out-of-Network Provider.

Weight Loss Programs: Programs, whether or not under medical supervision, unless specifically stated in the section titled **WHAT IS COVERED – MEDICAL**. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to Medically Necessary treatments for morbid obesity including bariatric surgery.

Workers' Compensation: Any injury, condition or disease arising out of employment for which benefits or payments are covered by any worker's compensation law or similar law. If We provide benefits for such injuries, conditions or diseases We shall be entitled to establish a lien or other recovery under section 4903 of the California Labor Code or any other applicable law.

WHAT IS NOT COVERED (EXCLUSIONS) – PRESCRIPTION DRUGS

In addition to the exclusions in **WHAT IS COVERED – PRESCRIPTION DRUGS**, certain items are not covered under the Prescription Drug Retail or Home Delivery (Mail Order) Pharmacy benefit:

Administration Charges: Charges for the administration of any Drug except for covered immunizations as approved by Us or the Pharmacy Benefits Manager (PBM).

Clinically Equivalent Alternatives: Certain Prescription Drugs are no longer covered when clinically equivalent alternatives are available unless otherwise required by law, or is otherwise determined to be Medically Necessary.

Compound Drugs: Compound Drugs unless all the ingredients are FDA-approved and require a prescription to dispense, and the compound medication is not essentially the same as an FDA-approved product from a drug manufacturer, unless Oscar has specifically authorized an exception. Exceptions to non-FDA approved compound ingredients may include multi-source, non-proprietary vehicles and/or pharmaceutical adjuvants.

Contrary to Approved Medical and Professional Standards: Drugs given to You or prescribed in a way that is against approved medical and professional standards of practice.

Drugs Over Quantity Limits: Drugs in quantities which are over the limits set by Oscar.

Drugs Over the Quantity Prescribed or Refills After One (1) Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one (1) Year after the date of the original Prescription Order.

Drugs that Do Not Need a Prescription: Coverage is not provided for Drugs, devices, products, or supplies with over-the-counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over-the- counter Drug device, product, or supply, unless medically necessary or specifically stated as a Covered Service in the formulary. See the section titled **WHAT IS COVERED – MEDICAL** under "Family Planning Services" and "Preventive Care." Also see the section titled **WHAT IS COVERED – PRESCRIPTION DRUGS**.

Drugs used for cosmetic purposes.

Items Covered as Durable Medical Equipment (DME) : Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors.

Note: Durable Medical Equipment (DME) is covered under WHAT IS COVERED – MEDICAL, in the section "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies."

Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.

Lost or Stolen Drugs: Stolen Drugs or refills of lost Drugs (excluding those from Home Delivery (Mail Order) Pharmacy or Specialty Pharmacy).

Mail Service Programs Other than Oscar Approved Home Delivery Program: Prescription Drugs dispensed by any Mail Service program other than a Participating Oscar Home Delivery program, unless We must cover them by law.

Non-Approved Drugs: Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require FDA approval in order to be sold in the United States but are not approved by the FDA.

Off Label Use: Prior authorization is required for a non-FDA-approved indication of a drug listed on Our Formulary. Off label use is covered, as long as:

- The Drug is FDA-approved and an In-Network Provider has prescribed the Drug for:
    - The treatment of a life-threatening condition; or
    - The treatment of a chronic and seriously debilitating condition, is medically necessary to treat that condition, and
    - The Drug is Medically Necessary to treat the condition and is on the Formulary. If the Drug is not on the Formulary, the request for coverage shall be considered pursuant to H&SC § 1367.24 45 CFR § 156.122; and
- The drug has been recognized for treatment of that condition by any of the following:
    - The American Hospital Formulary Serv'ce's Drug Information; or
    - One of the following compendia, if recognized by the federal Centers for Medicare & Medicaid Services (CMS) as part of an anticancer chemotherapeutic regimen:
        - The Elsevier Gold Stand'rd's Clinical Pharmacology;
        - The National Comprehensive Cancer Network Drugs and Biologics Compendium;
        - The Thomson Micromedex DrugDex; or

- At least two (2) articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

Over-the-Counter Items: Coverage is not provided for Drugs, devices, products, or supplies with over-the-counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over-the-counter Drug device, product, or supply, unless specifically stated as a Covered Service in this Agreement or as required by law. See the section titled **WHAT IS COVERED – MEDICAL** under "Family Planning Services" and "Preventive Care." Also see the section titled **WHAT IS COVERED – PRESCRIPTION DRUGS.**

Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.

Weight loss Drugs: Weight loss Drugs unless Medically Necessary for treatment of morbid obesity. Medically Necessary weight loss drugs are covered as set forth in the **WHAT IS COVERED – PRESCRIPTION DRUGS** section.

GETTING APPROVAL FOR BENEFITS

Certain Services require a review of the service's Medical Necessity through Authorization processes. If Your Provider is considering or provides a service requiring Authorization, Your Provider contacts Us and shares the relevant clinical information so that a determination of the service's Medical Necessity can be made. Authorization determinations consider factors including the circumstances of the service, medical policy, clinical guidelines, Pharmacy and therapeutics guidelines, and the setting of the service.

In these situations, it is the Provider's responsibility to obtain Authorization, but if You have any questions about the Authorization process or would like to confirm if Authorization is required, contact Oscar at 1-855-672-2755 or visit www.hioscar.com for information.

Types of Requests

- **Precertification** – A required review of a service, treatment for admission for a benefit coverage determination that must be done before the service, treatment or admission start date. For Emergency admissions, Your authorized representative or Physician must tell Us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time. For labor/childbirth admissions, You, Your authorized representative, or Provider must request precertification if Your length of stay is more than forty-eight (48) hours for a vaginal birth or ninety-six (96) hours after a C-section.
- **Predetermination** – An optional, voluntary Prospective or Concurrent Review request for a benefit coverage determination for a service or treatment. We will check Your Agreement to determine if there is an Exclusion for the service or treatment. If there is a related clinical coverage guideline, the benefit coverage review will include a review to decide whether the service meets the definition of Medical Necessity under this Agreement or is Experimental/Investigative as that term is defined in this Agreement.
- **Post Service Clinical Claims Review** – A retrospective review for a benefit coverage determination to decide the Medical Necessity or Experimental/Investigative nature of a service, treatment or admission that did not have a Precertification or Predetermination review performed where required. Emergency Services may also be subject to retrospective review to verify Medical Necessity; if authorization is denied, You have appeal rights. Please see the **GRIEVANCES**, **INDEPENDENT MEDICAL REVIEW**, and **INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE** sections for more information about appeals. Medical reviews are done for a service, treatment or admission for which there is a related clinical coverage guideline and are typically initiated by Us.

Services for which Precertification and/or Predetermination may be required (i.e., services that need to be reviewed to determine whether they are Medically Necessary) include, but are not limited to, the following:

- Inpatient Admissions
    - Acute/Elective Hospital
    - Hospice
    - Long-term Acute Care
    - Rehabilitation, Acute/Subacute
    - Skilled Nursing Facility
- Behavioral Health & Substance Abuse
    - All Inpatient Admissions (Non-emergent)
    - Adaptive behavior assessment & therapy
    - Applied behavior analysis (ABA)
    - Detoxification programs
    - Electroconvulsive treatment (ECT)
    - Intensive outpatient treatment
    - Invasive psychiatric treatment
    - Methadone maintenance treatment
    - Non-physician mental health assessment & management
    - Outpatient psychiatric testing
    - Partial hospitalization treatment
    - Residential treatment
    - Transcranial magnetic stimulation (TMS)
    - Unlisted psychiatric services
- Pharmaceuticals
    - Physician-Administered Drugs
    - Site of Care
    - Prescription medications
- Site of Care
- Durable Medical Equipment (DME), Prosthetics, Orthotics, and Supplies
    - High cost DME
    - Bone growth stimulators
    - Braces and Orthoses
    - Continuous glucose monitors / insulin pumps
    - Hearing aids
    - Hearing implants (cochlear, BAHA)
    - Hospital beds, including mattresses and overlays
    - Hospital grade breast pumps
    - Negative pressure wound therapy pumps
    - Noninvasive positive pressure ventilation (CPAP, BiPAP)
    - Powered wheelchairs and ambulatory devices

    - Ocular and corneal Implants
    - Oxygen therapy
    - Parenteral and enteral pumps and supplies
    - Prostheses
    - Speech devices
    - Wearable defibrillators
- Private Duty Nursing
- Rehabilitative &/or Habilitative Services (e.g., home health, therapy)
- Treatments & Procedures
    - Acupuncture
    - Apheresis
    - Cardiovascular (e.g., cardiac catheterization, implantable cardiac devices)
    - Chiropractic services
    - Digestive services (e.g., bariatric surgery, gastric neurostimulator)
    - Eye (e.g., blepharoplasty, refractive surgery)
    - Gender affirmation / sex reassignment surgery
    - Gene & cellular therapy
    - Gynecologic
    - Head & neck (e.g., otoplasty, rhinoplasty)
    - Home births
    - Hyperbaric oxygen therapy
    - Infertility services
    - Interventional pain procedures (e.g., epidurals, facet joint injections)
    - Medical oncology (e.g., chemotherapy, supportive oncology drugs)
    - Musculoskeletal surgery (e.g., bunionectomy, joint arthroscopy, spinal surgery)
    - Neurostimulation
    - Organ & tissue transplants
    - Penile implants
    - Prostate
    - Radiation therapy (e.g., brachytherapy, proton beam therapy)
    - Skin (e.g., panniculectomy)
    - Wound care (e.g., skin/tissue grafts)
- Tests & Evaluations
    - Advanced imaging (e.g., cardiac imaging, CT scans)
    - Attended sleep studies
    - Genetic testing
- Non-Emergency Transportation

Please note that this is not an exhaustive prior authorization list. For a list of current procedures requiring Precertification, please call Member Services at 1-855-672-2755 or visit www.hioscar.com.

Typically, In-Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Physician will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is eighteen (18) years of age or older.

Who is responsible for Precertification	
Services given by an In-Network Provider	Services given by an Out-of-Network Provider
Provider	Member has no benefit coverage for an Out-of-Network Provider unless: • You or Your Provider get Authorization to use an Out-of-Network Provider before the service is given; or • For Emergency admissions, You, Your authorized representative or Physician must tell Us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time.

Medical Necessity decisions, including decisions about Prescription and Specialty Drug services, will be based on clinical coverage guidelines, such as medical policies and other clinical guidelines, procedures, and preventive care clinical coverage guidelines. We reserve the right to review and update these clinical coverage guidelines from time to time. We will administer benefits for any Medically Necessary determination notwithstanding that it might otherwise be found to Experimental or Investigational as that term is defined in the Plan otherwise. Your Agreement takes precedence over these guidelines.

You are entitled to receive, free of charge, reasonable access to any records on which a determination relied. To ask for this information, call the phone number on the back of Your Identification Card.

Oscar may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Oscar's discretion, such change is in furtherance of the provision of cost-effective, value-based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt Your claim from medical review if certain conditions apply.

Just because Oscar exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Oscar will do so in the future, or will do so in the future for any other Provider, claim or Member. Oscar may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking Your on-line Provider directory, on-line pre-certification list or by contacting member services at **1-855-672-2755**.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, one or more clinical utilization management guideline may be used in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to the Plan's members.

Request Categories

- Urgent– A request for Precertification or Predetermination that in the view of the treating Provider or any Physician with knowledge of Your medical condition could, without such care or treatment, seriously threaten Your life or health or Your ability to regain maximum function or subject You to severe pain that cannot be adequately managed without such care or treatment.
- Prospective – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- Concurrent Review – Oscar will actively review and manage utilization decisions during an inpatient level of care or an ongoing outpatient course of treatment. The frequency with which Oscar conducts concurrent review for an inpatient level of care or an ongoing outpatient course of treatment depends on the severity of the member's case/condition, progress towards treatment goals, current level of stability, and impending discharge plans

- Retrospective – Oscar will also be available to review and evaluate medical appropriateness for services that have been provided where pre-authorization is required, but there has been no notification of admission by provider or request for a pre-authorization review by provider. Medical records will be required for this review and a medical necessity review will be completed using nationally recognized criteria.

Decision and Notice Requirements

Requests for benefits are reviewed according to the timeframes listed below. The timeframes and requirements listed are based on State and Federal laws. State laws apply where the State laws are stricter than the Federal laws. If You live in and/or get services in a state other than the State where Your Agreement was issued other State- specific requirements may apply. You may call member services at 1-855-672-2755 for more details.

Request Category	Timeframe Requirement for Decision and Notification when all necessary information is initially provided
Prospective Urgent	The decision will be within seventy-two (72) hours from the receipt of request.
Prospective non-Urgent	The decision will be within five (5) business days from the receipt of the request.
Concurrent Urgent	If the request is made within 24 hours of the expiration of the existing authorization, the decision will be within twenty-four (24) hours from the receipt of request. If the request is not made within 24 hours of the expiration of the existing authorization, the decision will be within seventy-two (72) hours from the receipt of request
Concurrent non-Urgent	The decision will be within five (5) business days from the receipt of the request
Retrospective	The decision will be within thirty (30) calendar days from the receipt of the request.

If more information is needed to make Our decision, the requesting Provider will be informed, and written notice will be sent to You or Your authorized representative of the specific information needed to finish the review. If You and/or Your requesting Provider do not provide the specific information needed or if the information is not complete by the timeframe identified in the written notice, the decision will be based upon the information available.

Notice of the decision, as required by State and federal law, will be given by one or both of the following methods, as required by state and/or federal law:

- Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.
- Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and You or Your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date You get service:

- You must be eligible for benefits;
- Premium must be paid for the time period that services are given;
- The service or supply must be a covered benefit under Your Plan;
- The service cannot be subject to an Exclusion under Your Plan; and
- You must not have exceeded any applicable limits under Your Plan.

Appealing Authorizations that Deny, Modify, or Delay Services

You may submit a grievance or request an Independent Medical Review (IMR) of disputed health care services if You believe that a request for authorization of a health care service has been improperly denied, modified, or delayed. For more information on submitting a grievance or requesting an IMR, see the **GRIEVANCES**, **INDEPENDENT MEDICAL REVIEW**, and **INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE** sections.

Case Management

Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the case management program to help meet their health-related needs.

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria

and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or Injury, We may provide benefits for alternate care through Our case management program that is not a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Plan. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us. Nothing in this provision shall prevent You from Appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

CONTINUATION OF COVERAGE

COBRA

You may be able to continue Your coverage under this Agreement for a limited time after You would otherwise lose eligibility, if required by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA applies to most employees (and their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Health Benefits Officer or Plan Administrator for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

Pursuant to federal COBRA coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Agreement in certain situations when You would otherwise lose coverage, known as qualifying events. In order to be eligible, an individual must have been covered by a Group Health Plan on the day before the qualifying even occurred. Additionally, any child born to or placed for adoption while on COBRA is automatically considered Eligible.

If Your coverage ends due to termination or reduction in hours for reasons other than gross misconduct, You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

If You are a covered Dependent, You may continue coverage if Your coverage ends due to:

- Voluntary or involuntary termination of the Subscriber's employment, other than for gross misconduct;
- Reduction in the hours worked by the Subscriber or other change in the Subscriber's class, other than for gross misconduct;
- A covered employee becoming entitled to Medicare per Medicare eligibility requirements
- Divorce or legal separation from the Subscriber; or
- Death of the Subscriber.

If You are a covered Child, You may continue coverage if Your coverage ends due to:

- Voluntary or involuntary termination of the Subscriber's employment, other than for gross misconduct;
- Reduction in the hours worked by the Subscriber or other change in the Subscriber's class, other than for gross misconduct;
- A covered employee becoming entitled to Medicare, per Medicare eligibility requirements
- Loss of covered Child status under the plan rules; or
- Death of the Subscriber.

If You want to enroll in COBRA continuation coverage, You must request continuation from the Group in writing and make the first Premium payment to the Group within the 60-day period following the later of:

- The date coverage would otherwise terminate; or
- The date You are sent notice by first class mail of the right of continuation by the Group.

Payment of COBRA Premiums

The Group may charge up to 102% of the Group Premium for continued COBRA coverage. However, if You are eligible to continue Group coverage to 29 months because of a Social Security disability determination, the COBRA Premiums for months 19 through 29 will be 150% of the Group Premium.

If You are enrolled in COBRA and are contributing to the cost of Coverage, the Group is responsible for collecting and submitting all Premium contributions to Us in the manner and for the period established under this Plan.

COBRA Termination of Group Continued Coverage

Continued coverage under federal COBRA will terminate at the earliest of the following:

- The date 18 months after the Subscriber's coverage would have terminated because of termination of employment or reduction in hours;
- If You are a covered Spouse or Child, the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
- The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
- The date You become entitled to Medicare;
- The date to which Premiums are paid if You fail to make a timely payment; or

- The date the Group Health Plan contract terminates. However, if the Group Health Plan contract is replaced with similar coverage, You have the right to become covered under the new Group Health Plan contract for the balance of the period remaining for Your continued coverage.

When Your Continuation of Coverage ends, You may have a right to conversion. See "Conversion Right to a New Contract after Termination" section of this Agreement."

Cal-COBRA
If You are ineligible for COBRA or exhaust Your COBRA coverage, and Your Employer employs two (2) to nineteen (19) employees, You are able to continue Group coverage under the state law California Continuation Benefits Replacement Act ("Cal-COBRA"). If you are eligible for COBRA, Cal-COBRA may extend coverage up to 36 months.

Continuing Coverage for Enrollees Who Have Exhausted COBRA Continuation Coverage If You have exhausted continuation coverage under COBRA, We provide the opportunity for Your to continue coverage for up to 36 months from the date Your continuation coverage began, if You are entitled to less than 36 months of continuation coverage under COBRA. The health care service plan shall offer coverage pursuant to the terms of this article, including the rate limitations contained in Section 1366.26.

Eligibility and Effective Date of Coverage for Cal-COBRA after COBRA
If Your Group is subject to COBRA and Your COBRA coverage ends, You may be able to continue Group coverage effective the date Your COBRA coverage ends if all of the following are true:

- Your effective date of COBRA coverage was on or after January 1, 2003
- You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months
- You do not have Medicare

You must request an enrollment application by calling Our member services at 1-855- 672-2755 within 60 days of the date of when your COBRA coverage ends.

Cal-COBRA Enrollment and Premiums
Within 10 days of Your request for an enrollment application, We will send You Our application, which will include Premium and billing information. You must return Your completed application within 63 days of the date of Our termination letter or of Your membership termination date (whichever date is later).

If We approve Your enrollment application, We will send you billing information within 30 days after We receive Your application. You must pay the bill within 45 days after the date We issue the bill. The first Premium payment will include coverage from Your Cal-COBRA effective date through Our current billing cycle. You must send Us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

After that first payment, Your Premium payment for the upcoming coverage month is due on first day of that month. The Premiums will not exceed 110 percent of the applicable Premiums charged to a similarly situated individual under the Group benefit plan except that Premiums for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent instead of 110 percent.

Changes to Cal-COBRA Coverage and Premiums

Your Cal-COBRA coverage is the same as for any similarly situated individual under Your Group's Agreement, and Your Cal-COBRA coverage and Premiums will change at the same time that coverage or Premiums change in Your Group's Agreement. Your Group's coverage and Premiums will change on the renewal date of its Agreement, and may also change at other times if Your Group's Agreement is amended. Your monthly invoice will reflect the current Premiums that are due for Cal-COBRA coverage, including any changes. For example, if Your Group makes a change that affects Premiums retroactively, the amount we bill You will be adjusted to reflect the retroactive adjustment in Premiums. Your Health Benefits Officer or Plan Administrator can tell you whether this Evidence of Coverage is still in effect and give You a current one if this Evidence of Coverage has expired or been amended. You can also request one from Our member services.

Cal-COBRA open enrollment or termination of another health plan

If You previously elected Cal-COBRA coverage through another health plan available through Your Group, You may be eligible to enroll in Oscar during your Group's annual open enrollment period, or if Your Group terminates its agreement with the health plan You are enrolled in. You will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA. Please ask Your Group for information about health plans available to You at open enrollment.

In order for You to switch from another health plan and continue your Cal-COBRA coverage with Us, We must receive Your enrollment application during your Group's open enrollment period, or within 63 days of receiving the Group's termination notice described under "Group responsibilities." To request an application, please call Us at 1-855-672-2755. We will send You our enrollment application and You must return Your completed application before open enrollment ends or within 63 days of receiving the termination

notice described under "Group responsibilities." If We approve Your enrollment application, We will send you billing information within 30 days after We receive Your application. You must pay the bill within 45 days after the date We issue the bill. You must send Us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

How you may terminate your Cal-COBRA coverage
You may terminate Your Cal-COBRA coverage by sending written notice, signed by the Subscriber, to the address below. Your membership will terminate at 11:59 p.m. on the last day of the month in which We receive Your notice. Also, You must include with Your notice all amounts payable related to your Cal-COBRA coverage, including Premiums, for the period prior to Your termination date.

Oscar Health Plan of California
Attn: Member Services
12777 West Jefferson Blvd, 1st Floor
Suite 100, Building D
Los Angeles, CA, 90066

Termination for Nonpayment of Cal-COBRA Premiums
If You do not pay your required Premiums by the due date, We may terminate Your membership as described in this section. If You intend to terminate Your membership, be sure to notify Us as described under "How you may terminate your Cal-COBRA coverage" in this "Cal-COBRA" section, as You will be responsible for any Premiums billed to You unless You let Us know before the first of the coverage month that You want Us to terminate Your coverage. Your Premium payment for the upcoming coverage month is due on the first day of that month. If We do not receive full Premium payment on or before the first day of the coverage month, We will send a notice of nonreceipt of payment "a "Late Notice") to the Subscriber's address of record. This Late Notice will include the following information:

- A statement that We have not received full Premium payment and that We will terminate the memberships of everyone in Your Family for nonpayment if We do not receive the required Premiums within 30 days after the date of the Late Notice
- The amount of Premiums that are due
- The specific date and time when the memberships of everyone in Your Family will end if We do not receive the Premiums

If We terminate Your Cal-COBRA coverage because We did not receive the required Premiums when due, Your membership will end at 11:59 p.m. on the 30th day after the date of the Late Notice. Your coverage will continue during this 30 day grace period, but upon

termination You will be responsible for paying all past due Premiums, including the Premiums for this grace period.

We will mail a Termination Notice to the Subscriber's address of record if We do not receive full Premium payment within 30 days after the date of the Late Notice. The Termination Notice will include the following information:

- A statement that We have terminated the memberships of everyone in Your Family for nonpayment of Premiums
- The specific date and time when the memberships of everyone in Your Family ended
- The amount of Premiums that are due
- Information explaining whether or not You can reinstate Your memberships
- Your appeal rights

If We terminate Your membership, You are still responsible for paying all amounts due.

Reinstatement of your membership after termination for nonpayment of Cal-COBRA Premiums

If We terminate Your membership for nonpayment of Premiums, We will permit reinstatement of Your membership three times during any 12-month period if We receive the amounts owed within 15 days of the date of the Termination Notice. We will not reinstate Your membership if You do not obtain reinstatement of Your terminated membership within the required 15 days, or if We terminate Your membership for nonpayment of Premiums more than three times in a 12-month period.

Termination of Cal-COBRA coverage

Cal-COBRA coverage continues only upon payment of applicable monthly Premiums to Us at the time We specify, and terminates on the earliest of:

- The date Your Group's Agreement with Us terminates (You may still be eligible for Cal-COBRA through another Group health plan)
- The date You get Medicare
- The date Your coverage begins under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition You may have (or that does contain such an exclusion or limitation, but it has been satisfied)
- The date that is 36 months after Your original COBRA effective date (under this or any other plan)
- The date Your membership is terminated for nonpayment of Premiums as described under "Termination for nonpayment of Cal-COBRA Premiums" in this section

Note: If the Social Security Administration determined that You were disabled at any time during the first 60 days of COBRA coverage, You must notify Your Group within 60 days of

receiving the determination from Social Security. Also, if Social Security issues a final determination that You are no longer disabled in the 35th or 36th month of Group continuation coverage, Your Cal-COBRA coverage will end the later of: (1) expiration of 36 months after Your original COBRA effective date, or (2) the first day of the first month following 31 days after Social Security issued its final determination.
You must notify Us within 30 days after You receive Social Security's final determination that You are no longer disabled.

Group responsibilities
If Your Group's agreement with a health plan is terminated, Your Group is required to provide written notice at least 30 days before the termination date to the persons whose Cal-COBRA coverage is terminating. This notice must inform CalCOBRA beneficiaries that they can continue Cal-COBRA coverage by enrolling in any health benefit plan offered by Your Group. It must also include information about benefits, premiums, payment instructions, and enrollment forms (including instructions on how to continue Cal-COBRA coverage under the new health plan). Your Group is required to send this information to the person's last known address, as provided by the prior health plan. We are not obligated to provide this information to qualified beneficiaries if your Group fails to provide the notice. These persons will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal- COBRA.

Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty
If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

- Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
- You serve no more than four (4) years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Agreement will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Group the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of Coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or

uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

- Your coverage under this Agreement may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which active duty terminated.
- If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to Us for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one (1) year.

Conversion Right to a New Health Plan Contract After Termination

You have the right to convert to a new Health Plan contract if coverage under this Agreement terminates under the circumstances described below:

- Termination of the Group Health Plan Contract. If the Group Health Plan contract between Us and the Group is terminated as set forth in the Termination of Coverage section of this Agreement, and the Group has not replaced the coverage with similar and continuous health care coverage, whether insured or self-insured, You are entitled to purchase a new Health Plan contract as a direct payment member.
- If You Are No Longer Covered in a Group. If Your coverage terminates under the Termination of Coverage section of this Agreement because You are no longer a member of a Group, You are entitled to purchase a new Health Plan contract as a direct payment member.
- On the Death of the Subscriber. If coverage terminates under the Termination of Coverage section of this Agreement because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Health Plan contract as direct payment members.
- Termination of Your Marriage. If a Spouse's coverage terminates under the Termination of Coverage section of this Agreement because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Health Plan contract as a direct payment member.
- Termination of Coverage of a Child. If a Child's coverage terminates under the Termination of Coverage section of this Agreement because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Health Plan contract as a direct payment member.
- Termination of Your Temporary Continuation of Coverage. If coverage terminates under the Termination of Coverage section of this Agreement because You are no longer eligible for

Continuation of Coverage, You are entitled to purchase a new Health Plan contract as a direct payment member.

When to Apply for the New Health Plan Contract

If You are entitled to purchase a new Health Plan contract as described above, You must apply to Us for the new Health Plan contract within 60 days after termination of coverage under this Agreement. You must also pay the first Premium of the new Health Plan contract at the time You apply for coverage.

The New Health Plan Contract

We will offer You an individual direct payment Health Plan contract at each level of coverage (i.e., bronze, silver, gold or platinum) that Covers all benefits required by state and federal law. You may choose among any of the four (4) Health Plan contract offered by Us. The coverage may not be the same as Your current coverage.

CONTINUITY AND TRANSITION OF CARE

Oscar will provide written notice within a reasonable time of any termination or breach of contract by, or inability to perform of, any contracting Provider if the Member may be materially and adversely affected.

If a Member is in an ongoing course of treatment when their Provider leaves Oscar's Network, then the Member may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider until the services being rendered are completed, unless We can make reasonable and medically appropriate provisions for services by an In-Network Provider. If the Member is pregnant and in the second or third trimester, the Member may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for the Member to continue to receive Covered Services, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also agree to provide Oscar the necessary medical information related to the member's care and adhere to Our policies and procedures, including those for assuring quality of care, obtaining Authorization, Referrals, and a treatment plan approved by Oscar If the Provider agrees to these conditions and Oscar agrees that the Member's request is eligible for continued care and the treatment is medically necessary, the Member will receive the Covered Services as if they were being provided by a Participating Provider. The Member will be responsible only for any applicable In-Network Cost-Sharing. If the Provider was terminated by Oscar due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

Your Dependents may be eligible for an extension of benefits if they incurred a total disability while enrolled in Our Plan.

Completion of Covered Services: Subject to the terms and conditions set forth below, at the request of a Member, We will pay benefits at the In-Network Provider level for Covered Services (subject to applicable Deductibles, Copayment and Coinsurance and other terms) rendered by a Provider whose participation We have terminated from Our network or by an Out-of-Network Provider to a newly covered Member who, at the time his or her coverage became effective, was receiving Covered Services from that Provider for one of the conditions described below.

In order to be eligible for the completion of Covered Services, the Member:

- Must be under the care of the In-Network Provider for one of the conditions described below, at the time of Our termination of the Provider's participation in Our network; or
- Must be a newly covered enrollee under an individual health care service plan contract whose prior coverage was terminated under paragraph (5) or (6) of subdivision (a) of Section 1365 of the Act , which includes circumstances when a health benefit plan is withdrawn from any portion of the market, and at the time his/her coverage became effective, he/she was receiving services from an Out-of-Network Provider for one of the conditions described below.

The terminated Provider must agree in writing to provide services to the Member in accordance with the terms and conditions of his/her agreement with Us prior to termination from Our network. The Provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with Oscar prior to termination from Our network. If the Provider does not agree with these contractual terms and conditions, We are not required to continue the Provider's services beyond the contract termination date.

The Out-of-Network Provider must agree in writing to be subject to the same contractual terms and conditions that are imposed upon current In-Network Providers providing similar Covered Services who are not capitated and who are practicing in the same or a similar geographic area as the Out-of-Network Provider. If the Out-of- Network Provider does not agree to comply or does not comply with these contractual terms and conditions, We are not required to continue the Provider's services. We are not required to continue the services of an Out-of-Network Provider if the Provider does not accept the payment rates provided for in this paragraph.

Such benefits will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud or other criminal activity. Also, such benefits will not apply to a newly covered Member who is offered an Out-of-Network Provider option or to had the option to continue with his or her previous health plan or Provider and instead voluntarily chose to change health plans.

We will furnish such benefits for the continuation of services by an eligible terminated Provider or Out-of-Network Provider only for any of the following conditions:

- An acute condition. An acute condition is a medical condition that involves asudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.
- A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires

ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by Us in consultation with the Member and the terminated Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.

- A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.
- Maternal Mental Health. We will cover completion of Mental Health Services by a Member's Provider through the duration of the pregnancy and the post-partum period, hat may arise up to one year after delivery. We will provide coverage for these Mental Health Services either 12 months from the diagnosis or from the end of pregnancy, whichever is later. The Member must present written documentation demonstrating the diagnosis of the Mental Health condition before, during, or after pregnancy in order to receive this benefit.
- A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) Year or less. Completion of Covered Services shall be provided for the duration of a terminal illness, which may exceed twelve (12) months from the Provider's contract termination date.
- The care of a Newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
- Performance of a surgery or other procedure that We have authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within one-hundred eighty (180) days of the Provider's contract termination date.

If You would like information on the process or the policy and procedure for requesting completion of Covered Services, contact Member services at **1-855-672- 2755**. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Agreement.

We will notify You as to whether or not Your request for continuation of care is approved. We will also notify the Provider if the request is approved. If approved, the Member will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this Agreement. Financial arrangements with terminated Providers are negotiated on a case-by-case basis. We will request that the terminated Provider agree to negotiate reimbursement and/or contractual requirements that apply to In-Network Providers, including payment terms. If the terminated Provider does not agree to the same reimbursement and/or contractual requirements, We are not required to continue that

Provider's services. If You disagree with Our determination regarding continuation of care, please refer to the section titled **INDEPENDENT MEDICAL REVIEW**.

RIGHT OF REIMBURSEMENT

Oscar's priority is Your health. If You become sick or are injured, even by someone else, Oscar will provide benefits covered under this Agreement.

However, if this Plan pays benefits under this Agreement to You for expenses incurred due to Third Party Injuries, then Oscar retains the right to repayment of the full cost of all benefits provided by this Plan on Your behalf that are associated with the Third Party Injuries. Oscar's rights of recovery apply to any recoveries made by or on Your behalf from the following sources, including but not limited to:

- Payments made by a Third Party or any insurance company on behalf of the Third Party;
- Any payments or awards under an uninsured or underinsured motorist coverage policy;
- Any Workers' Compensation or disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' medical payments coverage or premises or homeowners' insurance coverage; and
- Any other payments from a source intended to compensate You for injuries resulting from an accident or alleged negligence.

By accepting benefits under this Agreement, You specifically acknowledge Oscar's Right of Reimbursement. This Right of Reimbursement attaches when this Plan has paid health care benefits for expenses incurred due to Third Party Injuries and You or Your representative has recovered any amounts from a Third Party. By providing any benefits under this Agreement, Oscar is granted an assignment of the proceeds of any settlement, judgment or other payment received by You to the extent of the full cost of all benefits provided by this Plan.

By accepting benefits under this Agreement, You or Your representatives further agree to:

- Notify Oscar promptly and in writing when notice is given to any party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to Third Party Injuries sustained by You;
- Cooperate with Oscar and do whatever is necessary to secure Oscar's rights of reimbursement under this Agreement;
- Pay, from any recovery, settlement judgment, or other source of compensation, any and all amounts due Oscar as reimbursement for the full cost of all benefits associated with Third Party Injuries paid by this Plan (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by Oscar in writing;

- Do nothing to prejudice Oscar's rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits paid by Oscar; and
- Serve as a constructive trustee for the benefits of this Plan over any settlement or recovery funds received as a result of Third Party Injuries.

In the event You or Your representative fail to cooperate with Oscar, You shall be responsible for all benefits paid by this Plan in addition to costs and attorney's fees incurred by the Plan in obtaining repayment.

How the Amount of the Covered Person's Reimbursement is Determined
The following section is not applicable to Workers' Compensation liens and may not apply to certain ERISA plans, hospital liens, Medicare plans and certain other programs and may be modified by written agreement. (Reimbursement related to Workers' Compensation benefits, ERISA plans, hospital liens, Medicare and other programs not covered by California Civil Code, Section 3040 will be determined in accordance with the provisions of this Agreement and applicable law.)

Your reimbursement to Oscar is based on the value of the services received. For the purposes of determining the amount due back to the Plan the amount will be calculated in accordance with California Civil Code Section 3040, or as otherwise permitted by California law.

- The amount of the reimbursement owed to Oscar will be reduced by the percentage that the recovery is reduced if a judge, jury or arbitrator determines that You were responsible for some portion of Your injuries;
- The amount of the reimbursement owed to Oscar will also be reduced by a pro rata share for any legal fees or costs paid from money You received; and
- The amount You will be required to reimburse the Plan for services received under this Plan will not exceed one-third of the money You receive if You engage a lawyer or one- half of the money received if a lawyer is not engaged.

As used herein, the term "Third Party", means any party that is, or may be, or is claimed to be responsible for illness or injuries to You. Such illness or injuries are referred to as "Third Party Injuries." "Third Party" includes any party responsible for payment of expenses associated with the care of treatment of Third Party Injuries.

HEALTHCARE FRAUD

Fraud and Abuse
Reporting Healthcare Fraud
Oscar's mission is to make healthcare smart and simple. Our goal is to empower Members with information to help guide their health care decisions, including how to protect themselves, and Oscar, against healthcare fraud.

What is health care fraud?
Health care fraud occurs when someone intentionally provides false or misleading information to obtain health benefits or money. Health care fraud is a crime.

How does this impact me?
Health care fraud places a burden on both Oscar and Our Members. Providers who engage in fraud may be willing to prioritize their own financial gain over quality of treatment and diagnosis.

Also, health care fraud raises the cost of health insurance for everyone.
How do I know if someone has committed health care fraud? Health care fraud can be committed by a number of people including doctors, Hospitals, labs, medical equipment suppliers, and even Members.

Some examples are:

- Provider fraud:
    - Billing for services that were not performed
    - Using a falsified diagnosis to bill tests or procedures that are not Medically Necessary
    - "Upcoding" or billing for more expensive services than the ones that were performed
    - Accepting money from another Provider for Member Referrals or "kickback"
    - Waiving a Member's cost share in order to bill Your insurer more
    - Reselling Medical Items
- Examples of Member fraud:
    - Using someone else's Oscar coverage or card
    - Falsely alleging the theft of medical equipment

Help avoid health care fraud
Oscar keeps Your personal health data safe, and it's important that You take steps to protect Your information as well.

Be careful about sharing Your personal health information with others.

Make sure You keep Your Oscar card safe and use a password if You access the Oscar app.
When You go to the doctor, ask questions about the care You receive.
Once You receive medical bills from Your Provider compare them to Your Oscar explanation of benefits.

If You're confused by what You were charged, contact Oscar's Member services department at 1-855-672-2755 or help@hioscar.com.

Oscar has a Special Investigations Unit (SIU) to investigate allegations of fraud.
If You suspect fraud, report Your concern to Oscar's Special Investigations Unit at fraud@hioscar.com or call Our 24/7 toll-free fraud hotline at 1-844-392-7589.

You can also mail Oscar a report:

Attn: Special Investigations Unit
12777 West Jefferson Blvd, 1st Floor
Suite 100, Building D
Los Angeles, CA, 90066

When leaving Oscar's SIU a message, please provide as much information as You can (names of those involved, locations, and any other details), so that We can investigate and take appropriate action. Oscar does not trace calls and will not make an attempt to identify the caller.

Reports can be made without worry of retaliation or intimidation. Oscar also partners with the National HealthCare Anti-Fraud Association (NHCAA) to improve the prevention, detection, and investigation of health care fraud. For more information on the NHCAA's initiatives, visit their website here https://www.nhcaa.org/.

IMPORTANT INFORMATION ABOUT THIS AGREEMENT (GENERAL PROVISIONS)

Below is important information regarding this Agreement.

Agreement Between Us and Network Providers
Any agreement between Us and Network Providers may only be terminated by Us or the Providers. This Plan does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Network Provider or any health benefits program.

Benefits Not Transferable
You and Your covered Dependents are the only persons entitled to receive benefits under this Agreement. Fraudulent use of such benefits can result in cancellation of this Agreement and appropriate legal action may be taken.

Changes in Premium
This Evidence of Coverage is subject to amendment, modification or termination in accordance with any provision thereof or hereof without the consent or concurrence of or notice to You, except as provided for herein. When You elect coverage pursuant to this Evidence of Coverage or accepting benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, amendments and provisions thereof and hereof. We will send You a disclosure notice of any change to benefits 10 days prior to the start of the annual enrollment period applicable to the contract or 60 days prior to the effective date of the contract renewal, whichever occurs earlier in the calendar year.

Change in Beneficiary
Unless You make an irreversible designation of beneficiary, You reserve the right to change Your beneficiary. The consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Plan or to any change of beneficiary or beneficiaries, or to any other changes in this Plan.

Conformity with Law
This Agreement is subject to the laws of the State of California. Any provision of this Agreement which, on its Effective Date, is in conflict with any law is amended to conform to the minimum requirements of such law.

Content of the Agreement
This Evidence of Coverage, including an application for coverage and any enrollment forms; amendments, riders, and endorsements; and a Schedule of Benefits, if any, constitutes the exclusive and entire health care service plan contract between You and Oscar, and shall be binding upon all Covered Persons, Oscar, and any of our subsidiaries, affiliates, successors, heirs, and permitted assignees. All prior negotiations, agreements, and understandings are superseded hereby. No oral statements, representations, or understanding by any person can change, alter, delete, add or otherwise modify the express written terms of this contract. There are no warranties, representations, or other agreements between You and Us in connection with the subject matter of this Plan, except as specifically set forth herein.

No employee, agent, or other person is authorized to interpret, amend, modify, waive, or otherwise change the cost-sharing design terms and conditions of this contract when required by state or federal law. We will provide written notice to You of any such modifications.

Continuation of Benefit Limitations
Some of the benefits in this Agreement may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

Computation of Time
Unless We state otherwise, all references in this Evidence of Coverage to "day" shall mean calendar day. All references to "Evidence of Coverage Effective Date" shall mean 12:01 a.m. on the date on which coverage and enrollment under this Evidence of Coverage begins.

Clerical Error
Clerical error, whether by You or Us, with respect to this Plan, or any other documentation issued by Us in connection with this Plan, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Effective Date
Your benefits begin on the Effective Date of Your Agreement.

End Stage Renal Disease
Oscar will coordinate coverage with Medicare for Members with ESRD. Oscar follows Medicare Secondary Payer rules and regulations when coordinating coverage. Please contact Oscar's Member Services Team at 1-855-672-2755 or online at www.hioscar.com, for more information on coordination. You can also contact the Social Security Administration, at 1-800-772-1213, for more information on ESRD benefits.

Evidence of Coverage
You have been provided with this Plan and an Identification Card as evidence of coverage.

Family Changes
You are required to notify us of any events or changes in Your family, such as adoption, birth, marriage, divorce, death or the start of military service. We must receive Your notice when a dependent or Spouse is removed from coverage or added within 60 days of the change if Your coverage was not purchased on the Exchange. The Effective Date of the change to Your Plan is the date of the event. You are also required to notify the Exchange within 60 days of the change in Your family, if applicable. The Exchange will then notify Oscar of the Effective Date, which is determined by federal law.

Identification Cards
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Agreement. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

Implied Waiver
Any failure by Us at any time, or from time to time, to enforce or to require strict adherence to any of the terms or conditions set forth in this Agreement shall in no event be construed as a waiver of any such terms or conditions or Our right to enforce such terms or conditions in the future. Should We provide a Member with coverage for benefits to which the Member is not entitled under this Agreement, such provision of coverage shall not amend this Agreement to incorporate those benefits herein or entitle the Member to receive additional benefits not specifically listed under this Agreement. Further, it shall not affect Our right at any time to enforce or avail ourselves of any such remedies as We may be entitled to under applicable law, or this Plan.

Ineligible Use
The renewal date for this Agreement is January 1 of each year. This Agreement will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Agreement or by the Member upon 30 days' prior written notice to Us.

Laws Governing the Agreement
This Agreement will be governed by the laws of the State of California and federal law where applicable.

Legal Actions
No action at law or in equity or arbitration shall be brought against Us until 60 days after You furnish to Us a written proof of loss. No such action shall be brought more than three (3) years after the end of the time within which proof of loss was required to be furnished.

Notice
Any notice that We give You under this Agreement will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery. You agree to provide Us with notice of any change of Your mailing or electronic address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to:

Oscar Health Plan of California Attn: Member Services
12777 West Jefferson Blvd, 1st Floor
Suite 100, Building D
Los Angeles, CA, 90066

However, claims and requests for reimbursement should be sent to Oscar as outlined in **CLAIMS AND PAYMENTS** section.

Physical Examination and Autopsy
At Our own expense, We have the right and opportunity to examine the Member claiming benefits when and as often as it may reasonably be required during the pendency of a claim and also to have an autopsy done in the case of death where it is not otherwise prohibited by law.

Public Policy Participation Procedure
This procedure enables Members to participate in establishing the public policy of Oscar Health Plan of California. Members may apply to participate by contacting Oscar directly at 1-855-672-2755. This Procedure is not to be used as a substitute for the grievance procedure, complaints, inquiries or requests for information.

Public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public (California Health and Safety Code, Section 1369).

Oscar Health Plan of California is establishing a standing committee which shall be responsible for creating the public policy of the plan. The standing committee's recommendations and reports will be regularly reported to the governing board. The governing board shall consider the recommendations of the standing committee and record any action taken, in its minutes. Upon request, Oscar will provide Members who have initiated a public policy issue with the appropriate extracts of the minutes within thirty (30) business days after the minutes have been approved.

Rates
Your rate will be based upon the rating factors permitted by state law and the Knox-Keene Act: age, tobacco use and where You live.

Right to Receive and Release Information
Each Member, as part of participating in the delivery or receipt of services,

- authorizes any insurer, employer, organization, and health care services Provider to release to Us any and all information relating to administration of and coverage under this Plan, including but not limited to past, present and future health care examinations, treatments and diagnoses; and,
- authorizes Oscar to release the information described above to administer Your Plan.

You agree to assist us in obtaining this information if needed, including but not limited to executing a release and/or authorization for Us to obtain records if requested by Us during the term of Your coverage. Failure to assist Us in obtaining the necessary information when requested may result in the delay or rejection of Your claims until the necessary information is received by Us. We reserve the right to reject or suspend a Claim based on lack of medical information or records.

Our Notice of Privacy Practices describes our use of Your information. In order to administer coverage and benefits, we may, in accordance with applicable law, release to or obtain from any person, plan, or organization, any information with respect to persons applying for coverage under this Evidence of Coverage, or to You or Your Dependents covered under this Agreement which We deem to be necessary. You can access this document on our website, at hioscar.com. A copy of the Notice of Privacy Practices is available to you at no charge upon request. Contact us at 1-855-672-2755 to request a copy.

Recovery of Overpayments.
We reserve the right to recover any payments made by Us that were:

- Made in error;
- Made to You or any party on Your behalf, where We determine that such payment made is greater than the amount payable under this Agreement;
- Made to You and/or any party on Your behalf, based on fraudulent o misrepresented information; or
- Made to You and/or any party on Your behalf for charges that were discounted, waived or rebated.

We reserve the right to adjust any amount applied in error to the Deductible or Out-of-Pocket Limit.

Our right to recover payments, as specified above, will be limited to 24 month from the date of the payment.

Relationship of Parties
We do not ourselves undertake to directly furnish any Health Care Services under the Agreement. The relationship between Us and Network Providers, Physicians, Facilities, Skilled Nursing Facilities, Networks, other health professionals and/or facilities, and other community agencies, is that of independently contracting entities. Such independently contracting entities are neither agents nor employees of Oscar nor is Oscar or any employee of Oscar or its affiliates an employee or agent of such entities. We shall not be liable for any Claim, demand or cause of action regarding damages arising out of, or in any manner connected with, any Injuries, alleged or otherwise, suffered by the Member while receiving care in, from, or through any such entities.

Right of Recovery
When the amount paid by Us to You or Your Provider exceeds the amount for which We are liable under this Agreement, We have the right to recover the excess amount from You or Your Provider, unless prohibited by law.

Premium Refunds
We will give a refund for overpayment of Premium to You, if due, upon request. If You do not request a refund, the overpayment will be applied to your next month's Premium bill.

Severability
If any provision or any word, term, clause, or part of any provision of this Plan shall be determined to be invalid for any reason, the remainder of this Plan and the provisions

thereof shall not be affected and shall remain in full force and shall in no way be affected, impaired or invalidated.

Subrogation

Oscar has the right of Subrogation to the extent that the law permits. This right allows us to Subrogate against third parties that are legally liable for the expenses that We have paid, or will pay, as part of coverage under this Agreement. If we decide to exercise this right, You will not act to prejudice the outcome. We may recover benefits amounts paid under this Agreement under the right of Subrogation to the extent permitted by law. By accepting benefits under this Plan, You specifically acknowledge Oscar's right of subrogation. When We pay health care benefits for expenses incurred due to third party injuries, We shall be subrogated to Your right of recovery against any party to the extent of the full cost of all benefits provided by Us. Oscar may proceed against any party with or without Your consent. By accepting benefits under this Agreement, You also specifically acknowledge Our right of reimbursement. This right of reimbursement attaches when Oscar has paid benefits due to third party injuries and You or Your representative has recovered any amounts from a third party. By providing any benefit under this Agreement, We are granted an assignment of the proceeds of any settlement, judgment or other payment received by You to the extent of the full cost of all benefits provided by Us. Oscar's right of reimbursement is cumulative with and not exclusive of Our subrogation right and We may choose to exercise either or both rights of recovery. Oscar may recover full cost of all benefits paid by this plan under this Plan without regard to any claim of fault on your part, whether by comparative negligence or otherwise.

Substitution of Non-Covered Services

We have the right to provide any service, supply, equipment or benefit which we otherwise don't cover, or which is limited or excluded, when, in Our judgment, the service, supply, equipment or benefit is Medically Necessary and represents a less costly alternative to equal benefits available under this Evidence of Coverage. Any substitution of this nature will be subject to any quality assurance standards set by the Department of Managed Healthcare.

Third Party Beneficiaries

No third party beneficiaries are intended to be created by this Plan and nothing in this Plan shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Plan. No other party can enforce this Plan's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Plan, or to bring an action or pursuit for the breach of any terms of this Plan.

Workers' Compensation Insurance

The coverage provided under this Agreement is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law. Workers' compensation Claims that are not a benefit under this Agreement are not payable by Us.

Who Receives Payment Under this Plan

Payments under this Plan for services provided by a Network Provider will be made directly by Us to the Provider. If You receive services from an Out-of-Network Provider, We reserve the right to pay either You or the Provider. See the "Benefits Not Transferable" section of this Agreement for more information about assignment of benefits.

Non-Discrimination

Oscar does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, genetic information, or health status in the administration of the Plan, including enrollment functions and benefit determinations.

Headings

The heads of sections and paragraphs used in this Evidence of Coverage are only meant to be used for reference, and should not affect the meaning or interpretation of the provisions in the Evidence of Coverage.

GRIEVANCES

"Grievance" means a written or oral expression of dissatisfaction regarding the Plan and/or Provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative. Where the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

If You have a complaint or grievance relating to Your eligibility, Your benefits under this Agreement, concerning a claim, or any other matter, please call member services at **1-855-672-2755**, or You may write to Us at:

Oscar Health Plan of California
Attn: Member Services
12777 West Jefferson Blvd, 1st Floor
Suite 100, Building D
Los Angeles, CA, 90066

For Dental Services for Members under nineteen (19) years of age, please address Your correspondence to:

LIBERTY Dental Plan PO BOX 26110
Santa Ana, CA 92799

Please refer to the **GRIEVANCES** section to see a full description of grievance rights.

For Mental Health and Substance Use services, please address Your correspondence to:

Oscar Health Plan of California
Attn: Member Services
12777 West Jefferson Blvd, 1st Floor
Suite 100, Building D
Los Angeles, CA, 90066

For Vision Services for Members under nineteen (19) years of age, please address Your correspondence to:

Oscar Health Plan of California
Attn: Member Services Department- Oscar Vision
12777 West Jefferson Blvd, 1st Floor
Suite 100, Building D
Los Angeles, CA, 90066

Our member services staff will answer Your questions or assist You in resolving Your issue.

If You are dissatisfied and wish to file a grievance, You may request a copy of the grievance form to complete and return to Us. You may also ask the member services representative to complete the form for You over the telephone. You may also submit a grievance form online in the "Members" section at www.hioscar.com. You must submit Your grievance to Us no later than one-hundred eighty (180) days following the date You receive a denial notice or any other incident or action with which You are dissatisfied. You must include all pertinent information from Your identification card and the details and circumstances of Your concern or problem. Upon receipt of Your grievance, Your issue will become part of Our formal grievance process and will be resolved accordingly.

All grievances received by Us will be acknowledged in writing within five (5) days. We will send You a confirmation letter within five (5) days after We receive Your grievance. After We have reviewed Your grievance, We will send You a written statement on its resolution or pending status. If Your case involves an imminent and serious threat to Your health including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, You have the right to request an expedited review of a grievance. Expedited grievances must be resolved within three (3) days.

If You are dissatisfied with the resolution of Your grievance, or if Your grievance has not been resolved after at least thirty (30) days, You may submit Your grievance to the Department of Managed Health Care. For review prior to binding arbitration, see the section "Department of Managed Health Care." If Your case involves an imminent and serious threat to Your health, as described above, You are not required to complete our grievance process, but may immediately submit Your grievance to the Department of Managed Health Care for review.

You may at any time pursue Your ultimate additional remedies as provided under this plan. Specifically, you may seek an Independent Medical Review of a utilization review denial. Separately, you may contest the denial through binding arbitration. See the sections titled **INDEPENDENT MEDICAL REVIEW**, and **BINDING ARBITRATION** for more details.

INDEPENDENT MEDICAL REVIEW

If a Member has had coverage denied because proposed treatment is determined to be Investigational or Experimental, that Member may ask for review of that denial by an external, independent medical review organization contracting with the Department of Managed Health Care. A request for review may be submitted to the Department of Managed Health Care in accordance with the procedures described under "**INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE**."

To qualify for independent medical review for Investigational or Experimental Treatment, all of the following conditions must be satisfied:

- The Member has a life-threatening or seriously debilitating condition
    - A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the condition or disease is interrupted and/or a condition or disease with a potentially fatal outcome where the end-point of clinical intervention is survival.
    - A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- The Member's Physician certifies that the Member has a life-threatening or seriously debilitating condition which:
    - Standard therapies have not been effective in improving the condition of the Member, or
    - Standard therapies would not be medically appropriate for the Member, or
    - There is no more beneficial standard therapy covered by the plan than the therapy proposed, and
    - Who has provided the supporting evidence.
- The proposed treatment must be recommended by the Member, an In-Network Physician, or a board certified or a board certified or board eligible Physician qualified to treat the Member, who has certified in writing that the proposed treatment is likely to be more beneficial to the Member than available standard therapy.
- If independent medical review is requested by the Member or by a qualified Out-of-Network Physician, as described above, the requester must supply two (2) items of acceptable medical and scientific evidence (as defined below).

Within three (3) business days of Our receipt from the Department of Managed Health Care of a request by a qualified Member for an independent medical review (and within twenty-four (24) hours of approval of the request for review involving an imminent and serious threat to the health of the Member), the independent medical review organization designated by the Department will be provided with:

- A copy of all relevant medical records and documents for review with information pertaining to:
    - The enrollee's medical condition
    - The health care services being provided by the plan and its contracting providers for the condition.
    - The disputed health care services requested by the enrollee for the condition
    - any information submitted by the Member or the Member's Physician.
    - Additionally, any newly developed or discovered relevant medical records identified after the initial documents are provided will immediately be forwarded to the independent medical review organization.
- A copy of all information provided to the enrollee by the plan and any of its contracting providers concerning plan and provider decisions regarding the enrollee's condition and care, and a copy of any materials the enrollee or the enrollee's provider submitted to the plan and to the plan's contracting providers in support of the enrollee's request for disputed health care services
- A copy of any other relevant documents or information used by the plan or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the plan and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity

The independent medical review organization will render its determination within thirty (30) days of the request (if the Member's Physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the analyses and recommendations of the experts on the panel shall be rendered within three (3) days of the request for expedited review), except the reviewer may ask for three (3) more days if there was any delay in receiving the necessary records.

"Acceptable medical and scientific evidence" means the following sources:

- Peer reviewed scientific studies published in medical journals with national recognized standards;
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the Social Security Act;
- The American Hospital Formulary Service's-Drug Information and the American Dental Association Accepted Dental Therapeutics;
- Any of the following reference compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
    - The Elsevier Gold Standard's Clinical Pharmacology.
    - The National Comprehensive Cancer Network Drug and Biologics Compendium.
    - The Thomson Micromedex DrugDex.

- Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, MEDLARS database Health Services Technology Assessment Research;
- Finding, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE

You may request an independent medical review (IMR) of disputed health care services from the Department of Managed Health Care (DMHC) if You believe that a health care service has been improperly denied, modified, or delayed. A "disputed health care service" is any health care service eligible for coverage and payment under Your plan that has been denied, modified, or delayed, in whole or in part, because the service is not Medically Necessary. IMR is also available for any "disputed health care service" offered as part of Your pediatric dental benefits, pediatric vision benefits and acupuncture benefits offered under this Plan.

The IMR process is in addition to any other procedures or remedies that may be available to You. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. You must be provided with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause You to forfeit any statutory right to pursue legal action against Us regarding the disputed health care service.

Eligibility

The DMHC will review Your application for IMR to confirm that:

- At least one of the following has occurred:
    - Your Provider has recommended a health care service as Medically Necessary, or
    - You have received Urgent Care or Emergency Services that a Provider determined was Medically Necessary, or
    - You have been seen by an In-Network Provider for the diagnosis or treatment of the medical condition for which You seek independent review;
- The disputed health care service has been denied, modified, or delayed based in whole or in part on a decision that the health care service is not Medically Necessary; and
- You have filed a grievance with Us and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If Your grievance requires expedited review You may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that You follow Our grievance process in extraordinary and compelling cases.

If Your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in Your case. If the IMR determines the service is Medically Necessary, We will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within thirty (30) days of receipt of Your application and supporting documents. For urgent cases involving an imminent and serious threat to Your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health, the IMR organization must provide its determination within three (3) business days.

For more information regarding the IMR process, or to request an application form, please call Our member services department toll free at **1-855-672-2755**.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If You have a Grievance against Your health plan, You should first telephone Your health plan at 1-855-672-2755 and use Your health plan's Grievance process before contacting the department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to You. If You need help with a Grievance involving an Emergency, a Grievance that has not been satisfactorily resolved by Your health plan, or a Grievance that has remained unresolved for more than thirty (30) days, You may call the department for assistance. You may also be eligible for an independent medical review (IMR). If You are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for Emergency or urgent medical services. The department also has a toll-free telephone number (1-888-466-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's internet website http://www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

BINDING ARBITRATION

All disputes between You and Oscar, including but not limited to disputes relating to the delivery of services under the Agreement, claims of medical malpractice, and any other issues related to the Agreement must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limit of small claims court.

BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY DISPUTE RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN AND ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this Plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

The arbitration shall be administered by Judicial Arbitration and Mediation Services, Inc. (“JAMS”), in accordance with the JAMS Comprehensive Arbitration Rules and Procedures ("Rules"). The arbitration will be conducted before a single neutral arbitrator jointly agreed to by the parties. If the parties cannot agree on selection of the arbitrator, the arbitrator will be selected in accordance with JAMS Rules.

The arbitration proceeding shall be held in the Service Area and will be subject to the laws of California. The Parties may be represented by counsel. The cost of arbitration will be allocated according to JAMS Rules on consumer arbitration. The arbitrator shall have no authority to award punitive, exemplary, indirect or special damages. The parties acknowledge that the Federal Arbitration Act applies.

The party wishing to initiate arbitration must initiate such arbitration by serving a Demand for Arbitration on the other party within the time period specified in the Legal Actions Section, or such party shall be deemed to have waived its right to pursue the dispute in any forum.

Unless You and Oscar agree otherwise, any dispute relating to this Agreement will be resolved on an individual basis, such that no other dispute with any third party(ies) may be consolidated or joined with this dispute in any arbitration. You and Oscar acknowledge that this arbitration provision precludes consolidation of claims and precludes any party from participating in any form of a representative or class proceeding.

To serve a Demand for Arbitration, You must mail the Demand for Arbitration to:

Oscar Health Plan of California
Attn: Legal Department, Arbitration
12777 West Jefferson Blvd, 1st Floor
Suite 100, Building D
Los Angeles, CA, 90066

SERVICE AREA

Los Angeles County
The following ZIP codes are inside our Service Area:

90001, 90010, 90019, 90028, 90037, 90046, 90055, 90064, 90073, 90082, 90093, 90201, 90222, 90241, 90255, 90270, 90292, 90305, 93243, 90408, 90506, 91305, 91321, 91331, 91344, 91356, 91376, 91615, 91402, 91411, 91495, 91606, 91616, 90002, 90011, 90020, 90029, 90038, 90047, 90056, 90065, 90074, 90083, 90094, 90202, 90223, 90242, 90260, 90272, 90293, 90306, 91410, 90409, 90507, 91306, 91322, 91333, 91345, 91357, 91380, 91390, 91403, 91412, 91496, 91607, 91617, 90003, 90012, 90021, 90030, 90039, 90048, 90057, 90066, 90075, 90084, 90095, 90209, 90224, 90245, 90261, 90274, 90294, 90307, 90401, 90410, 90508, 91307, 91324, 91334, 91346, 91372, 91381, 91392, 91404, 91413, 91362, 91608, 90004, 90013, 90022, 90031, 90040, 90049, 90058, 90067, 90076, 90086, 90096, 90210, 90230, 90247, 90262, 90275, 90295, 90308, 90402, 90411, 90509, 91308, 91325, 91335, 91350, 91605, 91393, 91405, 91416, 91499, 91609, 90005, 90014, 90023, 90032, 90041, 90050, 90059, 90068, 90077, 90087, 90099, 90211, 90231, 90248, 90263, 90277, 90296, 90309, 90403, 90501, 90510, 91309, 91326, 91337, 91351, 91364, 91383, 91394, 91406, 91423, 91601, 91610, 90006, 90015, 90024, 90033, 90042, 90051, 90060, 90069, 90078, 90088, 91361, 90212, 90232, 90249, 90264, 90278, 90301, 90310, 90404, 90502, 91301, 91310, 91327, 91340, 91352, 91365, 91384, 91395, 91407, 91426, 91602, 91611, 90007, 90016, 90025, 90034, 90043, 90052, 90061, 90070, 90079, 90089, 91482, 90213, 90250, 90265, 90280, 90302, 90405, 90503, 91302, 91311, 91328, 91341, 91353, 91367, 91385, 91396, 91408, 91436, 91603, 91612, 90008, 90017, 90026, 90035, 90044, 90053, 90062, 90071, 90080, 90090, 91355, 90220, 90239, 90251, 90266, 90290, 90303, 90312, 90406, 90504, 91303, 91313, 91329, 91342, 91354, 91371, 91386, 91387, 91409, 91470, 91604, 91614, 90009, 90018, 90027, 90036, 90045, 90054, 90063, 90072, 90081, 90091, 90189, 90221, 90240, 90254, 90267, 90291, 90304, 91401, 90407, 90505, 91304, 91316, 91330, 91343, 90601, 90602, 90603, 90604, 90605, 90606, 90607, 90608, 90609, 90610, 90623, 90630, 90631, 90637, 90638, 90639, 90640, 90650, 90651, 90652, 90660, 90661, 90662, 90670, 90701, 90702, 90703, 90706, 90707, 90710, 90711, 90712, 90713, 90714, 90715, 90716, 90717, 90723, 90731, 90732, 90733, 90734, 90744, 90745, 90746, 90747, 90748, 90749, 90755, 90801, 90802, 90803, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90813, 90814, 90815, 90822, 90831, 90832, 90833, 90834, 90835, 90840, 90842, 90844, 90846, 90847, 90848, 90853, 90895, 91001, 91003, 91006, 91007, 91008, 91009, 91010, 91011, 91012, 91016, 91017, 91020, 91021, 91023, 91024, 91025, 91030, 91031, 91040, 91041, 91042, 91043, 91046, 91066, 91077, 91101, 91102, 91103, 91104, 91105, 91106, 91107, 91108, 91109, 91110, 91114, 91115, 91116, 91117, 91118, 91121, 91123, 91124, 91125, 91126, 91129, 91182, 91184, 91185, 91188, 91189, 91199, 91201,

91202, 91203, 91204, 91205, 91206, 91207, 91208, 91209, 91210, 91214, 91221, 91222, 91224, 91225, 91226, 91501, 91502, 91503, 91504, 91505, 91506, 91507, 91508, 91510, 91521, 91522, 91523, 91702, 91706, 91709, 91711, 91715, 91716, 91722, 91723, 91724, 91731, 91732, 91733, 91734, 91735, 91740, 91741, 91744, 91745, 91746, 91747, 91748, 91749, 91750, 91754, 91755, 91756, 91765, 91766, 91767, 91768, 91769, 91770, 91771, 91772, 91773, 91775, 91776, 91778, 91780, 91788, 91789, 91790, 91791, 91792, 91793, 91801, 91802, 91803.

Orange County

The following ZIP codes are inside our Service Area:

90630, 90631, 90680, 90720, 90740, 90742, 90743, 92602, 92603, 92604, 92606, 92609, 92610, 92612, 92614, 92617, 92618, 92620, 92624, 92625, 92626, 92627, 92629, 92630, 92637, 92646, 92647, 92648, 92649, 92651, 92653, 92655, 92656, 92657, 92660, 92661, 92662, 92663, 92672, 92673, 92675, 92676, 92677, 92678, 90620, 90621, 90622, 90623, 90624, 90632, 90633, 90638, 90721, 92605, 92607, 92615, 92616, 92619, 92623, 92628, 92650, 92652, 92654, 92658, 92659, 92674, 92684, 92685, 92690, 92693, 92697, 92698, 92702, 92711, 92679, 92683, 92688, 92691, 92692, 92694, 92701, 92703, 92704, 92705, 92706, 92707, 92708, 92780, 92782, 92801, 92802, 92804, 92805, 92806, 92807, 92808, 92821, 92823, 92831, 92832, 92833, 92835, 92840, 92841, 92843, 92844, 92845, 92861, 92865, 92866, 92867, 92868, 92869, 92870, 92886, 92887, 92728, 92735, 92781, 92799, 92803, 92809, 92811, 92812, 92814, 92815, 92816, 92817, 92822, 92825, 92834, 92836, 92837, 92838, 92842, 92846, 92856, 92857, 92859, 92863, 92871, 92885, 92899.

APPENDIX I – MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You have certain rights and responsibilities when receiving Your health care. You also have a responsibility to take an active role in Your care. As Your health care partner, We are committed to making sure Your rights are respected while providing Your health benefits. That also means giving You access to Our Network Providers and the information You need to make the best decisions for Your health and welfare.

These are Your Rights and Responsibilities

You have the right to:

- Speak freely and privately with Your doctors and other Health Providers about all health care options and treatment needed for Your condition. This is no matter what the cost or whether it is covered under Your Plan.
- Work with Your doctors in making choices about Your health care.
- Be treated with respect and dignity.
- Expect Us to keep Your personal health information private. This is as long as it follows State and federal laws and Our privacy policies.
- Get the information You need to help make sure You get the most from Your health Plan, and share Your feedback. This includes information on:
    - Our company and services,
    - Our network of doctors and other health care Providers,
    - Your Rights and Responsibilities,
    - The rules of Your health care Plan,
    - The way Your health Plan works.
- Make a complaint or file an appeal about:
    - Your health care Plan,
    - Any care You receive,
    - Any Covered Service or benefit ruling that Your health care Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care You may get in the future. This includes the right to have Your doctor tell You how that may affect Your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care Provider about the cause of Your illness, Your treatment and what may result from that illness or treatment from it. If You don't understand certain information, You can choose a person to be with You to help You understand.

You have the responsibility to:

- Read and understand, as well as You can, all information about Your health benefits or ask for help if You need it.
- Follow all health care Plan rules and policies.

- Choose a network Primary Care Physician (doctor), also called a PCP, if Your health Plan requires it.
- Treat all doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with Your health care Providers. Call their office if You may be late or need to cancel.
- Understand Your health problems, as well as You can and work with Your doctors or other health care Providers to make a treatment plan that You all agree on.
- Tell Your doctors or other health care Providers if You don't understand any type of care You're getting or what they want You to do as part of Your care plan.
- Follow the care plan that You have agreed on with Your Doctor and other health care Providers.
- Give Us, Your doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are entitled to. This may include information about other health and insurance benefits You have in addition to Your coverage with Us.
- Let Our member services department know if You have any changes to Your name, address or family members covered under Your Plan.

We are committed to providing high quality benefits and member services to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Subscriber Agreement (Your signed benefit contract) and not by this Member Rights and Responsibilities statement. The Subscriber Agreement will be provided to You by Us upon Your request.

If You need more information, or would like to contact Us, please go to www.hioscar.com and select Member Support > Contact Us, or call member services at **1-855-672-2755.**