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/2020/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**?	$250 individual / $500 family	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your **deductible**?	Yes. **Preventive care** and pre- and post-natal care.	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost sharing** and before you meet your **deductible**. See a list of covered **preventive services** at **https://www.healthcare.gov/coverage/preventive-care-benefits/**.
Are there other **deductibles** for specific services?	No.	You don't have to meet **deductibles** for specific services.
What is the **out-of-pocket limit** for this **plan**?	$7,800 individual / $15,600 family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, they have to meet their own **out-of-pocket limits** until the overall family **out-of-pocket limit** has been met.
What is not included in the **out-of-pocket limit**?	Premiums and healthcare this **plan** does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a **network provider**?	Yes. See **www.hioscar.com** or call **1-855-OSCAR-55** for a list of **network providers**.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan**'s **network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider**'s charge and what your **plan** pays (**balance billing**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a **referral** to see a **specialist**?	No.	You can see the **specialist** you choose without a **referral**.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 **copay**/visit **Deductible** does not apply	Not Covered	——————none——————
	Specialist visit	$50 **copay**/visit **Deductible** does not apply	Not Covered	——————none——————
	Preventive care/ **screening**/ immunization	No charge	Not Covered	You may have to pay for services that aren't preventive. Ask your **provider** if the services you need are preventive. Then check what your **plan** will pay for.
If you have a test	**Diagnostic test** (x-ray, blood work)	$65 **copay**/visit **Deductible** does not apply (x-ray), $25 **copay**/visit **Deductible** does not apply (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)	$275 **copay**/visit **Deductible** does not apply	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.hioscar.com/search/CA/drugs?year=2020**	Tier 1	$15 **copay**/30 day supply **Deductible** does not apply (retail), $37.50 **copay**/90 day supply **Deductible** does not apply (mail order)	Not Covered	——————none——————
	Tier 2	$50 **copay**/30 day supply **Deductible** does not apply (retail), $125 **copay**/90 day supply **Deductible** does not apply (mail order)	Not Covered	
	Tier 3	$80 **copay**/30 day supply **Deductible** does not apply (retail), $200 **copay**/90 day supply **Deductible** does not apply (mail order)	Not Covered	
	Tier 4	20% **coinsurance** **Deductible** does not apply (retail/mail order)	Not Covered	Limited to a 30-day supply. Up to $250 per script.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$300 **copay**/visit **Deductible** does not apply	Not Covered	**Preauthorization** may be required. If you don't get **preauthorization**, payment for care may be denied.
	Physician/surgeon fees	$40 **copay**/surgery **Deductible** does not apply	Not Covered	**Preauthorization** may be required. If you don't get **preauthorization**, payment for care may be denied.
If you need immediate medical attention	**Emergency room care**	$250 **copay**/visit subject to **deductible** (ER Facility Fee), No charge (ER Physician Fee)	$250 **copay**/visit subject to **deductible** (ER Facility Fee), No charge (ER Physician Fee)	——————none——————
	Emergency medical transportation	$250 **copay**/transport subject to **deductible**	$250 **copay**/transport subject to **deductible**	
	Urgent care	$25 **copay**/visit **Deductible** does not apply	Covered at **in-network** level	
If you have a hospital stay	Facility fee (e.g., hospital room)	$600 **copay**/admit subject to **deductible**	Not Covered	The $600 per day **copayment** will apply for a maximum of 5 days.
	Physician/surgeon fees	No charge	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	Outpatient services	$25 **copay**/visit **Deductible** does not apply (office visit/for other outpatient services)	Not Covered	——————none——————
	Inpatient services	$600 **copay**/admit subject to **deductible**	Not Covered	The $600 per day **copayment** will apply for a maximum of 5 days.
If you are pregnant	Office Visit	No charge	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).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Childbirth/delivery professional services	No charge	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 facility services	$600 **copay**/admit subject to **deductible**	Not Covered	The $600 per day **copayment** will apply for a maximum of 5 days.
If you need help recovering or have other special health needs	**Home health care**	$30 **copay**/visit **Deductible** does not apply	Not Covered	Up to 100 visits/year. **Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	Rehabilitation services	$25 **copay**/visit **Deductible** does not apply	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	Habilitation services	$25 **copay**/visit **Deductible** does not apply	Not Covered	**Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	Skilled nursing care	$300 **copay**/admit subject to **deductible**	Not Covered	Up to 100 visits per **Plan** Year. **Preauthorization** is required. If you don't get **preauthorization**, payment for care may be denied.
	Durable medical equipment	20% **coinsurance** **Deductible** does not apply	Not Covered	**Preauthorization** is required for purchases and rentals >$500. If you don't get **preauthorization**, payment for care may be denied.
	Hospice services	No charge	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	Children's eye exam	No charge	Not Covered	1 exam in a 12 month period.

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 your child needs dental or eye care	Children's glasses	No charge	Not Covered	1 pair of glasses or contact lenses in a 12 month period.
	Children's dental check-up	No charge	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
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

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

- Abortion
- Acupuncture
- Bariatric surgery
- Infertility treatment
- Private-duty nursing
- Routine foot care

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or **www.dol.gov/ebsa/healthreform**. Other coverage options may be available to you too, including buying individual insurance coverage through the **Health Insurance Marketplace**. 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: Department of Labor's Employee Benefits Security Administration at **1-866-444-EBSA (3272)** or **www.dol.gov/ebsa/healthreform**.

Does this plan provide Minimum Essential Coverage? Yes.

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**.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al **1-855-OSCAR-55**.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-855-OSCAR-55**.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 **1-855-OSCAR-55**.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-855-OSCAR-55**.]

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

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	$250
Specialist copay	$50
Hospital (facility) copay	$300
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/delivery professional services
Childbirth/delivery facility services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copays	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay:	**$1,110**

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

The plan's overall deductible	$250
Specialist copay	$50
Hospital (facility) copay	$300
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copays	$1,100
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay:	**$1,560**

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

The plan's overall deductible	$250
Specialist copay	$50
Hospital (facility) copay	$300
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copays	$900
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay:	**$1,190**

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, at all points of contact, at all times, to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at 1-855-OSCAR-55 (TTY: 7-1-1).

If you believe that Oscar has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

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

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

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

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

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

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

Language Assistance Services for the Deaf or Hard of Hearing

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

Multi-language interpreter services

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

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

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

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

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

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

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

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

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

العربية (Arabic): ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1–558–RACSO–55.

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

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

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

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

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

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

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

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

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

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

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

ພາສາລາວ (Lao): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນมีພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-OSCAR-55.

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

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

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

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

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

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

ภาษาไทย (Thai): ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ ฟรี โทร 1-855-OSCAR-55.

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

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

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

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

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

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

An Exclusive Provider Organization (EPO) Plan

2020 Group Subscriber Agreement

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

Effective January 1, 2020

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

This Agreement is entered into between Oscar Health Plan of California (hereinafter referred to as "We", "Us" or "Our") and the Group Health Plan contract holder (hereinafter referred to as "You" or "Your"). This Agreement is a contract between You and Us.

This Agreement consists of all provisions set forth in this document as well as the provisions found in the Combined Evidence of Coverage and Disclosure Form including the Schedule of Benefits
(collectively, the "Plan Documents") issued to Eligible Employees under the Group Health Plan. Any amendment changing the provisions of the Evidence of Coverage is also made part of this Agreement as of the effective date of the amendment.

READ THIS ENTIRE AGREEMENT CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS AGREEMENT.

This Agreement is governed by the laws of the State of California.

Mario Schlosser
CEO, Oscar Insurance Corporation
75 Varick Street
5th Floor
NY, NY 10013

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SECTION I: DEFINITIONS

Agreement: This contract issued by Oscar Health Plan of California to You and the Plan Documents which are incorporated herein by reference.

Effective Date: The date this Agreement is made and entered into by and between the Group Health Plan contract holder and Oscar.

Eligible Employee: An Eligible Employee is a Full-Time Employee who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the Group's business and included as employees under a Group Health Plan of the Group, but does not include employees who work on a part-time, temporary, or substitute basis. Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be Eligible Employees if all four of the following apply: (1) they otherwise meet the definition of an Eligible Employee except for the number of hours worked; (2) the Group offers the employees health coverage under the Group Health Plan; (C) all similarly situated individuals are offered coverage under the Group Health Plan; and (D) the employee has worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. We may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

Full-Time Employee: A Full-Time Employee is a permanent employee who is actively engaged on a full-time basis in the conduct of the business of the Group with a normal workweek of an average of 30 hours per week over the course of a month, at the Group's regular places of business.

Full-Time Equivalent ("FTE") Employee: This term describes the number of employees counted towards a Group's size determination. For purposes of determining Group eligibility in the Small Employer market, Group size will be determined using the method for counting Full-Time Employees and Full-Time Equivalent Employees set forth in Section 4980H(c)(2) of the Internal Revenue Code.

Group: You or the party that has entered into the Agreement with Us as a Group Health Plan contract holder that meets the definition of a Small Employer.

Group Health Plan: A health care service plan with at least one Eligible Employee enrolled.

Member: The Subscriber or a covered dependent for whom required premiums have been paid. Whenever a Member is required to provide a notice pursuant to a grievance or emergency department visit or admission, "Member" also means the Member's designee.

Small Employer: A Small Employer is any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, employees, the majority of whom were employed within the State of California, that was not formed primarily for purposes of buying the Group Health Plan, and in which a bona fide employer-employee relationship exists.

Subscriber: A Eligible Employee of the Group that receives the benefits described in the Plan Documents.

Us, We, Our: Oscar Health Plan of California and anyone to whom We legally delegate performance, on Our behalf, under this Agreement.

You, Your: The Group.

SECTION II: HOW YOUR COVERAGE WORKS

Coverage Under this Agreement.
You have purchased a Group Health Plan from Us. We will provide the benefits described in the Plan Documents to covered Members of the Group, that is, to Your Eligible Employees and their covered dependents. You should keep this Agreement with other important papers so that it is available for future reference.

You have a right to apply for any Group Health Plan contract written, issued, or administered by Oscar at the time of application for a new Group Health Plan contract, or at the time of renewal of a Group Health Plan contract. Oscar will provide, upon request, a listing of all contracts and benefit designs Oscar offers to Small Employers, including the rates for each contract.

Term and Renewal.
This Group Health Plan is guaranteed issue, regardless of health status or age. The initial term of this Group Health Plan begins on the Effective Date. This Group Health Plan shall continue in effect for a period of 12 months and shall automatically renew thereafter for one-year terms, unless terminated pursuant to the Plan Documents. Pursuant to Section 1357.500(k)(1)(A) of the California Health and Safety Code, any Group that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, Employees, the majority of whom were employed within the State of California, that was not formed primarily for the purpose of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists must be issued Small Employer coverage.

This Group Health Plan is guaranteed renewable except in the case of fraud or failure to pay premium, or as permitted to be canceled, rescinded, or not renewed under applicable State and federal law.

Pursuant to 45 C.F.R. 147.106(h), guaranteed renewability rights do not allow a Group to continue its existing coverage if it would not otherwise be permitted to enroll in

such coverage per federal law. Consequently, if You experience a reclassification as a large group on renewal, You are required to be issued coverage appropriate for that size group.

Group Health Plan Services.
Oscar will provide the Group with Plan Documents as required by Section 1363 of the California Health and Safety Code and Section 1300.63.2 of Title 28 of the California Code of Regulations. The Plan Documents are an integral part of this Agreement and include a complete description of the benefits and conditions of coverage of the Group Health Plan. We will provide the benefits described in the Plan Documents (the "Covered Services"). We will maintain a network of participating providers available to Members. These providers will act as independent contractors to render the Covered Services as described in and in accordance with the Plan Documents.

Oscar may make periodic administrative modifications. For example, Oscar may modify its process for filing a grievance, or the address to which correspondence must be sent. Oscar will not modify Your benefits, cost-shares, or premium within a plan year.

Oscar shall not include any preexisting condition provisions in its coverage.

Premiums.
In addition to premiums owed to Us, You must reimburse Us for payment of any applicable federal, state or local sales or excise tax liability relating to claims payments and/or Our administration of coverage under this Agreement. The applicable tax liability includes, but is not limited to, the Comparative Effectiveness Research Fee imposed on Us under Sections 4375-4377 of the Internal Revenue Code, and regulations implementing the same. However, You will not be responsible to pay for incomes taxes, payroll taxes or taxes, fees and assessments based solely on Our net income.

The premiums, copayments, coinsurances, and deductibles set forth upon Your enrollment with Us will be effective for the entire Plan Year, unless required or otherwise allowed by law.

Upon renewal, a change in premium rates or changes in coverage stated in the Group Health Plan contract will not become effective unless We notify You of the change(s) at least 60 days prior to the contract renewal Effective Date.

Oscar will consider a variety of factors in determining its premium, including medical costs and utilization, but may not use specific claims experience in determining that rate change.

Paying Premiums and Grace Periods.
For Subscribers added or terminated before the end of a month, that month's premium will be prorated to reflect the number of days they are covered in that month.

Premium payments are due in full to Us on or before the first day of each month for that month's coverage. Payments may be made electronically as instructed by Us or by mail to 9942 Culver City Blvd., PO Box 1279, Culver City, CA 90232. You are responsible for paying any and all costs and expenses, including reasonable attorney's fees, incurred by Us in collecting any past due premiums from You.

After the initial payment, premium payments to Us are subject to a 30 day grace period , during which time premiums may be paid to Us without lapse of coverage. If premiums are not paid by the end of the grace period, We will notify You that coverage will terminate the day after the last day of the grace period. . If You fail to pay the required premiums and coverage is terminated, Members will be responsible for the costs of all Covered Services received by them after the termination date.

You are responsible for reviewing Your monthly billing invoices and for notifying Us of any corrections within 30 calendar days after the date of each invoice. Failure to promptly notify Us of changes may limit premium adjustments.

SECTION III: WHO IS COVERED

Group Eligibility.
In order to be eligible for Oscar coverage, You must qualify as a Small Employer, defined by the Affordable Care Act ("ACA") in conjunction with California law. A Small Employer is any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. In determining whether to apply the calendar quarter or calendar year test, We will use the test that ensures eligibility if only one test would establish eligibility.

Subsequent to the issuance of the Group Health Plan to You, and for the purpose of determining Your eligibility, Your Group size will be determined using the method for counting Full-Time Employees and Full-Time Equivalent Employees set forth in Section 4980H(c)(2) of the Internal Revenue Code.

Under this counting method, first calculate the number of Full-Time Employees. Full-Time Employees are permanent employees actively engaged in the conduct of business on a full-time basis. They must have a normal work week averaging 30 hours per week over the course of a month, work at Your regular place of business, and have met their waiting period, if applicable.

Once You determine the number of Full-Time Employees, You then calculate the number of FTE Employees. FTE Employees are a combination of employees, each of whom individually is not a Full- Time Employee (because they're not employed on average at least 30 hours per week) but who, in combination, are counted as the equivalent of a Full-Time Employee. To calculate FTE Employees, take the total hours worked by non-full time employees in a month and divide that amount by 120. That number (rounded down to the nearest whole number) equals the number of FTE

Employees.

Finally, add the number of FTE Employees to the total number of Full-Time Employees to determine Your Group size. Mid-year fluctuations in the number of employees do not affect the determination of Group size. Group size is only determined on issuance and at the time of renewal. To confirm you Group size, We will ask and may rely upon the information You provide, including appropriate tax documentation.

Oscar is guaranteed issue and will not consider any health status-related factor or age in determining eligibility upon enrollment or renewal.

Employee Eligibility and Enrollment.
Once You have determined that You, the Group, are eligible for Oscar's Group Health Plan, you may offer coverage to Your Eligible Employees. An Eligible Employee is any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the Group with a normal workweek averaging 30 hours over the course of a month, at the Group's regular place of business. An Eligible Employee may be a sole proprietor or partners of a partnership, if they are actively engaged on a full-time basis in the Group's business and are included as employees under a health care service plan contract of the Group. An Eligible Employee is not an employee who works on a part-time, temporary, or substitute basis. Permanent employees who work at least 20 hours but not more than 29 hours per week may be Eligible Employees if (1) They otherwise meet the definition of Eligible Employee except for the number of hours worked, (2) the Group offers the employees health coverage under the Group Health Plan, (3) all similarly situated individuals are offered coverage under the Group Health Plan, and (4) the employee has worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. We may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

Only Eligible Employees described above may enroll as Subscribers in the Group Health Plan. The Group must enroll each Eligible Employee in the Group Health Plan or obtain a declination of Group- sponsored coverage as described below. If an

Eligible Employee does not enroll, or if a Subscriber is terminating coverage (disenrolling), the Group must obtain a written notice, signed by the Eligible Employee or Subscriber, that the individual declines the Group-sponsored coverage or is terminating coverage in the Group Health Plan. This notice must clearly indicate that the individual is aware that if he or she does not enroll or does not enroll any eligible dependents for coverage in the Group Health Plan within 30 days after the individual's eligibility date, or disenrolls, the individual may be excluded from coverage until the Group's next plan year.

Any exceptions to standard eligibility and enrollment procedures applicable to You must be documented with Us upon either enrollment with Us or for a renewal period. Any revised eligibility and enrollment procedures will amend this Agreement and supersede any previous eligibility and enrollment procedures for this Agreement.

You must notify Oscar in writing when an employee has a Qualifying Event pursuant to 1366 (2)(d) of the California Health and Safety Code, within 30 days of the Qualifying Event and within 30 days of the date, when the employer becomes subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Sec. 1161 et seq.

As between Us and You, You are responsible for complying with the terms of this Section even if You have contracted with a third party administrator to administer Your enrollment functions.

Furnishing of Necessary Information to Employees.
You must forward all applicable enrollment forms that You receive from employees to Us within 10 business days of receipt from any employee. After we receive and accept an employee's enrollment, We will provide an identification card to each Subscriber. The identification card will contain Our address and telephone number, and serves as evidence of enrollment.

We will prepare and deliver, at no cost to You, the Schedule of Benefits documents (the "SOB"), as well as the Summary of Benefits and Coverage documents (the "SBC"). SOBs and SBCs will be delivered to You in electronic format, unless a paper

copy is requested. You will distribute the SOBs and SBCs to Your employees at the time the Group Health Plan is offered, enrolled in, renewed, in accordance with law, or as otherwise requested. A single SBC may be provided for an employee and all relevant beneficiaries.

If, at the time of renewal, Oscar increases copayments or coinsurance, or reduces Covered Services provided under the Group Health Plan, You must promptly notify all Subscribers of the increase or reduction. In addition, You shall promptly notify Subscribers of any other changes in the terms or conditions of this Agreement affecting the Subscriber benefits or obligations under the Group Health Plan. You must provide such notice by delivering to each Subscriber a true, legible copy of the notice of the copayments or coinsurance increase or reduction in Covered Services sent from Oscar to You at the Subscriber's then current address and promptly provided proof of such mailing and the date thereof to Oscar.

In accordance with Section 1366.27 of the California Health and Safety Code, You must notify qualified beneficiaries currently receiving continuation coverage, whose continuation coverage will terminate under one group benefit plan prior to the end of the period the qualified beneficiary would have remained covered, of the qualified beneficiary's ability to continue coverage under a new group benefit plan for the balance of the period the qualified beneficiary would have remained covered under the prior group benefit plan. This notice shall be provided either 30 days prior to the termination or when all enrolled employees are notified, whichever is later.

The Group must facilitate Our distribution of any and all written material that We are required to provide to Members to comply with the terms of this Agreement, state or federal laws or regulations, or to fulfill health plan accreditation standards. We are not required to issue to Members any notice of termination, cancellation, or non-renewal of this Agreement, except as required by law.

Non-Discriminatory Terms.
You must offer Eligible Employees coverage under the Group Health Plan on terms no less favorable than those on which You offer any other health benefits plan. You agree to make no attempt, whether through differential premium contributions or

otherwise, to encourage or discourage coverage of employees and their eligible dependents under this Agreement. If Your contributions to coverage under any other health benefits plan are increased during the term of this Group Health Plan, You agree to make a similar change in Your contribution rate to coverage under this Agreement.

We agree that We will not provide for coverage under conditions less favorable for employees than coverage provided for covered spouses dependent upon the employees.

Notice Requirements.
If the Group or We terminate this Agreement pursuant to Section V (below), the Group shall promptly notify all Members enrolled through the Group of the termination of coverage in the Group Health Plan. The Group shall provide to each Subscriber a true, legible copy of any Notice of Cancellation for Nonpayment of Premiums and Grace Period or Notice of Cancellation, Rescission or Nonrenewal (whichever is applicable and received from Us) to the Group at the Subscriber's then current address and promptly provide proof of such mailing and the date thereof to Us.

You will notify Us of an employee's loss of eligibility within 30 days following such employee's loss of eligibility. By notifying Us, You acknowledge that You have informed such employee of his or her loss of eligibility at the time the loss occurred. Your failure to provide such notification may limit premium refund.

We may grant retroactive premium credit for enrollment changes that are effective more than 30 days before We received notification of the change if You certify to Us that You notified the affected employee at the time of loss of eligibility. This provision is intended to comply with the ACA regarding rescissions, as amended and pursuant to regulations promulgated thereunder.

You are responsible for compliance with all notice requirements including, but not limited to, notices that are Your obligation under the ACA, COBRA, Knox-Keene Act, Title 28 of the California Code of Regulations, Cal-COBRA and the Health Insurance

Portability and Accountability Act ("HIPAA"), and any amendments thereto. You are not responsible for notices that must be provided by Oscar. Oscar will send the Cal-COBRA Initial Rights notice to You, and will send the Election Notice to any Members eligible for Cal-COBRA.

We will provide Certificates of Creditable Coverage required at the time Our coverage terminates unless otherwise agreed by Us and You. You are responsible for notifying Us of all terminations of coverage as set forth in the Plan Documents.

SECTION IV: EXCLUSIONS AND LIMITATIONS

Exclusions.

Notwithstanding anything contained in this Agreement, We will have no obligations to You for any coverage not specified in the Plan Document's nor any coverage that You, in whole or in part, contract with other carriers to provide on Your behalf.

SECTION V: TERMINATION OF COVERAGE

Termination by the Group.
The Group may terminate this Agreement with or without cause by giving a minimum of 30 days written notice of termination to Oscar. Group termination must be effective on the first day of the month. The Group shall continue to be liable for Group Health Plan premiums for all Members enrolled in this Group Health Plan through the Group until the date of termination.

Termination by Oscar for Nonpayment of Premium.
Oscar may terminate this Agreement in the event the Group or its designee fails to remit Group Health Plan premiums in full by the due date to Oscar. Oscar will duly notify the Group and provide at least a 30 day grace period in accordance with Section 1365 of the California Health and Safety Code. Nonpayment of Group Health Plan premiums includes without limitation payments returned due to insufficient funds and checks post-dated beyond the 30 day grace period. If We terminate this Agreement for nonpayment of premium, We will first give the Group 30 days prior written notice of cancellation. The notice of cancellation will state that this Agreement will not be terminated if the Group makes appropriate payment in full before the end of the 30 day grace period.

Termination by Oscar when the Group Provides Misleading or Fraudulent Information.
Oscar may terminate this Agreement 30 days after Oscar sends written notice to the Group if Oscar demonstrates fraud or an intentional misrepresentation of material fact under the terms of the Agreement by the Group.

Post-Termination.
No termination will relieve Us of any obligation imposed upon Us by the terms of the Plan Documents for health care services rendered before the date of termination, or relieve You of any obligation incurred prior to the date of termination of the Plan Documents.

In the event that You become the subject of a bankruptcy or similar proceeding, You agree that any pre-petition benefits provided by Us on credit will be allowed under 11 U.S.C. § 502 and entitled to Your maximum priority under 11 U.S.C. § 507(a)(4) and § 507(a)(5). You further agree that any post- petition benefits that are provided by Us on credit will be allowed under 11 U.S.C. § 503(b) and entitled to administrative expense priority.

You are responsible for notifying Your employees and their covered dependents of any termination of the Group Health Plan.

In the event that You and/or a Member is determined to have engaged in fraud or material misrepresentation, premium will not be refunded.

SECTION VI: GENERAL PROVISIONS

Acceptance of the Agreement.
The Group accepts this Agreement by execution of this Agreement. Member accepts the terms, conditions and provisions of this Agreement upon completion and execution of the enrollment form. Acceptance by any of these methods shall render all terms and provisions of this Agreement binding on Oscar, the Group, and Members.

Amendments.
The Plan Documents may be amended by either party upon written notice to the other if amendment is necessary in order to comply with applicable laws and regulations. It may be amended by Us on an annual basis, effective upon renewal of the Group Health Plan, with not less than 60 days' prior written notice to You.

Confidential Information.
The parties acknowledge that, in the performance of this Agreement, they may share confidential and proprietary information belonging exclusively to the other. For the purposes of this Agreement, confidential and proprietary information shall include but not be limited to the personal, financial or business affairs of either party, know how, processes, procedures, technology, and any other information, which under the circumstances ought reasonably to be treated as confidential and/or proprietary ("Confidential Information"). Confidential Information shall not include information:

- Which has become generally known to the public other than by a breach of this Section;
- Which is or becomes known to the other on a non-confidential basis from a third party, provided that the third party is not known to the receiving party to be prohibited from disclosing such information by a contractual, fiduciary or other duty owned;
- Independently developed by the receiving party without the use of any of the information received from disclosing party; or
- Information required to be disclosed by law or judicial order.

With respect to Confidential Information, and except as expressly authorized herein, the parties agree that during the term of the Group Health Plan and at all times

thereafter, they shall not use or otherwise disclose such Confidential Information to any person, except its own employees, contractors and/or agents having a "need to know" or other such recipients as agreed to in writing by the parties prior to disclosure. The parties and their employees, contractors and/or agents shall use at least the same degree of care in safeguarding the Confidential Information of each other as they use in safeguarding their own confidential information, but in no event shall less than due diligence and care be exercised.

This Section shall survive the termination of the Group Health Plan.

Contracted Provider.
In accordance with Section 1300.67.4(a)(10) of the California Code of Regulations, if one of Oscar's contract health care providers terminates its contract with Oscar, Oscar will be liable for Covered Services rendered by such provider (other than for copayments and coinsurance) to a Member who retains eligibility under the Group Health Plan or by operation of law under the care of such provider at the time of such termination until the services being rendered to the Member by such provider are completed, unless Oscar makes reasonable and medically appropriate provision for the assumption of such services by a contracting provider

Dispute Resolution.
If a dispute between the Group Health Plan contract holder and Oscar concerning the Group Health Plan cannot be resolved by the parties, the dispute will be resolved by arbitration in accordance with the commercial arbitration rules of the American Arbitration Association then in effect. Such arbitration may be initiated by any party by making a written demand for arbitration on the other party within 30 days of the time the dispute arises. Within 30 days of that demand, the parties will designate an arbitrator and give written notice of such designation to the other. The two arbitrators selected by this process will select a third arbitrator and give notice of the selection to Us and You. The three arbitrators will hold a hearing and decide the matter within 30 days thereafter. The results of the arbitration will be final and binding on both parties. Judgment upon and award rendered by the arbitrators may be entered in any court having jurisdiction thereof. Each party will pay the fee of the arbitrator it chooses, and the parties will share equally the fee of the third arbitrator. The requirements of this

Section shall survive termination of the Group Health Plan.

Effect of Payment or Providing Services.
Whether or not signed by You, this Agreement shall be effective upon the payment of premiums by You or the furnishing of covered services by Us.

ERISA Fiduciaries.
If Your Group Health Plan is subject to ERISA, You, or Your designee (other than Us), will be the plan administrator of Your Group Health Plan under ERISA and will have all the responsibilities and authority of that position including ensuring compliance with ERISA, preparing and distributing summary plan descriptions, and advising all Members of (i) available benefits and any changes in benefits; (ii) termination of coverage for any reason, including the failure to make any payments when due; and (iii) their COBRA rights, if any. We may not be named as, and will not be considered to be, a "named fiduciary" or "plan administrator" within the meaning of ERISA for Your Group Health Plan governed by ERISA.

You may delegate the responsibility and discretionary authority to process and pay claims to Us as "claims administrator" and retain all other responsibilities and duties under ERISA not specifically delegated to Us. We agree to assume such responsibility and authority, including any responsibility

We may have as a "named fiduciary" (as defined under ERISA § 402) for purposes of Our claims administration duties, to the extent that under the Group Health Plan and ERISA We meets the definition of a "named fiduciary." As the named administrator, We will have the power and discretion to construe the terms of the Plan Documents and to determine all questions pertaining to the administration, interpretation, and application of the Plan Documents that involve eligibility for benefits and the payment or denial of claims. In addition, the parties agree that We will have the responsibility for ensuring that Our claim procedures comply with the Department of Labor's Claims Procedures (described in 29 C.F.R. § 2560) and for handling all levels of appeals.

Entire Agreement.
This Agreement, including the Plan Documents, any new or renewal Group applications

(if applicable), any rate proposals, letters, and amendments or attachments/exhibits thereto, constitutes the entire Agreement between You and Us. On the Effective Date, this Agreement supersedes all other agreements for health care services and benefits between the parties. However, if this Agreement, including but not limited to any document referenced herein, contains a typographical error which is a mistake that is known or should have been known by the parties, the parties agree that this Agreement will be amended to correct such error.

Furnishing Information and Audit.
You shall make payroll and other records available to Us for inspection for the purpose of confirming Member eligibility or whether You meet Our underwriting guidelines pursuant to this Agreement.
When necessary, inspection will be conducted at Your offices, during regular business hours, and upon reasonable advance request from Us. If necessary to resolve outstanding issues, this provision shall survive the termination of this Agreement.

Governing Law.
Oscar is subject to the requirements of Chapter 2.2 of Division 2 of the California Health and Safety Code and Chapter 1 of Title 28 of the California Code of Regulations, and any provision required to be in this Agreement by either of the above shall bind the Us whether or not set forth herein. This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State of California and the United States of America, including, without limitation, the Knox-Keene Health Care Service Plan Act of 1975, as amended, and the regulations adopted thereunder by the California Department of Managed Health Care.

Group as Agent.
For all purposes of this Agreement, including the payment of premiums, You are the agent for all Members covered under the Group Health Plan. Notice by or to You will satisfy any notice requirements of this Agreement or the Plan Documents, unless Oscar is required to give notice directly to Members.

HIPAA Privacy Notices.
We will prepare Notices of Privacy Practices appropriate for You under 45 C.F.R. Parts 160 and 167 ("Privacy Standards"). You represent and warrant that You do not create or receive Protected Health Information ("PHI") (as defined in 45 C.F.R. § 164.501) and are not entitled to receive any PHI from Us, except as permitted in 45 C.F.R. § 164.520(a)(2)(iii), or the law of the State of California where more stringent, so that the burden to maintain and provide Notices of Privacy Practices is entirely that of Us. You will cooperate with Us in the preparation of Notices of Privacy Practices and will not prepare any such notices independently.

Maximum Contractual Benefits.
When a husband and wife are both employed as employees, and both have enrolled themselves and their eligible family members under a group health care service plan provided by their respective employers, and each spouse is covered as an employee under the terms of the same master contract, each spouse may claim on his or her behalf, or on behalf of his or her enrolled dependents, the combined maximum contractual benefits to which an employee is entitled under the terms of the master contract, not to exceed in the aggregate 100 percent of the charge for the covered expense or service.

Renewal Date.
The renewal date for this Agreement is the anniversary of the Effective Date of the Group Health Plan of each year. This Agreement will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Agreement or by the Subscriber upon 45 days' prior written notice to Us.

Right to Use Vendors.
We reserve the right to administer Our plans through the use of third party administration and other vendors.

State of California Review of Member Grievances.
Pursuant to Section 1368.02 of the California Health and Safety Code, the California Department of Managed Health Care is responsible for regulating health care service plans. If Subscribers have a grievance against Oscar, Subscribers should first telephone Oscar at 1-855-Oscar-55 and use Oscar's grievance process before contacting the

Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available. If a Subscriber needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Oscar, or a grievance that has remained unresolved for more than 30 days, the Subscriber may call the Department for assistance. The Subscriber may also be eligible for an Independent Medical Review ("IMR"). If the Subscriber is 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.

Workers' Compensation.
Upon Our request, You will submit proof of Your workers' compensation coverage or an exclusion form which has been accepted by the Workers' Compensation Board. You will cooperate with Us to secure Oscar's right to subrogation and reimbursement related to workers' compensation claims or settlements involving any employee under this Agreement.

An Exclusive Provider Organization (EPO) Plan

2020 Subscriber Agreement and Combined Evidence of Coverage and Disclosure Form

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

Effective January 1, 2020

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

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INTRODUCTION

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

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

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

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

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

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

- 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 **DEFINITIONS** section; and
- Covered Services received at an In-Network Facility, at which, or as a result of which, the Member receives Covered Services from and Out-of-Network Provider. Authorized Referrals are provided at in-network Cost-Sharing.

To maximize Your benefits, be sure to confirm that the Provider (e.g. a Physician or Hospital) You wish to see is an In-Network Hospital or an In-Network Provider (for

Providers other than Hospitals) under Your Plan. Services must be performed or supplies furnished by an In-Network Provider in order for benefits to be payable, unless one of the exceptions listed above apply.

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

Your Network of Providers

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

How to Find a Provider in the Network

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

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

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

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 member services number at 1-855-672-2755. 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	1-800-735-2929
	Spanish	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

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

To reach CA Relay, please use the numbers below:

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

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

- Spanish
- Any threshold language

Oral interpretation services are available in additional languages.

Triage or Screening Services

If You believe Your medical or dental condition is an Emergency, call 911 or go to the nearest 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 1-855-672-2755, 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 member services department at 1-855-672-2755 or by accessing Our website at www.hioscar.com.

- Mario Schlosser (CEO)

HOW TO CONTACT US

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

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

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

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

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

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

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

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

To reach CA Relay, please use the numbers below:

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

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 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 similarly covered.

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You will have to pay any In-Network Deductible, Coinsurance, and/or Copayment(s) that apply. Please see Your **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. Our programs coordinate benefits and educate Members who agree to take part in the Case Management program to help meet their health-related needs. The programs are confidential and voluntary and are made available at no extra cost to You.

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

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

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

Code means the California Health and Safety Code.

Coinsurance is Your share of the costs of a covered health care service or prescription, calculated as a percentage (for example, 20%) of the allowed amount for the service as stated in the 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 Individual means a person for whom the Planholder has submitted an Enrollment Application Form and the required Premium, and whom Oscar has accepted for coverage under this Plan.

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

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

Deductible: The term Deductible means the amount of charges You must pay for any Covered Services and Prescription Drugs before any benefits are available to You under this Agreement. Your Deductible is stated in Your 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 **CLAIMS AND PAYMENTS** and **WHAT IS COVERED – PRESCRIPTION DRUGS** sections.

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

Department means the California Department of Managed Health Care.

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

Diabetes Equipment and Supplies means the following items for the treatment of

diabetes (insulin or non-insulin and gestational) as Medically Necessary:

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

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

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

Drugs means Prescription Drugs.

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

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

result:

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

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

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

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

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

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

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

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

- Is not accepted as Standard Medical Treatment of the condition; or
- Has not been approved by the U.S. Food and Drug Administration (FDA) to be lawfully used; or
- Has not been identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use; or
- Requires review and approval by any Institutional Review Board (IRB) for the proposed use or are subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trials set forth in the FDA regulations; or
- Requires any Federal or other governmental agency approval not listed above that has not been and will not be granted at the time services will be provided.

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

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

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

Gender Identity Disorder (Gender Dysphoria) (GID) is defined as is in the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Edition. It is a formal

diagnosis used by psychologists and Physicians to describe people who experience significant dysphoria (discontent) with the sex they were assigned at birth and/or the gender roles associated with that sex.

Gender 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.

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

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

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

For the purpose of Serious Emotional Disturbance of a Child, Severe Mental Illness, and mental health conditions identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Edition, the term "Hospital" includes an acute psychiatric Facility which is a Hospital specializing in psychiatric treatment or a designated psychiatric unit of a Hospital licensed by the state to

provide twenty-four (24) hour acute inpatient care for persons with psychiatric disorders. For the purpose of this Plan, the term acute psychiatric Facility also includes a psychiatric health Facility which is an acute twenty-four (24) hour Facility as defined in California Health and Safety code 1250.2. It must be:

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

Infertility means either:

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

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

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

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

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

In-Network Pharmacy is a Pharmacy that has an In-Network Pharmacy agreement in effect with or for the benefit of Oscar at the time services are rendered. To find an In-Network Pharmacy near You call member services at **1-855-672-2755** or access Our

website at www.hioscar.com.

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

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

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

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

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

Prudent clinical judgment shall reflect:

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

Generally accepted standards of medical practice shall reflect:

- Evidence-based guidelines, including MCG (formerly Milliman Care Guidelines), that have been established in the scientific literature via their inclusion in peer-reviewed medical (or similar) journals.

- Expert opinions based on experiential history of Physicians practicing in relevant clinical area;
- Clinical guidelines established by Physician Specialty Societies, such as National Comprehensive Cancer Network NCCN, and similar;
- Clinical guidelines that are established to Oscar physicians with input from licensed participating providers in Oscar's network
- Any other relevant factors.

Medically Necessary services shall not be:

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

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

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

Severe Mental Illness includes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Out-of-Network Provider is a Provider that does not have an agreement or contract with Us, or Our subcontractor(s) to provide services to Our Member through negotiated payment arrangements under this Plan. There are no benefits provided when using an Out-of-Network Provider and You may be responsible for the total amount billed by an Out-of-Network Provider. The only exceptions are:

- Services received by an Out-of-Network Provider as a result of a medical Emergency, or an Authorized Referral as defined in this section and;
- Covered Services received at an In-Network Facility, at which, or as a result of which, the Member receives Covered Services from an Out-of-Network Provider. 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 (mail order) Pharmacy.

Pharmacy Benefits Manager (PBM)) means a person, business, or other entity that, pursuant to a contract with a health care service plan, manages the prescription drug coverage provided by the health care service plan, including, but not limited to, the processing and payment of claims for prescription drugs, the performance of drug utilization review, the processing of drug prior authorization requests, the adjudication of appeals or grievances related to prescription drug coverage, contracting with network pharmacies, and controlling the cost of covered prescription drugs

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

Physician means:

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

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

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

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

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

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

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

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

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

Prescription means a written order issued by a Physician.

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

prescription." This includes the following:

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

A Prescription Drug will be classified by a tier.

- Tier 1 consists of most generic drugs and low cost preferred brand name drugs.
- Tier 2 consists of non-preferred generic drugs, preferred brand drugs and any other drugs recommended by Our pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
- Tier 3 consists of non-preferred brand name drugs or drugs recommended by Our P&T committee based on drug safety, efficacy and cost, that generally have a preferred and often less costly therapeutic alternative at a lower tier.
- Tier 4 consists of drugs that are biologics, drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost the health plan more than six hundred dollars ($600) net of rebates for a one-month supply

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

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

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

A Provider is

- Licensed to practice where the care is provided;

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

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

- Dentist (D.D.S.)
- Optometrist (O.D.)
- Dispensing optician
- Podiatrist (D.P.M.)
- Clinical psychologist
- Certified registered nurse anesthetist (C.R.N.A.)
- Clinical social worker (C.S.W. or L.C.S.W.)
- Marriage, family and child therapist (M.F.C.T.)
- Physical therapist (P.T. or R.P.T.)
- Speech pathologist
- Speech therapist
- Audiologist
- Occupational therapist (O.T.R.)
- Respiratory therapist
- Registered nurse practitioner (R.N.P.)
- Certified nurse midwife
- Psychiatric Mental Health Nurse
- Acupuncturist

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

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

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

Reconstructive Surgery is surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma,

infection, tumors, or disease in order to improve function or to create a normal appearance, to the extent possible.

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

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

Service Area is the geographic area within the State of California within which this Agreement is offered and issued. Oscar's Service Area for its small group business includes Los Angeles County and Orange County. Please refer to the SERVICE AREA section for a full list of the zip codes which make up the Service Area. Below are the specific zip codes which make up the Service Area:

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

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

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

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

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

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

- Has been demonstrated through reliable evidence in peer reviewed medical literature to have scientifically established medical value for diagnosing, curing or alleviating the condition being treated; *and*
- Is appropriate for the hospital or other facility provider in which it is performed; *and*
- The performing physician or other professional provider has had the appropriate training and experience to provide the service, treatment or procedure.

State means the State of California.

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

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

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

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

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

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

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

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

YOUR ELIGIBILITY

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

Types of Coverage
We offer the following types of coverage:

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

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

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

sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; or that the Dependent Child is chiefly dependent upon You for support and maintenance, to the plan within 60 days of receiving such a request from Us. We will send this notice at least 90 days prior to the date the Child attains the limiting age.

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

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

When Coverage Begins

Coverage under this Agreement will begin as follows:

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

Special Enrollment Periods

A special enrollment period is a period during which a Qualified Individual or enrollee who previously did not enroll at initial enrollment or annual open enrollment,

experiences certain qualifying events or changes in eligibility and due to those events may enroll in, or change enrollment in, their health plan outside of the annual open enrollment period.

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

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

health plan

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

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

Termination of Coverage

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

- The Group and/or Subscriber has failed to pay Premiums, and the Grace Period has been exhausted.
- Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.
- For Spouses in cases of divorce, the date of the divorce.
- For Children, until the end of the month in which the Child turns 26 years of age. (See "Children Covered Under this Agreement" for exceptions.)
- For all other Dependents, the end of the month in which the Dependent ceases to be eligible.
- The end of the month during which the Group or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.
- If We can demonstrate fraud or an intentional misrepresentation of material fact under the terms of the Group Health Plan contract by an individual contract holder or Your employer.
- The date that the Group Health Plan Contract is terminated. If We terminate and/or decide to stop offering a particular class of group policies, without regard to claims experience or health related status, to which this Agreement belongs, We will provide the Group and Subscribers at least 90 days' prior written notice. In this case, we will make available to the Group Health Plan contract holder or employer all health benefit plans that it makes available to new group business.
- If We elect to terminate or cease to provide or arrange for the provision of health benefits for new health care service plan contracts in the small group market in this state, We will provide written notice to the Group and Subscriber at least 180 days prior to when the coverage will cease.
- The Group has performed an act or practice that constitutes fraud or made an

intentional misrepresentation of material fact under the terms of the coverage.

- The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.
- The date there is no longer any enrollee who lives, resides, or works in Our Service Area.
- The Member dies.

"Grace period" refers to either:

- 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
- A thirty one (31) 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 one (31) days from the end of the last month for which premium was paid.

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

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

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

You may submit a Request for Review to Oscar by calling 1-855-672-2755, or submitting a request at hioscar.com, or by mailing your written Request for Review to Oscar Health Plan of California, 9942 Culver City Blvd., PO Box 1279, Culver City, CA 90232.

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

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

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

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

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

This Agreement may also be terminated if You knowingly participate in or permit fraud or deception by any Provider, vendor or any other person associated with this

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

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

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

HOW YOUR COVERAGE WORKS

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

Any limits on the number of visits or days covered are 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 the **DEFINITIONS** section; and (2) Covered Services received at an In-Network Facility, at which, or as a result of which, the Member receives Covered Services from an Out-of-Network Provider. 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 member services at 1-855-672-2755 or access Our website at www.hioscar.com.

Services offered by providers

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

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

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

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

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

To see a Provider, call their office:

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

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

Provider Status

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

In-Network Providers: For Covered Services performed by an In-Network Provider, the Negotiated Fee Rate for Your Agreement is the rate the Provider has agreed with

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

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

Member Cost Share

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

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

Network Providers are prohibited by their contract with Us from billing or collecting from You for any services that are provided but denied because they are not Medically

necessary unless they obtain a written agreement from You wherein You agree to pay for such services. Out-of-Network Providers do not have a contract with Us and You will be responsible for the total amount billed by an Out-of-Network Provider for services that are denied because they are not Medically Necessary.

Timely Access to Care

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional information on claims for services received while traveling abroad:

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

CLAIMS AND PAYMENTS

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

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

Submission of Claims

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

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 Claims 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
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.

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

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

These amounts are Your financial responsibility. After Your Deductible is satisfied, Copayments are normally paid by You at the time services are performed. If Your Plan contains a Deductible, You must satisfy the In-Network medical Deductible before We will make payment for services You receive, except for certain services as stated in the sections below. Additionally, the medical Deductible is explained in the 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.

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

Described below are Your Coinsurance and Out of Pocket Maximums.

You may be required to pay Coinsurance for services received while You are covered under this Plan. Coinsurance is the percentage amount of the Negotiated Fee Rate

that You are responsible for as stated in the 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 **YOUR ELIGIBILITY** section.

WHAT IS COVERED – MEDICAL

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

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

You should also know that many Covered Services can be received in several settings, including a Physician's office, an Urgent Care setting, an outpatient Facility, or an Inpatient Facility. Benefits will often vary depending on where You choose to get Covered Services, and this can result in a change in the amount You need to pay. Please see the 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** section for a definition of medically necessary. Additional information on the review process is available in the section titled **GETTING APPROVAL FOR BENEFITS** or call member

services.

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

Acupuncture
Please see "Therapy Services" later in this 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 section titled **GETTING APPROVAL FOR BENEFITS** for details).

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

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

        - From the scene of an accident or medical Emergency to a Hospital;
        - Between Hospitals, including when We require You to move from an Out-of-Network Hospital to an In-Network Hospital; or
        - Between a Hospital and an approved Facility.
    - Transportation is approved by Oscar.

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

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

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

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

Air and Water Ambulance
Air Ambulance Services are subject to Medical Necessity review by Oscar. We retain the right to select the Air Ambulance Provider. This includes fixed wing, rotary wing or water transportation. Air ambulance services for non- Emergency Hospital to Hospital transports require Precertification.

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

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

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

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

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

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

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

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

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

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

appropriate.

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

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

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

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

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

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

Providers responsible for the autism treatment plan.

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

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

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

Breast Cancer

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

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.
- Health care services required for the clinically appropriate monitoring of the investigational item or service.

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:

- Federally funded trials approved or funded by one of the following:
    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
        - (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and
        - (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.
    - 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.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- Studies or investigations done as part of an Investigational new Drug application reviewed by the Food and Drug Administration;
- 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 immunosuppressives. 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.

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

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 in which 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 in which 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, peridontic, 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.
        - We will cover up to five (5) units of crown or bridgework per arch. Upon the sixth 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 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:

- When treatment begins (appliances are installed), and
- 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 section titled **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:

- The following Diabetes Equipment and Supplies
    - Blood glucose monitors, including monitors designed to assist the visually impaired, and blood glucose testing strips
    - Insulin Pumps and all related necessary supplies
    - Pen delivery systems for Insulin administration
    - Podiatric devices, such as therapeutic shoes and shoe inserts, to prevent or treat diabetes-related complications

    - Visual aids (but not eyeglasses) to help the visually impaired to properly dose Insulin
        - 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
- Diabetes Outpatient Self-Management Training Program, which:
    - 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;
    - 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;
    - Is supervised by a Physician
        - Diabetes education services are covered under the Agreement's benefits as professional services by Physicians
- The following medications and supplies are covered under **WHAT IS COVERED – PRESCRIPTION DRUGS**:
    - Insulin, glucagon and other Prescription Drugs for the treatment of diabetes
    - Insulin syringes
    - Urine testing strips, lancets, and lancet puncture devices.
- 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 section titled **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:

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

Benefits include purchase-only equipment and devices (e.g., crutches), purchase or rent to purchase equipment and devices (e.g., Hospital beds and wheelchairs), and continuous rental equipment and devices (e.g., oxygen concentrator, ventilator, and negative pressure wound therapy devices). Continuous rental equipment must be

approved. We may limit the amount of coverage for ongoing rental of equipment as medically appropriate. We may not cover more in rental costs than the cost of purchasing the equipment.

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

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

- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies
- Dry pressure pad for a mattress
- IV pole
- Enteral pump and supplies
- Bone stimulator
- Cervical traction (over door) equipment
- Phototherapy blankets for treatment of jaundice in Newborns
- Non-segmental home model pneumatic compressor for the lower extremities
- Nebulizer and supplies
- Peakflow meters
- Traecheostomy tube and supplies

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) ofthe 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 beenremoved 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** section and the "Ambulance Services" provision above.

Emergency Services

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

Emergency (Emergency Medical Condition)

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

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

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

Emergency Dental Service (covered by your LIBERTY Dental Plan) is defined in the California Health & Safety Code, to include a dental screening, examination, evaluation by dentist or Specialist to determine if an Emergency Dental Condition exists, and to provide care that would be acknowledged as within professionally recognized standards of dental care and in order to alleviate any emergency symptoms in a dental office/clinic setting and emergency department in a hospital. Emergency medical services may be an allowable benefit, in accordance with the schedule of benefits. LIBERTY shall provide benefits for such emergency dental services and shall ensure the availability of a provider in the event that an on-call network provider is unavailable in a dental setting or hospital. LIBERTY does not cover services that LIBERTY determines were not dental in nature.

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

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

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

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

Emergency Care

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

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

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

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

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

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

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

Family Planning Services

Covered Services include:

- Family planning counseling and education (see "Health Education" and "Preventive

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

Foot Care

Coverage is provided for:

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

Habilitation Services

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

Health Education

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

Home Care Services

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

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

- A registered nurse
- A medical social service worker
- Diagnostic services
- Nutritional guidance

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

Limitations:

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

Hospice Care

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

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

Your condition, including oxygen, related respiratory therapy supplies and incontinence supplies.
- Bereavement (grief) services for the Member and the Member's direct family members.

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

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

Limitations:
The following services, supplies or care are not covered:
- Services or supplies for personal comfort or convenience, including homemaker services that are not under the supervision of a registered nurse
- Food services, meals, formulas and supplements other than listed above or for dietary counseling even if the food, meal, formula or supplement is the sole source of nutrition
- Services not directly related to the medical care of the Member, including estate planning, drafting of wills, funeral counseling or arrangement or other legal services
- Services provided by volunteers

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

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

Services for In vitro fertilization are not covered.
An In-Network Physician determines the appropriate number of drug-induced ovulation attempts for the GIFT treatment cycle. Services are limited to three (3) cycles per year.

The benefits included under this subsection are generally determined on the same basis as other inpatient, outpatient, and prescription drug coverage. The cost shares for these services as indicated on the Summary of Benefits will apply. Remember that certain services require prior authorization.

Your cost share for Covered Infertility Services do not apply towards the Plan Deductible or Out-Of-Pocket Maximum. There is a lifetime benefit limit of $5,000 for Covered Infertility Services. Once the lifetime benefit limit is reached, You will be responsible for 100% of the allowed amount.

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 admissions and the length of Hospital stays associated with mastectomy and lymph node dissections. For emergency admissions, You, Your authorized representative or Physician must tell Us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time (see the section titled **GETTING APPROVAL FOR BENEFITS** for details).

Inpatient Facility Care

Covered Services include acute care in a Hospital or Residential Treatment Center setting. Benefits for room, board, and nursing services include:

- A room with two or more beds.
- An approved room in a Special Care Unit. The unit must have Facilities, equipment, and supportive services for intensive care or critically ill patients.
- A private room, if medically necessary
- Meals, special diets.
- General nursing services.

Benefits for ancillary services include:

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

Inpatient Professional Services

Covered Services include:

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

Maternity Care

Maternity Services

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

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

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

Maternal Mental Health

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

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

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

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

Mental Health and Substance Abuse (Chemical Dependency) Services

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

Covered Services include services for Mental Health and Substance Abuse, including

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

Mental Health Covered Services include the following:

- Inpatient Services in a Hospital, Residential Treatment Center, or any Facility that We must cover per State law. Inpatient benefits include:
    - Inpatient facility services for acute Mental Health Conditions, including Physician Services;
    - Inpatient psychiatric observation for acute psychiatric crisis, including Physician Services;
    - Short-term Mental Health crisis Residential Treatment.
- Outpatient Office Visits
    - Individual and group mental health evaluation and treatment;
    - Outpatient services for monitoring drug therapy;
    - Behavioral Health Treatment Office Visit for Pervasive Developmental Disorder or Autism (See also "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" earlier in this section for a description of additional Covered Services.
- Outpatient Items and Services
    - Short-term partial hospitalization;
    - Short-term intensive outpatient psychiatric treatment;
    - Outpatient psychiatric observation for an acute psychiatric crisis;
    - Psychological testing to evaluate a mental condition;
    - Behavioral Health Therapy Home Visit for Pervasive Developmental Disorder or Autism (See also "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" earlier in this section for a description of additional Covered Services); and
    - Non-emergency psychiatric transportation.

Substance Abuse (Chemical Dependency) Services include the following:

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

- Day treatment program for substance use disorder
- Intensive outpatient treatment for substance use disorder
- Non-emergency psychiatric transportation

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

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

We offer certain Medically Necessary Outpatient Office Visits for Mental Health Covered Services and Substance Abuse (Chemical Dependency) through Telehealth. To obtain a list of Mental Health and Substance Use Providers within Our network please contact Us at 1- 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 services provided:

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

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

Covered Services include:

- Office Visits with Primary care Physicians and Providers (PCP) and Specialty Care Physicians and Providers
- Urgent Care as described in "Urgent Care" later in this section
- After Hours Care. If You need care after normal business hours, Your Physician may have several options for You. You should call Your Physician's office for instructions if You need care in the evenings, on weekends, or during the holidays and cannot wait

until the office reopens. If You have an Emergency, call 911 or go to the nearest Emergency room (see the section titled **WHAT IS NOT COVERED (EXCLUSIONS) – MEDICAL**).

- Second Opinions. If You have a question about Your condition or about a plan of treatment, which Your Provider has recommended, You may receive a second medical opinion from another qualified health care professional. 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 Provider to refer You to an In-Network Provider to receive a second opinion. There is no need to obtain a referral to see a specialist. 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, and
- Consistent with the recommendations and best practices of qualified Health Professionals with expertise in the treatment and care of PKU, and
- Used in place of normal food products, such as grocery store foods, used by the general population.
    - It does not include a food that is natural low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

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 broad categories as described below:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendation of the United States Preventive Services Task Force
- Immunizations for routine use in children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control

and Prevention;

- Preventive care and screenings for infants, children and adolescents as listed in the guidelines supported by the Health Resources and Services Administration, including:
    - The American Academy of Pediatrics Bright Futures Recommendations for Preventive Pediatric Health Care and
- Additional preventive care and screening for women provided for in the comprehensive guidelines supported by the Health Resources and Services Administration, including:
    - FDA-approved contraceptive drugs, devices, and other products for women, including FDA-approved contraceptive drugs, devices, and products available over the counter, as prescribed by the enrollee's provider.
        - Oscar will not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this subdivision, unless
            - The FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product. In that case, Oscar will cover at least one without cost sharing.
            - If a covered therapeutic equivalent of a drug, device, or product is not available, or is deemed medically inadvisable by Your Provider, Oscar will provide coverage, subject to Our utilization management procedures, for the prescribed contraceptive drug, device, or product without cost sharing. (See the section titled **GETTING APPROVAL FOR BENEFITS**.)
        - Oscar will cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed or furnished by an In-Network Provider or pharmacist, or location licensed or otherwise authorized to dispense drugs or supplies.
    - Voluntary sterilization procedures
    - Injectable contraceptives and patches,
    - Contraceptive devices such as diaphragms, intra-uterine devices (IUDs), cervical caps and implants,
    - Family planning counseling and education,
    - Follow up services related to the drugs, devices, products, and procedures covered under this subdivision, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.
    - Breastfeeding support, supplies, and counseling. Benefits for breast pumps are limited to one (1) pump per pregnancy. Breast pumps are covered under Your Agreement's medical benefits,
    - Gestational diabetes screening,
    - Well woman visits that are age and developmentally appropriate, including preconception and prenatal care,

- Screening and counseling for sexually transmitted infections,
- Screening and counseling for Human Immunodeficiency Virus (HIV),
- Screening and counseling for interpersonal and domestic violence and
- Testing for Human Papillomavirus (HPV).
- BRCA testing

Examples of Preventive care Covered Services are provided below.

Well Baby and Well Child Preventive Care

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

Adult Preventive Care

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

services.

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

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

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

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

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

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

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

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

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 1-855-672-2755.

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

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

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

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

Reconstructive Surgery
Benefits include Reconstructive Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease in order to improve function or to create a normal appearance, to the extent possible. Benefits also include Medically Necessary dental or orthodontic service that are an integral part of reconstructive surgery for cleft palate procedures and surgery performed to restore symmetry after a mastectomy.

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

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

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

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

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

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

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

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

- Physical Therapy – The treatment by a physical method to ease pain, restore health,

and to avoid disability after an illness, injury, or loss of an arm or a leg. It also includes services related to Pervasive Development Disorder or Autism. It includes the use of heat, cold, exercise, electricity, ultraviolet, massage and aquatic therapy (as part of a Physician Therapy treatment plan) to improve circulation, strengthen muscles and encourage return of motion.

- Speech therapy and speech-language pathology (SLP) services – Services to identify, assess, and treat speech, language, and swallowing disorders in children and adults. Therapy will develop or treat communication or swallowing skills to correct speech impairment. It also includes services related to Pervasive Development Disorder or Autism.
- Occupational Therapy – Treatment to restore a physically disabled person's ability to do activities of daily living, such as walking, eating, drinking, dressing, using the toilet, moving from a wheelchair to a bed, and bathing. It also includes services related to Pervasive Development Disorder and Autism.
- Acupuncture – Typically provided only for limited conditions outlined in Oscar's coverage criteria, such as treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.

Infusion Therapy

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

- If services are performed in the home, those services must be billed by and performed by a Provider licensed by State and local laws.
- Drugs and other substances used in Infusion Therapy.
- Professional services to order, prepare, dispense, deliver, administer, train or monitor, including clinical Pharmacy support and any Drugs or other substances used in a Course of Therapy.
- Durable, reusable supplies, and durable medical equipment including, but not limited to, pump, pole and electric monitor.
- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products.

Infusion Therapy benefits will not be provided for:

- Compounding fees such as charges for mixing or diluting Drugs, medicines or solutions or incidental supplies including disposable items such as cotton swabs, tubing, syringes and needles for Drugs, adhesive bandages and intravenous starter kits.
- Drugs and medicines not requiring a Prescription.
- Drugs labeled "Caution, limited by federal law to Investigational use" or Drugs prescribed for Experimental use.
    - If Oscar determines that the requested Drug, device, procedure, or therapy is

not covered because it is Investigational or prescribed for Experimental indications, the Member may request an independent medical review. Refer to the section titled **INDEPENDENT MEDICAL REVIEW**.

- Drugs or other substances obtained outside the United States.
- Non-FDA approved homeopathic medications or other herbal medications.
- Charges, including the preparation of the finished product, by an Out-of-Network Provider that exceeds the Prescription Drug Maximum Allowed Amount.
- Medical Supplies and Equipment used in Infusion Therapy will not be reimbursed under any other benefit of this Plan.

Other Therapy Services

Benefits are available for:

- Cardiac Rehabilitation – Medical evaluation, training, supervised exercise, and psychosocial support to care for You after a cardiac event (heart problem).
- Chemotherapy – Treatment of an illness by chemical or biological antineoplastic agents.
- Dialysis – Services for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home Hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis Facility. Covered Services also include home dialysis and training for You and the person who will help You with home self-dialysis. We also cover equipment and medical supplies required for home Hemodialysis and home peritoneal dialysis. Coverage is limited to the standard item of equipment of supplies that adequately meets Your medical needs. Covered Services include treatment by an Out-of-Network Provider subject to all the following conditions:
    - The Out-of-Network Provider is duly licensed to practice and authorized to provide such treatment.
    - The Out-of-Network Provider is located outside Our Service Area.
    - The In-Network Provider who is treating You has issued a written order indicating that dialysis treatment by the Out-of-Network Provider is necessary.
    - You notify Us in writing at least thirty (30) days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
    - We have the right to Preauthorize the dialysis treatment and schedule.
    - We will provide benefits for no more than ten (10) dialysis treatments by an Out-of-Network Provider per Member per calendar year, unless Medically Necessary.
    - Benefits for services of an Out-of-Network Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that

applies to dialysis treatments by a Participating Provider.

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

Transgender Services

Precertification is required for certain Transgender Services (see the section titled **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 authorization in order for coverage to be provided. Please refer to the section titled **GETTING APPROVAL FOR BENEFITS** for information on how to obtain the proper reviews and authorization.

Telehealth

We cover Medically Necessary Covered Services offered through Telehealth by an In-

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

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

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

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

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

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

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

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

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

payable by that donor's own coverage.

Transplant Travel Expense

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

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

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

When You request reimbursement of covered travel expenses, You must submit 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 member services 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 the **WHAT IS COVERED – MEDICAL** section, under the "Preventive Care" provision.

Vision Services – Child
Vision Care that is Covered:

The following vision care benefits are available to Members until the end of the month in which the Member turns nineteen (19) years of age. We will cover vision care that is listed in this section. See Your 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 itwill result in significantly better visual acuity and/or improved binocular function, including avoidance of diplopia or suppression.

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

Low Vision

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

Low vision benefits include:

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

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

Oscar Health Plan of California
Attn: Oscar Vision
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.

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

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

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.

If You have a question regarding whether a Drug is on the Prescription Drug List, please call Us toll free at 1-855-672-2755 or visit Oscar's 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;
- Supplies and equipment used to administer insulin, including syringes;
- Disposable needles and syringes needed for injecting Covered Prescription Drugsand 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 the **WHAT IS COVERED – MEDICAL** section 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

Some medication may be reviewed for medical necessity from time to time, even though they are not subject to our Prior Authorization requirements. If so, your prescribing doctor may be asked for clinical information to support your use of the medicine. In instances where the medical necessity determination (MND) results in an unfavorable decision, please remember such determinations may also be eligible for the appeals process or you may choose to buy the medicine at your own expense. We will give you 30 days notice before We kick off any such review. Please refer to the Grievances section for more information on appeals and grievances.

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.

Growth Hormone Treatment
Is excluded except for the treatment of documented growth retardation due to deficiency of growth hormones).

Continuation of growth hormone therapy will not be covered except for Conditions associated with significant growth hormone deficiency when there is evidence of continued responsiveness to treatment.

Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.

Retail or Home Delivery (Mail Order) Pharmacy
Your Agreement includes benefits for Prescription Drugs You get at a Retail or Home Delivery Pharmacies. 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 member services representative will coordinate the exception and You will not be required to pay additional Coinsurance/Copayment.

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 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.

If You decide to use Home Delivery, We suggest that Your 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 member services toll-free at 1-855-672-2755.

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

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, injectables, including Self Administered Injectables except Insulin. These drugs are subject to prior authorization. Please check with the Home Delivery Prescription Drug program member services department at 1-855-672-2755 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.

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 1-855-672-2755.

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 Member Services at 1-855-672-2755 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 **1-855-672-2755** 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.

How to obtain an override for an Out-of-Network 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 **1-855-672-2755** 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 member services 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 Formulary.

Your Physician may submit a prior authorization form to Oscar. This form is available by calling **1-855-672-2755**, or online at www.hioscar.com. You may call member services **1-855-672-2755** 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 cost share. If approved, Drugs requiring prior authorization will be provided to You after You make the required payment. You do not need to resubmit a drug You are already taking for Prior Authorization upon enrolling with Oscar.

The prior authorization review process is outlined below. Upon receipt of a completed Prior Authorization request from a prescribing Clinician, 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 1-855-672-2755 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.

Expedited Review

Members and prescribers may request an expedited review of an authorization request 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. 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 authorization request process. We will make a decision and notify the Member and prescriber no later than twenty-four (24) hours after receipt of the request.

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 filled 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," and the **GETTING APPROVAL FOR BENEFITS** and **COMPLAINTS AND GRIEVANCES** sections 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 member services at **1-855-672-2755** or write Us at:

Oscar Health Plan of
California 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. Additionally, Your access to Medically Necessary Health Care Services will continue if You have been displaced by a declared state of emergency. We will coordinate benefits with other entities that may offer You coverage, such as coverage offered through the United States military to those on active military duty.

Administrative Charges

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

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

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

Alternative/Complementary Medicine: Coverage is not provided for (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy (unless part of a Physical Therapy treatment plan), reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy,

thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback. This exclusion does not apply to Medically Necessary biofeedback.

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

Chiropractic Services: Coverage is not provided for chiropractic services except as described in the WHAT IS COVERED section.

Clinical ecology

Coma stimulation

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

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

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

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

Dental implants for Member age nineteen (19) and over: Material implanted into or

on bone or soft tissue or any associated procedure as part of the implantation or removal of implants unless specifically stated as a Covered Service.

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

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

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

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

Devices that are:

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

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

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

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).
- For erectile dysfunction

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

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

- Orthopedic shoes or shoe inserts (except as specifically stated in the section titled **WHAT IS COVERED – MEDICAL** under "Diabetes Equipment, Education and

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

- Equipment primarily for comfort or convenience, including but not limited to, scooters and wheelchair add ons which do not serve a medical purpose
- Air purifiers, air conditioners, humidifiers
- Exercise equipment, treadmills
- Pools and spas
- Elevators
- Supplies for comfort, hygiene or beautification
- Correction appliances or support appliances and supplies such as stockings.

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

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

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

Experimental or Investigational Services: Services or supplies that are 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 the section titled **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 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" in the section titled WHAT IS COVERED - MEDICAL.

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

Home Care:

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

Home delivery of childbirth

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

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

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

Massage therapy

Missed or Canceled Appointments.

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

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

- Your Medicare coverage will be applied first (primary) to any services covered 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.
- 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.

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

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

Out-of-Network Providers: Services from an Out-of-Network Provider except as

specifically stated under the benefit sections of this Agreement.

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

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

- Air conditioners, humidifiers, air purifiers;
- Physical fitness equipment such as a treadmill or exercise cycles; charges from a physical fitness instructor or personal trainer, even if ordered by a Physician. This exclusion also applies to spas.
- Special exercise testing or equipment solely to evaluate exercise competency or assist in an exercise program;
- Charges from a health spa or similar facility;
- Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
- Charges for non-medical self-care except as otherwise stated;
- Purchase or rental of supplies for common household use, such as water purifiers;
- Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
- Infant helmets to treat positional plagiocephaly;
- Safety helmets for Members with neuromuscular diseases; or
- Sports helmets.

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

Physician/Other Providers' Charges including:

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

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

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

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

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

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

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

Services not approved by the Federal Food and Drug Administration: Drugs, supplements, tests, vaccines, devices, radioactive materials and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the United States but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside the United States.

This exclusion does not apply to any of the following:

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

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

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

Shipping and Handling

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

Teeth (Congenital Anomaly): Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly, except as stated in this Agreement under the part **WHAT IS COVERED – MEDICAL** in the sections "Dental Services" or "Dental Services – Pediatric" or as required by law. This exclusion does not apply to Members under the age nineteen (19).

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

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

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

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

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

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

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

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

- Vision care for Member age nineteen (19) and older, unless covered by the medical benefits of this Agreement.
- For any condition, disease, defect, ailment or injury arising out of and in the course of employment if benefits are available under the Workers' Compensation Act or any similar law. This exclusion applies if the Member receives the benefits in whole or in part. This exclusion also applies whether or not the Member claims the benefits or compensation. It also applies whether or not the Member recovers from any third party.
- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For which the Member has no legal obligation to pay in the absence of this or like coverage.
- Prescribed, ordered or referred by, or received from a member of the Member's immediate family, including the Member's spouse, Domestic Partner, child, brother, sister or parent.
- For completion of claim forms or charges for medical records or reports unless otherwise required by law.
- For missed or canceled appointments.
- For which benefits are payable under Medicare Part A and/or Medicare Part B except as specified elsewhere in this booklet or as otherwise prohibited by federal law.
- For services or supplies primarily for educational, vocational or training purposes,

except as otherwise specified herein.

- Received from an optical or medical department maintained by or on behalf of a group, mutual benefit association, labor union, trust or similar person or group (unless received by a network Provider).
- For safety glasses and accompanying frames.
- For inpatient or outpatient Hospital vision care, unless covered by the medical benefits of this Agreement.
- For orthoptics or vision training and any associated supplemental testing.
- For two (2) pairs of glasses in lieu of bifocals.
- For plano lenses (lenses that have no refractive power).
- For medical or surgical treatment of the eyes, unless covered by the medical benefits of this Agreement.
- Lost or broken lenses or frames, unless the Member has reached the Member's normal interval for service when seeking replacements.
- Oversize lenses.
- For sunglasses.
- Benefit is not available on certain frame brands in which the manufacturer imposes a no discount policy.
- No benefit is available for frames purchased outside of our formulary.
- For vision care received Out-of-Network.

Vocational rehab

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

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

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

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

Code or any other applicable law

WHAT IS NOT COVERED (EXCLUSIONS) – PRESCRIPTION DRUGS

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

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

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

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

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

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

Drugs Over the Quantity Prescribed or Refills After One (1) Year: Drugs in amounts over the quantity prescribed, or for any refill given more than one (1) Year after the date of the original Prescription Order.

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

Drugs used for cosmetic purposes.

Items Covered as Durable Medical Equipment (DME) : Therapeutic DME, devices and supplies except peak flow meters, spacers, and blood glucose monitors.

Note: Durable Medical Equipment (DME) is covered under WHAT IS COVERED – MEDICAL, in the section "Durable Medical Equipment and Medical Devices, Special Footwear, Orthotics, Prosthetics and Medical and Surgical Supplies."

Growth hormone treatment for idiopathic short stature, or improved athletic performance is not covered under any circumstances.

Lost or Stolen Drugs: Stolen Drugs or refills of lost Drugs (excluding those from Home Delivery (Mail Order) Pharmacy or Specialty Pharmacy).

Mail Service Programs Other than Oscar Approved Home Delivery Program: Prescription Drugs dispensed by any Mail Service program other than a Participating Oscar Home Delivery program, unless We must cover them by law.

Non-Approved Drugs: Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require FDA approval in order to be sold in the United States but are not approved by the FDA.

Off Label Use: Prior authorization is required for a non-FDA-approved indication of a drug listed on Our Formulary. Off label use is covered, as long as:

- The Drug is FDA-approved and an In-Network Provider has prescribed the Drug for:
  - The treatment of a life-threatening condition; or
  - The treatment of a chronic and seriously debilitating condition, is medically necessary to treat that condition, and

The Drug is Medically Necessary to treat the condition and is on the Formulary. If the Drug is not on the Formulary, the request for coverage shall be considered pursuant to H&SC § 1367.24 45 CFR § 156.122; and

- The drug has been recognized for treatment of that condition by any of the following:
  - The American Hospital Formulary Service's Drug Information; or
  - One of the following compendia, if recognized by the federal Centers for Medicare & Medicaid Services (CMS) as part of an anticancer chemotherapeutic regimen:
    - The Elsevier Gold Standard's Clinical Pharmacology;
    - The National Comprehensive Cancer Network Drugs and Biologics Compendium;

- The Thomson Micromedex DrugDex; or
- At least two (2) articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

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

Syringes: Hypodermic syringes except when given for use with insulin and other covered self-injectable Drugs and medicine.

Weight loss Drugs: Weight loss Drugs unless Medically Necessary for treatment of morbid obesity. Medically Necessary weight loss drugs are covered as set forth in the **WHAT IS COVERED – PRESCRIPTION DRUGS** section.

GETTING APPROVAL FOR BENEFITS

Certain Services require a review of the service's Medical Necessity through Authorization processes. If Your Provider is considering or provides a service requiring Authorization, Your Provider contacts Us and shares the relevant clinical information so that a determination of the service's Medical Necessity can be made. Authorization determinations consider factors including the circumstances of the service, medical policy, clinical guidelines, Pharmacy and therapeutics guidelines, and the setting of the service.

In these situations, it is the Provider's responsibility to obtain Authorization, but if You have any questions about the Authorization process or would like to confirm if Authorization is required, contact Oscar at 1-855-672-2755 or visit www.hioscar.com for information.

Types of Requests

- **Precertification** – A required review of a service, treatment for admission for a benefit coverage determination that must be done before the service, treatment or admission start date. For Emergency admissions, Your authorized representative or Physician must tell Us within forty-eight (48) hours of the admission or as soon as possible within a reasonable period of time. For labor/childbirth admissions, 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 have a Precertification or Predetermination review performed where required. Emergency Services may also be subject to retrospective review to verify Medical Necessity; if authorization is denied, You have appeal rights. Please see "Complaints and Grievances," "Independent Medical Review," and "Independent Medical Review of Grievances Involving a Disputed Health Care Service" for more information about appeals. Medical reviews are done for a service, treatment or admission for which there is a related clinical coverage guideline and are typically initiated by Us.

Services for which Precertification and/or Predetermination may be required (i.e., services that need to be reviewed to determine whether they are Medically Necessary) include, but are not limited to, the following:

- 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
- 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)
    - 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 Member Services at 1-855-672-2755 or visit www.hioscar.com.

Typically, In-Network Providers know which services need Precertification and will get any Precertification or ask for a Predetermination when needed. Your Primary Care Physician and other In-Network Providers have been given detailed information about these procedures and are responsible for meeting these requirements. Generally, the ordering Provider, Facility or attending Physician will get in touch with Us to ask for a Precertification or Predetermination review ("requesting Provider"). We will work with the requesting Provider for the Precertification request. However, You may choose an authorized representative to act on Your behalf for a specific request. The authorized representative can be anyone who is eighteen (18) years of age or older.

Who is responsible for Precertification	
Services given by an In-Network Provider	Services given by 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 Experimental or Investigational as that term is defined in the Plan otherwise. Your Agreement takes precedence over these guidelines.

You are entitled to receive, free of charge, reasonable access to any records on which a determination relied. To ask for this information, call the phone number on the back of Your Identification Card.

Oscar may, from time to time, waive, enhance, modify or discontinue certain medical management processes (including utilization management, case management, and disease management) if in Oscar's discretion, such change is in furtherance of the provision of cost-effective, value-based and/or quality services.

In addition, We may select certain qualifying Providers to participate in a program that exempts them from certain procedural or medical management processes that would otherwise apply. We may also exempt Your claim from medical review if certain conditions apply.

Just because Oscar exempts a process, Provider or claim from the standards which otherwise would apply, it does not mean that Oscar will do so in the future, or will do so in the future for any other Provider, claim or Member. Oscar may stop or modify any such exemption with or without advance notice.

You may determine whether a Provider is participating in certain programs by checking Your on-line Provider directory, on-line pre-certification list or by contacting

member services at **1-855-672-2755**.

We also may identify certain Providers to review for potential fraud, waste, abuse or other inappropriate activity if the claims data suggests there may be inappropriate billing practices. If a Provider is selected under this program, one or more clinical utilization management guideline may be used in the review of claims submitted by this Provider, even if those guidelines are not used for all Providers delivering services to the Plan's members.

Request Categories

- Urgent– A request for Precertification or Predetermination that in the view of the treating Provider or any Physician with knowledge of Your medical condition could, without such care or treatment, seriously threaten Your life or health or Your ability to regain maximum function or subject You to severe pain that cannot be adequately managed without such care or treatment.
- Prospective – A request for Precertification or Predetermination that is conducted before the service, treatment or admission.
- Concurrent Review – Oscar will actively review and manage utilization decisions during an inpatient level of care or an ongoing outpatient course of treatment. The frequency with which Oscar conducts concurrent review for an inpatient level of care or an ongoing outpatient course of treatment depends on the severity of the member's case/condition, progress towards treatment goals, current level of stability, and impending discharge plans
- Retrospective – Oscar will also be available to review and evaluate medical appropriateness for services that have been provided where pre-authorization is required, but there has been no notification of admission by provider or request for a pre-authorization review by provider. Medical records will be required for this review and a medical necessity review will be completed using nationally recognized criteria

Decision and Notice Requirements

Requests for benefits are reviewed according to the timeframes listed below. The timeframes and requirements listed are based on State and Federal laws. State laws apply where the State laws are stricter than the Federal laws. If You live in and/or get services in a state other than the State where Your Agreement was issued other State- specific requirements may apply. You may call member services at 1-855-672-2755 for more details.

Request Category	Timeframe Requirement for Decision and Notification when all necessary information is initially provided

Prospective Urgent	The decision will be within seventy-two (72) hours from the receipt of request.
Prospective non-Urgent	The decision will be within five (5) business days from the receipt of the request.
Concurrent Urgent	If the request is made within 24 hours of the expiration of the existing authorization, the decision will be within twenty-four (24) hours from the receipt of request. If the request is not made within 24 hours of the expiration of the existing authorization, the decision will be within seventy-two (72) hours from the receipt of request
Concurrent non-Urgent	The decision will be within five (5) business days from the receipt of the request
Retrospective	The decision will be within thirty (30) calendar days from the receipt of the request.

If more information is needed to make Our decision, the requesting Provider will be informed, and written notice will be sent to You or Your authorized representative of the specific information needed to finish the review. If You and/or Your requesting Provider do not provide the specific information needed or if the information is not complete by the timeframe identified in the written notice, the decision will be based upon the information available.

Notice of the decision, as required by State and federal law, will be given by one or both of the following methods, as required by state and/or federal law:

- Verbal: Oral notice given to the requesting Provider by phone or by electronic means if agreed to by the Provider.
- Written: Mailed letter or electronic means including email and fax given to, at a minimum, the requesting Provider and You or Your authorized representative.

Precertification does not guarantee coverage for or payment of the service or treatment reviewed. For benefits to be covered, on the date You get service:

- You must be eligible for benefits;
- Premium must be paid for the time period that services are given;
- The service or supply must be a covered benefit under Your Plan;
- The service cannot be subject to an Exclusion under Your Plan; and
- You must not have exceeded any applicable limits under Your Plan.

Appealing Authorizations that Deny, Modify, or Delay Services

You may submit a grievance or request an Independent Medical Review (IMR) of disputed health care services if You believe that a request for authorization of a health care service has been improperly denied, modified, or delayed. For more information on submitting a grievance or requesting an IMR, see the "Complaints and Grievances," "Independent Medical Review," and "Independent Medical Review of Grievances Involving a Disputed Health Care Service" sections.

Case Management

Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the case management program to help meet their health-related needs.

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or Injury, We may provide benefits for alternate care through Our case management program that is not a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Plan. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us. Nothing in this provision shall prevent You from Appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

CONTINUATION OF COVERAGE

COBRA

You may be able to continue Your coverage under this Agreement for a limited time after You would otherwise lose eligibility, if required by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA applies to most employees (and their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Health Benefits Officer or Plan Administrator for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

Pursuant to federal COBRA coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Agreement in certain situations when You would otherwise lose coverage, known as qualifying events. In order to be eligible, an individual must have been covered by a Group Health Plan on the day before the qualifying even occurred. Additionally, any child born to or placed for adoption while on COBRA is automatically considered Eligible.

1. If Your coverage ends due to termination or reduction in hours for reasons other than gross misconduct, You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

2. If You are a covered Dependent, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment, other than for gross misconduct;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class, other than for gross misconduct;
    - A covered employee becoming entitled to Medicare per Medicare eligibility requirements
    - Divorce or legal separation from the Subscriber; or
    - Death of the Subscriber.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
    - Voluntary or involuntary termination of the Subscriber's employment, other than for gross misconduct;
    - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class, other than for gross misconduct;
    - A covered employee becoming entitled to Medicare, per Medicare eligibility requirements
    - Loss of covered Child status under the plan rules; or
    - Death of the Subscriber.

If You want to enroll in COBRA continuation coverage, You must request continuation from the Group in writing and make the first Premium payment to the Group within the 60-day period following the later of:

- The date coverage would otherwise terminate; or
- The date You are sent notice by first class mail of the right of continuation by the Group.

Payment of COBRA Premiums

The Group may charge up to 102% of the Group Premium for continued COBRA coverage. However, if You are eligible to continue Group coverage to 29 months because of a Social Security disability determination, the COBRA Premiums for months 19 through 29 will be 150% of the Group Premium.

If You are enrolled in COBRA and are contributing to the cost of Coverage, the Group is responsible for collecting and submitting all Premium contributions to Us in the manner and for the period established under this Plan.

COBRA Termination of Group Continued Coverage

Continued coverage under federal COBRA will terminate at the earliest of the following:

- The date 18 months after the Subscriber's coverage would have terminated because of termination of employment or reduction in hours;
- If You are a covered Spouse or Child, the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
- The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;

- The date You become entitled to Medicare;
- The date to which Premiums are paid if You fail to make a timely payment; or
- The date the Group Health Plan contract terminates. However, if the Group Health Plan contract is replaced with similar coverage, You have the right to become covered under the new Group Health Plan contract for the balance of the period remaining for Your continued coverage.

When Your Continuation of Coverage ends, You may have a right to conversion. See "Conversion Right to a New Contract after Termination" section of this Agreement."

Cal-COBRA
If You are ineligible for COBRA or exhaust Your COBRA coverage, and Your Employer employs two (2) to nineteen (19) employees, You are able to continue Group coverage under the state law California Continuation Benefits Replacement Act ("Cal-COBRA"). If you are eligible for COBRA, Cal-COBRA may extend coverage up to 36 months.

Continuing Coverage for Enrollees Who Have Exhausted COBRA Continuation Coverage If You have exhausted continuation coverage under COBRA, We provide the opportunity for Your to continue coverage for up to 36 months from the date Your continuation coverage began, if You are entitled to less than 36 months of continuation coverage under COBRA. The health care service plan shall offer coverage pursuant to the terms of this article, including the rate limitations contained in Section 1366.26.

Eligibility and Effective Date of Coverage for Cal-COBRA after COBRA
If Your Group is subject to COBRA and Your COBRA coverage ends, You may be able to continue Group coverage effective the date Your COBRA coverage ends if all of the following are true:

- Your effective date of COBRA coverage was on or after January 1, 2003
- You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months
- You do not have Medicare

You must request an enrollment application by calling Our member services at 1-855-672-2755 within 60 days of the date of when your COBRA coverage ends.

Cal-COBRA Enrollment and Premiums
Within 10 days of Your request for an enrollment application, We will send You Our application, which will include Premium and billing information. You must return Your

completed application within 63 days of the date of Our termination letter or of Your membership termination date (whichever date is later).

If We approve Your enrollment application, We will send you billing information within 30 days after We receive Your application. You must pay the bill within 45 days after the date We issue the bill. The first Premium payment will include coverage from Your Cal-COBRA effective date through Our current billing cycle. You must send Us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

After that first payment, Your Premium payment for the upcoming coverage month is due on first day of that month. The Premiums will not exceed 110 percent of the applicable Premiums charged to a similarly situated individual under the Group benefit plan except that Premiums for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent instead of 110 percent.

Changes to Cal-COBRA Coverage and Premiums

Your Cal-COBRA coverage is the same as for any similarly situated individual under Your Group's Agreement, and Your Cal-COBRA coverage and Premiums will change at the same time that coverage or Premiums change in Your Group's Agreement. Your Group's coverage and Premiums will change on the renewal date of its Agreement, and may also change at other times if Your Group's Agreement is amended. Your monthly invoice will reflect the current Premiums that are due for Cal-COBRA coverage, including any changes. For example, if Your Group makes a change that affects Premiums retroactively, the amount we bill You will be adjusted to reflect the retroactive adjustment in Premiums. Your Health Benefits Officer or Plan Administrator can tell you whether this Evidence of Coverage is still in effect and give You a current one if this Evidence of Coverage has expired or been amended. You can also request one from Our member services.

Cal-COBRA open enrollment or termination of another health plan

If You previously elected Cal-COBRA coverage through another health plan available through Your Group, You may be eligible to enroll in Oscar during your Group's annual open enrollment period, or if Your Group terminates its agreement with the health plan You are enrolled in. You will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA. Please ask Your Group for information about health plans available to You at open enrollment.

In order for You to switch from another health plan and continue your Cal-COBRA coverage with Us, We must receive Your enrollment application during your Group's

open enrollment period, or within 63 days of receiving the Group's termination notice described under "Group responsibilities." To request an application, please call Us at 1-855-672-2755. We will send You our enrollment application and You must return Your completed application before open enrollment ends or within 63 days of receiving the termination notice described under "Group responsibilities." If We approve Your enrollment application, We will send you billing information within 30 days after We receive Your application. You must pay the bill within 45 days after the date We issue the bill. You must send Us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

How you may terminate your Cal-COBRA coverage

You may terminate Your Cal-COBRA coverage by sending written notice, signed by the Subscriber, to the address below. Your membership will terminate at 11:59 p.m. on the last day of the month in which We receive Your notice. Also, You must include with Your notice all amounts payable related to your Cal-COBRA coverage, including Premiums, for the period prior to Your termination date.

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

Termination for Nonpayment of Cal-COBRA Premiums

If You do not pay your required Premiums by the due date, We may terminate Your membership as described in this section. If You intend to terminate Your membership, be sure to notify Us as described under "How you may terminate your Cal-COBRA coverage" in this "Cal-COBRA" section, as You will be responsible for any Premiums billed to You unless You let Us know before the first of the coverage month that You want Us to terminate Your coverage. Your Premium payment for the upcoming coverage month is due on the first day of that month. If We do not receive full Premium payment on or before the first day of the coverage month, We will send a notice of nonreceipt of payment (a "Late Notice") to the Subscriber's address of record. This Late Notice will include the following information:

- A statement that We have not received full Premium payment and that We will terminate the memberships of everyone in Your Family for nonpayment if We do not receive the required Premiums within 30 days after the date of the Late Notice
- The amount of Premiums that are due
- The specific date and time when the memberships of everyone in Your Family will end

if We do not receive the Premiums

If We terminate Your Cal-COBRA coverage because We did not receive the required Premiums when due, Your membership will end at 11:59 p.m. on the 30th day after the date of the Late Notice. Your coverage will continue during this 30 day grace period, but upon termination You will be responsible for paying all past due Premiums, including the Premiums for this grace period.

We will mail a Termination Notice to the Subscriber's address of record if We do not receive full Premium payment within 30 days after the date of the Late Notice. The Termination Notice will include the following information:

- A statement that We have terminated the memberships of everyone in Your Family for nonpayment of Premiums
- The specific date and time when the memberships of everyone in Your Family ended
- The amount of Premiums that are due
- Information explaining whether or not You can reinstate Your memberships
- Your appeal rights

If We terminate Your membership, You are still responsible for paying all amounts due.

Reinstatement of your membership after termination for nonpayment of Cal-COBRA Premiums

If We terminate Your membership for nonpayment of Premiums, We will permit reinstatement of Your membership three times during any 12-month period if We receive the amounts owed within 15 days of the date of the Termination Notice. We will not reinstate Your membership if You do not obtain reinstatement of Your terminated membership within the required 15 days, or if We terminate Your membership for nonpayment of Premiums more than three times in a 12-month period.

Termination of Cal-COBRA coverage

Cal-COBRA coverage continues only upon payment of applicable monthly Premiums to Us at the time We specify, and terminates on the earliest of:

- The date Your Group's Agreement with Us terminates (You may still be eligible for Cal-COBRA through another Group health plan)
- The date You get Medicare
- The date Your coverage begins under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition You may have (or that does contain such an exclusion or limitation, but it has been satisfied)

- The date that is 36 months after Your original COBRA effective date (under this or any other plan)
- The date Your membership is terminated for nonpayment of Premiums as described under "Termination for nonpayment of Cal-COBRA Premiums" in this section

Note: If the Social Security Administration determined that You were disabled at any time during the first 60 days of COBRA coverage, You must notify Your Group within 60 days of receiving the determination from Social Security. Also, if Social Security issues a final determination that You are no longer disabled in the 35th or 36th month of Group continuation coverage, Your Cal-COBRA coverage will end the later of: (1) expiration of 36 months after Your original COBRA effective date, or (2) the first day of the first month following 31 days after Social Security issued its final determination. You must notify Us within 30 days after You receive Social Security's final determination that You are no longer disabled.

Group responsibilities

If Your Group's agreement with a health plan is terminated, Your Group is required to provide written notice at least 30 days before the termination date to the persons whose Cal-COBRA coverage is terminating. This notice must inform CalCOBRA beneficiaries that they can continue Cal-COBRA coverage by enrolling in any health benefit plan offered by Your Group. It must also include information about benefits, premiums, payment instructions, and enrollment forms (including instructions on how to continue Cal-COBRA coverage under the new health plan). Your Group is required to send this information to the person's last known address, as provided by the prior health plan. We are not obligated to provide this information to qualified beneficiaries if your Group fails to provide the notice. These persons will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA.

Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty

If You, the Subscriber are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

- Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and

- You serve no more than four (4) years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Agreement will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Group the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of Coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

- Your coverage under this Agreement may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which active duty terminated.
- If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to Us for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one (1) year.

Conversion Right to a New Health Plan Contract After Termination

You have the right to convert to a new Health Plan contract if coverage under this Agreement terminates under the circumstances described below.

- Termination of the Group Health Plan Contract. If the Group Health Plan contract between Us and the Group is terminated as set forth in the Termination of Coverage section of this Agreement, and the Group has not replaced the coverage with similar and continuous health care coverage, whether insured or self-insured, You are entitled to purchase a new Health Plan contract as a direct payment member.
- If You Are No Longer Covered in a Group. If Your coverage terminates under the Termination of Coverage section of this Agreement because You are no longer a member of a Group, You are entitled to purchase a new Health Plan contract as a direct payment member.
- On the Death of the Subscriber. If coverage terminates under the Termination of Coverage section of this Agreement because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Health Plan contract as direct

payment members.

- Termination of Your Marriage. If a Spouse's coverage terminates under the Termination of Coverage section of this Agreement because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Health Plan contract as a direct payment member.
- Termination of Coverage of a Child. If a Child's coverage terminates under the Termination of Coverage section of this Agreement because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Health Plan contract as a direct payment member.
- Termination of Your Temporary Continuation of Coverage. If coverage terminates under the Termination of Coverage section of this Agreement because You are no longer eligible for Continuation of Coverage, You are entitled to purchase a new Health Plan contract as a direct payment member.

When to Apply for the New Health Plan Contract

If You are entitled to purchase a new Health Plan contract as described above, You must apply to Us for the new Health Plan contract within 60 days after termination of coverage under this Agreement. You must also pay the first Premium of the new Health Plan contract at the time You apply for coverage.

The New Health Plan Contract

We will offer You an individual direct payment Health Plan contract at each level of coverage (i.e., bronze, silver, gold or platinum) that Covers all benefits required by state and federal law. You may choose among any of the four (4) Health Plan contract offered by Us. The coverage may not be the same as Your current coverage.

CONTINUITY AND TRANSITION OF CARE

Oscar will provide written notice within a reasonable time of any termination or breach of contract by, or inability to perform of, any contracting Provider if the Member may be materially and adversely affected.

If a Member is in an ongoing course of treatment when their Provider leaves Oscar's Network, then the Member may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider until the services being rendered are completed, unless We can make reasonable and medically appropriate provisions for services by an In-Network Provider. If the Member is pregnant and in the second or third trimester, the Member may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for the Member to continue to receive Covered Services, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also agree to provide Oscar the necessary medical information related to the member's care and adhere to Our policies and procedures, including those for assuring quality of care, obtaining Authorization, Referrals, and a treatment plan approved by Oscar. If the Provider agrees to these conditions, the Member will receive the Covered services as if they were being provided by a Participating Provider. The Member will be responsible only for any applicable In-Network Cost-Sharing. If the Provider was terminated by Oscar due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

Your Dependents may be eligible for an extension of benefits if they incurred a total disability while enrolled in Our Plan.

Completion of Covered Services: Subject to the terms and conditions set forth below, at the request of a Member, We will pay benefits at the In-Network Provider level for Covered Services (subject to applicable Deductibles, Copayment and Coinsurance and other terms) rendered by a Provider whose participation We have terminated from Our network or by an Out-of-Network Provider to a newly covered Member who, at the time his or her coverage became effective, was receiving Covered Services from that Provider for one of the conditions described below.

In order to be eligible for the completion of Covered Services, the Member:

- Must be under the care of the In-Network Provider for one of the conditions described below, at the time of Our termination of the Provider's participation in Our network; or
- Must be a newly covered enrollee under an individual health care service plan contract whose prior coverage was terminated under paragraph (5) or (6) of subdivision (a) of Section 1365 of the Act , which includes circumstances when a health benefit plan is withdrawn from any portion of the market, and at the time his/her coverage became effective, he/she was receiving services from an Out-of-Network Provider for one of the conditions described below.

The terminated Provider must agree in writing to provide services to the Member in accordance with the terms and conditions of his/her agreement with Us prior to termination from Our network. The Provider must also agree in writing to accept the terms and reimbursement rates under his/her agreement with Oscar prior to termination from Our network. If the Provider does not agree with these contractual terms and conditions, We are not required to continue the Provider's services beyond the contract termination date.

The Out-of-Network Provider must agree in writing to be subject to the same contractual terms and conditions that are imposed upon current In-Network Providers providing similar Covered Services who are not capitated and who are practicing in the same or a similar geographic area as the Out-of-Network Provider. If the Out-of-Network Provider does not agree to comply or does not comply with these contractual terms and conditions, We are not required to continue the Provider's services. We are not required to continue the services of an Out-of-Network Provider if the Provider does not accept the payment rates provided for in this paragraph.

Such benefits will not apply to Providers who have been terminated due to medical disciplinary cause or reason, fraud or other criminal activity. Also, such benefits will not apply to a newly covered Member who is offered an Out-of-Network Provider option or to had the option to continue with his or her previous health plan or Provider and instead voluntarily chose to change health plans.

We will furnish such benefits for the continuation of services by an eligible terminated Provider or Out-of-Network Provider only for any of the following conditions:

- An acute condition. An acute condition is a medical condition that involves asudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services shall be provided for the duration of the acute condition.

- A serious chronic condition. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, as determined by Us in consultation with the Member and the terminated Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
- A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of Covered Services shall be provided for the duration of the pregnancy.
- A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) Year or less. Completion of Covered Services shall be provided for the duration of a terminal illness, which may exceed twelve (12) months from the Provider's contract termination date.
- The care of a Newborn child between birth and age thirty-six (36) months. Completion of Covered Services shall not exceed twelve (12) months from the Provider's contract termination date.
- Performance of a surgery or other procedure that We have authorized as part of a documented course of treatment and that has been recommended and documented by the Provider to occur within one-hundred eighty (180) days of the Provider's contract termination date.

If You would like information on the process or the policy and procedure for requesting completion of Covered Services, contact Member services at **1-855-672-2755**. Eligibility is based on the Member's clinical condition; it is not determined by diagnostic classifications. Continuation of care does not provide coverage for services not otherwise covered under the Agreement.

We will notify You as to whether or not Your request for continuation of care is approved. We will also notify the Provider if the request is approved. If approved, the Member will be financially responsible only for applicable Deductibles, Coinsurance and/or Copayments under this Agreement. Financial arrangements with terminated Providers are negotiated on a case-by-case basis. We will request that the terminated Provider agree to negotiate reimbursement and/or contractual requirements that apply to In-Network Providers, including payment terms. If the terminated Provider does not agree to the same reimbursement and/or contractual requirements, We are not required to continue that Provider's services. If You disagree with Our determination regarding continuation of care, please refer to the section titled

INDEPENDENT MEDICAL REVIEW.

COORDINATION OF BENEFITS

The following definitions are applicable to this "**COORDINATION OF BENEFITS** section only. For all other defined terms, please refer to the **DEFINITIONS** section.

- Plan means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by (i) group, blanket or franchise insurance coverage, (ii) service plan contracts, group practice, individual practice and other prepayment coverage, (iii) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (iv) any coverage under governmental programs, and any coverage required or provided by any statute. The term "Plan'' shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.
- This Plan' means that portion of this contract which provides the benefits that are subject to this provision.
- Allowable Expense' means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.
- Claim Determination Period means a calendar year.

We Coordinate Benefits when a Member is covered by more than one medical or dental contract. All of the benefits provided under this Group Health Plan Contract are subject to this provision. You must comply with any request to provide Us with certain information in relation to any Coordination of Benefits.

If you are covered under an Oscar-issued individual policy and an Oscar-issued small group policy, the Oscar-issued small group policy is the primary payer

Payments for Allowable Expenses will be coordinated between Plans up to the maximum benefit amount payable by each Plan separately, never to exceed 100% of Allowable Expenses. In determining which Plan will pay, one Plan is determined to be "primary," while another is "secondary."

Coordination of Benefits will be determined as outlined in California Code of Regulations, Title 28, Section 1300.67.13, including as follows:

- Any Plan without a Coordination of Benefits provision will always provide its benefits

first ("primary"). Otherwise, the Plan covering the Member other than as a Dependent (e.g. as an employee) will provide its benefits before the Plan covering the Member as a Dependent.

- The Benefits of a Plan covering the Member as a Dependent of a person whose date of birth (month and day) occurs earlier in a calendar year, are determined before the benefits of a Plan covering the Member as a Dependent of a person whose date of birth (month and day) occurs later in a calendar year (except in the case of a Dependent Child whose parents are separated or divorced).
- Coordination of Benefits for Dependent Children whose parents are separated or divorced:
    - If there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, the benefits of a Plan which covers the child as a Dependent of the parent with such financial responsibility will be primary.
    - If the parent with custody of the Dependent Child has not remarried, the Plan which covers the child as a Dependent of the parent with custody of the child is primary.
    - If the parent with custody of the child has remarried, the Plan which covers the child as a Dependent of the parent with custody is primary before the benefits of a Plan which covers that child as a dependent of the stepparent, and the Plan which covers that child as a Dependent of the stepparent is primary before the Plan which covers that child as a Dependent of the parent without custody.
- If the above rules do not apply, the Plan which has covered the Member for the longer period of time is primary (subject to exceptions for laid-off or retired employees).
- If You have Medicare coverage, We will coordinate benefits under all applicable rules.

Right of Recovery

Whenever payments have been made by Oscar with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time there been a Coordination of Benefits, We will have the right to recover such payments, to the extent of such excess.

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 Group 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 Group, 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 Group 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 contact 1-855-672-2755.

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:

- The Billing for services that were not performed
- Using 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're 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:

Attn: Special Investigations Unit
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.

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.

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: Member Services
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

- 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 **DEFINITIONS** section; and
- Covered Services received at an In-Network Facility, at which, or as a result of which, the Member receives Covered Services from an Out-of-Network Provider. 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:

- Services received by an out-of-network provider as a result of a medical emergency, urgent care or an authorized referral as defined in the **DEFINITIONS** section and
- Covered services received at an in-network facility, at which, or as a result of which, the member receives covered services from an out-of-network provider. 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 1-855-672-2755. This Procedure is not to be used as a substitute for the grievance procedure, complaints, inquiries or requests for information.

Public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity, and convenience of patients who rely on the plan's facilities to provide health care services to them, their families, and the public (California Health and Safety Code, Section 1369).

Oscar Health Plan of California is establishing a standing committee which shall be responsible for creating the public policy of the plan. The standing committee's recommendations and reports will be regularly reported to the governing board. The governing board shall consider the recommendations of the standing committee and record any action taken, in its minutes. Upon request, Oscar will provide Members who have initiated a public policy issue with the appropriate extracts of the minutes within thirty (30) business days after the minutes have been approved.

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 **1-855-672-2755** 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.

Recovery of Overpayments

On occasion, a payment will be made to You in error, such as a payment made when You are not covered; a payment made for a service that is not covered; or a payment made for more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after

receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

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 otherwise stated elsewhere in this Agreement.
- This Agreement, including all terms, benefits, conditions, limitations and exclusions, may be changed by Us as provided in the section titled **RIGHT TO MODIFY OR CHANGE THE AGREEMENT.**
- The benefits to which You may be entitled will depend on the terms of coverage asset 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 forty-five (45) working days after We receive a complete written proof of loss and determination that benefits are payable. A claim together with all additional information reasonably necessary to determine Our obligation under this Agreement and reasonable access to information concerning Provider services is required. Information necessary to determine Our obligation under this Agreement claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for Us to determine the Medical Necessity for the health care services provided.

Incentive Program

We may offer incentives to Members who participate in programs that help reduce Our administrative expenses; make retaining coverage more convenient; educate Members; or provide input on Oscar and its products. Such programs may include paying Premiums electronically instead of receiving a paper bill; learning more about health insurance and/or specific Oscar Plan features; participating in surveys about Oscar and its network, products and services; discounts for paying medical bills through Oscar's Member portal; and scheduling a provider through the Oscar portal. We may also offer giveaways and

discounts to Members, such as discounts on select vendor partner products and services. The products and services available under this program are not Covered Services under the Plan. As such, program features are not guaranteed under the Plan 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.

Wellness Program

The purpose of the wellness program is to encourage You to take a more active role in managing Your health and well-being. Throughout the course of the year, We may provide incentives in connection with the use of or participation in wellness and health promotion actions and activities, including but not limited to: a health risk assessment tool, health risk assessment visits, a designated smoking cessation program, a designated weight management program, self-management of chronic diseases, self-management of follow-up care, use of Oscar-designated high-value providers, obtaining preventive care, one annual wellness exam per adult Member, per Plan year through an In-Network Oscar-designated Telehealth Provider or through an in-home health assessment facilitated by Oscar, and a designated health or fitness program (such as step tracking).

Rewards for participation in the wellness program may include but are not limited to the waiver or reduction of Copayments, Coinsurance, or Deductibles; full or partial reimbursement of the cost of participating in smoking cessation or weight management programs; payment for care-adjacent services that directly address social determinants of health, such as transportation to medical visits, or food costs; and monetary rewards and financial incentives in the form of gift cards. We encourage You to use Your gift card for a product or service that promotes good health, such as healthy cookbooks, over-the-counter vitamins or exercise equipment. Based on the terms of the program being offered, You (the Subscriber), and in some cases, Your Dependent(s) 18 years of age or older can receive rewards. You are responsible for any taxes related to the redemption of rewards. For more information, visit Our website at www.hioscar.com or call Us at 1-855-672-2788. Oscar is committed to helping you achieve your best health. If you think you might be unable to participate in this program, you might qualify for an opportunity to earn the same reward in a different way. Contact Your Customer Service team at 1-855-672-2788 and We will work with you (and, if you'd like, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. Our wellness program and any products and services available under this program are not Covered Services under the Plan.

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 the section titled **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 member services at **1-855-672-2755**, or You may write to Us at:

Oscar Health Plan of California
Attn: Member Services
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

Please refer to the COMPLAINTS AND GRIEVANCE section to see a full description of grievance rights.

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

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

Our member services staff will answer Your questions or assist You in resolving Your issue.

If You are dissatisfied and wish to file a grievance, You may request a copy of the grievance form to complete and return to Us. You may also ask the member services representative to complete the form for You over the telephone. You may also submit a grievance form online in the "Members" section at www.hioscar.com. You must submit Your grievance to Us no later than one-hundred eighty (180) days following the date You receive a denial notice or any other incident or action with which You are dissatisfied. You must include all pertinent information from Your identification card and the details and circumstances of Your concern or problem. Upon receipt of Your grievance, Your issue will become part of Our formal grievance process and will be resolved accordingly.

All grievances received by Us will be acknowledged in writing within five (5) days. We will send You a confirmation letter within five (5) days after We receive Your grievance. After We have reviewed Your grievance, We will send You a written statement on its resolution or pending status. If Your case involves an imminent and serious threat to Your health including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, You have the right to request an expedited review of a grievance. Expedited grievances must be resolved within three (3) days.

If You are dissatisfied with the resolution of Your grievance, or if Your grievance has not been resolved after at least thirty (30) days, You may submit Your grievance to the Department of Managed Health Care. For review prior to binding arbitration, see the section "Department of Managed Health Care." If Your case involves an imminent and serious threat to Your health, as described above, You are not required to complete our grievance process, but may immediately submit Your grievance to the Department of Managed Health Care for review.

You may at any time pursue Your ultimate remedy, which is binding arbitration. See the sections titled **INDEPENDENT MEDICAL REVIEW**, and **BINDING ARBITRATION**.

INDEPENDENT MEDICAL REVIEW

If a Member has had coverage denied because proposed treatment is determined to be Investigational or Experimental, that Member may ask for review of that denial by an external, independent medical review organization contracting with the Department of Managed Health Care. A request for review may be submitted to the Department of Managed Health Care in accordance with the procedures described under "**INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE**."

To qualify for independent medical review for Investigational or Experimental Treatment, all of the following conditions must be satisfied:

- The Member has a life-threatening or seriously debilitating condition
    - A life-threatening condition is a condition or disease where the likelihood of death is high unless the course of the condition or disease is interrupted and/or a condition or disease with a potentially fatal outcome where the end-point of clinical intervention is survival.
    - A seriously debilitating condition is a disease or condition that causes major, irreversible morbidity.
- The Member's Physician certifies that the Member has a life-threatening or seriously debilitating condition which:
    - Standard therapies have not been effective in improving the condition of the Member, or
    - Standard therapies would not be medically appropriate for the Member, or
    - There is no more beneficial standard therapy covered by the plan than the therapy proposed, and
    - Who has provided the supporting evidence.
- The proposed treatment must be recommended by the Member, an In-Network Physician, or a board certified or a board certified or board eligible Physician qualified to treat the Member, who has certified in writing that the proposed treatment is likely to be more beneficial to the Member than available standard therapy.
- If independent medical review is requested by the Member or by a qualified Out-of-Network Physician, as described above, the requester must supply two (2) items of acceptable medical and scientific evidence (as defined below).

Within three (3) business days of Our receipt from the Department of Managed Health Care of a request by a qualified Member for an independent medical review (and within twenty-four (24) hours of approval of the request for review involving an imminent and serious threat to the health of the Member), the independent medical review organization designated by the Department will be provided with:

- A copy of all relevant medical records and documents for review with information pertaining to:
    - The enrollee's medical condition
    - The health care services being provided by the plan and its contracting providers for the condition.
    - The disputed health care services requested by the enrollee for the condition
    - any information submitted by the Member or the Member's Physician.
    - Additionally, any newly developed or discovered relevant medical records identified after the initial documents are provided will immediately be forwarded to the independent medical review organization.
- A copy of all information provided to the enrollee by the plan and any of its contracting providers concerning plan and provider decisions regarding the enrollee's condition and care, and a copy of any materials the enrollee or the enrollee's provider submitted to the plan and to the plan's contracting providers in support of the enrollee's request for disputed health care services
- A copy of any other relevant documents or information used by the plan or its contracting providers in determining whether disputed health care services should have been provided, and any statements by the plan and its contracting providers explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity

The independent medical review organization will render its determination within thirty (30) days of the request (if the Member's Physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the analyses and recommendations of the experts on the panel shall be rendered within three (3) days of the request for expedited review), except the reviewer may ask for three (3) more days if there was any delay in receiving the necessary records.

"Acceptable medical and scientific evidence" means the following sources:

- Peer reviewed scientific studies published in medical journals with national recognized standards;
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the Social Security Act;
- The American Hospital Formulary Service's-Drug Information and the American Dental Association Accepted Dental Therapeutics;
- Any of the following reference compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
    - The Elsevier Gold Standard's Clinical Pharmacology.
    - The National Comprehensive Cancer Network Drug and Biologics Compendium.
    - The Thomson Micromedex DrugDex.

- Medical literature meeting the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, MEDLARS database Health Services Technology Assessment Research;
- Finding, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
- Peer reviewed abstracts accepted for presentation at major medical association meetings.

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE

You may request an independent medical review (IMR) of disputed health care services from the Department of Managed Health Care (DMHC) if You believe that a health care service has been improperly denied, modified, or delayed. A "disputed health care service" is any health care service eligible for coverage and payment under Your plan that has been denied, modified, or delayed, in whole or in part, because the service is not Medically Necessary. IMR is also available for any "disputed health care service" offered as part of Your pediatric dental benefits, pediatric vision benefits and acupuncture benefits offered under this Plan.

The IMR process is in addition to any other procedures or remedies that may be available to You. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. You must be provided with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause You to forfeit any statutory right to pursue legal action against Us regarding the disputed health care service.

Eligibility

The DMHC will review Your application for IMR to confirm that:

- At least one of the following has occurred:
  - Your Provider has recommended a health care service as Medically Necessary, or
  - You have received Urgent Care or Emergency Services that a Provider determined was Medically Necessary, or
  - You have been seen by an In-Network Provider for the diagnosis or treatment of the medical condition for which You seek independent review;
- The disputed health care service has been denied, modified, or delayed based in whole or in part on a decision that the health care service is not Medically Necessary; and
- You have filed a grievance with Us and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If Your grievance requires expedited review You may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that You follow Our grievance process in extraordinary and compelling cases.

If Your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the care is Medically

Necessary. You will receive a copy of the assessment made in Your case. If the IMR determines the service is Medically Necessary, We will provide benefits for the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within thirty (30) days of receipt of Your application and supporting documents. For urgent cases involving an imminent and serious threat to Your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of Your health, the IMR organization must provide its determination within three (3) business days.

For more information regarding the IMR process, or to request an application form, please call Our member services department toll free at **1-855-672-2755**.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If You have a grievance against Your health plan, You should first telephone Your health plan at **1-855-672-2755** and use Your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to You. If You need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by Your health plan, or a grievance that has remained unresolved for more than thirty (30) days, You may call the department for assistance. You may also be eligible for an independent medical review (IMR). If You are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for Emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-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** section. 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

SERVICE AREA

Los Angeles County
The following ZIP codes are inside our Service Area:

90001, 90010, 90019, 90028, 90037, 90046, 90055, 90064, 90073, 90082, 90093, 90201, 90222, 90241, 90255, 90270, 90292, 90305, 93243, 90408, 90506, 91305, 91321, 91331, 91344, 91356, 91376, 91615, 91402, 91411, 91495, 91606, 91616, 90002, 90011, 90020, 90029, 90038, 90047, 90056, 90065, 90074, 90083, 90094, 90202, 90223, 90242, 90260, 90272, 90293, 90306, 91410, 90409, 90507, 91306, 91322, 91333, 91345, 91357, 91380, 91390, 91403, 91412, 91496, 91607, 91617, 90003, 90012, 90021, 90030, 90039, 90048, 90057, 90066, 90075, 90084, 90095, 90209, 90224, 90245, 90261, 90274, 90294, 90307, 90401, 90410, 90508, 91307, 91324, 91334, 91346, 91372, 91381, 91392, 91404, 91413, 91362, 91608, 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

The following ZIP codes are inside our 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

APPENDIX I – MEMBER RIGHTS AND RESPONSIBILITIES

As a Member, You have certain rights and responsibilities when receiving Your health care. You also have a responsibility to take an active role in Your care. As Your health care partner, We are committed to making sure Your rights are respected while providing Your health benefits. That also means giving You access to Our Network Providers and the information You need to make the best decisions for Your health and welfare.

These are Your Rights and Responsibilities

You have the right to:

- Speak freely and privately with Your doctors and other Health Providers about all health care options and treatment needed for Your condition. This is no matter what the cost or whether it is covered under Your Plan.
- Work with Your doctors in making choices about Your health care.
- Be treated with respect and dignity.
- Expect Us to keep Your personal health information private. This is as long as it follows State and federal laws and Our privacy policies.
- Get the information You need to help make sure You get the most from Your health Plan, and share Your feedback. This includes information on:
    - Our company and services,
    - Our network of doctors and other health care Providers,
    - Your Rights and Responsibilities,
    - The rules of Your health care Plan,
    - The way Your health Plan works.
- Make a complaint or file an appeal about:
    - Your health care Plan,
    - Any care You receive,
    - Any Covered Service or benefit ruling that Your health care Plan makes.
- Say no to any care, for any condition, sickness or disease, without it affecting any care You may get in the future. This includes the right to have Your doctor tell You how that may affect Your health now and in the future.
- Get all of the most up-to-date information from a doctor or other health care Provider about the cause of Your illness, Your treatment and what may result from that illness or treatment from it. If You don't understand certain information, You can choose a person to be with You to help You understand.

You have the responsibility to:

- Read and understand, as well as You can, all information about Your health benefits or ask for help if You need it.
- Follow all health care Plan rules and policies.

- Choose a network Primary Care Physician (doctor), also called a PCP, if Your health Plan requires it.
- Treat all doctors, health care Providers and staff with courtesy and respect.
- Keep all scheduled appointments with Your health care Providers. Call their office if You may be late or need to cancel.
- Understand Your health problems, as well as You can and work with Your doctors or other health care Providers to make a treatment plan that You all agree on.
- Tell Your doctors or other health care Providers if You don't understand any type of care You're getting or what they want You to do as part of Your care plan.
- Follow the care plan that You have agreed on with Your Doctor and other health care Providers.
- Give Us, Your doctors and other health care Providers the information needed to help You get the best possible care and all the benefits You are entitled to. This may include information about other health and insurance benefits You have in addition to Your coverage with Us.
- Let Our member services department know if You have any changes to Your name, address or family members covered under Your Plan.

We are committed to providing high quality benefits and member services to Our Members. Benefits and coverage for services provided under the benefit program are overseen by the Subscriber Agreement (Your signed benefit contract) and not by this Member Rights and Responsibilities statement. The Subscriber Agreement will be provided to You by Us upon Your request.

If You need more information, or would like to contact Us, please go to www.hioscar.com and select Member Support > Contact Us, or call member services at **1-855-672-2755**.