Oscar Bronze 60 EPO

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/?planYear=2019&planState=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.dol.gov/ebsa/healthreform** or call **1-855-OSCAR-55** to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$6,300 individual / $12,600 family	Generally, you must pay all the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. **Preventive care**, pre- and post-natal care, outpatient hab/rehab, labs, hospice and telemedicine.	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?	Yes. $500 individual / $1,000 family for **prescription drug coverage**. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this **plan** begins to pay for these services.
What is the out-of-pocket limit for this plan?	$7,550 individual / $15,100 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	$75.00 **copay**/visit subject to **deductible**	Not Covered	First three (3) non-preventive visits are not subject to **deductible**.
	Specialist visit	$105.00 **copay**/visit subject to **deductible**	Not Covered	——————none——————
	Preventive care/**screening**/immunization	$0.00 **copay**/visit not subject to **deductible**	Not Covered	You may have to pay for services that aren't preventive. Ask your **provider** if the services you need are preventive. Then check what your **plan** will pay for.
If you have a test	**Diagnostic test** (x-ray, blood work)	100% **coinsurance** subject to **deductible** (x-ray), $40.00 **copay**/visit not subject to **deductible** (lab work)	Not Covered	**Preauthorization** may be required. If you don't get **preauthorization**, payment for care may be denied.
	Imaging (CT/PET scans, MRIs)	100% **coinsurance** subject to **deductible**	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.

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=2019**	Tier 1	100% coinsurance subject to pharmacy deductible (retail/mail order)	Not Covered	Up to $500 per script. Covers up to 30 day supply at retail and up to 90 day supply for mail order. **Preauthorization**/ step therapy may be required. If you don't get **preauthorization**, payment for care may be denied
	Tier 2	100% coinsurance subject to pharmacy deductible (retail/mail order)	Not Covered	Inpatient hospice care is subject to the inpatient hospital **cost-sharing**. **Preauthorization** may be required. If you don't get **preauthorization**, payment for care may be denied.
	Tier 3	100% coinsurance subject to pharmacy deductible (retail/mail order)	Not Covered	Up to $500 per script. Covers up to 30 day supply at retail and up to 90 day supply for mail order. **Preauthorization**/ step therapy may be required. If you don't get **preauthorization**, payment for care may be denied
	Tier 4	100% coinsurance subject to pharmacy deductible (retail/mail order)	Not Covered	Up to $500 per script. Covers up to 30 day supply through Oscar Specialty Pharmacy. **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)	100% coinsurance subject to deductible	Not Covered	**Preauthorization** may be required. If you don't get **preauthorization**, payment for care may be denied.
	Physician/surgeon fees	100% coinsurance subject to deductible	Not Covered	**Preauthorization** may be required. If you don't get **preauthorization**, payment for care may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	**Emergency room care**	100% coinsurance subject to deductible (ER Facility Fee), $0.00 copay/visit not subject to deductible (ER Physician Fee)	100% coinsurance subject to deductible (ER Facility Fee), $0.00 copay/visit not subject to deductible (ER Physician Fee)	——————none——————
	Emergency medical transportation	100% coinsurance subject to deductible	100% coinsurance subject to deductible	——————none——————
	Urgent care	$75.00 copay/visit subject to deductible	Not Covered	First three (3) non-preventive visits are not subject to **deductible**.
If you have a hospital stay	Facility fee (e.g., hospital room)	100% coinsurance subject to deductible	Not Covered	**Preauthorization** is required for inpatient stays, except for emergency admissions. If you don't get **preauthorization**, payment for care may be denied.
	Physician/surgeon fees	100% coinsurance subject to deductible	Not Covered	**Preauthorization** required. If you don't get **preauthorization**, payment for care may be denied.
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	$75.00 copay/visit subject to deductible (office visit), $75.00 copay/visit subject to deductible (for other outpatient services)	Not Covered	First three (3) non-preventive visits are not subject to **deductible**. **Preauthorization** may be required. If you don't get **preauthorization**, payment for care may be denied.
	Mental/Behavioral health inpatient services	100% coinsurance subject to deductible	Not Covered	**Preauthorization** is required for inpatient stays, except for emergency admissions. If you don't get **preauthorization**, payment for care may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office Visit	$0.00 copay/visit not subject to deductible	Not Covered	Cost-sharing does not apply to certain preventive services. Depending on the type of services, cost-sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	100% coinsurance subject to deductible	Not Covered	
	Childbirth/delivery facility services	100% coinsurance subject to deductible	Not Covered	**Preauthorization** is not required if patient stay <48 hours (<96 hours for a cesarean). 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**	100% coinsurance subject to deductible	Not Covered	Up to 100 visits/year. **Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	Rehabilitation services	$75.00 copay/visit not subject to deductible	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	Habilitation services	$75.00 copay/visit not subject to deductible	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	Skilled nursing care	100% coinsurance subject to deductible	Not Covered	Up to 100 visits/year. **Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	Durable medical equipment	100% coinsurance subject to deductible	Not Covered	**Preauthorization** is required for purchases and rentals >$500. If you don't get **preauthorization**, payment for care may be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	**Hospice services**	$0.00 copay/visit not subject to deductible	Not Covered	Inpatient hospice care is subject to the inpatient hospital **cost-sharing**. **Preauthorization** may be required. If you don't get **preauthorization**, payment for care may be denied.
If your child needs dental or eye care	Eye exam	$0.00 copay/visit not subject to deductible	Not Covered	1 exam in a 12 month period.
	Glasses	$0.00 copay/item not subject to deductible	Not Covered	1 pair of glasses or contact lenses in a 12 month period.
	Dental check-up	$0.00 copay/visit not subject to deductible	Not Covered	Limited to 1 exam every 6 months. **Deductible** does not apply to preventive visits.

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**.)

- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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
- Routine foot care

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. To contact Oscar call **1-855-OSCAR-55**, or the contact information for those agencies is: California Department of Managed Health Care, California Help Center, 980 9th Street, Suite 500 Sacramento, CA 95814 at **1-888-466-2219** or **http://www.HealthHelp.ca.gov**. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance **Marketplace**. For more information about the **Marketplace**, visit **www.HealthCare.gov** or call **1-800-318-2596**.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your **plan** for a denial of a **claim**. This complaint is called a **grievance** or **appeal**. For more information about your rights, look at the explanation of benefits you will receive for that medical **claim**. Your **plan** documents also provide complete information to submit a **claim**, **appeal**, or a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, contact: **http://www.HealthHelp.ca.gov**

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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**.

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

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:** $6,300
- **Specialist:** $105.00 copay/visit subject to deductible
- **Hospital (facility):** 100% coinsurance subject to deductible
- **Other:** 100% coinsurance subject to deductible

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	**$7,500**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,800
Copays	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
Total	**$6,120**

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

- **The plan's overall deductible:** $6,300
- **Specialist:** $105.00 copay/visit subject to deductible
- **Hospital (facility):** 100% coinsurance subject to deductible
- **Other:** 100% coinsurance subject to deductible

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	**$5,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles *	$2,000
Copays	$300
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$80
Total	**$5,080**

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

- **The plan's overall deductible:** $6,300
- **Specialist:** $105.00 copay/visit subject to deductible
- **Hospital (facility):** 100% coinsurance subject to deductible
- **Other:** 100% coinsurance subject to deductible

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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,600
Copays	$200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
Total	**$1,800**

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

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

Notice of Non-Discrimination:
Discrimination is Against the Law

Oscar complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Oscar does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Oscar:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services 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:

NY/NJ/TX/OH/TN Members: Oscar Insurance, Attention Grievances PO Box 52146, Phoenix AZ, 85072

CA Members: Oscar Health Plan of California, Attention Grievances 9942 Culver City Blvd., PO Box 1279, Culver City, CA 90232

1-855-OSCAR-55 (TTY: 7-1-1), Mon - Fri 8 am - 8 pm/ Sat - Sun 9 am - 5 pm (EST), Fax: 1-888-977-2062, Email: help@hioscar.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Oscar's Grievances Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F,
HHH Building Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services for the Deaf or Hard of Hearing

ATTENTION: If you are deaf or hard of hearing, talk to text services, free of charge, are available to you. Call 1-855-Oscar-55 and dial 711 to receive TTY/TDD services.

Nëse ju, ose dikush që po ndihmoni, ka pyetje për Oscar, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin 1-855-OSCAR-55.

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Oscar، فلديك الحق في الحصول على المساعدة والمعلومات بلغتك من دون أية تكلفة. للتحدث مع مترجم، اتصل بالرقم 1-855-OSCAR-55.

Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Oscar մասին, Դուք իրավունք ունեք ստանալ անվճար օգնություն և տեղեկություն Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք 1-855-OSCAR-55

যদি আপনি, অথবা আপনি অন্য কাউকে সহায়তা করছেন, Oscar, সম্পর্কে প্রশ্ন আছে আপনার অধিকার আছে বিনা খরচে আপনার নিজস্ব ভাষাতে সাহায্য পাবার এবং তথ্য জানবার। অনুবাদকের সাথে কথা বলার জন্য, কল করুন ১-৮৫৫-অস্কার-৫৫.

如果您，或是您正在協助的對象，有關於 Oscar 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1-855-OSCAR-55。

اگر شما، یا فردی که شما به او کمک مي کنید ، سوالی در مورد Oscar داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. لطفا با شماره 1-855-OSCAR-55 تماس بگیرید.

Si vous, ou une personne que vous aidez, a des questions à propos d'Oscar, vous avez le droit d'obtenir de l'aide et des informations dans votre langue gratuitement. Pour parler à un interprète, appelez le 1-855-OSCAR-55.

Falls Sie oder jemand, dem Sie helfen, Fragen zu Oscar haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte 1-855-OSCAR-55 an.

Εάν εσείς ή κάποιος που βοηθάτε έχετε απορίες σχετικά με την Oscar, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς καμία χρέωση. Για να μιλήσετε με έναν διερμηνέα, καλέστε στον αριθμό 1-855-OSCAR-55.

જો તમે અથવા તમે મદદ કરી રહ્યા હો તેમાથી કોઈને Oscar વિશે પ્રશ્નો હોય તો, તમને તમારી ભાષામાં નિશૂલ્ક મદદ અને માહિતી મેળવવાનો અધિકાર છે. દુભાષિયા સાથે વાત કરવા માટે 1-855-OSCAR-55 પર ફોન કરો.

Si oumenm oswa yon moun w ap ede gen kesyon konsènan Oscar, se dwa w pou resevwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèprèt, rele nan 1-855-OSCAR-55.

यदि आपके, या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के पास Oscar के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दोभाषिए से बात करने के लिए, 1-855-OSCAR-55 पर कॉल करें।

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Oscar, koj muaj cai kom lawv muab cov ntsiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-855-OSCAR-55.

Se tu o qualcuno che stai aiutando avete domande su Oscar, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-855-OSCAR-55.

貴殿または貴殿の援助されている方でも、Oscarについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話をされる場合、1-855-OSCAR-55までお電話ください。

ប្រសិនបើលោកអ្នក ឬនរណាម្នាក់ដែលលោកអ្នកកំពុងជួយ មានសំណួរនានាអំពី Oscar លោកអ្នកមានសិទ្ធិទទួលបានជំនួយនិងព័ត៌មានជាភាសារបស់លោកអ្នកដោយឥតគិតថ្លៃ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូមទូរសព្ទទៅលេខ 1-855-OSCAR-55 ។

귀하 또는 귀하가 돕고 있는 사람이 Oscar에 관해서 문의사항이 있는 경우, 귀하에게는 이러한 도움과 정보를 귀하의 언어로 비용 부담없이 제공받을 권리가 있습니다. 통역 서비스를 원하시면 1-855-OSCAR-55번으로 전화해 주십시오.

ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອຢູ່ມີຄຳຖາມກ່ຽວກັບ Oscar, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບຜູ້ແປພາສາ, ໃຫ້ໂທຫາ 1-855-OSCAR-55.

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie Oscar, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-855-OSCAR-55.

ਜੇ ਤੁਹਾਡੇ ਕੋਲ, ਜਾਂ ਤੁਸੀ ਜਸਿ ਦੀ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, Oscar ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਬਨਿਾਂ ਕਸਿ ਕੀਮਤ 'ਤੇ ਆਪਣੀ ਭਾਸਾ ਵਚਿ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਕਿਾਰ ਹੈ। ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 1-855-OSCAR-55 'ਤੇ ਕਾਲ ਕਰੋ।

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Oscar, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-OSCAR-55.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Oscar, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-OSCAR-55.

Kung ikaw o ang iyong tinutulungan ay may mga tanong tungkol sa Oscar, may karapatan kang makatanggap ng libreng tulong at impormasyon nang nasa iyong wika. Upang makipag-usap sa isang tagasalin, tumawag sa 1-855-OSCAR-55.

หากคุณหรือคนที่คุณก าลังช่วยเหลือมีค าถามเกี่ยวกับ Oscar
คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร 1-855-OSCAR-55.

Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про програму OSCAR, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть за номером 1-855-OSCAR-55.

اگر آپ یا آپ کسی کی مدد کر رہے /رہی ہیں ان کو Oscar کے بارے سوالات پوچھنے ہیں ، تو آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے 1-855-OSCAR-55 پر کال کریں۔

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Oscar, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-OSCAR-55.

אויב איר, אודר עמצער איר העלפסט, האט פראגעס וועגן Oscar, איר האט דאס רעכט צו באקומען הילף און אינפארמאציע און אייער שפראך אומזיסט. צו רעדן מיט דער אייבערזעצער, קלונג 1-855-OSCAR-55

Oscar Health Plan of California

Subscriber Agreement and Combined Evidence of Coverage and Disclosure Form

2019

An Exclusive Provider Organization (EPO) Plan

Oscar Health Plan of California
3535 Hayden Ave.
Suite 230
Culver City, CA 90232

Effective January 1, 2019

Por favor contáctenos al 1-855-OSCAR-55 para obtener una versión en Español.

Table of Contents

INTRODUCTION

We know that health insurance can be confusing, so at Oscar we try to make Our plans as simple as possible. It's important that You understand how Your plan works. In this Subscriber Agreement and Combined Evidence of Coverage and Disclosure Form (the "Agreement"), You will find an explanation of the rights and duties between You and Oscar. The Agreement describes how You can get health care, what services are covered, and what part of the costs You will need to pay.

In this Agreement, "We," "Us", "Our", and "Oscar" shall mean Oscar. "You" are the Eligible Subscriber whose individual enrollment application has been accepted by Us. "You" and "Your" also mean any Eligible Dependents who are covered under this Agreement. When We use the word "Member" in this Agreement, We mean You and any Eligible Dependents who are covered under this Agreement.

It is important that You read this Agreement carefully and completely, so that You have a full understanding of Your coverage. If You are an individual with special health care needs, please thoroughly read the sections that apply to You.

This Agreement is only offered and issued in certain geographic areas within the state of California. If You change Your residence to a location that is outside of the service area, You will no longer be able to enroll or remain enrolled in Oscar, even if You continue to reside in the state of California.

You have the right to view this Agreement prior to enrollment. Once enrolled, You have thirty (30) days from the date this Agreement is delivered to You to review it. If You are not satisfied with the terms of this Agreement for any reason, You may return the Agreement to Us, by requesting cancellation in writing, within the thirty (30) days. Consistent with California law, You are required to pay for any services that Oscar paid on Your behalf during the thirty (30) day period. Oscar will refund any premium paid by You, less any medical and pharmacy expenses that Oscar paid on Your behalf. If no services were rendered, You are entitled to receive a full refund of any premium paid. This Agreement is thereafter null and void.

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.

Oscar enters into this Agreement with You based upon the answers submitted by You and Your applicable Dependents on the signed individual enrollment application. In consideration for the payment of the premiums stated in this Agreement, We will provide services and benefits as described in this Agreement to You and Your enrolled Dependents.

You hereby expressly acknowledge that You understand this Agreement constitutes a contract solely between You and Oscar, an independent corporation operating under a license from the California Department of Managed Health Care. You further acknowledge and agree that You have not entered into this Agreement based upon representations by any person other than Oscar, and that no person, entity or organization other than Oscar shall be held accountable or liable to You for any of Our obligations to You created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Oscar other than those obligations created under other provisions of 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 (1) services received by an Out-of-Network provider as a result of a Medical

Emergency, Urgent Care Visit, or an Authorized Referral as defined in the section titled 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 and Out-of-Network Provider. Authorized Referrals and Covered Services received under the second exception 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 APPLIES.**

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 customer service at 1-855-Oscar-55 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 customer service at 1-855-Oscar-55 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)

Oscar encourages You to select a PCP. You may choose an internist, general practitioner, family practitioner, or OB- GYN as Your PCP.

If You need help choosing a Physician who is right for You, call the customer service number at 1-855-Oscar-55. TTY/TDD services also are available by dialing 711 or the numbers 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** **1-800-854-7784**

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.

Requesting language assistance is easy. Just contact Customer Service by calling 1-855-Oscar-55 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** **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 condition is an Emergency, call 911 or go to the nearest provider. 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, triage or screening services are available to You from Us by telephone. Triage or screening services are the evaluation of Your health by a Physician or a nurse who is trained to screen for the purpose of determining the urgency of Your need for care. Please contact Oscar's service by calling Us at 1-855- Oscar-55, utilizing the Oscar app or accessing www.hioscar.com, available 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 customer service department at 1-855-Oscar-55 or by accessing Our website at www.hioscar.com.

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.

Adopted Child and Adoptive Child: 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.

Advance Payments of the Premium Tax Credit means payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a QHP through the Exchange.

Agreement means this Oscar Individual Subscriber Agreement and Combined Evidence of Coverage and Disclosure Form, including any endorsements or attached paper, 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.

American Indian means an individual who is a member of a Federally Recognized Indian tribe. A tribe is defined as any Indian tribe, band, nation, or other organized group or community, including any Alaska native village or regional or village corporation which is recognized as eligible for the special programs and services provided by the United States because of their status as Indians.

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:

1. 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
2. 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. 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 SUMMARY 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, including mental health and substance use disorders. Programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their 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 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.

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 SUMMARY 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 SUMMARY 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 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 sections titled WHAT IS COVERED – MEDICAL and WHAT IS COVERED – PRESCRIPTION DRUGS.

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 SUMMARY 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 sections titled CLAIMS AND PAYMENTS and WHAT IS COVERED – PRESCRIPTION DRUGS.

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.

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

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

- blood glucose monitors
- blood glucose monitors designed to assist the visually impaired
- blood glucose testing strips
- 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 section titled YOUR ELIGIBILITY.

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 be expected to result in any of the following:

- 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.

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:

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

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.

Exchange is the Health Benefit Exchange of California also known as Covered California.

Experimental and Experimental Procedures are those that are mainly limited to laboratory and/or animal research but which are not widely accepted as proven and effective procedures within the organized medical community.

Facility includes, but 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 section titled YOUR ELIGIBILITY.

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.

Gender Identity Disorder (Gender Dysphoria) (GID) 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 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 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 Oscar is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.

[**High Deductible Health Plan (HDHP)** This Plan is a High Deductible Health Plan. The coverage described in this EOC is designed to be compatible for use with a Health Savings Account (HSA) under federal tax law. The tax references contained in this EOC relate to federal income tax only. The tax treatment of HSA contributions and distributions under your state's income tax laws may differ from the federal tax treatment, and differs from state to state. We do not provide tax advice. You should consult with your financial or tax advisor for tax advice or more information, including information about your eligibility for an HSA.]

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.

Individual Plan means this Plan when only the Subscriber is enrolled.

Infertility means the presence of a demonstrated condition recognized by a licensed medical Physician as:

- The inability for women age 35 and less, to conceive or carry a pregnancy to a live birth after a Year or more of regular sexual relations without contraception; or

- The inability for women over age 35 to conceive or carry a pregnancy to a live birth after six months or more of regular sexual relations without contraception.

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 customer service at **1-855-Oscar-55** 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 customer service at **1-855-Oscar-55** 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 customer service at 1-855-Oscar-55 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.

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 customer service at 1-855-Oscar-55 or check Our website at www.hioscar.com for more details.

Medical Emergency 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 be expected to result in any of the following:

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

Medical Emergency 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:

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

Medically Necessary and Medical Necessity services are procedures, treatments, supplies, devices, equipment, Facilities or Drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a Member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, or disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the Member's illness, injury or disease;
- Not primarily for the convenience of the Member, Physician or other health care Provider; and
- Not 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 Member's illness, injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society

recommendations, the views of medical practitioners practicing in relevant clinical areas, and any other relevant factors. In evaluating new technology and whether to consider it as eligible for coverage under Our Agreement, We consider peer-reviewed medical literature; consultations with physicians, specialists and other health care professionals; policies and procedures of government agencies; and study results showing the impact of the new technology on long-term health.

Member shall mean both the Subscriber and all other Dependents 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:

1. Schizophrenia,
2. Schizoaffective disorder,
3. Bipolar disorder (manic-depressive illness),
4. Major depressive disorders,
5. Panic disorder,
6. Obsessive-compulsive disorder,
7. Pervasive developmental disorder or autism,
8. Anorexia nervosa, and
9. Bulimia nervosa.

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

1. 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
2. Meets one (1) or more of the following criteria:
    a. As a result of the mental disorder:
        i. 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;

ii. 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.

3. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.
4. 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 (c) 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 Providers 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) services received by an Out-of-Network provider as a result of a Medical Emergency, Urgent Care Visit, or an Authorized Referral 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 Provier. Authorized Referrals and Covered Services received under the second exception 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 SUMMARY OF BENEFITS. Such expense does not include charges for any non-Covered Services.

Refer to the SUMMARY OF BENEFITS for other services that may not be included in the Out of Pocket Maximum. 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 Pharmacy.

Pharmacy Benefits Manager (PBM) is a Pharmacy benefits management company with which Oscar contracts to manage Pharmacy benefits. Oscar's Pharmacy Benefits Manager has a nationwide network of retail Pharmacies, a mail service Pharmacy, and clinical services that include Formulary management.

The management and other services the Pharmacy Benefits Manager provides include, but are not limited to, managing a network of retail Pharmacies and operating a mail service Pharmacy. Oscar's Pharmacy Benefits Manager, in consultation with Oscar, also provides services to promote and assist Members in the appropriate use of Pharmacy benefits, such as review for possible excessive use, proper dosage, Drug interactions or Drug/pregnancy concerns.

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.

Premium is the monthly charge You 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 that has been approved by Your financial institution. If funds are not approved by Your financial institution, they are not considered received and this Agreement may be canceled for non-payment of Premium. Refer to "When Coverage Ends" in the section titled YOUR ELIGIBILITY for additional information regarding cancellation when You do not pay Premiums.

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.
- Insulin, diabetic supplies, and syringes.

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 name 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, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.
- **Tier 4** consists of drugs where the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through a specialty pharmacy, drugs that require the user to have special training or clinical monitoring for self-administration or drugs that cost Us more than $600 net of rebates for one-month supply.

Primary Care Physician (PCP) is a Physician who gives or directs health care services for You. 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 customer service at **1-855-Oscar-55**.

- 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, 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 Health Plan (QHP) means a health plan that has in effect a certification issued or recognized by each Exchange through which such health plan is offered.

Qualified Individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

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.

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.

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 has three Service Areas in the State of California: the San Francisco Service Area and the Los Angeles & Orange County Service Area. This Agreement describes benefits for three Service Areas.

San Francisco Service Area

The following ZIP codes are inside our San Francisco Service Area:

94101, 94102, 94103, 94104, 94105, 94106, 94107, 94108, 94109, 94110, 94111, 94112, 94114, 94115, 94116, 94117, 94118, 94119, 94120, 94121, 94122, 94123, 94124, 94125, 94126, 94127, 94128, 94129, 94130, 94131, 94132, 94133, 94134, 94135, 94136, 94137, 94138, 94139, 94140, 94141, 94142, 94143, 94144, 94145, 94146, 94147, 94150, 94151, 94152, 94153, 94154, 94155, 94156, 94158, 94159, 94160, 94161, 94162, 94163, 94164, 94171, 94172, 94175, 94177, 94188, 94199.

Los Angeles Service Area

The following ZIP codes are inside our Los Angeles 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, 91618, 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, 91382, 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, 90233, 90250, 90265, 90280, 90302, 90311, 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 Service Area

The following ZIP codes are inside our Orange County Service Area:

90630, 90631, 90680, 90720, 90740, 90742, 90743, 92602, 92603, 92604, 92606, 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, 9260,9 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, 92712, 92728, 92735, 92781, 92799, 92803, 92809, 92811, 92812, 92814,

92815, 92816, 92817, 92822, 92825, 92834, 92836, 92837, 92838, 92842, 92846, 92850, 92856, 92857, 92859, 92862, 92863, 92864, 92871, 92885, 92899.

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.

State means the State of California.

Subscriber is the person whose individual enrollment application has been accepted by Us for coverage under this Plan.

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.

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 and any Dependents covered under this Agreement.

RIGHT TO MODIFY OR CHANGE THE AGREEMENT

Except as described below, Oscar has the right to and may modify or otherwise change the terms and conditions of the Agreement in order to make periodic administrative modifications. For example, Oscar may modify its process for filing a grievance, or the address to which a complaint must be sent. We will provide written notice to You of any material modifications to this Agreement.

Oscar will not modify Your cost-sharing amount or premium within a Plan Year. Oscar will not modify this Agreement on an individual basis, but only for all Members covered under the same Agreement as You.

YOUR ELIGIBILITY

This Agreement is only offered and issued in certain geographic areas within the State of California. If You change Your residence to a location that is outside of the Service Area, but You continue to reside in the State of California, contact the Exchange to change Your plan.

The benefits, terms and conditions of this Agreement are applicable to Individuals who are determined by the Exchange to be Qualified Individuals for purposes of enrollment in a Qualified Health Plan (QHP).

Who is Eligible for Coverage

Subscriber

To be eligible for membership as a Subscriber under this Agreement, the applicant must:

1. Be determined by the Exchange to be a Qualified Individual for enrollment in a QHP;
2. Be qualified by the Exchange as eligible, if applying to purchase a Catastrophic Plan;
3. Be a United States citizen or national; or
4. Be a lawfully present non-citizen for the entire period for which coverage is sought; and
5. Be a resident of the State of California; and meet the following applicable residency standards:
    a. For a Qualified Individual age twenty-one (21) and over, the applicant must:
        i. Not be living in an institution;
        ii. Not be receiving optional Supplemental Security Income/State Supplementary Payments (SSI/SSP); and
        iii. Reside or intend to reside in the Service Area of Oscar, including without a fixed address, or have entered into a job commitment or be seeking employment (whether or not currently employed) in the Service Area of Oscar.
    b. For a Qualified Individual under age twenty-one (21), the applicant must:
        i. Not be living in an institution;
        ii. Not be emancipated;

iii. Not be receiving optional Supplemental Security Income/State Supplementary Payments (SSI/SSP);
iv. Reside or intend to reside in the Oscar Service Area of Oscar, including without a fixed address, or have entered into a job commitment or be seeking employment (whether or not currently employed) in the Service Area of Oscar; and
v. Not eligible for Medi-Cal.

6. Agree to pay for the cost of Premium that Oscar requires;
7. Reveal any coordination of benefits arrangements or other health benefit arrangements for the applicant or Dependents as they become effective;
8. Not be incarcerated (except pending disposition of charges);
9. Not be entitled to or enrolled in Medicare Parts A/B and/or D;
10. Not be covered by any other group or individual health benefit plan. For purposes of Eligibility, a Qualified Individual's Service Area is the area in which the Qualified Individual:
    a. Lives; or
    b. Resides.

For tax households with Members in multiple Exchange Service Areas:

1. If all of the members of a tax household are not living within the same Exchange Service Area, any member of the tax household may enroll in a Qualified Health Plan through any of the Exchanges for which one of the Tax Filers meets the residency requirements.
2. If both spouses in a tax household enroll in a Qualified Health Plan through the same Exchange, a Tax Dependent may only enroll in a Qualified Health Plan through that Exchange, or through the Exchange that services the area in which the Dependent meets a residency standard.

Dependents

To be eligible for coverage to enroll as a Dependent, You must be listed on the enrollment form completed by the Subscriber, be determined by the Exchange to be a Qualified Individual, meet all Dependent eligibility criteria established by the Exchange, and be:

1. The Subscriber's legal spouse.

2. The Subscriber's Domestic Partner. Domestic Partner means a person who has established a Domestic Partnership under California law. For purposes of this Agreement, a Domestic Partner shall be treated the same as a spouse.
3. The Subscriber's or the Subscriber's spouse's or the Subscriber's Domestic Partner's children who are under age twenty-six (26), including stepchildren, Newborn and legally Adopted Children.
4. Children for whom the Subscriber or the Subscriber's spouse or Subscriber's Domestic Partner is a legal guardian and who are under age twenty-six (26).

An enrolled Dependent child who reaches age 26 during a benefit year may remain enrolled as a Dependent until the end of that benefit year. The Dependent coverage shall end on the last day of the benefit year during which the Dependent child becomes ineligible. 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 be continued past the age limit only for those already enrolled Dependent children who cannot work to support themselves by reason of intellectual or physical disability. These Dependents must be allowed as a federal tax exemption by the Subscriber or Subscriber's spouse. The Dependent's disability must start before the end of the period he or she would become ineligible for coverage. The Exchange must certify the Dependent's eligibility. The Plan will notify the subscriber that the dependent child(s) coverage will terminate upon attainment of the limiting age unless the subscriber submits proof of the criteria described in subparagraphs (1) and (2) of paragraph (1) to the plan within 60 days of the date of receipt of the notification. The Plan will send this notification to the subscriber at least 90 days prior to the date the child attains the limiting age. Upon receipt of a request by the subscriber for continued coverage of the child and proof of the criteria described in subparagraphs (1) and (2) of paragraph (1), the Plan shall determine whether the child meets that criteria before the child attains the limiting age. If the plan fails to make the determination by that date, it shall continue coverage of the child pending its determination.

Open Enrollment

Exchange Qualified Individuals are only permitted to enroll in a Qualified Health Plan (QHP), or as an enrollee to change QHPs, during an annual open enrollment period or a special enrollment period

for which the Qualified Individual has experienced a qualifying event. Open Enrollment for 2017 Plans will begin on November 1, 2017 and end on January 31, 2018. Enrollees may change QHPs during that time according to rules established by the Exchange.

American Indians may move from one QHP to another QHP once per month.

Changes Affecting Eligibility and Special Enrollment

A special enrollment period is a period during which a Qualified Individual or enrollee who experiences certain qualifying events or changes in eligibility may enroll in, or change enrollment in, a QHP through the Exchange outside of the annual open enrollment period.

Length of special enrollment periods: Unless specifically stated otherwise, a Qualified Individual or enrollee has sixty (60) calendar days from the date of a triggering event to select a QHP.

The Exchange must allow Qualified Individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

- A Qualified Individual or Dependent loses Minimum Essential Coverage, for example due to a loss of employer- sponsored coverage;
- A Qualified Individual gains a Dependent or becomes a Dependent through marriage, birth, adoption or placement for adoption, or through a Qualified Medical Child Support Order or court order;
- An individual, not previously a citizen, national, or lawfully present, gains such status;
- A Qualified Individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of an error of the Exchange or the Department of Health and Human Services (HHS), or its instrumentalities as determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error;
- An enrollee demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

- An individual is determined newly eligible or newly ineligible for Advance Payments of the Premium Tax Credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP;
- The Exchange must permit individuals whose existing coverage through an eligible employer sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming Plan Year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;
- A Qualified Individual or enrollee gains access to new QHPs as a result of a permanent move, and a Qualified Individual or enrollee demonstrates to the Exchange, in accordance with HHS guidelines, that the individual meets other exceptional circumstances as the Exchange may provide;
- An individual was receiving services from a contracting provider under another health benefit plan and that provider ceases to participate in that plan, providing that the services are for an acute condition, serious chronic condition, pregnancy, terminal illness, the care of a newborn child between birth and thirty-six (36) months, or performance of a surgery or other procedure that has been authorized by their previous plan and is documented by the provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee **(see the section titled CONTINUITY AND TRANSITION OF CARE for details)**;
- An individual demonstrates to the Exchange that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period available to the individual because he or she was misinformed that he or she was covered under minimum essential coverage;
- An individual 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; and
- An individual has been released from incarceration.

Newborn and Adopted Child Coverage

Newborn and Adopted Child(ren) of the Subscriber, Subscriber's spouse , or Subscriber's Domestic Partner will be covered for an initial period of thirty-one (31) days from the date of birth or adoption. Coverage for Newborn and Adopted Child(ren) will continue beyond the thirty-one (31) days,

provided the Subscriber with other than Family Coverage submits through the Exchange a form to add the child under the Subscriber's Plan. The form must be submitted along with the additional Premium, if applicable, within sixty (60) days after the birth of the child. If the child is not added within this 60 day period, coverage does not extend beyond thirty-one (31) days after the child was born or adopted.

A child will be considered adopted from the earlier of:

1. The moment of placement for adoption; or
2. The date of an entry of an order granting custody of the child to You.

The child will continue to be considered adopted unless the child is removed from Your home prior to issuance of a legal decree of adoption.

Newborn and Adopted Child(ren) of the Subscriber's, Subscriber's spouse's or Subscriber's Domestic Partner's Dependent children are not covered under this Agreement (unless they are eligible for coverage under another provision of this Agreement).

Adding a Child due to Award of Legal Custody or Guardianship

If a Subscriber or the Subscriber's spouse or the Subscriber's Domestic Partner files an application for appointment of guardianship for a child, an application to cover the child under the Subscriber's Plan must be submitted to the Exchange within sixty (60) days of the date the appointment of guardianship is granted. Coverage will be effective on the date the appointment of guardianship is awarded by the court.

Qualified Medical Child Support Order

If You are required by a Qualified Medical Child Support Order or court order, as defined by applicable State or federal law, to enroll Your child under this Agreement, and the child is otherwise eligible for the coverage, You must request permission from the Exchange for Your child to enroll under this Agreement, and once approved by the Exchange, We will provide the benefits of this Agreement in accordance with the applicable requirements of such order.

Coverage for Dependents, gained through a court order, including a child support order, will be effective the first day of the court order. If permitted by the Exchange, the qualified individual may elect a later coverage effective date in accordance with the rules of the Exchange.

A child's coverage under this provision will not extend beyond any Dependent age limit. Any claims payable under this Agreement will be paid to the child or the child's custodial parent or legal guardian, for any expenses paid by the child, custodial parent, or legal guardian. We will make information available to the child, custodial parent, or legal guardian on how to obtain benefits and submit claims to Us directly.

Effective Date of Coverage

The earliest Effective date for the annual open enrollment period is the first day of the following Benefit Period for a Qualified Individual who has made a QHP selection during the annual open enrollment period. A Subscriber's actual Effective date is determined by the date he or she submits a complete application and the applicable Premium to the Exchange.

Effective Dates for special enrollment periods:

1. In the case of birth, adoption or placement for adoption, coverage is effective on the date of birth, adoption, placement for adoption, or the first day of the month following the event. Advance Payments of the Premium Tax Credit and Cost-Sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and
2. In the case of marriage, Domestic Partnership or in the case where a Qualified Individual loses Minimum Essential Coverage, coverage is effective on the first day of the following month after Your application is received.

Qualifying Events for loss of Minimum Essential Coverage includes loss of eligibility for coverage as a result of:

1. Legal separation or divorce;
2. Cessation of Dependent status, such as attaining the maximum age;
3. Death of an employee;

4. Termination of employment;
5. Reduction in the number of hours of employment; or
6. Any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing:
    a. Individual who no longer resides, lives or works in the Plan's Service Area;
    b. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual;
    c. Termination of employer contributions; and
    d. Exhaustion of COBRA benefits.

Qualifying Events for loss of Minimum Essential Coverage does not include termination or loss due to:

1. Failure to pay Premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or
2. Situations allowing for a rescission such as fraud or intentional misrepresentation of material fact.

Notice of Changes

The Subscriber is responsible for notifying the Exchange of any changes that will affect his or her eligibility or that of Dependents for services or benefits under this Agreement. The Exchange must be notified of any changes as soon as possible but no later than within sixty (60) days of the event. This includes changes in address, marriage, divorce, Domestic Partnership, dissolution of Domestic Partnership, death, change of Dependent disability or dependency status. If You fail to notify the Exchange, You or one of Your Dependents are no longer eligible for services and We will not be obligated to pay for such services. Acceptance of Premium for persons no longer eligible for services will not obligate Us to pay for such services.

A Family Agreement will be changed to an Individual Agreement when only the Subscriber is eligible. The Effective Date of coverage is the event date causing the change to an Individual Agreement.

The Exchange must be notified when the Subscriber becomes eligible for Medicare. In this case, a Family Agreement will not automatically be changed to an Individual Agreement and any remaining Member must re-enroll in a Plan.

All notifications must be in writing and on approved forms or as otherwise required by the Exchange. Such notifications must include all information required to effect the necessary changes.

Statements and Forms

Subscribers or applicants for membership shall complete and submit to the Exchange applications or other forms or statements the Exchange may request. Subscribers or applicants for membership represent to the best of their knowledge and belief that all information contained in such applications, questionnaires, forms, or statements submitted to the Exchange is true, correct and complete. Any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact by the Member may result in termination or rescission of coverage.

Delivery of Documents

We will provide an Identification Card as well as a printed copy of the Schedule of Benefits to each Subscriber. Evidence of Coverage and other related documents can be accessed via the member section of Our website at www.hioscar.com for each Subscriber. A copy of the plan contract can be furnished upon request.

Monthly Premiums/Prepayment Fees

Premiums are due monthly and are the charges You must pay Oscar to establish and maintain coverage. We determine and establish the required Premiums based on the Subscriber's age, number of Members, and the specific regional area in which the Subscriber resides.

When You initiate changes to the Agreement that result in a change to the Premiums, the changes to the Premiums will be reflected on the next billing statement. When Oscar initiates a change to this Agreement, We will provide You sixty (60) days advance written notification of the changes.

Monthly Premiums are printed on Your monthly billing statement. All Monthly Premium Payments and administrative fees are payable in advance and due on the Monthly Premium Due Date.

If the Subscriber changes residence, he or she may be subject to a change in Premiums. Such change in Premiums will be effective on the next billing statement following notification of the change of residence. We will recalculate the Premiums to the new rate of Your regional area of residence. If the Subscriber does not notify Us of a change in residence and We later learn of the change in residential address, We may bill the Subscriber for the difference in Premiums from the date the address changed.

Coverage under this Agreement will end if the Member moves out of the Service Area. You will be eligible for a special open enrollment to change to the plans available in the new Service Area in which You have moved to in California. You will need to find a new In-Network Provider in Your new Service Area.

How to pay Your Premium

You can make Your Premium Payment online at www.hioscar.com, by contacting customer service at **1-855-Oscar-55,** or by mailing it to us. For Your convenience, You may authorize Us to automatically deduct Your Premium Payment from Your financial institution account every month. To learn more about this option, contact customer service.

If You choose to mail Your Premium Payment, send it to Us at:

Oscar Health Plan of California
P.O. Box 740703
Los Angeles, CA 90074-0703

Electronic Funds Transfer

If You submit a personal check for Premiums payment, You automatically authorize Us to convert that check into an electronic payment. We will store a copy of the check and destroy the original paper check. Your payment will be listed on the financial institution account statement as an

Electronic Funds Transfer (EFT). Converting Your paper check into an electronic payment does not authorize Us to deduct Premiums from Your account on a monthly basis unless You have given Us prior authorization to do so.

Termination of Benefits

This section describes how coverage for the Member can be canceled, rescinded, suspended or not renewed.

Termination of the Member

The Member's coverage will terminate if any of the following occurs:

1. The Member terminates his or her coverage with appropriate notice to the Exchange;
2. The Member no longer meets eligibility requirements for coverage in a QHP through the Exchange (examples: divorce, dissolution of Domestic Partnership, over-age Dependent, move outside the Service Area, etc.). The Member is required to notify the Exchange about a change in eligibility. Coverage ends on the last day of the month following the month in which the Exchange notifies the Member (unless the Member requests an earlier termination date);
3. The Member fails to pay his or her Premium, and the grace period has been exhausted.
4. Rescission of the Member's coverage;
5. The QHP terminates or is decertified; or
6. The Member changes to another QHP.

"Grace period" refers to either:

1. The three (3) month grace period required for individuals receiving Advance Payments of the Premium Tax Credit. In this case, if full Premium payment is not received during the grace period, the last day of coverage will be the latter of the last day of the first month of the three (3) month grace period or the last day through which Premium is paid. We must pay claims incurred during the first month of the three (3) month grace period. During the second and third month of the grace period, Your coverage will be suspended and You will be ineligible for benefits under Your health benefit plan unless You pay all premiums due before the end of the grace period; or

2. A thirty (30) day grace period for individuals not receiving Advance Payments of the Premium Tax Credit. In this case, the last day of coverage will be thirty (30) days from the end of the last month for which premium was paid.

During the Grace period, We will continue to provide Covered Services under this Agreement.

If the Subscriber does not pay the required Premium by the end of the grace period, the Agreement is canceled. The application of the grace period to claims is based on the date of service and not on the date the claim was submitted.

Notices Provided During the Grace Period

A Subscriber who receives an Advanced Premium Tax Credit will receive a "Notice of Suspension of Coverage" which will include a description of the notice, the dollar amount due, date of last day of paid coverage, a notice-unique identification number, name and contact information for Subscriber, names of all enrollees affected by the notice, an explanation of the three-month federal grace period and the date the grace period expires, Our telephone number (1-855- Oscar-55), and the consequences of losing coverage, including financial responsibility for the payment of claims incurred and the obligation of the Subscriber.

A Subscriber who does not receive an Advanced Premium Tax Credit will receive a "Notice of Cancellation for Nonpayment of Premiums and Grace Period" which will include the reason for the cancellation (non-payment), the effective date of the cancellation, the dollar amount due, the last date of paid coverage, the date the grace period begins and ends, and contact information for Covered California. The notice will also inform enrollees or subscribers who cease to be enrolled in coverage that they may be eligible for reduced-cost coverage through the California Health Benefit Exchange established under Title 22 (commencing with Section 100500) of the Government Code or no-cost coverage through Medi-Cal, and will include information on obtaining coverage pursuant to those programs.

Effective Dates of Termination

Termination of coverage is effective on the following date(s):

1. In the case of termination initiated by the Member, the last day of coverage is:
    a. The last day through which the Member paid their premium.
2. If the Member is newly eligible for Medicaid, Children's Health Insurance Program (CHIP), or the Basic Health Plan, the last day of coverage is the day before such coverage begins.
3. In the case of a termination for non-payment of Premium and the three (3) month grace period required for Members receiving Advance Payments of the Premium Tax Credit has been exhausted, the last day of coverage will be the last day of the first month of the three (3) month grace period, or the 30th day after the last day through which the Member paid their premium, whichever is later. In the case of a termination for non-payment of Premium, and the Member is not receiving Advance Payments of the Premium Tax Credit, the last day of coverage is the last day of the grace period.
4. In the case of a termination when a Member changes QHPs, the last day of coverage in a Member's prior QHP is the day before the Effective Date of coverage in his or her new QHP.
5. If the Member has died, the last day of coverage will be the end of the month in which death occurs. When a Subscriber dies, the surviving Spouse or Domestic Partner of the deceased Subscriber, if covered under the Agreement, will be eligible for a Special Enrollment Period.

Guaranteed Renewable

Coverage under this Agreement is guaranteed renewable except as permitted to be canceled, rescinded, or not renewed under applicable State and federal law, provided the Member is a Qualified Individual as determined by the Exchange. The Member may renew this Agreement by payment of the renewal Premium by the end of the grace period of the Premium due date, provided the following requirements are satisfied:

1. Eligibility criteria as a Qualified Individual continues to be met;
2. There are no fraudulent or intentional misrepresentations of material fact on the application or under the terms of this Agreement; and
3. This Agreement has not been terminated by the Exchange.

Loss of Eligibility

Coverage ends for a Member when he or she no longer meets the eligibility requirements for coverage. You must timely furnish to the Exchange any information requested regarding Your

eligibility and the eligibility of Your Dependents. Failure to give timely notification of a loss of eligibility will not obligate Us to provide benefits for ineligible persons, even if We have accepted Premiums or paid benefits.

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.

Discontinuation of Health Coverage

We can refuse to renew Your Agreement if We decide to discontinue a health coverage plan that We offer in the individual market. If We discontinue a health coverage plan, We will provide You with at least one (1) ninety (90) days notice of the discontinuation. In addition, You will be given the option to purchase any health coverage plan that We currently offer without regard to claims status or health history. Non-renewal will not affect an existing claim.

Reinstatement of Coverage for Members of the Military

Members who are members of the United States Military Reserve and National Guard who lose coverage upon release are eligible for special enrollment. Please contact customer service at 1-855-Oscar-55 for information on how to apply for coverage.

Subscriber Receives Advanced Premium Tax Credit (APTC)

If the Subscriber receiving the APTC has previously paid at least one (1) month's Premium in a Benefit Period, We must provide a grace period of at least three (3) consecutive months. During the grace period, We must apply any payment received to the first billing cycle in which payment was delinquent and continue to collect the APTC. If full Premium payment is not received during the grace period, the last day of coverage will be the latter of the last day of the first month of the three (3) month grace period or the last day through which Premium is paid. We must pay claims incurred during the first month of the three (3) month grace period. During the second and third month of the grace period, Your coverage will be suspended and You will be ineligible for benefits under Your health benefit plan unless You pay all premiums due before the end of the grace period. You may be required by Your health care Providers to pay for any health care services You need. Please note that if Your full Premium payment is not received during the grace period, You will have no coverage for claims incurred after the first month of the three (3) month grace period and this means You will be liable for the full cost of any services You receive after the first month of the three (3) month grace period. If You do not pay Your full Premium during the grace period, You will be liable to Us for the Premium payment due for the period through the last day of the first month of the three (3) month grace period. You will also be liable to Us for any claims payments made for services incurred after the last day of the first month of the three (3) month grace period.

Subscriber Does Not Receive APTC

If the Subscriber is not receiving an APTC, this Agreement has a grace period of thirty (30) days. This means if any Premium payment, except the first, is not paid on or before the date it is due, it may be paid during the grace period. During the grace period, the Agreement will stay in force unless prior to the date Premium Payment is due You give timely notice in writing or over the phone to Us that the Agreement is to be canceled. If You do not make the full Premium Payment during the grace period, the Agreement will be canceled on the last day of the grace period. You will be liable to Us for the Premium Payment due including those for the grace period. You will also be liable to Us for any claims payments made for services incurred after the grace period.

Cancellation

Once this Agreement is canceled, former Member(s) cannot reapply until the next annual open enrollment period unless they experience an event that qualifies for a Special Enrollment period prior to the annual open enrollment period.

Removal of Members

A Subscriber may cancel the enrollment of any Member from the Agreement. If this happens, no benefits will be provided for Covered Services provided after the Member's termination date.

Right to Request Review of Cancellation or Non-Renewal of this Agreement

Any notice We provide You regarding a decision to cancel, terminate or not renew this Agreement will include notice of Your appeal rights, including the right to request review by Us or the Department of Managed Health Care if You believe that this Agreement has or will be improperly canceled, rescinded or not renewed. If You believe that Your Agreement has been cancelled or not renewed because of Your health status or requirements for health care services, You may request a review of cancellation by the Director of DMHC. For additional information on these rights, see the section titled COMPLAINTS AND GRIEVANCES or contact customer service at 1-855-Oscar-55.

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 SUMMARY OF BENEFITS, the sections called WHAT IS COVERED – MEDICAL and WHAT IS COVERED – PRESCRIPTION DRUGS 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 stated under the specific benefit and also listed in the SUMMARY 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) services received by an Out-of-Network Provider as a result of a Medical Emergency, Urgent Care or as an Authorized Service 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 Provier. Authorized Referrals and Covered Services received under the second exception 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 customer service at 1-855-Oscar-55 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-Oscar-55 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 or collect amounts above the Negotiated Fee Rate, please call Us at 1-855-Oscar-55 or write to Us at:

Oscar Health Plan of California
9942 Culver City Blvd.
PO Box 1279
Culver City, CA 90232

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.

Reminder: If You utilize an In-Network Provider, the Provider will send Us a claim on Your behalf. If You utilize an Other Eligible Providers, 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 SUMMARY OF BENEFITS and the section titled WHAT IS COVERED – MEDICAL for Your Cost Share responsibilities and limitations, or call Us at **1-855-Oscar-55** 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.

Coverage for American Indians and Alaskan Natives

Eligible American Indians and Alaskan Natives (AI/AN) whose income is over 300% of the Federal Poverty Limit (FPL) have no-cost sharing obligation under the plan contract for services that are essential health benefits if those services are provided by a In-Network Provider and if that In-Network Provider is also a Provider of Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services.

Eligible American Indians and Alaskan Natives whose income is under 300%FPL have no cost-sharing obligation under the plan contract for services that are essential health benefits if those services are provided by an In-Network Provider.

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 prior authorization may be obtained within forty-

eight (48) hours of the request for an appointment.

- Urgent care appointments requiring prior 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 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-Oscar-55** 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.

Important: 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 beginning of this 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 customer service at 1-855-Oscar-55 or visit Us at www.hioscar.com.

Reminder: Carry Your identification ("ID") card

Your Oscar ID card identifies You and contains important health care coverage information. Carrying Your ID card at all times will ensure You always have access to this coverage information when You need it. Make sure You show Your ID card to Your doctor, Hospital, pharmacist, or other health care Provider so they know You are covered by Oscar.

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-Oscar-55. 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 customer service at 1-855-Oscar-55 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 **SUMMARY OF BENEFITS**.

Submission of Claims

Either You or the Provider of service must claims 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.

How to file In-Network Medical Claims

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.

How to file Out-of-Network Emergency and Urgent Care claims:

After You get Covered Services for Out-of-Network Emergency or Urgent Care, We must receive written notice of Your claim within one-hundred eighty (180) days, or as soon thereafter as reasonably possible.

Either the Subscriber or Provider of service must claim benefits by sending Us properly completed claim forms itemizing the services or supplies received and the charges. These claim forms must be received by Us within one- hundred eighty (180) calendar days from the date the services or supplies are received. We will not be liable for benefits if We do not receive completed claim forms within this time period.

General claim filing guidelines:

Claim forms must be used; canceled checks or receipts are not acceptable. Claim forms are available by accessing Our web site at www.hioscar.com by calling the telephone number on the back of Your Identification Card or by writing to Us at the address in the next sentence.

Prior to submitting Your member claim form and itemized bill, You should make copies of the documents for Your own records and attach the original bills to the completed member claim form. The bills and the member claim form should be mailed to:

Oscar Health Plan of California
Attn: Claims
9942 Culver City Blvd.
PO Box 1279
Culver City, CA 90232

Out-of-Network providers must submit claims within one-hundred eighty (180) calendar days following the dates of service unless otherwise mandated by law. A claim received after the one-hundred eighty (180) days billing time limit is subject to denial.

When You receive health care outside of the United States, You will need to submit an itemized bill and medical records for services rendered. The itemized bill and medical records must be translated into English and include the billed charges.

Note: You are responsible, at Your own expense, for obtaining an English language translation of foreign country Provider claims and medical records.

Other Charges

Copayments and Coinsurance are outlined in the **SUMMARY 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.

Important: 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. Call customer service at 1-855-Oscar-55 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 SUMMARY 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.

Described below are Your Coinsurance and Out of Pocket Maximums.

Note: 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.

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 SUMMARY 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 **SUMMARY 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 section titled **YOUR ELIGIBILITY**.

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 SUMMARY OF BENEFITS for details on the amounts You must pay for Covered Services. Also be sure to read HOW YOUR COVERAGE WORKS 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) services received by 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 Provier. Authorized Referrals and Covered Services received under the second exception 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 – PRESCRIPTION DRUGS.

Note: Several sections may apply to Your claims. For example, if You have surgery, benefits for Your Hospital stay will be described under "Surgery" and "Inpatient Facility Services." Benefits for Your Physician's services will be described under "Office Visits." As a result, You should read all sections that may apply to Your claims.

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 SUMMARY 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 FOR A DEFINITION OF MEDICALLY NECESSARY. ADDITIONAL INFORMATION ON THE REVIEW PROCESS IS AVAILABLE IN THE SECTION TITLED GETTING APPROVAL FOR BENEFITS OR CALL CUSTOMER SERVICE.

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 part.

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 part GETTING APPROVAL FOR BENEFITS for details).

Medically Necessary ambulance and transport services are a Covered Service when one or more 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.
- 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.

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 or 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. 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:

A. The treatment is prescribed by a licensed Physician or is developed by a licensed psychologist.
B. The treatment is provided under a treatment plan prescribed by a Qualified Autism Service Provider and is administered by one of the following:

i. A Qualified Autism Service Provider.
ii. A Qualified Autism Service Professional supervised by the Qualified Autism Service Provider.
iii. A Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional.

C. 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:
   i. Describes the patient's behavioral health impairments or developmental challenges that are to be treated;
   ii. 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;
   iii. Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Pervasive Developmental Disorder or Autism; and
   iv. Discontinues Intensive Behavioral Intervention services when the treatment goals and objectives are achieved or no longer appropriate.

D. 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** 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 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 described in State Law for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program;
- Has training and experience in providing services for Pervasive Developmental Disorder or Autism pursuant to applicable State law; and
- Is employed by the Participating 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

Conditions of Services

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.

Cardiac Rehabilitation Therapy

Please see "Therapy Services" later in this section.

Chemotherapy

Please see "Therapy Services" later in this section.

Child Dental Services

Please see "Dental Services" later in this section.

Child Vision Services

Please see "Vision Services" later in this section.

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 the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including:

- Health care services typically provided absent a clinical trial.
- Health care services required solely for the provision of the investigational drug, item, device, or service.
- Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.
- 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 costs associated with the provision of any of the following:

- Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.

- Services other than health care services, such as travel, housing, companion expenses, and other nonclinical expenses, that an Enrollee may require as a result of the treatment being provided for purposes of the clinical trial.
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the Plan.
- Health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Eligibility to participate in the clinical trial will be determined according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways: (i) determination is made by a Plan Provider; (ii) Enrollee provides Oscar with medical and scientific information establishing this determination. If any In-Network providers participate in the clinical trial and will accept the enrollee as a participant in the clinical trial, the enrollee must participate in the clinical trial through an In-Network provider unless the clinical trial is outside the state where the enrollee lives; or the clinical trial is an approved clinical trial, meaning it is 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:

1. Federally funded trials approved or funded by one of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. The Department of Veterans Affairs, the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:

i. It is comparable to the National Institute of Health system of peer review of studies and investigations; and
ii. It assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of review.

f. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
g. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

2. Studies or investigations done as part of an Investigational new Drug application reviewed by the Food and Drug Administration;
3. Studies or investigations done for Drug trials which are exempt from the Investigational new Drug application.

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 immunosuppresives. Covered Services include:

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

Dental Anesthesia

General anesthesia and associated facility charges for dental procedures rendered in a Hospital or Ambulatory Surgery Center setting is a Covered Service when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting if the Member:

1. Is under seven years of age;
2. Is developmentally disabled, regardless of age; or
3. Has compromised health and for whom general anesthesia is medically necessary, regardless of age.

Please see "Dental Services – Child" for more information on Covered Services.

Important: 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 customer service at **1-855-Oscar-55.**

Dental Services – Child

For Members under nineteen (19) years of age

The dental benefits described in this section only apply to Members until the end of the month when the member turns nineteen (19) years of age. See "Dental – Child Dental Services" in the SUMMARY OF BENEFITS for additional information.

This Agreement covers the dental services below for Members until the end of the month when the member turns nineteen (19) years of age when they are performed by a licensed dentist and when they are necessary and customary, as determined by the standards of generally accepted dental practice. If there is more than one professionally acceptable treatment for Your dental condition, the Plan will cover the least expensive treatment.

Benefits for pediatric oral care are covered under the dental benefit received by children under the Medi-Cal program as of 2014, pursuant to the Medi-Cal Dental Program Provider Handbook in effect during the first quarter of 2014, including coverage pursuant to the Early Periodic Screening.

Your Dental Benefits

Oscar does not determine whether the dental services (except orthodontic services) listed in the following sections are Medically Necessary to treat Your specific condition or restore Your dentition.

When orthodontic care is covered by this Agreement, claims will be reviewed to determine if it was Medically Necessary orthodontic care. See the section "Orthodontic Care" below for more information.

Your dentist may recommend or prescribe dental care services that are not covered by this Agreement, including those that are cosmetic in nature. We will cover pediatric dental benefits when medically necessary. Additional requests, beyond the stated frequency limitations shall be considered when documented dental necessity is justified due to a physical limitation and/or an oral condition that prevents daily hygiene.

The decision as to what dental care treatment is best for You is solely between You and Your dentist.

Pretreatment Estimate

A pretreatment estimate is a valuable tool for You and Your dentist. It gives You and the dentist an idea of what Your out of pocket costs will be. This allows You and Your dentist to make any necessary financial arrangements before treatment begins. It is a good idea to get a pretreatment estimate for dental care that involves major restorative, periodontics, prosthetic, or orthodontic care.

The pretreatment estimate is recommended, but not required for You to get benefits for Covered Services. A pretreatment estimate does not authorize treatment or determine its Medical Necessity (except for orthodontics), and does not guarantee benefits. The estimate will be based on Your current eligibility and the Agreement benefits in effect at the time the estimate is sent to Us. This is an estimate only. Our final payment will be based on the claim that is sent to Us at the time of the completed dental care service(s). Sending in other claims or changes to Your eligibility or to the Agreement may affect Our final payment.

You can ask Your dentist to send pretreatment estimate for You, or You can send it to Us Yourself. Please include the procedure codes for the services to be performed (Your dentist can give these to You). Pretreatment estimate requests can be sent to Oscar. If You have questions on where to send the estimate, call Us at the number on the back of Your ID card.

Diagnostic and Preventive Services

- **Oral evaluations** – Periodic Oral Evaluation is covered up to one (1) time per six (6) months, per provider. Comprehensive Oral Evaluation is limited to one (1) per patient for initial evaluation.
    - Limited and problem focused oral evaluations are covered up to one per patient per provider.
    - Limited problem-focused oral re-evaluations are is covered up to six (6) in a three (3) month period, no more than twelve (12) in twelve (12) months.
    - Comprehensive periodontal evaluation covered as a comprehensive oral evaluation.
- **Radiographs (x-rays)**
    - **Bitewings** – Four (4) bitewing x-rays covered once (1) per six (6) months per provider, age 10 and over; three (3) bitewings are covered one (1) per date of service

as D0270 and D0272; two (2) bitewings are covered once (1) per six (6) months per provider; one (1) bitewing is covered one (1) per date of service.

- **Single intraoral periapical x-rays** – Up to twenty (20) are covered in any twelve (12) month period, by the same provider.
- **Intraoral, occlusal x-rays** – Up to two (2) per six (6) months per provider.
- **Extra-oral 2D projection radiographic image, stationary radiation source** – One (1) per date of service.
- **Full mouth** – Covered up to one (1) in any thirty-six (36) month period, per provider.
- **Panoramic** – Covered up to one (1) in any thirty-six (36) month period, per provider.
- **Vertical bitewings –** covered as four (4) bitewings.
- **Posterior-anterior, lateral skull & facial bone survey** – Covered up to three (3) per date of service.
- **Sialography**
- **Temporomandibular joint arthrogram, including injection** – Covered for the survey of trauma or pathology for a maximum of three (3) per date of service.
- **Tomographic survey** – Covered twice (2) in a twelve (12) month period, per provider,
- **2D Cephalometric radiographic image** – Covered twice (2) in a twelve (12) month period, per provider.
- **2D oral/facial photographic image, intra-orally/extra-orally** – Covered four (4) per date of service.

- **Pulp vitality tests**
- **Diagnostic casts** – Covered for the evaluation of orthodontic benefits only, once (1) per provider, for permanent dentition.
- **Caries risk assessment and documentation**
- **Other oral pathology procedures, by report**
- **Unspecified diagnostic procedure, by report**
- **Dental cleaning (prophylaxis)** – Covered once (1) in a six (6) month period. Prophylaxis is a procedure to remove plaque, tartar (calculus), and stain from teeth.
- **Fluoride treatment** - Topical application of fluoride or fluoride varnish covered once (1) in a six (6) month period.
- **Additional prophylaxis and fluoride treatment if medically necessary**

- **Preventive dental education and oral hygiene instruction**
- **Dental sealant treatments, including preventive resin restoration** – Limited to one (1) (D1351, D1352) every thirty-six (36) months for 1st, 2nd and 3rd molars only.
- **Space maintainers** (including acrylic and fixed band type) – One (1) per quad per arch every twelve (12) months, under age 18.
- **Re-cement or re-bond space maintainer – One per quad or per arch every twelve (12) months, under age 18**
- **Removal of fixed space maintainer**

Basic Restorative Services

- **Amalgam and resin-based composite restorations (fillings)** – Primary teeth, one (1) per surface per tooth every twelve (12) months; Permanent teeth, one (1) per surface per tooth every thirty-six (36) months.
- **Resin-based composite crown, anterior** – Primary teeth, one (1) per tooth every twelve (12) months; Permanent teeth, one (1) per tooth every thirty-six (36) months.

  Restorations are limited by the following conditions:
  - When medically necessary, when carious activity or fractures have extended through the dentinoenamel junction and when the tooth demonstrates a reasonable longevity.
  - If the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries (decay), any other restoration, such as a crown, is considered an optional treatment.
  - Replacement of a restoration is covered only if it is defective, as shown by conditions as recurrent decay or fracture, and replacement is medically necessary.

- **Recementation of crowns, inlays, and onlays**
  - Re-cement or re-bond inlay, onlay, veneer or partial coverage - Covered one (1) per tooth every 12 months, per provider.
  - Re-cement or re-bond crown limited to after twelve (12) months of initial placement .

- **Prefabricated crowns** – Covered once (1) in a twelve (12) month period for primary teeth, covered once (1) in a 36 month period for permanent teeth.
- **Prefabricated resin crown or stainless steel crown with resin window** – Covered once (1) per tooth in a twelve (12) month period for primary teeth, covered once (1) in a thirty-six (36) month period for permanent teeth.
- **Crown repair necessitated by restorative material failure** – Covered after twelve (12) months of initial crown placement with same provider.
- **Core buildup, including any pins when required**
- **Pin retention, post and core and prefabricated post and core in addition to crown** - Limited to one (1) per tooth.
- **Crown repair necessitated by restorative material failure** – Covered after twelve (12) months of initial crown placement with same provider.
- **Protective restoration** - covered one (1) per tooth every six (6) months, per provider.
- **Post removal**
- **Unspecified restorative procedure, by report**

Endodontic Services

- **Direct and indirect pulp capping**
- **Therapeutic pulpotomy (excluding final restoration)** – Covered once (1) per primary tooth.
- **Pulpal debridement, partial pulpotomy and pulpal therapy** – Covered once (1) per tooth.
- **Treatment of root canal obstruction and Internal root repair**
- **Apexification/recalcification, initial visit and interim medication replacement** – Covered once (1) per tooth.
- **Retrograde filling, per root**
- **Surgical procedure for isolation of tooth with rubber dam**
- **Root canal therapy** – Initial treatment is covered once (1) per tooth per lifetime, retreatment is limited to once (1) after twelve (12) months of initial treatment.
- **Apicoectomy**
- **Unspecified endodontic procedure, by report**

Periodontal Services

- **Periodontal scaling, root planing and subgingival curettage** – Covered up to one (1) per site/quadrant in any twenty-four (24) month period for ages thirteen (13) and over.
- **Gingivectomy or gingivolplasty** – One (1) (D4210, D4211, D4260, D4261) per site/quad every thirty-six (36) months, age 13 and over.
- **Clinical crown lengthening, hard tissue**
- **Full mouth debridement**
- **Osseous or muco-gingival surgery** – One (1) (D4210, D4211, D4260, D4261) per site/quad every thirty-six (36) months, age 13 and over.
- **Biologic materials to aid in soft and osseous tissue regeneration**
- **Localized delivery of antimicrobial agent/per tooth**
- **Periodontal maintenance** – One (1) every three (3) months.
- **Unscheduled dressing change (other than treating dentist or staff)** – Covered one (1) per patient per provider, age thirteen (13) and over.
- **Unspecified periodontal procedure, by report**

Oral Surgery and Maxillofacial Services

- **Oral Surgery Services** - These services include post-operative care such as examinations, suture removal and treatment of complications.
- **Basic Tooth extractions**
- **Extractions, including Surgical extractions** - Removal of impacted teeth is covered only when evidence of pathology exists.
- **Surgical access of an unerupted tooth**
- **Placement, device to facilitate eruption, impaction**
- **Alveoloplasty**
- **Biopsy of oral tissues** - Incisional biopsy of oral tissue, hard (bone, tooth) limited to one (1) per arch per date of service; incisional biopsy of oral tissue, soft limited to three (3) per date of service.
- **Excision and removal of lesions, cysts and neoplasms**
- **Destruction of lesions by physical or chemical method, by report**

- **Incision and drainage of abscesses** - Intraoral soft tissue limited to one (1) per quadrant, same date of service.
- **Root recovery (separate procedure)**
- **Removal of lateral exostosis** – Limited to one (1) per quadrant.
- **Treatment of palatal torus and mandibular torus** - Removal of lateral exostosis, torus mandibularis, and surgical reduction of osseous tuberosity is limited to one (1) per quadrant; removal of torus palatinus is limited to one (1) per lifetime.
- **Surgical reduction of osseous tuberosity – limited to one (1) per quadrant**
- **Radical resection of maxilla or mandible**
- **Arthroscopy**
- **Sialolithotomy**
- **Sialodochoplasty**
- **Emergency tracheotomy**
- **Oroantral fistula closure**
- **Primary closure of a sinus perforation**
- **Maxilla and Mandible open and closed reduction**
- **Stabilization of teeth**
- **Tooth reimplantation and/or stabilization, accident** – Covered one (1) per arch.
- **Surgical repositioning of teeth** – Covered one (1) per arch, for active orthodontic treatment only.
- **Transseptal fiberotomy** – Covered one (1) per arch, for active orthodontic treatment only.
- **Vestibuloplasty, ridge extension** – Covered one (1) per arch, 2nd epithelialization limited to one (1) per arch per five (5) year period.
- **Removal of foreign bodies** – Limited to one (1) per date of service.
- **Maxillary sinusotomy for removal of tooth fragment or foreign body**
- **Treatment for upper or lower jaw fractures or dislocations**
- **Treatment for Temporomandibular Joint Disorder**
- **Occlusal orthotic device, by report**
- **Sutures**
- **Skin grafts**
- **Osteoplasty and Osteotomy**

- **Partial ostectomy/sequestrectomy for removal of non-vital bone** - Covered one (1) per quadrant per date of service.
- **Facial reconstruction, including LeFort I, Le Fort II or LeFort III**
- **Frenulectomy** – Covered one (1) per arch per date of service.
- **Frenuloplasty** - Covered one (1) per arch per date of service.
- **Excision of hyperplastic tissue, per arch** - Covered one (1) per arch per date of service.
- **Surgical reduction of fibrous tuberosity** – Covered once (1) per quadrant per date of service.
- **Excision of salivary gland, by report**
- **Synthetic graft, mandible or facial bones, by report**
- **Coronoidectomy**
- **Appliance removal (not by dentist who placed appliance), includes removal of archbar** – Covered one (1) per arch per date of service.
- **Unspecified oral surgery procedure, by report**

Major Restorative Services

Benefits include the following:

- **Crowns** – Including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown. Crowns are covered as followed:
    - Crowns are covered only if there is not enough retentive quality left in the tooth to hold a filling.
    - Covered once per tooth per five (5) year period for ages thirteen (13) and over.
- **Implants** – Covered when exceptional medical conditions are met with pre-authorization only.

Prosthodontic Services

Benefits include the following:

- **Fixed bridges** – Bridges made of cast, porcelain baked with metal, or plastic processed to gold are covered as follows:

- A fixed bridge is covered when it is necessary to replace a missing permanent anterior (front) tooth and the patient's oral health and general dental condition permits.
- Fixed bridges are covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered an optional treatment.
- Fixed bridges used to replace missing posterior teeth are considered optional treatment when the abutment teeth are sound and would be crowned only for the purpose of supporting a pontic.
- 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.
- Limited to one (1) per tooth every five (5) year period only on permanent teeth.

Note: We will cover up to five (5) units of crown or bridgework per arch. Upon the sixth (6^{th}) unit, the treatment is considered full mouth reconstruction and is an optional treatment.

- **Fixed partial denture repair**
- **Recementation of bridges**
- **Unspecified fixed prosthodontic procedure, by report**
- **Dentures** – Including full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers and prosthetics. Dentures are covered as follows:
  - Complete and partial dentures limited to one (1) per arch every five (5) year period.
  - Immediate dentures limited to one (1) per arch per patient. Stayplates only a covered when used as an anterior space maintainer for children.
  - Adjustments limited to two (2) per arch every twelve (12) months, one (1) per arch per date of service per provider.
  - Repairs for broken complete denture limited to once (1) per arch per date of service per provider, limited to twice (2) per arch every twelve (12) months per provider.

- Replacement of missing or broken teeth, complete denture limited to four (4) per arch per provider, limited to twice (2) every twelve (12) months per provider.
- Repairs for resin denture base, and cast framework limited to two (2) per arch per provider every twelve (12) months, limited to one (1) per arch per date of service per provider.
- Repair or replace broken clasp, per tooth limited to three (3) per arch per provider every twelve (12) months, limited to one (1) per arch per date of service per provider.
- Replace broken teeth, per tooth limited to four (4) per arch per provider every twelve (12) months, limited to one (1) per arch per date of service per provider
- Add tooth to existing partial denture, limited to three (3) per arch per date of service per provider, one (1) per tooth.
- Add clasp to existing partial denture, limited to three (3) per date of service per provider, twice (2) per arch per provider every twelve (12) months.
- Complete or Partial denture Relines limited to one (1) every twelve (12) months, covered six (6) months after initial placement of appliance if extractions were required, twelve (12) months after initial placement of appliance if extractions were not required.
- Tissue conditioning limited to two (2) per arch every thirty-six (36) months
- Precision attachment, by report.
- Complete overdenture limited to one (1) per arch every five (5) year period.
- Unspecified removable prosthodontic procedure, by report.

- **Maxillofacial Prosthetic Services**
  - Maxillofacial prosthetic services are for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.
  - All maxillofacial prosthetic procedures require written documentation for payment or prior authorization.
  - Obturator prosthesis modification limited to two (2) every twelve (12) months.
  - Feeding aid limited to under age eighteen (18).

- Modifications for Palatal lift and speech aid prostheses limited to two (2) every twelve (12) months.

Other Services

- Adjunctive General Services – Covered for the following:
  - Emergency treatment, palliative treatment – limited to one (1) per date of service
  - Anesthesia and local anesthetics.
  - Oral, IV conscious sedatives and nitrous oxide when dispensed at a dental office by a provider acting within the scope of their licensure.
  - Local anesthesia not in conjunction, operative or surgical procedures limited to one (1) per date of service.
  - Consultations – This benefit includes specialist consultations.
  - Therapeutic parenteral drug - limited to four (4) per date of service
  - Fixed partial denture sectioning.
  - House/extended care facility call.
  - Hospital or ambulatory surgical center call.
  - Office visit, observation, regular hours, no other services - limited to one (1) per date of service per provider.
  - Office visit, after regularly scheduled hours - limited to one (1) per date of service per provider.
  - Application of desensitizing medicament – limited to (one) 1 per tooth every twelve (12) months, for permanent teeth only.
  - Treatment of complications, post-surgical unusual, by report – limited to one (1) per date of service per provider.
  - Occlusion analysis - limited to one (1) per twelve (12) months, age thirteen (13) and over.
  - Occlusal adjustment, limited – covered one (1) per quadrant every twelve (12) months per provider, age thirteen (13) and over.
  - Occlusal adjustment, complete – covered one (1) per twelve (12) months, age thirteen (13) and over.
  - Unspecified adjunctive procedure, by report.

Orthodontic Services

Orthodontic treatment is the prevention and correction of malocclusion of teeth and associated dental and facial disharmonies. To be considered Medically Necessary orthodontic care, the service must be preauthorized by Us. Medical Necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, or facial trauma resulting in functional difficulties. Oscar will authorize the service if it is necessary to restore the form and function of the oral cavity, such as through a result of injury or dysfunction resulting from congenital deformities. Medically Necessary orthodontic care can be beneficial to generally prevent disease and promote oral health. To be considered Medically Necessary orthodontic care, at least one of the following must be present:

- There is spacing between adjacent teeth which interferes with the biting function;
- There is an overbite to the extent that the lower anterior teeth impinge on the roof of the mouth when You bite;
- Positioning of the jaws or teeth impair chewing or biting function;
- On an objective professionally recognized dental orthodontic severity index, the condition scores at a level consistent with the need for orthodontic care; or
- Based on a comparable assessment of the above bullets, there is an overall orthodontic problem that interferes with the biting function.
- Any of the following automatic qualifying conditions:
    - Cleft Palate deformity
    - Cranio-facial Anomaly
    - Deep Impinging Overbite
    - Crossbite of Individual Anterior Teeth
    - Severe Traumatic Deviation
    - Overjet/Mandibular Protrusion
    - Conditions creating a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD)

You or Your orthodontist should send Your treatment plan to Us to find out if it will be covered under this Agreement.

Benefits include, but are not limited to, the following:

- **Limited Treatment** – Treatments which are not full treatment cases and are usually done for minor tooth movement.
- **Interceptive Treatment** – A limited (phase I) treatment phase used to prevent or assist in the severity of future treatment.
- **Comprehensive (complete) Treatment** – Full treatment includes all radiographs, diagnostic casts/models, appliances and visits.
- **Minor Treatment** – Treatment to control harmful habits.
- **Removable Appliance Therapy** – An appliance that is removable and not cemented or bonded to the teeth.
- **Fixed Appliance Therapy** – A component that is cemented or bonded to the teeth.
- **Other Complex Surgical Procedures** – Surgical exposure of impacted or unerupted tooth for orthodontic reasons; or surgical repositioning of teeth.
- Repair or replacement of broken appliances.

Treatment that is already in progress with appliances placed before You were covered by this Agreement will be covered on a pro-rated basis.

See "What is Not Covered (Exclusions) – Medical" for Exclusions.

Orthodontic Payments

Because orthodontic treatment normally occurs over a long period of time, benefit payments are made over the course of treatment. You must continue to be eligible under the Agreement in order to receive ongoing payments for Your orthodontic treatment.

Payments for treatment are made:

1. When treatment begins (appliances are installed), and
2. At six (6) month intervals thereafter, until treatment is completed or this Agreement's coverage ends. Before treatment begins, the treating orthodontist should send a pre-treatment estimate to Us. An Estimate of Benefits form will be sent to You and Your

orthodontist indicating the estimated Negotiated Fee Rate, including any amount You may owe. This form serves as a claim form when treatment begins.

When treatment begins, the orthodontist should send the Estimate of Benefit form with the date of appliance placement and his/her signature. After We have verified Your Agreement's benefits and Your eligibility, a benefit payment will be issued. A new/revised Estimate of Benefits form will also be sent to You and Your orthodontist. This again serves as the claim form to be sent in six (6) months after the appliances are placed.

Please submit appeals regarding Your dental coverage for Members under nineteen (19) years of age to the following address:

LIBERTY Dental Plan
PO BOX 26110
Santa Ana, CA 92799

Diabetes Equipment, Education and Supplies

Certain prosthesis and assistive devices require Precertification (see the part called GETTING APPROVAL FOR BENEFITS for details).

Benefits for Covered Services and supplies for the treatment of diabetes are provided on the same basis, at the same Cost Share, as any other medical condition. Benefits will be provided for:

1. The following Diabetes Equipment and Supplies:
    a. Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips.
    b. Insulin Pumps and all related necessary supplies.
    c. Pen delivery systems for Insulin administration.
    d. Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent or treat diabetes-related complications.
    e. Visual aids (but not eyeglasses) to help the visually impaired to properly dose Insulin.

Note: Such equipment and supplies are covered under the Agreement's benefits for the section Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics, and Medical and Surgical Supplies.

2. Diabetes Outpatient Self-Management Training Program, which:
    a. Is designed to teach the Member who is a patient, and the patient's family, about the disease process and the daily management of diabetic therapy;
    b. Includes self-management training, education and medical nutrition therapy to enable the Member to properly use the equipment, supplies and medications necessary to manage the disease; and
    c. Is supervised by a Physician.

Note: Diabetes education services are covered under the Agreement's benefits as professional services by Physicians.

3. The following medications and supplies are covered under WHAT IS COVERED – PRESCRIPTION DRUGS:
    a. Insulin, glucagon and other Prescription Drugs for the treatment of diabetes.
    b. Insulin syringes.
    c. Urine testing strips, lancets, and lancet puncture devices.

Note: These items must be obtained either from a retail Pharmacy that is in Oscar's network or through Oscar's mail order Prescription Drug program.

4. Screening for gestational diabetes and Type 2 Diabetes Mellitus are covered under "Preventive Care" later in this section.

Diagnostic

Certain diagnostic procedures, including advance imaging procedures, wherever performed, require Precertification (see the part called GETTING APPROVAL FOR BENEFITS for details).

Diagnostic Services

Your Agreement includes benefits for tests or procedures to find or check a condition when specific symptoms exist. Tests must be ordered by a Physician and include diagnostic services ordered before a surgery or Hospital admission. Benefits include the following services:

- **Diagnostic Laboratory and Pathology Services**
- **Diagnostic Imaging Services and Electronic Diagnostic Tests**
    - X-rays / regular imaging services
    - Ultrasound
    - Electrocardiograms (EKG)
    - Electroencephalography (EEG)
    - Echocardiograms
    - Hearing and vision tests for a medical condition or injury (not for screenings or preventive care)
    - Tests ordered before a surgery or admission
- **Advanced Diagnostic Imaging Services** Benefits include, but are not limited to:
    - Computed Tomography (CT) scan
    - Computed Tomography Angiography (CTA) scan
    - Magnetic Resonance Imaging (MRI) scan
    - Magnetic Resonance Angiogram (MRA) scan
    - Magnetic Resonance Spectroscopy (MRS) scan
    - Nuclear Cardiology (NC) scan
    - Positron Emission Tomography (PET) scans
    - PET/CT Fusion scans
    - Quantitative Computed Tomography (QCT) Bone Densitometry
    - Diagnostic CT Colonography

The list of advanced imaging services may change as medical technologies change.

Dialysis

Please see "Therapy Services" later in this section.

Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies

Certain Durable Medical Equipment, Medical Devices, Footwear, Orthotics, Prosthetics, and Supplies require Precertification (see the section titled GETTING APPROVAL FOR BENEFITS for details).

Durable Medical Equipment and Medical Devices

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

- Is meant for repeated use and is not disposable
- Is used for a medical purpose and is of no further use when medical need ends
- Is meant for use outside a medical Facility
- Is only for the use of the patient
- Is made to serve a medical use
- 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

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 SUMMARY OF BENEFITS, HOW YOUR COVERAGE WORKS and the "Ambulance Services" section 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 be expected to result in any of the following:

1. 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;
2. Serious impairment to bodily functions; or
3. 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 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:

1. An immediate danger to himself or herself or to others; or
2. 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.

Hearing Services

Covered Services include:

- Routine hearing screenings (see "Preventive Care" later in this section).
- Hearing exams to determine the need for hearing correction (see "Preventive Care" later in this section).

- Services related to the ear or hearing, such as outpatient care to treat an ear infection and outpatient Prescription Drugs, supplies and supplements (see "Office Visits" later in this section and the section titled WHAT IS COVERED – PRESCRIPTION DRUGS).
- Cochlear implants (see "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies" earlier in this section).

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
- Private Duty Nursing when Medically Necessary and approved by Oscar

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 twelve (12) 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

Covered services include the diagnosis of the underlying cause of infertility. Treatment for infertility after diagnosis is not covered.

Infusion Therapy

Please see "Therapy Services" later in this part.

Inpatient Facility Services

Precertification is required for all inpatient Facility admissions and stays. Precertification is NOT required for emergency and inpatient Hospital stays for the delivery of a child or mastectomy surgery, including the length of Hospital stays associated with mastectomy and/or breast reconstruction surgery for breast. 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-Oscar-55 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;

- 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; and
- Participation in the Expanded Alpha Feto Protein Program, a statewide prenatal testing program administered by California's State Department of Health Services.

Important Note About Maternity Admissions: 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) hours, 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) hours, 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.

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 Condition, including Physician Services
    - Inpatient psychiatric observation for acute psychiatric crisis, including Physian 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 Autism and Pervasive Developmental Disorder (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 mental condition;
    - Behavioral Health Therapy Home Visit for Autism and Pervasive Development Disorder (See also "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" earlier in this section for a description of additional Covered Services); and
    - Nonemergency 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 evaluation and counseling;
    - Medical treatment for withdrawal symptoms.
- **Outpatient Items and Services**
    - Day treatment program for substance use disorder
    - Intensive outpatient treatment for substance use disorder
    - Nonemergency Psychiatric Transportation

For a list of conditions covered under Mental Health and Substance Abuse, please see the section titled DEFINITIONS. 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)

To obtain a list of Mental Health and Substance Use Providers within Our network, please contact Us at 1- 855-Oscar-55 or access Our website at www.hioscar.com.

Occupational Therapy

Please see "Therapy Services" later in this section.

Office Visits

An Office Visit is when You go to a Physician's office and have one 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.

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.

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).
- **Second Opinions**. If You have a question about Your condition or about a plan of treatment which Your Physician has recommended, You may receive a second medical opinion from another Physician. This second opinion visit will be provided according to the benefits, limitations, and exclusions of this Agreement. There is no need to obtain a referral to see a Specialist. To obtain a second opinion, You may ask Your Physician to refer You to an In-Network Provider to receive a second opinion. If You wish to receive a second medical opinion, remember that greater benefits are provided when You choose an In-Network Provider. However, if there is no participating plan Provider within the network, then We will authorize a second opinion by an appropriately qualified health professional outside of the Network at in-network costs.

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;
- 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.

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

Physical Therapy

Please see "Therapy Services" later in this section.

Preventive Care

Preventive care is given during an Office Visit. 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 (4) broad categories as described below:

1. 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;

2. 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;
3. Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration, including:
    a. The American Academy of Pediatrics Bright Futures Recommendations for Preventive Pediatric Health Care;
4. Additional preventive care and screening for women provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, including:
    a. All FDA-approved contraceptive drugs, devices, and other products for women, including all FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the enrollee's provider.
        i. Oscar will not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this subdivision, unless:
            1. 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 (1) without cost sharing.
            2. 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 "GETTING APPROVAL FOR BENEFITS.")
        ii. Oscar will cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time by an In-Network Provider or pharmacist, or location licensed or otherwise authorized to dispense Drugs or supplies.
    b. Voluntary sterilization procedures.
    c. Injectable contraceptives and patches.
    d. Contraceptive devices such as diaphragms, intra-uterine devices (IUDs), cervical caps and implants.

e. Family planning counseling and education.
f. 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.
g. 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.
h. Gestational diabetes screening.
i. Well woman visits that are age and developmentally appropriate, including preconception and prenatal care.
j. Screening and counseling for sexually transmitted infections.
k. Screening and counseling for Human Immunodeficiency Virus (HIV).
l. Screening and counseling for interpersonal and domestic violence.
m. Testing for Human Papillomavirus (HPV).
n. 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 seven (7) forms of smoking cessation products at no cost sharing. Please contact Us or refer to Our Drug Formulary for a list of qualifying products. There are no limitations on the number of days for a course of treatment (either alone or in combination) for all FDA-approved tobacco cessation medications listed on Our Drug Formulary.
- 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; and the Office Visit related to these services.

You may call customer service at **1-855-Oscar-55** 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.

Pulmonary Therapy

Please see "Therapy Services" later in this section.

Radiation Therapy

Please see "Therapy Services" later in this section.

Rehabilitation and Habilitation Services

Precertification is required for a Skilled Nursing Facility and certain Mental Health and Substance Abuse services (see the section titled GETTING APPROVAL FOR BENEFITS for details).

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.

Respiratory Therapy

Please see "Therapy Services" later in this section.

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

Limitations:

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

Speech Therapy

Please see "Therapy Services" later in this section.

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-Oscar-55.

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

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.

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.

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.

Temporomandibular Joint (TMJ) and Craniomandibular Joint Services

Precertification is required for certain diagnostic procedures and tests (see 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 Physical Therapy, Occupational Therapy, Speech Therapy, Infusion Therapy and Other Therapy Services (in all settings) (see 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 and 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 and 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 the 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.

Limitations:

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.

Transgender Services

Precertification is required for certain Transgender Services (see GETTING APPROVAL FOR BENEFITS for details).

Benefits are provided for services and supplies in connection with Gender Transition 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 Transition 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 prior 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.

Transplant Services

Precertification is required for all services related to Human Organ and Tissue Transplants (see 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 center. For further information, please contact customer service at 1-855-Oscar-55.

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-Oscar-55**.

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.

Note: 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 a completed travel reimbursement form and itemized, 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 customer service at 1-855-Oscar- 55 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 WHAT IS COVERED – MEDICAL, under the section "Preventive Care."

Vision Services - Child

Vision Care that is Covered

The following vision care benefits are available to Members **until the end of the month when the member turns nineteen (19) years of age**. We will cover vision care that is listed in this section. See Your SUMMARY OF BENEFITS for the benefit frequencies and Your Cost Share amounts 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.

Note: 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

9942 Culver City Blvd.

PO Box 1279

Culver City, CA 90232

WHAT IS COVERED – PRESCRIPTION DRUGS

What You Pay for Prescription Drugs

Tier One, Tier Two, Tier Three, Tier Four

Your Copayment/Coinsurance amount may vary based on whether the Prescription Drug, including covered Specialty Drugs, has been classified by Us as a first, second, third, or fourth "Tier" Drug. Prescription Drugs for Mental Health/Substance Use Disorder are covered in the same manner as Medical/Surgical Drugs.

Refer to Your SUMMARY OF BENEFITS to determine Your Copayment, Coinsurance and Deductible (if any) amounts for each tier. The determination of Tiers is made by Us, through the Pharmacy and Therapeutics (P&T) Process, based upon clinical information, and where appropriate, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition; the availability of over-the-counter alternatives; and certain clinical economic factors. The Tier placement of a Prescription Drug may vary based on the dosage and administration (i.e., by mouth, shots, topical or inhaled) of the Prescription Drug. This may result in the coverage of one form of a Prescription Drug but not another or the other forms of administration of a Prescription Drug in a different Tier. The placement of a particular drug on a given Tier is subject to change.

Note: Your Copayments and/or Coinsurance will not be reduced by any discounts, rebates or other funds received by Oscar's designated Pharmacy benefits manager from Drug manufacturers, wholesalers, distributors, and/or similar vendors and/or funds received by Oscar from Oscar's designated Pharmacy Benefits Manager.

Prescription Drug List

We also have a Prescription Drug List (Formulary), which is a list of FDA-approved Drugs that has been reviewed and recommended for use based on their quality and cost effectiveness.

The Drug List is developed by Us based upon clinical findings, and where proper, the cost of the Drug relative to other Drugs in its therapeutic class or used to treat the same or similar condition. It

is also based on the availability of over-the-counter medicines, Tier 1 Drugs, the use of one Drug over another by Our Members, and where proper, certain clinical economic reasons. Some otherwise Tier 4 drugs may be required to be classified as Tier 1, 2 or 3 drugs instead of Tier 4. Not all forms of a Prescription Drug may be included on the Drug List. The inclusion of a Prescription Drug on the Drug List may vary by the dosage and administration (i.e., mouth, shots, topical or inhaled) of the Prescription Drug. This may result in the coverage of one dosage or form of a Prescription Drug but not another. The presence of a drug on the formulary does not guarantee that it will be prescribed for a particular medical condition. The Drug List is subject to change.

If You have a question regarding whether a Drug is on the Prescription Drug List, please call Us toll free at 1-855- Oscar-55 or visit Our website at www.hioscar.com.

Your Prescription Drug coverage is limited to those Drugs listed on Our Prescription Drug List. To receive Drugs that are not on Our Prescription Drug List, see "Prior Authorization" later in this section. This Prescription Drug List includes Drugs on four tiers (Tier 1, Tier 2, Tier 3, and Tier 4). 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 Prescription Drug List is available upon request and online at www.hioscar.com. In cases where Your Physician prescribes a medication that is not on the Oscar Drug List, it may be necessary to obtain Prior Authorization in order for the Prescription to be a covered benefit. Physicians and Members are informed of the Prior Authorization process through the Member's Agreement, Oscar's web site (www.hioscar.com), and the Provider's manual. Please see the "Prior Authorization" section below on how to file a claim for Medically Necessary Prescription Drugs if payment is denied at the Pharmacy due to failure to obtain prior authorization. Any cost-sharing payments for prescription drugs that are not on-formulary, but are approved by exception, accumulate towards Your Out of Pocket Maximum.

Covered Prescription Drugs

To be a Covered Service, Prescription Drugs must be approved by the Food and Drug Administration (FDA) and, under Federal law, require a Prescription. Prescription Drugs must be prescribed by a licensed Provider and You must get them from a licensed Pharmacy.

Benefits are available for the following:

- Prescription Drugs from either a Retail Pharmacy or the Pharmacy Benefit Manager's (PBM) Home Delivery Pharmacy;
- Tier 4 Drugs;
- Self Administered Injectable Drugs. These are Drugs that do not need administration or monitoring by a Provider in an office or Facility. Office-based injectables and infused Drugs that require Provider administration and/or supervision are covered under the "Prescription Drugs Administered by a Medical Provider" benefit;
- Self-injectable insulin and supplies and equipment used to administer insulin, including syringes;
- Disposable needles and syringes needed for injecting Covered Prescription Drugs and supplements;
- Certain contraceptives, including oral contraceptive Drugs, injectable contraceptive Drugs, contraceptive patches, and contraceptive rings, including over the counter FDA-approved contraceptive methods as prescribed by a health care Provider are covered at no-cost-share. Certain contraceptives are covered under the medical benefits (See WHAT IS COVERED – MEDICAL under the section "Preventive Care" for more details);
- Flu Shots (including administration);
- AIDS vaccine (when approved);
- Appropriate pain management medications for terminally ill patients;
- Weight loss Drugs when Medically Necessary for the treatment of morbid obesity (See WHAT IS NOT COVERED (Exclusions) – PRESCRIPTION DRUGS for exclusions);
- Compound drugs when a commercially available dosage form of a medically necessary medication is not available, all the ingredients of the compound drug are FDA approved and require a prescription to dispense, and it is not essentially the same as an FDA approved product from a drug manufacturer. Non-FDA approved non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered;

- Medically Necessary non-formulary drugs.

Oral Anti-Cancer Drugs

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

Retail or Home Delivery (Mail Order) Pharmacy

Your Agreement includes benefits for Prescription Drugs You get at a Retail or Home Delivery Pharmacy. We use a Pharmacy Benefits Manager (PBM) to manage these benefits. The PBM has a network of Retail Pharmacies, a Home Delivery Pharmacy and a Specialty Pharmacy. The PBM works to make sure Drugs are used properly. This includes checking that Prescriptions are based on recognized and appropriate doses and checking for Drug interactions or pregnancy concerns.

You can visit one of the local Retail Pharmacies in Our network. Give the Pharmacy the Prescription from Your Physician and Your Identification Card and they will file Your claim for You. Refer to Your SUMMARY OF BENEFITS for any Copayment, Coinsurance, and/or Deductible that applies when You obtain Prescription Drugs. If You do not have Your Identification Card, the Pharmacy will charge You the full retail price of the Prescription and will not be able to file the claim for You. You will need to ask the Pharmacy for a detailed receipt and send it to Us with a written request for payment.

If You order Your Mail Order Drug through the Home Delivery (Mail Order) Pharmacy and it does not arrive, Your Physician may request an override for You to receive the drug immediately. If approved, we will authorize a thirty (30) day supply or less. This allows You to get an Emergency supply of medication from an In-Network Pharmacy near You. A customer service representative will coordinate the exception and You will not be required to pay additional Coinsurance/Copayment.

Helpful tip: Benefits for Drugs that You inject or get at a Pharmacy (i.e., Self Administered Injectable Drugs) are covered under this section.

Benefits for Prescription Drugs, including Specialty Drugs, which are administered to You in a medical setting (e.g., Physician's office, home care visit, or outpatient Facility) are covered in the part called WHAT IS COVERED – MEDICAL in the sections "Home Care Services," "Inpatient Facility Services," "Office Visits," "Office Visits – Additional Services in an Office Setting," "Outpatient Facility Services," "Skilled Nursing Facility," "Therapy Services" or "Urgent Care Services." Please read those sections for important details.

Some specialty medications may qualify for third party copayment assistance programs which could lower your out of pocket costs for those products, subject to prior approval of Oscar. For any such specialty medication where third party copayment assistance is used, the Member 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. For further information as to third party copayment assistance programs approved by Oscar for certain specialty medications, please call Us at 1-855-OSCAR-55.

Maintenance Medication - Home Delivery Pharmacy

If You are taking a Maintenance Medication, You may choose to fill Your medication via the Home Delivery Pharmacy. To do so, You must contact the Home Delivery Pharmacy and tell them if You would like to keep getting Your Maintenance Medications from Your local Retail Pharmacy or if You would like to use the Home Delivery Pharmacy.

Your Home Delivery Prescription Drug program is administered by Oscar's PBM which lets You get certain Drugs by mail if You take them on a regular basis. Your Home Delivery Prescriptions are filled by an independent, licensed Pharmacy. Oscar does not dispense Drugs or fill Prescriptions.

Helpful Tip: If You decide to use Home Delivery, We suggest that You order Your refill two weeks before You need it to avoid running out of Your medication. For any questions concerning the Home Delivery Prescription Drug program, You can call customer service toll-free at **1-855-Oscar-55.**

The Prescription must state the dosage and Your name and address and be signed by Your Physician.

The first Home Delivery Prescription You submit must include a completed patient profile form. This form will be sent to You upon becoming eligible for this program. Any subsequent Home Delivery Prescriptions for that Member need only the Prescription and payment enclosed.

You must authorize the pharmacist to release information needed in connection with the filling of a Prescription to the designated Home Delivery Prescription Drug program.

Note: Some Prescription Drugs and/or medicines may not be available or may not be covered for purchase through the Home Delivery Prescription Drug program including, but not limited to antibiotics and injectables (including Self Administered Injectables except Insulin). Drugs that are not on Our Formulary may not be covered at all. These Drugs are subject to prior authorization. Please check with the Home Delivery Prescription Drug program customer service department at 1-855-Oscar-55 for availability of the Drug or medication.

Specialty Pharmacy-Generally Tier 4 Drugs

Tier 4 Drugs are high-cost, injectable, infused, oral or inhaled medications (including therapeutic biological products) that are used to treat chronic or complex illnesses or conditions. **Certain Tier 4 Drugs may only be covered when purchased from an Oscar Specialty Pharmacy**.

The list of Specialty Drugs is based upon clinical findings from the Pharmacy and Therapeutics (P&T) Process, and where appropriate, certain clinical economic reasons. This list will change from time to time.

When You Order Your Prescription Through an Oscar Specialty Pharmacy

You can only have Your Prescription for a Specialty Drug filled through an Oscar Specialty Pharmacy. For a list of all Tier 4 Drugs, please contact Customer Service at 1-855-Oscar-55 or visit www.hioscar.com. Tier 4 Drugs are limited to a thirty (30) day supply per fill. Our Specialty Pharmacy will deliver Your Tier 4 Drugs to You by mail or common carrier for self administration in Your home, or You may pick up at a CVS retail pharmacy. You cannot pick up Your medication at Oscar.

The Prescription for the Tier 4 Drug must be signed by a Physician and state the Drug name, dosage, directions for use, quantity, the Physician's name and phone number, and the patient's name and address.

You or Your Physician may order Your Tier 4 Drug through the Oscar Specialty Pharmacy by calling **1-855-Oscar-55.** Once You have met Your Deductible, if any, You will only have to pay the cost of Your Copayment or Coinsurance as found in the SUMMARY OF BENEFITS. When You order Your Tier 4 Drug by mail, You will need to use a check, money order, credit or debit card to pay for it.

You or Your Physician may obtain a list of Tier 4 Drugs available through the Oscar Specialty Pharmacy by contacting Member Services at 1-855-Oscar-55 or contacting:

CVS/Caremark
P.O. Box 6590
Lee's Summit, MO 64064

How to obtain an exception to the Oscar Specialty Pharmacy

If You believe that You should not be required to get Your Tier 4 Drug through the Oscar Specialty Pharmacy, Your Physician must call Us at **1-855-Oscar-55** to request an exception. If We have given You an exception, it will be in writing for the approved amount of time as medically appropriate. If You believe that You still should not be required to get Your medication through the Specialty Pharmacy Program, when Your prior exception approval expires, You must again request an exception. If We deny Your request for an exception, it will be in writing and will tell You why We did not approve the exception.

If an exception is denied, You have the right to file a Grievance as outlined in the sections titled COMPLAINTS AND GRIEVANCES and INDEPENDENT MEDICAL REVIEW.

Urgent or Emergency Need of a Tier 4 Drug subject to the Oscar Specialty Pharmacy

If You are out of a Tier 4 Drug which must be obtained through the Specialty Pharmacy Program, We will authorize an override of the requirement for seventy-two (72) hours, or until the next business day following a holiday or weekend, to allow You to get up to thirty (30) day Emergency supply of medication, or the smallest packaged quantity, whichever is greater, if Your doctor decides that it is appropriate and Medically Necessary. You may have to pay the applicable Copayment/Coinsurance, if any.

If You order Your Tier 4 Drug through an Oscar Specialty Pharmacy and it does not arrive, and Your Physician decides that it is Medically Necessary for You to have the Drug immediately, We will authorize an override of the Specialty Pharmacy Program requirement for a thirty (30) day supply or less to allow You to get an Emergency supply of medication from an In-Network Pharmacy near You. A customer service representative will coordinate the exception and You will not be required to pay additional Coinsurance/Copayment.

Important Details about Prescription Drug Coverage

Your Prescription Drug coverage includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, Your prescribing Physician may be asked to give more details before We can decide if the Drug is Medically Necessary. We may also set quantity and/or age limits for specific Prescription Drugs or use recommendations made as part of Our Medical Policy and Technology Assessment Committee and/or Pharmacy and Therapeutics Process. Prescription Drug benefits may depend on reviews to decide when Drugs should be covered. These reviews may include Prior Authorization, Step Therapy, use of a Prescription Drug List, Therapeutic Substitution, day / supply limits, and other utilization reviews. Your In-Network Pharmacist will be told of any rules when You fill a Prescription, and will be also told about any details We need to decide benefits.

Drug Utilization Review

Your Prescription Drug benefits include utilization review of Prescription Drug usage for Your health and safety. Certain Drugs may require prior authorization. Also, an In-Network Pharmacist can help arrange prior authorization. If there are patterns of over-utilization or misuse of Drugs, We will notify Your personal Physician and Your pharmacist. We reserve the right to limit benefits to prevent over-utilization of Drugs.

Prior Authorization

Prior authorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. We will contact Your Provider to get the details We need to decide if prior authorization should be given. We will give the results of Our decision to both You and Your Provider. Members must use the prior authorization process outlined here to request coverage for medications not on the Oscar Select Drug List.

Your Physician may submit a prior authorization form to Oscar. This form is available by calling **1-855-Oscar-55** or online at www.hioscar.com. You may call customer service **1-855-Oscar-55** to ask that a prior authorization form be faxed to Your Physician.

If We determine through the prior authorization process that the Drug originally prescribed is Medically Necessary, You will be provided the Drug originally requested at the applicable Copayment. If approved, Drugs requiring prior authorization will be provided to You after You make the required Copayment. (If, when You become enrolled, You are already being treated for a medical condition with a Drug that has been prescribed and is considered safe and effective for Your medical condition and Oscar has previously approved coverage of the Drug, we will not require You to try a Drug other than the one You are currently taking.)

The prior authorization review process is outlined below. Upon receipt of a completed prior authorization request from a prescribing Provider, a response will be provided within seventy-two (72) hours for non-urgent requests and twenty-four (24) hours if exigent circumstances exist.

- The PBM handles the first review.

- If the Oscar defined criteria is met, the PBM will communicate to the Physician and Member about length of time and approval provided.
- If the Oscar defined criteria is NOT met, the PBM will communicate to the Physician and Member about the denial.
  - The letter contains an option to request the criteria used to make the decision, details on how You can discuss the issue with a clinical reviewer, and steps for additional review including information about filing a Grievance. If Your situation is urgent as defined by law, You may ask for an expedited appeal.
  - In some cases, a secondary review is handled by the Medical Reviewers at Oscar if additional medical justification needs to be established.

- A second review (appeal) will be handled by a clinical reviewer who was not involved in the initial review.
  - This review may require or include Physician peer-to-peer discussion and additional documentation prior to final decision.
  - Any decision is communicated to both Physician and Member along with Our standard Grievance process for the Member to use if needed.

If prior authorization is denied, You have the right to file a Grievance as outlined in the sections titled COMPLAINTS AND GRIEVANCES and INDEPENDENT MEDICAL REVIEW.

For a list of Drugs that need prior authorization, please call **1-855-Oscar-55** or visit www.hioscar.com. The list will be reviewed and updated from time to time. Including a Drug or related item on the list does not promise coverage under Your Prescription Drug coverage. Your Provider may check with Us to verify Drug coverage, to find out whether any quantity (amount) and/or age limits apply, and to find out which brand or Generic Drugs are covered under the Prescription Drug coverage.

Medically Necessary Non-Formulary Prescription Drugs

Members and prescribers may request an expedited review of a formulary exception in writing, electronically or telephonically, if the Member is suffering from a health condition that may seriously jeopardize their health, life or ability to regain maximum function, or if they are undergoing a current course of treatment using a non-formulary prescription Drug. The request should include a statement from the prescriber that harm could reasonably come to the Member if the requested Drug is not provided within the timeframes of Our standard formulary exception process and that all formulary drugs will be or have been ineffective, would not be as effective as the non-formulary drug, or would have adverse effects. We will make a decision and notify the Member and prescriber no later than twenty-four (24) hours after receipt of the request.

Pain Management and Schedule II Prescription Drugs

A pharmacist may dispense a Schedule II controlled substance, as listed in State Law, as a partial fill if requested by you or the prescriber. If a pharmacist dispenses to you a partial fill (a quantity less than the entire prescription) of a Schedule II prescription drug, the pharmacy will retain the original prescription, with a notation of how much of the prescription has been filled, until the prescription has been fully dispensed. The total quantity dispensed will not exceed the total quantity your provider prescribed to you. Any subsequent refill must occur at the pharmacy where the original prescription was partially fille original prescription is completely dispensed. The pharmacy will not dispense the full prescription more than 30 days after the date on which the prescription was written. Thirty-one days after the date on which the prescription was written, the prescription will expire and no more of the drug will be dispensed to you without a subsequent prescription.

We will prorate Your cost sharing for a partial fill of a prescription of an oral, solid dosage form of Schedule II Prescription Drug,

Step Therapy

Step therapy is a process in which You may need to use one type of drug before We will cover another. Drugs requiring Step Therapy have been marked with an indicator on Our Formulary, and can be found online at www.hioscar.com. We check certain Prescription Drugs to make sure that

proper prescribing guidelines are followed. These guidelines help You get high quality and cost effective Prescription Drugs. If a Physician decides that a certain Prescription Drug is needed, the prior authorization will apply.

A request for an exception to Oscar's Step Therapy process for prescription drugs may be submitted in the same manner as a request for prior authorization for prescription Drugs. The request will be treated and responded to in the same manner as a request for prior authorization for prescription Drugs. See "Prior Authorization," "GETTING APPROVAL FOR BENEFITS" and "COMPLAINTS AND GRIEVANCES" for more details.

Administered by a Medical Provider

Your Agreement also covers Prescription Drugs when they are administered to You as part of a Physician's visit, home care visit, or at an outpatient Facility. This includes Drugs for Infusion Therapy, chemotherapy, Specialty Drugs, blood products, and office-based injectables that must be administered by a Provider. This section applies when Your Provider orders the Drug and administers it to You.

Additional Features

Day Supply and Refill Limits

Certain day supply limits apply to Prescription Drugs as listed in the SUMMARY OF BENEFITS. We may require that You use a certain amount of Your Prescription (e.g., 75%) before it can be refilled.

Claims and Member Service

For information and assistance, You or Your Physician may call customer service at **1-855-Oscar-55** or write Us at:

Oscar Health Plan of California
Attn: Customer Service
9942 Culver City Blvd.
PO Box 1279
Culver City, CA 90232

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. We will not be responsible for any delay or failure to give services due to lack of available Facilities or staff.

Benefits will not be given for any illness or injury that is a result of service in the armed forces.

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.

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.

Ambulance: Ambulance usage is not covered when another type of transportation can be used without endangering the Member's health. Any ambulance usage for the convenience of the Member, family or Physician is not a Covered Service. Non-Covered Services for ambulance include, but are not limited to, trips to:

- **A Physician's office or clinic.**
- **A morgue or funeral home.**

Coverage is not available for air ambulance transport from a Hospital capable of treating the patient because the patient and/or the patient's family prefer a specific Hospital or Physician. Air ambulance services are not covered for transport

to a Hospital that is not an acute care Hospital, such as a nursing facility, Physician's office, or Your home.

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.

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 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.**

Dental X Rays, Supplies & Appliances and 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.

Drugs, medications or other substances that are:

- **Not generally accepted under professional medical standards as being safe, effective or whose use is in question even though they are approved by the federal Food and Drug Administration.**
- **Dispensed or administered in any setting except as specifically stated in the section titled WHAT IS COVERED – PRESCRIPTION DRUGS.**
- **Obtained with a non-prescription chemical and dose equivalent (over the counter 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")**
- **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.

Experimental or Investigational Services: Services or supplies that are Experimental or Investigational. This exclusion applies to services related to Experimental / Investigational services, whether You get them before, during, or after You get the Experimental / Investigational service or supply.

The fact that a service or supply is the only available treatment will not make it a Covered Service if it is Experimental/Investigational.

If the Member has a life-threatening or seriously debilitating condition and the requested treatment is not a Covered Service because it is Experimental or Investigational, the Member may request an Independent Medical Review. See INDEPENDENT MEDICAL REVIEW for further details. This exclusion does not apply to services covered under "Clinical Trials" in the section titled WHAT IS COVERED – MEDICAL, nor to the complications that may arise from non-Covered Services such as Cosmetic Surgery or Experimental Services.

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 a 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.

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" under 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 WHAT IS COVERED – MEDICAL in the section "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.**

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

Illegal Occupation: Any claim to which a contributing cause was Your commission of or attempt to commit a felony or to which a contributing cause was Your being engaged in an illegal occupation.

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.

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 by both 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.**

Note: 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: 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.

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 for consulting with Members by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to- face) care with the Member except as otherwise specified in the benefits section of this Agreement or as required by law.**
- **Surcharges for furnishing and/or receiving medical records and reports.**
- **Charges for doing research with Providers not directly responsible for Your care.**
- **Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.**

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.

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 under WHAT IS COVERED – MEDICAL in the section "Diabetes Equipment, Education and Supplies," or as required by law.

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" and "Urgent Care Services" sections of 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 (10) 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.

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 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 WHAT IS COVERED – MEDICAL in the sections "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 under WHAT IS COVERED – MEDICAL.

Unlisted services: Services not specifically stated in this Agreement as Covered Services, unless a covered essential health benefit.

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.**

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. 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 and specifically stated as a Covered Service in this Agreement. See WHAT IS COVERED – MEDICAL in the sections "Family Planning Services" and "Preventive Care." Also see 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."

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:**

1. **The Drug is FDA-approved and an In-Network Provider has prescribed the Drug for:**
    a. **A life-threatening condition; or**
    b. **The treatment of a chronic and seriously debilitating condition; and**
2. **The Drug is Medically Necessary to treat that 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; and**
3. **The drug has been recognized for treatment of that condition by any of the following:**
    a. **The American Hospital Formulary Service's Drug Information; or**
    b. **One of the following compendia, if recognized by the federal Centers for Medicare & Medicaid Services (CMS) as part of an anticancer chemotherapeutic regimen:**
        i. **The Elsevier Gold Standard's Clinical Pharmacology;**
        ii. **The National Comprehensive Cancer Network Drug and Biologics Compendium;**
        iii. **The Thomson Micromedex DrugDex; or**
        iv. **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 WHAT IS COVERED – MEDICAL in the sections "Family Planning Services" and "Preventive Care." Also see 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.

Note: Medically Necessary weight loss Drugs are covered in WHAT IS COVERED – PRESCRIPTION DRUGS in the section "Covered Prescription Drugs."

GETTING APPROVAL FOR BENEFITS

Certain Services require a review of the service's Medical Necessity in advance through a process called Prior Authorization. If Your Provider is considering a service requiring Prior Authorization, Your Provider first contacts Us and shares the relevant clinical information so that a determination of the service's Medical Necessity can be made. The determination considers 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 Prior Authorization, but if You have any questions about the Prior Authorization process or would like to confirm if Prior Authorization is required, contact Oscar at 1-855- Oscar-55 or visit www.hioscar.com for information.

Types of Requests

- **Precertification** – 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 labor/childbirth admissions, Precertification is not needed unless there is a problem and/or the mother and baby are not sent home at the same time.
- **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 require Precertification and did not have a Predetermination review performed. 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.

Your In-Network Provider is solely responsible for obtaining Precertification of In-Network services, including the services mentioned below.

Services for which Precertification 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:

- All inpatient Facility admissions, including, but not limited to, bariatric surgery and organ and tissue transplants, except for Emergency admissions and inpatient Hospital stays for the delivery of a child or mastectomy surgery, including the length of Hospital stays associated with mastectomy and/or breast reconstruction surgery for breast cancer. 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;
- Hospice Care;
- Home Care Services;
- Skilled Nursing Facility stays;
- Mental Health and Substance Abuse services:
    - Inpatient Facility admissions for Mental Health and Substance Abuse services, including detoxification and rehabilitation (except for Emergency admissions)
    - Residential treatment (including detoxification and rehabilitation)
    - Partial Hospitalization
    - Intensive Outpatient
    - Electro-convulsive treatment (ECT)
    - Transcranial Magnetic Stimulation (TMS)
    - Outpatient Psych Testing
    - ABA – Applied Behavioral Analysis
    - Methadone Maintenance
    - Suboxone Maintenance
    - Outpatient Biofeedback
- The following services:

  - Bariatric surgery
  - Breast reduction and reconstruction surgery
  - Cardiac imaging
  - Cosmetic and reconstructive surgery
  - Genetic testing for cancer susceptibility
  - Genital modification (transsexual surgery)
  - Hyperbaric oxygen
  - Infusion therapy
  - Pain management, including:
    - Interventional pain management
  - Physician-administered medication, including:
    - Medical oncology
    - Other Physician-administered specialty Drugs
  - Radiation therapy
  - Radiology services
    - Complex imaging (e.g., MRI, CT, PET, and cardiac imaging)
  - Rehabilitation therapy (visit limits may also apply), including:
    - Physical therapy
    - Occupational therapy
    - Speech therapy
  - Sleep diagnostics, management, and therapy
- Durable medical equipment (DME) and supplies (only if annual cost above $500), including, but not limited to:
  - External ambulatory insulin delivery system
  - Automatic external defibrillator
  - Functional neuromuscular stimulator
  - High frequency chest wall oscillation system vest
  - Intrapulmonary percussive ventilation system
  - Neuromuscular stimulator, electronic shock unit
  - External mobile cardiovascular telemetry with electrocardiographic recording
  - Standing Frame system

  - Sleep equipment and supplies
  - Wheelchairs and Accessories;
- Orthotic appliances & prosthetics (only if annual cost is above $500), including, but not limited to:
  - Custom prosthesis
  - Cochlear implant
  - Speech generating devices;
- Ambulance or transport in a non-Emergency.
- Orthodontic Services

For a list of current procedures requiring Precertification, please call customer service at 1-855-Oscar-55 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 a 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 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 customer service at **1-855-Oscar-55**.

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** – A request for Precertification or Predetermination that is conducted during the course of treatment or admission.
- **Retrospective** – A request for approval that is made after the service, treatment, or admission has happened. Post Service Clinical Claims Reviews are also retrospective. Retrospective review does not include a review that is limited to an evaluation of reimbursement levels, accuracy of documentation, or coding or adjudication of payment.

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 customer service at 1-855-Oscar-55 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 Review when hospitalized at the time of the request	The decision will be within seventy-two (72) hours from the receipt of the request and prior to expiration of current certification.
Concurrent Review Urgent when request is received more than twenty-four (24) hours before the end of the previous Authorization	The decision will be within twenty-four (24) hours from the receipt of the request.
Concurrent Review non-Urgent not hospitalized	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 the following methods:

- **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.

Health Plan Individual Case Management

Health plan case management programs (Case Management) help coordinate services for Members with health care or mental health and substance use disorder needs due to serious, complex, and/or chronic health conditions. Programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs.

Case Management programs are confidential and voluntary and are made available at no extra cost to You. These programs are provided by, or on behalf of and at the request of, Your health plan case management staff. These Case Management programs are separate from any Covered Services You are receiving.

If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. We, and Our partners, will work directly with You and/or Your chosen representative, treating Physician(s), and other Providers to meet Your goals.

In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs. This 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 that is not listed as a Covered Service through Our Case Management program. Decisions will be made case-by-case, if the alternate or extended benefit is in the best interest of the Member and Oscar.

We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, You or Your representative will be notified in writing.

CONTINUED BENEFITS

If, on the date We cancel Your coverage by written notice (except for cancellation due to misrepresentation or fraudulent statements, ceasing coverage in the individual market, or cancellation due to withdrawal of the health benefit plan from the individual health care market as stated in the section titled YOUR ELIGIBILITY), You are suffering from either an injury sustained or an illness arising while Your coverage under this Agreement was in effect, benefits will continue, but limited by and subject to all of the following:

1. These continued benefits cover only treatment of an injury sustained or an illness arising while Your coverage under this Agreement was in effect. When We refer to an injury sustained while Your coverage under this Agreement was in effect, We mean that the incident or accident directly causing the injury must have occurred while Your coverage under this Agreement was in effect. When We refer to an illness arising while Your coverage under this Agreement was in effect, We mean that either the illness was first diagnosed while Your coverage under this Agreement was in effect or Your illness first manifested itself by signs or symptoms by which a Physician could have diagnosed the illness while Your coverage under this Agreement was in effect.
2. These benefits will be provided only for treatment actually received during the ninety (90) day period following cancellation of Your coverage under this Agreement. If You are in a Hospital or Skilled Nursing Facility on the last day of that ninety (90) day period for treatment of a condition covered under these continued benefits, benefits will continue until the first of the following occurs:
    a. The date of discharge from the Hospital or Skilled Nursing Facility, or
    b. Care or treatment is no longer Medically Necessary.

Note: All conditions, reductions, limitations and exclusions of this Agreement will apply to these continued benefits.

For information about continuation of care when an agreement terminates between an In-Network Provider and Us, see the section titled IMPORTANT INFORMATION ABOUT THIS AGREEMENT (General Provisions).

CONTINUITY AND TRANSITION OF CARE

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. 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 Prior Authorization, Referrals, and a treatment plan approved by Oscar. If the Provider agrees to these conditions, 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.

Continuation of Care After Termination of a Provider: Subject to the terms and conditions set forth below, 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.

- The Member must be under the care of the In-Network Provider at the time of Our termination of the Provider's participation in Our network. 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.

- Such benefits will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity. We will furnish such benefits for the continuation of services by a terminated Provider only for any of the following conditions:
  - An acute condition. An acute condition is a medical condition that involves a sudden 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.
  - 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 customer service at **1-855-Oscar-55**. 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.

DUPLICATION OF OSCAR BENEFITS

If, while covered under this Agreement, You are also covered by another Oscar Individual Agreement:

- You will be entitled only to the benefits of the Agreement with the greater benefits, and
- We will refund any Premiums received under the Agreement with the lesser benefits, covering the time period both Agreements were in effect. However, any claims payments made by Us under the Agreement with the lesser benefits will be deducted from any such refund of Premiums.

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.

Policy on Third-Party Payment of Cost-Sharing and Premium

The Subscriber is responsible for payment of Subscription Charges to Oscar. Oscar does not accept Payment of Subscription Charges from any person or entity other than the Subscriber, his or her Dependents, or third party payors to the extent required by state and federal law. Upon discovery that Subscription Charges were paid directly by a person or entity other than those listed above, Oscar will reject the payment and inform the Subscriber that the payment was not accepted and that the Subscription Charges remain due.

If You or Your Authorized Representative has a subrogation or lien inquiry, please send it to oscarmanualreferrals@rawlingscompany.com.

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.

Examples of 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 a "kickback"
- Waiving a Member's cost share in order to bill Your insurer more

Examples of Member fraud:

- Using someone else's Oscar coverage or card
- Falsely alleging the theft of medical equipment
- Reselling medical items

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 are confused by what You were charged, contact Oscar's member services department at 855-OSCAR-55 or help@hioscar.com.

Fighting and reporting health care fraud. 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 at:

Attn: Special Investigations Unit
Oscar
9942 Culver City Blvd.
PO Box 1279
Culver City, CA 90232

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. Please do not include any of Your personal health information in the message, in order to protect Your privacy. 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.

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: The Premium for this Agreement may change year over year, pursuant to automatic renewals, subject to, and as permitted by, applicable law. You will be notified of a Premium change at the address in Our records sixty (60) days in advance. Any such change will apply to Premiums due on or after the Effective Date of change. If advance Premiums have been paid beyond the Effective Date of a rate change, such Premiums will be adjusted as of that Effective Date to comply with the rate change. Additional Premiums may be billed, if necessary, for future periods.

Content of the Agreement: This Agreement, including any endorsements or attached paper, is the entire contract of insurance. Its terms can only be changed by a written endorsement signed by one of Our authorized officers. NO AGENT OR EMPLOYEE OF OURS IS AUTHORIZED TO CHANGE THE TERMS OR WAIVE ANY OF THE PROVISIONS OF THIS AGREEMENT.

Coordination of Dental Benefits:

Coordination of Benefits (COB) provisions apply when You or members of Your family have other coverage through another plan that offers dental benefits. When You have other dental coverage, both plans will work together to provide the maximum dental benefits for which You are entitled. Coordinated benefits will never be less than those normally provided under this Plan. This provision is only applicable to the dental benefits found under WHAT IS COVERED – MEDICAL, in the section 'Dental Services – Child.'

If You are eligible for dental benefits through two or more plans, one of the plans will be responsible for "primary coverage." This means full benefits will be provided by the primary coverage before benefits of the other plan will be provided.

A plan determined to be secondary shall pay the lesser of either the amount that it would have paid in the absence of any other dental benefit coverage, or the enrollee's total out of pocket cost payable under the primary dental benefit plan for benefits covered under the secondary plan.

1. If You have Pediatric Essential Health Benefits that are included as part of Your medical plan, the medical plan will be the primary coverage and any standalone dental plan will be secondary coverage.
2. If the spouses both have separate dental plans, each offering coverage for spouse and family, the plan that covers the person other than as a Dependent (for example, as an employee, Member, Subscriber, policyholder or retiree) is the primary plan and the plan that covers the person as a Dependent is the secondary plan.
3. If the Subscriber is the same person on each plan, the plan under which he or she has been enrolled for the longer period of time will be primary.
4. As required by law, if a covered Member of Your family also has coverage under Medicaid, this Plan is always primary.
5. If Dependent children are covered under both plans, one of the following rules will apply, unless there is a court order stating otherwise:
    - The plan covering the parent with the earlier birthday in the Year will be primary. If both parents have the same birthday, the plan covering the Dependent for the longer period of time will be primary; OR
    - Some insurance companies always designate the father's plan as the primary carrier for children. If Oscar must coordinate benefits with a company that has that rule, the father's policy will be primary. You will be asked to complete questionnaires from time to time asking about other dental coverage. Please complete and return the questionnaire quickly and let Us know when other insurance coverage changes or is canceled to avoid possible claims denials.

Laws Governing the Agreement: 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.

Legal Actions: No action at law or at equity may be brought to recover this Agreement sooner than sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Agreement. No such action may be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

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.

Notice: We will meet any notice requirements by mailing the notice to You at the address listed in Our records. You will meet any notice requirements by mailing the notice to:

Oscar Health Plan of California
Attn: Customer Service
9942 Culver City Blvd.
PO Box 1279
Culver City, CA 90232

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) services received by an Out-of-Network provider as a result of a Medical Emergency, Urgent Care Visit, or an Authorized Referral as defined in the section titled 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 Provier. Authorized Referrals and Covered Services received under the second exception are provided at in-network Cost-Sharing.

You will be responsible for any charges for Out-of-Network Providers. You should read the SUMMARY OF BENEFITS and 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) services received by 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 Provier. Authorized Referrals and Covered Services received under the second exception are provided at in-network Cost-Sharing.**

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-Oscar-55. 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.

Receipt of Information: We are entitled to receive from any Provider of service information about You that is necessary to administer claims on Your behalf according to Federal/State law. This right is subject to all applicable confidentiality requirements. You agree to assist in obtaining this information if needed. 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.

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. Contact Us at **1-855-Oscar-55** for a copy of Our policies and procedures for preserving Your medical record confidentiality.

Relationship of Parties: 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.

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.

Terms of Coverage:

- In order for You to be entitled to benefits under this Agreement on a specific date, Your coverage under this Agreement must be in effect on the date You received services or supplies except as specifically stated elsewhere in this Agreement.
- This Agreement, including all terms, benefits, conditions, limitations and exclusions, may be changed by Us as provided in RIGHT TO MODIFY OR CHANGE THE AGREEMENT.
- The benefits to which You may be entitled will depend on the terms of coverage as set out in the Agreement in effect on the date You receive the service or supply.

Time of Payment of Claim: Any benefits determined to be due under this Agreement shall be paid and delivered within thirty (30) 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.

Value-Added and Incentive Programs: We may offer health or fitness related programs and products to Our Members. We may also offer value-added services that include discounts on Pharmacy products (over the counter drugs, consultations and biometrics).

The products and services available under this program are not Covered Services under the Plan but are in addition to Plan benefits and may include giveaways that promote a healthy lifestyle. As such, program features are not guaranteed under Your Agreement and could be discontinued at any time. We do not endorse any vendor, product or service associated with this program. Program vendors are solely responsible for the products and services You receive.

Finally, We may offer incentives to Members who participate in programs that help to reduce administrative expenses or make retaining coverage more convenient. Such programs may include enrolling to automatically pay Premiums electronically instead of receiving a bill each month.

Voluntary Clinical Quality Programs: We may offer additional opportunities to assist You in obtaining certain covered Preventive or other care (e.g., well child check-ups or certain laboratory screening tests) that You have not received in the recommended timeframe. These opportunities are called voluntary clinical quality programs. They are designed to encourage You to get certain care when You need it and are separate from Covered Services under Your Plan. These programs are not guaranteed and could be discontinued at any time. We will give You the choice and if You choose to participate in one of these programs, and obtain the recommended care within the program's

timeframe, You may receive incentives such as gift cards. Under other clinical quality programs, You may receive a home test kit that allows You to collect the specimen for certain covered laboratory tests at home and mail it to the laboratory for processing. You may need to pay any cost shares that normally apply to such covered laboratory tests (e.g., those applicable to the laboratory processing fee) but will not need to pay for the home test kit. (If You receive a gift card and use it for purposes other than for qualified medical expenses, this may result in taxable income to You. For additional guidance, please consult Your tax advisor.)

Workers' Compensation Insurance: This Agreement does not take the place of or affect any requirement for or coverage by workers' compensation insurance. Additionally, as stated in WHAT IS NOT COVERED (Exclusions) – MEDICAL, this Agreement does not cover any condition for which benefits are covered by any worker's compensation law or similar law.

COMPLAINTS AND 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 customer service at **1-855-Oscar-55**, or You may write to us at:

Oscar Health Plan of California
Attn: Customer Service
9942 Culver City Blvd.
PO Box 1279
Culver City, CA 90232

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

For Mental Health and Substance Use services, please address Your correspondence to:

Oscar Health Plan of California
Attn: Customer Service
9942 Culver City Blvd.
PO Box 1279
Culver City, CA 90232

For Vision Services for Members under nineteen (19) years of age, please address Your correspondence to:

Attn: Customer Service Department- Oscar Vision
Oscar Health Plan of California
9942 Culver City Blvd.
PO Box 1279
Culver City, CA 90232

Our customer service 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 customer service 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 remedy, which is Binding Arbitration. See the sections titled INDEPENDENT MEDICAL REVIEW, BINDING ARBITRATION, and IMPORTANT INFORMATION ABOUT YOUR PLAN.

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, and 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.

- 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 seven (7) 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:

1. At least one of the following has occurred:
    a. Your Provider has recommended a health care service as Medically Necessary, or
    b. You have received Urgent Care or Emergency Services that a Provider determined was Medically Necessary, or
    c. You have been seen by an In-Network Provider for the diagnosis or treatment of the medical condition for which You seek independent review.
2. 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
3. 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 customer service department toll free at **1-855-Oscar-55**.

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-Oscar-55** 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-HMO-2219**) and a TDD line (**1-877-688-**

9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms, and instructions online.

BINDING ARBITRATION

ALL DISPUTES INCLUDING, BUT NOT LIMITED TO, DISPUTES RELATING TO THE DELIVERY OF SERVICES UNDER THE AGREEMENT OR ANY OTHER ISSUES RELATED TO THE AGREEMENT AND CLAIMS OF MEDICAL MALPRACTICE MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT. It is understood that any dispute including disputes relating to the delivery of services under the Plan or any other issues related to the Plan, including any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by Federal and 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.

YOU AND OSCAR AGREE TO BE BOUND BY THIS ARBITRATION PROVISION AND ACKNOWLEDGE THAT THE RIGHT TO A JURY TRIAL OR TO PARTICIPATE IN A CLASS ACTION IS WAIVED FOR BOTH DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE AGREEMENT OR ANY OTHER ISSUES RELATED TO THE AGREEMENT AND MEDICAL MALPRACTICE CLAIMS.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is initiated by the Member making a written demand on Oscar. The arbitration will be conducted by a single neutral arbitrator from Judicial Arbitration and Mediation Services ("JAMS"), according to JAMS' applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by a single neutral arbitrator from another neutral arbitration entity, by agreement of the Member and Oscar, or by order of the court, if the Member and Oscar cannot agree. If the parties cannot agree on the individual neutral arbitrator, the arbitrator will be selected in accordance with JAMS Rule 15 (or any successor rule).

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. Unless You and Oscar agree otherwise, the arbitrator may not consolidate more than one person's claims, and may not otherwise preside over any form of a representative or class proceeding. In cases of extreme hardship, Oscar will assume some of the enrollee's or subscriber's share of the fees and expenses of the arbitrator.

Please send all Binding Arbitration demands in writing to:

Oscar Health Plan of California
Attn: Oscar Arbitration
9942 Culver City Blvd.
PO Box 1279
Culver City, CA 90232

HOW TO CONTACT US

If You have any questions about the information provided, please feel free to contact Us.

For information about...	Contact	Email	Phone Number	Address
Enrollment	Customer Service	help@ hioscar.com	1-855-Oscar-55	Oscar Health Plan of California Attn: Customer Service 9942 Culver City Blvd. PO Box 1279 Culver City, CA 90232
Medical Benefits & Claims	Customer Service	help@ hioscar.com	1-855-Oscar-55	
Hearing and Speech Impaired Customer	Customer Service	help@ hioscar.com	Via the National Relay Service by dialing 711 or CA Relay-See below	
Precertification	Customer Service	help@ hioscar.com	1-855-Oscar-55	

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 are 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-HMO-2219).The Department of Managed Health Care also has a TDD line (1-877-688-9891) for the hearing and speech impaired.

To reach CA Relay, please use the numbers below:

For Questions, call Customer Service at 1-855-Oscar-55 or login at www.hioscar.com

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** **1-800-854-7784**

OSCAR HEALTH PLAN OF CALIFORNIA

Mario Schlosser (CEO)

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 customer service 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 customer service 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 Customer Support > Contact Us, or call customer service at **1-855-Oscar-55**.