



2027

Oscar Health Provider Manual

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Introduction

Overview

Welcome to Oscar Health and its affiliate insurers (collectively, “Oscar”). We think health insurance should be smart, simple, and friendly. That’s why we built Oscar, and we’re so glad to be working with you. Our goal is to change the way Providers and consumers interact with healthcare by using technology, design, and data. This manual explains Oscar’s policies and procedures for Providers. It also explains important administrative and regulatory requirements. Use this manual together with your Provider Agreement and any State Specific Supplement that applies to you, which are available on our website: <https://www.hioscar.com/for-providers/resources>.

This Manual applies to Covered Services you provide to Oscar members. It covers members enrolled in Oscar Insurance plans or plans that Oscar manages, unless stated otherwise. We update this manual regularly to support our healthcare Providers, so its contents change over time.

Our Philosophy

Great health insurance starts with a strong network. We partner with Providers and health systems to improve healthcare. We want to make it easier for you to manage your practice and care for members. Oscar is here when you need us.

Terms and definitions as used in this guide

Terms in this Manual have the meanings in your Provider Agreement unless otherwise defined below.

- “Covered Services” means those Medically Necessary health care services covered under the terms of a Member’s Benefit Plan and subject to each Benefit Plan’s limitations and exclusions.
- “Enrollee” refers to anyone covered under the health insurance contract.
- “Law” means any statute, code, regulation, rule, court order or mandate, or sub-regulatory guidance issued by a federal, state, or local governmental authority which has jurisdiction over the Agreement.
- “Member” means an individual enrolled in a Benefit Plan as of the date the Covered Services are provided.
- “Oscar” refers to Oscar Health, Inc. and its affiliate insurers.
- “Provider Manual” or “Manual” refers to this document, which should be read in conjunction with your Agreement, Law, and State Specific Supplement(s), if applicable, in the state(s) in which you service Oscar members.
- “Provider Portal” refers to Oscar’s dedicated online platform for Providers.



- “Us,” “We” or “Our” refers to Oscar.
- “You,” “Your” or “Provider” refers to any health care Provider subject to this Manual.
- “Your Agreement,” “Provider Agreement” or “Agreement” refers to your Participation Agreement with Oscar.
- “Policies” and “Protocols.” Policies are those requirements used by Oscar for things such as calculating and approving payment to Providers. Protocols are those programs and administrative requirements adopted by Oscar concerning the provision of providing services to members and doing business with Oscar. Per your Agreement, you must comply with Oscar’s Policies and Protocols. Payment may be denied, in whole or in part, for failure to comply with a policy, and your Agreement may be terminated for failure to abide by Oscar’s protocols. Updates regarding a policy, protocol, product, or reimbursement change are posted online at provider.hioscar.com/resources and subject to notification requirements in your Agreement.

Please note that should any conflict exist between this Provider Manual and your Agreement’s state program requirements, your Agreement’s state program requirements will control for those benefit plans covered by that regulatory exhibit. In addition, should any conflict exist between your Agreement and this Provider Manual, your Agreement will control unless the Provider Manual contains specific Oscar benefit plan administrative and clinical requirements applicable to services provided to an Oscar member. Any failure to follow specific benefit plan requirements set forth in this Provider Manual may result in either a delay or denial of payment.

If you ever have questions, please do not hesitate to reach out to us. We look forward to working together!



Our Products Referenced in this Manual

Use the product table to confirm which Oscar qualified health plans are subject to this manual. For plan-specific rules, check the applicable State specific supplement.

Oscar qualified health plans subject to this Manual:

HMO Plans Offered		
Product Type	States Offered	OON Coverage
HMO	AZ, GA, NC, OH, PA, IL**, TX**, MS, FL, OK, SC	No*
EPO Plans Offered		
Product Type	States Offered	OON Coverage
EPO	FL (Off-Ex only), IA, KS, MI, MO, NE, NJ, NY, TN, TX, VA, AL	No*
PPO Plans Offered		
Product Type	States Offered	OON Coverage
PPO	OK (Off-Ex only)	Yes
*Emergency room care and transportation by an Out-of-Network Provider is covered if the services are for an emergency condition. ** Plan specific guidance is set forth in the State Supplement as applicable.		

Resources

Welcome to the Oscar family. Questions? We're here to help.

Resource	Contact / Access Information
Provider Services, and other general information	(855) 672-2755, option 4 <i>Provider Services Hours:</i> Mon-Fri, 8:00am-6:00pm (local time across markets)
Utilization Management	(855) 672-2755, option 4 <i>Utilization Management Hours:</i> Mon-Fri, 8:00am-5:00pm (local time across markets)
Oscar's Website: Provider Overview	https://www.hioscar.com/for-providers

Resources Site

Use Oscar's Provider Overview and Provider Resources pages to find tools, forms, policies, and training materials. These pages can help your team spend less time on administration and more time caring for patients.

On the Provider Overview page - <https://www.hioscar.com/for-providers> you can search the Provider directory, log in to the Provider Portal, and request to join Oscar's network.

Provider Resources - Tools to support your patients at

<https://www.hioscar.com/for-providers/resources>:

- o Oscar's Provider Manual
- o State Supplements for Ohio, Texas, and Illinois
- o Clinical guidelines: Medical and Pharmacy
- o Provider Forms: Claims Disputes, Clinical Appeals, Claims-Related Documents
- o Provider Quick Start: Get Started with Oscar

Search our drug Formulary: <https://www.hioscar.com/search-documents/drug-formularies/> to find out what medications Oscar covers.

Portal Tasks

Oscar Portal

Connect staff to your Provider Portal account and give them the permissions they need. Once your account is set up, you can use the Portal to complete common tasks online:

- Check member eligibility
- Check status of claims



- Submit claim documents and disputes
- Submit referrals electronically
- Edit your Provider data information
- Review members' clinical information

Availity Essentials Portal

Use Availity Essentials to check whether authorization is required, submit prior authorization requests, check authorization status, and use Availity payer-space workflows and quick links for support.

Our Providers

Provider Orientation and Training

Oscar will send contracted Providers and Provider organizations a Provider Welcome Kit. New Providers and Provider organizations should attend Oscar's New Provider Orientation. You can find dates and register on the Provider Quick Start page:

<https://www.hioscar.com/for-providers/provider-quick-start>.

Provider's Notification of Important Changes

Oscar is committed to providing our members with accurate Provider information. You are required to send Oscar an updated roster every 30 calendar days. This is to help Oscar keep your name, address, phone number, specialty, accepting-new-patients status, and other directory information current.

Oscar must keep accurate Provider directory information so members can access care. Please tell Oscar about changes to your practice, office, or Provider entity as early as possible. Oscar is required to have accurate Provider directory information to ensure that our members have access to care under their benefit.

Every quarter, you or your delegate must review, update, and attest to the Provider information available to members. If the information is wrong, correct it in the Provider Portal or send an updated roster. Tell Oscar about changes at least 30 calendar days before they take effect. You must submit changes through Oscar's Provider portal or by sending updated rosters.

- You can find our most up-to-date Provider information by searching our online directory at <https://www.hioscar.com/search/networks>.
- Provider roster updates should be submitted to rosters@hioscar.com.



Information Subject to Accuracy Requirements

You or your delegate(s) must keep the following Provider information accurate and up to date.

- Patient acceptance status
- Address(es) of practice location(s)
- Office phone number(s)
- FAX number
- Email address(es)
- Health care Provider groups affiliation
- Facility affiliation
- Specialty
- License(s)
- Tax identification number (TIN) including W-9 form
- National Provider Identifier (NPIs)
- Languages spoken/written by staff
- Ages/genders served
- Office hours
- Americans with Disabilities Act Accessible
- Use of telehealth by office
 - For telehealth, tell Oscar whether you offer telehealth or telemedicine, which services you offer this way, and whether you can include a family caregiver in a different location with the patient's consent.

Invalid Information and/or Practice Inactivity

Oscar may contact you to confirm your demographic information and whether you accept new patients. Please respond promptly. If Oscar cannot confirm required information, Oscar may take the actions listed below, in addition to any rights in the Provider Agreement.

- Administratively terminate a Participation Agreement or a Participating Provider if there have not been claims submitted for over 1 year.
- Deactivate any Tax Identification Number (TIN) under which no claims there have been submitted for 1 year.
- Terminate or inactivate a practitioner when a practice or facility tells us of a practitioner leaving a practice. Oscar will make multiple attempts to get documentation of that change.

Oscar may also administratively terminate a Participating Provider if:

- Oscar receives notice that a practitioner with the Participating Provider is no longer with the practice.



- Oscar makes at least 3 attempts to obtain documentation confirming the practitioner's departure with the Participating Provider but does not receive the requested documentation.
- The practitioner has not submitted claims under that practice's TIN(s) for 6 months prior to our receipt of oral notice the practitioner left the practice, or the effective date of departure provided to Oscar, whichever is sooner.
- The physical address of the Participating Provider is determined to be invalid.

Access to Care

Overview

Oscar is dedicated to give members access to high-quality Providers and strong network coverage. Oscar will work with members and Providers so members can get appropriate, timely, and continued care. Providers may discuss all treatment options with patients, regardless of benefit coverage limitations. Encourage members to call Oscar about benefit coverage.

Availability Standards

Oscar follows applicable state and federal laws, CMS policies, regulations, and National Committee for Quality Assurance (NCQA) guidelines for network access. As a Qualified Health Plan (QHP), Oscar has adopted quantifiable and measurable network access standards consistent with the Center for Medicare and Medicaid Services (CMS) policies, applicable state regulations, and NCQA guidelines.

These standards cover appointment timeliness, preventive care, routine primary care, specialty care, urgent care, emergency care, after-hours care, and office wait times. Providers must offer Oscar members appointment access and office wait times comparable to other commercial members. PCPs must make medical guidance available to Oscar members 24 hours a day, 7 days a week for urgent needs. If your office is closed, have a process for urgent calls. If you use a substitute Provider, use an in-network Provider for the member's benefit plan. In-network Providers are listed in Oscar online directory.

Office Appointment Standards

Type of Service	Appointment Requirement
Behavioral Health initial routine care	Within 10 business days
Behavioral Health urgent care	Within 48 hours
Behavioral Health non-life-threatening emergency care	Within 6 hours

Type of Service	Appointment Requirement
Behavioral Health initial routine care	Within 10 business days
Preventative care	Within 15 business days
Regular or routine care	Within 15 business days
Specialty care (non-urgent)	Within 30 business days
Urgent care	Same day
Emergency care	Immediate
After hour services	24 hours/ 7 days a week for Primary Care Providers (PCP)

These standards are general guidelines. State or federal rules, including Qualified Health Plan rules, may require faster appointment access.

Message recording suggestions for after hour messages

For urgent needs that cannot wait until the next business day, your message may tell members to go to an in-network urgent care center, stay on the line for the on-call physician, leave a name and phone number for a call back, or call another phone or pager number.

For members with medical emergencies, direct the caller to hang up and dial 911 or local equivalent, or the caller may be directed to the nearest emergency room.

For Members with non-medical emergencies but urgent need

- If the medical need cannot wait until the next business day, the member may be advised to go to a network urgent care center; or, if available,
- The member may be directed to stay on the line to connect to the physician on call; or
- The member may be directed to leave a name and number with your answering service (if applicable) for a physician or qualified health care professional to call back within specified time frames; or
- The member may be directed to call an alternative phone or pager number to contact you or the physician on call.

Panel Opening and Closing

Participating Providers are required to keep panels open to Oscar members, when possible. If you must close a panel because of panel size, give Oscar written notice at least sixty (60) days' before closing it. When you reopen the panel, notify Oscar within forty-eight (48) hours.

Referrals

Some benefit plans require referrals for specialist visits. The member's primary care Provider (PCP), or another PCP allowed by the member's benefit plan, must submit the referral. Check the member's plan details and State Specific Supplement to confirm referral requirements. Referrals may be submitted and viewed on our portal at <https://www.hioscar.com/for-providers/resources>.

Primary Care Providers and Referrals

A PCP may be a family practitioner, pediatrician, internist, general practitioner, nurse practitioner, obstetrician, or physician assistant, as allowed by state law. In plans that require PCP referrals, the PCP oversees referrals for specialty or facility care. Authorizing an Out-of-Network Provider

Coverage of out-of-network services requires prior authorization to determine the medical necessity of the services, and an Out-of-Network exception approval that confirms eligibility for an exception under the member's benefit plan. If either the prior authorization or the exception is not received and/or approved, any services rendered by the out of network Provider will not be covered. Prior authorization medical necessity determinations and Out-of-Network exception determinations will be communicated separately, and both are required before Out-of-Network care is approved.

Out-of-Network Provider Submission Guidelines and Procedures

When an out-of-network Provider is requested for a member's specific medical needs, Oscar allows members to request approval for out-of-network care. All requests must follow the intake procedures outlined in this section. The Out-of-Network Authorization and Exception Form for all Out-of-Network service requests is mandatory and must be completed for the request to be considered.

Submission Request

- Oscar recommends that Providers submit this form for the member to make sure all needed medical details are included.
- The Out-of-Network Exception Form asks for specific details about the request, such as past efforts to find an in-network doctor and the medical or practical reasons for using an out-of-network Provider.

Submission Guidelines & Delays

- If you do not include this form with your initial request, the decision will remain on hold until we receive and process the completed form.
- Get forms and instructions online at hioscar.com/forms.

All submissions must adhere to the documentation standards procedures outlined in this section.

- Approvals are based on the medical necessity of the service and eligibility.
- Out-of-Network exceptions are considered only when there is no availability in Oscar's network of an in-network Provider with the appropriate experience to provide the requested service in a timely manner.
- Other qualifying exceptions may include Continuity of Care and Transition of Care, subject to Oscar's policies.
- Approvals will not be made for reasons of convenience for either the member or the Provider.
- Oscar may not approve the specific Out-of-Network Provider requested.
- Requested services performed by the Out-of-Network Provider are subject to a treatment plan approved by Oscar in consultation with the member and the Out-of-Network Provider.
- Services rendered by the Out-of-Network Provider will be paid as if they were provided by an in-network Provider, and members are responsible for any applicable in-network cost-sharing.

Continuity and Transition of Care

Oscar understands that when Providers leave the network or are terminated from the plan (Continuity of Care) or when members first join Oscar and their current Provider(s) are not in-network (Transition of Care), members may require coverage for a period of time to ensure continuity or transition of treatment. As such, qualifying members may be able to continue ongoing treatment for Covered Services. The Out-of-Network Authorization and Exception Form for all Out-of-Network service requests is mandatory and must be completed for the request to be considered.

Continuity and Transition of Care Submission Guidelines and Procedures

- Continuity of Care or Transition of Care must be authorized prior to service.
- For Continuity of Care requests, Providers previously in-network must accept the negotiated fee rate active prior to termination.
- The Provider must provide Oscar with necessary clinical information related to the member's care.
- The Provider must adhere to Oscar's policies and procedures, including those for assuring quality of care, obtaining preauthorization, authorization, and a treatment plan approved by Oscar.



If a Provider was terminated by Oscar due to fraud, possible imminent harm to patients, or final disciplinary action by a state board or agency, continued treatment with that Provider is not available.

Oscar's Commitment to Cultural Competency

Cultural competency means providing high-quality care that respects a member's social, ethnic, religious, disability, and language needs. These needs can affect how members receive care and their health outcomes. Oscar is committed to ensuring that our members are treated with dignity and respect and that their cultural needs and preferences are considered when interacting with Providers.

Differences in culture, identity, language, disability status, and life experience can affect how members communicate, understand care instructions, and follow medical advice. Provider education and/or training on cultural and identity differences can not only accomplish the goal of culturally sensitive care, but can also help address ethnic and other disparities in healthcare in support of attaining greater health equity. Moreover, knowledge of, and sensitivity to, cultural and/or sexual orientation and disability status can impact the way members communicate their medical needs, and how physicians, nurses or other healthcare Providers can enhance diagnosis and treatment.

Cultural Competency Resources and Training

Oscar strives to offer Providers the resources they need to deliver high-quality, culturally sensitive services, and encourages all Providers to further their training and skill sets by reviewing the offered resources.

The U.S. Department of Health and Human Services (HHS) - offers free e-learning modules on culturally and linguistically appropriate services. Providers can use these modules to improve communication with members who have language, cultural, or ethnic preferences. The e-learning modules can be found at: [https:// thinkculturalhealth.hhs.gov/education](https://thinkculturalhealth.hhs.gov/education) or by visiting the HHS web homepage and searching for keyword "education".

Understanding & Adhering to Culturally and Linguistically Appropriate Services Standards

Contracted Providers must follow state and federal requirements that align with Culturally and Linguistically Appropriate Services (CLAS) principles. Culturally and Linguistically Appropriate Services (CLAS). By familiarizing themselves with these regulations and adhering to the CLAS standards, Providers can promote equity, improve patient outcomes, and reduce health disparities among diverse populations.



For more information on CLAS standards, visit the [HHS web homepage](#) and search for keyword “CLAS,” or visit the web links below:

- CLAS Standards: [CLAS Standards - Think Cultural Health](#)
- General CLAS Information: [National CLAS Standards](#)

Language Assistance for Limited English Proficiency

Oscar assesses a member's language needs. Oscar provides access to translation and interpretation services for medical services, customer service, and health plan administration documents as needed and according to state regulations. Oscar also provides translated or alternative-format documents when needed. This option is inclusive of visually and hearing impaired members. Members requiring translation or interpreter services can contact Oscar's Member Services at 1-855-672-2755 (Option 2) to access, free of charge, Oscar's language services.

Language Assistance Services for Members

Oscar provides language help to members with limited English proficiency (LEP). Services include:

1. **Qualified Interpreter Services:** Available at no cost to our members, we provide access to qualified interpreters via telephone or video for effective communication between healthcare Providers and LEP members.
2. **Document Translations:** Oscar offers translation services for vital documents and healthcare materials to help LEP members understand their healthcare options and make informed decisions.
3. **Bilingual Staff:** We employ bilingual Care Guides who can provide assistance to our LEP Spanish-speaking members in their preferred language.
4. **Language Data:** Practitioners will have access to detailed information about the language patterns of Oscar's population or service area. Providers can send a request to translations@hioscar.com to receive this data. Requests will be completed within 21 calendar days.

Please note: The language assistance services mentioned above are accessible to our contracted Providers as part of their partnership with Oscar. Providers seeking language assistance should call 1-855-672-2755 (Option 4) to obtain information on how to access these services. Our dedicated support team will guide Providers through the process and ensure they have the



necessary resources to communicate effectively with LEP members. This approach helps us maintain a high level of service and support for both our Providers and members.

Compliance with Language Assistance Regulations

Providers must follow state and federal language-assistance guidelines for LEP members.

Providers must provide qualified interpreters and translators, in person or remotely, when needed and at no cost to the member.

To ensure appropriate language assistance services, Providers should:

- Update spoken languages in credentialing files and directories: Identify bilingual Providers and office staff, and include their language capabilities in Provider directories
- Attest to CLAS requirements: Provider quarterly updates on language capabilities of Providers and office staff. Ensure quality assurance audits to confirm and document the accuracy of Provider language capabilities.

Support and Assistance

For questions about language services or cultural competency, call Oscar at 1-855-672-2755.

Oscar also welcomes feedback about improving language assistance and culturally competent care. We value your feedback and are committed to continuous improvement in serving our diverse member population. Please contact us at 1-855-672-2755 to share your feedback.

Confidentiality and Protected Health Information

Oscar and its Providers are “Covered Entities” under the Privacy Rule, implemented pursuant to Health Insurance Portability and Accountability Act (HIPAA), and you must comply with the strictest applicable federal and state standards for the use and disclosure of Protected Health Information (PHI).

Oscar and its Providers are required by federal and state laws to protect a member’s PHI and are also required to report any breaches pursuant to federal and state laws. Oscar maintains physical, administrative, and technical security measures to safeguard PHI, and you must maintain these safeguards of PHI.

Contact our Health Insurance Portability and Accountability Act (HIPAA) Privacy Officer at privacy@hioscar.com immediately for any suspected or known breaches of PHI. Please utilize encrypted email if the content includes PHI. When relevant, additional information about confidentiality and PHI may be found in the State Specific Supplement(s).



Our Network

Overview

Some markets have more than one Oscar Provider network in the same service area. Check Oscar's Provider directory to confirm your network status. If a member's plan has a specific network, refer the member to Providers in that network whenever possible.

Oscar operates multiple Provider networks in certain geographic markets. A member's network is identified within their plan name, and Providers can confirm network participation at hioscar.com/search/networks/.

When making referrals, Providers should make best efforts to direct members to participating Providers within the member's assigned network. Additional details may be found in applicable State Specific Supplements.

Our Delegated Vendors

Providers for delegated services must be in the applicable vendor's network. Submit claims to the address listed for that vendor. For utilization management and review details, see the Utilization Management section.

See below for a list of our nationally delegated vendors.

Service	Partner	Contact Information	States
Behavioral Health and Substance Abuse Services Review Types: Authorizations Reconsiderations and First Level Member and Provider Appeals, and Certain Second Level Appeals Required by Law	Optum	<u>Phone:</u> 877-614-0484 Fax numbers specificity by state and region: https://public.providerexpress.com/content/ope-provexpr/us/en/contact-us.html <u>Electronic Payor ID:</u> 87726 <u>Claims Submission Address:</u> Optum P.O. Box 30757 Salt Lake City, UT 84130-0757	All States
Dental (Adult Only) -Dental network contracting and credentialing -Dental claims adjudication	United Concordia Dental (UCD)	Phone number: 844-447-0132 Dental Claims Submission Address: P.O. Box 69444, Harrisburg, PA 17106-9444	States: TX, OH, FL, AZ, GA, TN, NC, SC

Clinical guidelines and frequency rules Provider network management Member services Complaints, Grievances, & Appeals Provider Disputes Provider onboarding Issue resolution		Electronic Claims Submission Payor ID - 89070	
Vision (Adult and Pediatric) -Vision network -Vision claims adjudication Network contracting and credentialing Clinical guidelines and frequency rules Provider network management Member services Complaints, Grievances, & Appeals Provider Disputes Provider onboarding Issue resolution	Vision Service Plan (VSP)	Phone number: 800-877-7195 Claims address: VSP PO Box 495918 Cincinnati, OH 45249-5918	Adult Coverage: TX, OH, FL, AZ, GA, TN, NC, SC Pediatric Coverage: All States
Prescriptions / Specialty Pharmacy Claims Authorizations are done by Oscar Health.	CVS/Caremark	Standard: CVS Pharmacy Help Desk: 1-800-364-6331 Specialty: 800-237-2767 <u>Claims Submission Address:</u> CVS/Caremark Claims Department PO Box 52136 Phoenix, AZ 85072-2136	All States

Utilization Management: -Lab -Radiation Oncology -Medical Oncology Review Types: Authorizations, Reconsiderations and First Level Member and Provider Appeals	EviCore Healthcare	Phone: 855-252-1118 Fax: 800-540-2406 <u>Mailing Address:</u> EviCore healthcare 400 Buckwalter Place Blvd. Bluffton, SC 29910 *All Michigan requests will be submitted to Oscar through Availity Essentials: essentials.availity.com	All States except for MI*
Outpatient Utilization Management: -Physical Therapy (PT) -Occupational Therapy (OT) Review Types: Authorizations, Reconsiderations and First Level Member and Provider Appeals	American Specialty Health (ASH)	Phone: (800) 848-3555 Fax: 877-248-2746 <u>Mailing Address:</u> American Specialty Health (ASH) P.O. Box 509077, San Diego, CA 92150-9077	All States
Utilization and Case Management: All NICU and SCN admissions through discharge, continuing through the first year of life (365 days after birth). Review Type(s): Authorizations and Reconsiderations	Progeny	Phone: (610) 832-2001 Fax: 1-866-465-8926 <u>Mailing Address:</u> Progeny Health 450 Plymouth Rd, Plymouth Meeting, PA 19462	All States
Transplants <i>Submit transplant claims to the contracted vendor assigned to the member's plan.</i>	Cigna LifeSOURCE NAC	Cigna LifeSOURCE NAC Claims Claim Submission Address: PO Box 7297 Philadelphia, PA 19101-7297 Optum Healthcare Solutions Claim Submission:	All States

Network contracting and credentialing Clinical guidelines and frequency rules Provider network management Provider onboarding	Optum Healthcare Solutions	EDI claim submission: Payer ID# 41194 Mail paper claims to : OptumHealth RMO Receiving Unit PO Box 30758 Salt Lake City, UT 84130	
QualCare In Network Providers: Network Participation Status Credentialing Contract verification Billing Inquiry Pricing verification Demographic Updates	QualCare	Network Provider inquiries: Email: grouphealth@qualcareinc.com	New Jersey

Plan Design Details

Overview

Oscar offers different plan designs and benefits. Some plans are sold on a State-Based Exchange, a Federally-Facilitated Marketplace, or off exchange. Plans may differ by network, referral rules, and benefit structure. Review this Manual and the member's plan details for plan-specific rules. This includes new benefit plans brought into your market after the effective date of your Agreement. Oscar's plans vary by network size and make-up, gated or non-gated requirements, and benefit structure.

Understanding Your Network Participation Status

Unless your Agreement says otherwise, you are contracted to see members in Oscar Health plans. Check your Agreement and the member's plan details to confirm participation. Currently, Oscar Health plans are offered by Oscar's insurance affiliates, which may be updated during the plan year. Oscar Health consists of the following insurance affiliates:

- Oscar Buckeye State Insurance Corporation
- Oscar Garden State Insurance Corporation
- Oscar Health Maintenance Organization of Florida, Inc.
- Oscar Health Plan, Inc.
- Oscar Health Plan of Georgia
- Oscar Health Plan of New York, Inc.



- Oscar Health Plan of North Carolina, Inc.
- Oscar Health Plan of Pennsylvania Inc
- Oscar Insurance Company
- Oscar Insurance Company of Florida
- Oscar Insurance Corporation
- Oscar Insurance Corporation of Ohio
- Oscar Managed Care of South Florida, Inc.

Oscar will compensate for authorized services or those necessitated by medical circumstances, based on the member's benefits. Reimbursement will be at the rate specified in the compensation section of your Agreement.

Network Overview

Oscar operates multiple Provider networks in certain geographic markets. A member's network is identified within their plan name, and Providers can confirm network participation at hioscar.com/search/networks/.

When making referrals, Providers should make best efforts to direct members to participating Providers within the member's assigned network. Additional details may be found in applicable State Specific Supplements.

Primary Care Provider and Eligible Specialties

A PCP oversees care for assigned members. PCPs may include physicians and other Providers allowed by state law. To be designated as a PCP, complete the required attestation for service locations and group affiliations, including the PCP flag on your roster.

Please confirm your service locations using the PCP flag on your roster, and list any group affiliations where the physician provides services as a PCP.

Eligibility

Verifying Eligibility

Verify eligibility before each service. Use the Provider Portal or real-time eligibility tools when available. Eligibility information can change, so do not rely only on a past verification.

Be aware that we offer different plans and you may not be participating in every plan. It is important that you verify the member is eligible for the specific plan(s) in which you participate. If a member is eligible for an Oscar plan in which you do not participate, you should refer them to a



Provider that participates in that plan or tell the member to call Oscar Member Services so that we can arrange for the member to see a Provider who participates in their plan.

If a member has non-Oscar coverage when admitted the other coverage or program will pay for all covered inpatient and professional services received until the member is discharged no matter which program or health plan the member has at discharge.

Newborn Eligibility

Newborns are covered on the mother's plan (for the birth) as part of the federal ACA requirement.

Coverage periods:

- Vaginal delivery for the first 48 hours
- Cesarean delivery for the first 96 hours

Depending on the state, newborn children may be automatically covered for the first 31 days of life or more. A child whose adoptive or parental placement has occurred within thirty-one days of birth or longer based on state requirements, will also be considered a newborn child.

Member ID Cards

Oscar members Identification (ID) Cards are provided digitally, however, members may also present a physical ID card when receiving services. Sample member ID cards noted are illustrative; actual information will vary based on the payer, plan, and other requirements.

	OR	
1 [member_firstname] [member_lastname] [plan name] [on/off ex_optional]		5 Contact the Oscar Team hioscar.com/member or call 855-672-2755
2 Your plan information		6 Mental health Call Optum at [phone-number]
Member ID [member_id] Network [network_name] Coverage start date [start_date]		7 For your doctors & pharmacy RxBIN [XXX] Payer ID [XXX] RxPCN [XXX] Dental ID [XXX] RxGRP [XXX] Plan type [XXX] Providers call [phone-number] Pharmacists call [phone-number]
3 In-network individual / family spending		8 Where to send claims Medical Oscar PO Box 52146, Phoenix, AZ 85072-2146 Pharmacy CVS Caremark Mental health Optum Adult dental United Concordia PO Box 69444, Harrisburg, PA 17106-9444 Vision VSP
4 In-network cost before / after deductible		
Oscar Virtual Care visits [\$] / [\$] Primary care [\$] / [\$] Specialist [\$] / [\$] Urgent care [\$] / [\$] Emergency room [\$] / [\$] COI		



1. Member first and last name
2. Member ID, network, and coverage start date
3. Individual & Family deductible and maximum out of pocket amounts
4. Cost to the member, before and after, deductibles
5. Oscar Customer Service contact information
6. Behavioral Health services contact information
7. For doctors and pharmacy
8. Where to send claims based on services provided

Verifying Benefits

Our partnership with Availity helps you check patient benefits and eligibility faster than before with real time eligibility transactions. These quick and accurate updates make it easier to care for your patients without delay.

This solution provides the option to connect directly with Availity or utilize your current clearinghouse. When working with your clearinghouse, please use payor ID: OSCAR.

Payor Name: Oscar Health
Payor ID: OSCAR
Enrollment Required: No

Providers can also verify Oscar benefits through the Availity Essentials portal, by logging in to Oscar's Provider Portal (<https://www.hioscar.com/for-providers/resources>), or call Oscar Provider Services at (855) 672-2755 (Option 4) and request assistance with benefit verification.

Tiered benefit plans and tiered networks

Some Oscar plans use tiered Provider networks. You can check a Provider's tier status on the Oscar Provider Portal when verifying a member's benefits. Members usually pay lower out-of-pocket costs when they see a tiered Provider.

Non-Covered Benefits

Before collecting payment for non-covered services, get the member's written consent. The member must sign and date the consent before the service. Keep a copy in the medical record. If Oscar has determined the service is not covered, the consent must say that Oscar made that decision and that the member agrees to pay.

You cannot bill a plan member for a non-covered service in cases where you do not follow this protocol.

The consent must include:

- An estimate of the charges for that service.



- A reason for your belief the service may not be covered.
- A reference to the fact that Oscar has determined the planned services are not Covered Services, a statement that Oscar has determined the service is not covered and that the member knows of our determination and agrees to be responsible for those charges.

General Provider Requirements

On Site Audits

Where applicable, you must allow Oscar, Health and Human Services (HHS), the General Accounting Office (GAO), Peer Review Organization (PRO) or accrediting organizations, regulatory or accrediting bodies to conduct on-site evaluations. You must also allow authorized reviewers to audit or inspect records related to services provided on behalf of Oscar. This may include books, contracts, medical records, patient care documents, contractor records, and subcontractor records. These access rights continue for the period required by Law after the Agreement ends or an audit is completed.

Provision of Covered Services

You must provide Covered Services under your Participation Agreement, Oscar policies and procedures, this Manual, and accepted professional standards in your healthcare community, and meet the standard healthcare practices recognized within the community you provide care.

As an Oscar Provider, you must treat all Oscar members the same way you treat your other patients. Do not refuse Covered Services unless your Participation Agreement allows it. Refer Oscar members to in-network contracted Providers, hospitals, labs, and facilities unless an exception applies.

Please note that your Participation Agreement requires you to refer Oscar members to other in-network contracted physicians, hospitals, and other Providers, labs, and facilities. Exceptions to in-network referrals shall be made for emergency services that cannot be provided by in-network Providers and those set forth in the Participation Agreement or the Provider Manual, and those approved by Oscar.

The following may be grounds for a Provider's termination from Oscar's network:

- No admitting privileges to an in-network hospital; Providers are required to report if they lose their admitting privileges and must show best efforts to regain them
- Admitting members to out-of-network hospitals
- Performing procedures at out-of-network facilities
- Referrals to out-of-network Providers (including laboratories)



Provider Insurance Requirements

Throughout the term of your Participation Agreement, you and your Providers must maintain all insurance required by your Provider Agreement and applicable Law, and provide proof of coverage to Oscar when requested. Additionally, you must bond in the amounts usual and customary for Covered Services provided with a licensed managed care company admitted to do business in the state and acceptable to Oscar.

In the event that Providers procure a “claims made” policy as distinguished from an occurrence policy, Providers must procure and maintain prior to termination of such insurance, continuing “tail” coverage or any other insurance for a period of not less than five (5) years following such termination. Upon request, you will provide to Oscar, within five (5) business days from the date of service (or any shorter timeframe as required by law), notice of any member lawsuit alleging malpractice.

Americans with Disabilities Act

Oscar employees, business partners and contracted Providers must comply with Americans with Disabilities Act (ADA) requirements, including compliance with Section 504 and Section 508 of the Rehabilitation Act which requires:

- Electronic and information technology are accessible to people with disabilities and special needs.
- Web pages, portals and other electronic forms of communication are compliant with these standards.
- Any documents provided on member-based portals are compliant with the Section 504 standards allowing the use of assistive reading programs.

Your office must comply with those requirements under the ADA for member physical accessibility to your office. You must follow the established accessibility standards of the ADA guidelines. For complete details go to [Guide to Disability Rights Laws | ADA.gov](#).

As part of our obligations under the ADA we may request any of the following ADA-related descriptions of:

- Accessibility to your office or facility.
- The methods you or your staff use to communicate with members with disabilities. This may also include any electronic communications.
- The training your staff receives to learn and implement these guidelines.

Concerning Oscar members who are deaf or hearing impaired:

You must provide a sign language interpreter if a member requests one. You must also have written office procedures for taking phone calls or providing Virtual Visits. Please contact Oscar's



Provider Services department toll free at 1-855-672-2755 (option 4) with any comments or questions about content and accessibility.

Civil Rights Non-Discrimination

Do not discriminate against any patient in service quality or access to services. This includes discrimination based on insurance type, race, ethnicity, color, national origin, religion, sex, gender, age, disability, medical condition, sexual orientation, gender identity, marital status, claims experience, medical history, genetic information, or payment type.

You must maintain policies and procedures to demonstrate you do not discriminate in the delivery of services and must provide treatment for any members who need your service.

Cooperation with Quality Improvement and Patient Safety Activities

You must participate in Oscar's quality improvement and patient safety activities as required by your Provider Agreement. This includes giving timely access to records when requested, responding timely to quality inquiries, participating in audits, Healthcare Effectiveness Data and Information Set (HEDIS®) record review, collaborating on corrective action plans and quality of care investigations, allowing use of performance data, and notifying Oscar about patient safety concerns.

Retroactive Eligibility Changes

A member's eligibility may change retroactively. If a claim is affected by a retroactive eligibility change, Oscar may need to reconsider the claim unless state or federal law requires a different process. A member's eligibility under an Oscar benefit plan may change retroactively if:

- Oscar has received information that an individual is no longer a member.
- The member's policy/benefit contract has been terminated.
- The member decides not to purchase continuation coverage.
- The member fails to pay their full premium and is termed for nonpayment (see Grace Period section for detail).
- The eligibility information we receive is later determined to be incorrect.

If you have submitted a claim affected by a retroactive eligibility change, a claim reconsideration may be necessary, unless otherwise required by state and/or federal law.

Provider Member Medical Records Requirements

Access to Records

Unless otherwise specified in your Agreement, Oscar Providers must furnish medical records as requested. To support streamlined processing, using our claims-related cover forms, available at hioscar.com/for-providers/cover-forms is strongly encouraged.

Key medical record access requirements include:

- Oscar has the right to assess its member's medical records in order to determine the accuracy of ICD-10-CM and Current Procedural Terminology (CPT) coding. Oscar will notify you of the results. We may charge a penalty if you fail to submit the information.
- Supply copies of requested members' medical, financial, administrative, or purchasing and leasing records.
- Provide 24/7 Electronic Medical Records (EMR) access to Oscar.
- Provide access to records for all dates of service that occurred while you were a contracted Provider.
- Supply records within requested timeframe upon request (not related to urgent requests), free of charge.
 - Supply member records to Oscar within 14 days upon request, free of charge.
 - Provide records within 24 to 48 hours for urgent care, prior authorization, or expedited clinical review requests.
 - Supply requested HEDIS medical records within requested timeframes to maintain compliance and support quality reporting standards.
 - To support risk adjustment and attestation requirements, Providers are required to submit requested medical records to Oscar in a timely manner.
- Maintain and protect records for 10 years.
- Assist us, or our designee, in completing chart reviews for Oscar members.

Monitoring the quality of medical care through review of medical records

Keep medical records current, detailed, and organized. This supports quality patient care, enables confidential treatment, and supports reviews by accreditation and regulatory bodies. Proper documentation also ensures accurate annual risk-scoring and CMS reimbursement for Oscar members. Because diagnoses do not carry forward, you must assess and report patient diagnoses annually.

Communications from Oscar's Clinical or Quality of Care Department are privileged and confidential. Do not share them with the patient, member, or member representative unless



allowed by Law, and do not file them in the patient record.

Medical record standards

Clear point-of-care documentation improves care quality, reduces medical-error risk, supports communication among Providers, and helps show the care provided.

For each visit, member point of care documentation must include:

- The member's chief complaint or reason for the visit.
- Physical assessment.
- Unresolved issues or problems from previous visit.
- Diagnosis and treatment plans.
- Member education, counseling or coordination of care with other health care Providers.
- Date of return visit or other follow-up care, including phone calls.
- Record the Evaluation and Management (E/M) code level that accurately reflects the complexity and severity of the member's clinical condition at the time of care.
- Primary Care Providers (PCP) initiated review of all patient records, including lab results, imaging, consultation notes, special studies, and inpatient or outpatient visits.
- Follow-up care plans.

Medical Records Duplication

Follow these medical record copy rules for specialist referrals, member transfers, and member requests:

- **Specialist Referrals:** The referring Primary Care Providers (PCP) office covers the cost of duplication or transfer cost associated referrals. Members may not be charged for records used during the member's course of treatment.
- **Member PCP Transfers:** A member may not be charged for the transfer of their medical records to another PCP.
- **Member Requests:** Members or their authorized representatives, may request copies of records.

Medical record guidelines

Medical records must contain all necessary documentation to support submitted claims. Provider offices are expected to maintain written policies covering:

Record Maintenance

- Maintain a single, permanent record for each member.
- Ensure all entries are legible, detailed, and reflect the most current clinical information.

- Handling missed appointments and follow-ups.
- Non-discrimination of health care delivery.
- Maintaining accurate reporting on ICD-10-CM diagnosis codes, the medical record documentation must describe the Oscar member's condition. Documentation should be clear and concise and include specific diagnosis, symptoms, problems or reasons for the visit. You are responsible for making sure ICD-10-CM coding adheres to ethical standards. Member charts are subject to review by Oscar to identify conditions not coded on claims.
- Maintain industry accepted clinical decision criteria and ensure safety support tools are in place to ensure evidence-based care and follow-up care.
- Utilization of Medicare's Medical Record Documentation standards in the absence of others, as well as compliance with national coding and billing standards (e.g. Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS)).

Staff Training

- Staff training on confidentiality, Health Insurance Portability and Accountability Act (HIPAA) and data security, and safe record keeping.
- Release of information procedures.
- Maintain standardized processes for medical record retention and timely retrieval.
- Ensure full availability and prompt accessibility of medical records, including those stored in secondary or off-site locations.

Care Coordination

- Care coordination between medical and behavioral health care Providers.
- Process for notifying Oscar upon discovering a patient safety issue, concern, or adverse event.

General Documentation Guidelines

Oscar has standards that require Providers and facilities to maintain medical records in a manner that is current, organized, and facilitates effective and confidential member care and quality review. Oscar performs medical record reviews to assess whether network primary care Providers Primary Care Providers (PCP) are compliant with current medical record standards and SOAP (Subjective, Objective, Assessment, Plan) encounter format.

All clinical documentation must adhere to standard CMS and industry guidelines:

Documentation & Signature Standards

- Date all entries, and identify the author and their credentials. The documentation should show which individual performed a given service.
- Clearly label or document changes to a medical record entry by including the author's identity, credentials, and date of change. You must retain the original entry.
- All medical records must be signed by the appropriate medical professional.
- Handwritten or electronic signatures must be completed within a reasonable timeframe by the appropriate medical professional per CMS guidelines.
- Generate documentation at the time of service or shortly thereafter.
- Clearly label any documentation generated at a previous visit as previously obtained, if it is included in the current record.

Member Demographics, History & Legal Forms

- Gather demographic information including full name, gender, date of birth, member number, emergency contact name, family and social history (marital and occupational status), phone numbers and insurance information.
- Gather biographical information.
- Prominently document whether the member has executed an Advance Directive, Living Will, or Power of Attorney. If declined, document the member's decision.
- Document medical history, chronic conditions and significant illnesses, accidents and operations. Include the chief complaint, diagnosis and treatment plan at each visit.

Medication & Allergy Tracking

- Prominently display medication list, allergies and adverse reactions in a consistent location. Document "No Known Drug Allergies" (NKDA) if applicable.
- Maintain updated lists of prescription medications, dosages, and over-the-counter (OTC) drugs.

Clinical Encounters & Diagnosis Coding

- Medical records must reflect all conditions evaluated during the visit.
- Providers are expected to assess and document all acute and chronic conditions at least annually.
- Report the appropriate diagnosis code for all documented conditions that coexist at the time of the visit that require or affect care.
- Document member history, physical exam, health behaviors

Visit Notes, Reports & Orders

- Progress or office visit notes, if applicable
- Operative notes, if applicable

- Inpatient/ER discharge summary reports, if applicable
- Daily clinician notes
- Physicians orders
- Consultation reports, including specialist consultations
- Document all services provided, ancillary services/tests ordered and all diagnostic/therapeutic, lab, and imaging services reports performed or referred by the health care Provider

Preventive Care, Vitals & Health Screenings

- Record vitals, pediatric growth charts, physical assessments, physical activity, nutritional counseling and preventive health screening.
- Screening and lifestyle habits (age 11 and older): Tobacco habits, including cessation counseling, alcohol use and substance use.
- Screenings for depression and evidence of coordination with behavioral health care Providers. Immunization record.
- Preventive screenings/services and risk screenings.
- Blood pressure, height and weight and body mass index.
- Physical assessment for each visit.
- Growth charts for children and developmental assessments.
- Physical activity and nutritional counseling.

Medical Record Elements Defined

Patient Identification & Record Integrity

- Every page in the record contains the patient name or ID number.
- All member encounter entries are legible, signed, and dated, including phone entries.
- Dictated notes should be signed or initialed to signify review.
- If initialed, signature sheet for initials are noted.
- Evidence that the record was created contemporaneously with submission of the claim. Include dates and signatures on any late entries, addendums, or corrections.

Signature & Credential Requirements

- Handwritten signatures and handwritten initials require the following contributors to be an acceptable signature:
 - Credentials must be present and the Provider's typed name or written name must be present and legible.
 - Handwritten signatures and handwritten initials should include servicing and Provider credentials.
 - Handwritten signatures should be legible.

Clinical Documentation & Visit Structure

- Documentation of allergies or No Known Drug Allergies (NKDA) and adverse reactions are prominently displayed in a consistent location
- The important diagnoses are summarized and highlighted
- Providers must use the most current and up to date ICD-10 CM diagnostic code set.
- A problem list is maintained and updated for significant illnesses and medical conditions in daily clinician notes
- A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications
- History and physical exam identify appropriate subjective and objective information pertinent to the patient's presenting symptoms, and treatment plan is consistent with findings
- Past medical history is documented including significant illnesses, accidents, and operations, and prenatal and birth information for pediatric members
- Each visit notation includes the following:
 - Subjective Data: Chief complaint (or reason for visit)
 - Objective Data: Focused (problem-specific) physical examination
 - Assessment: Diagnosis or impression
 - Plan: Treatment plan, goals

Care Coordination, Testing & Referrals

- Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record (note: the clinical reviewer should see documentation of appropriate follow-up recommendations and / or non-compliance to the care plan)
- Follow-up care is scheduled for abnormal findings
- Referrals to specialists are clearly documented
- Follow-up report received and acknowledged when referred specialist care was obtained.
- Continuity and coordination of care between the Primary Care Providers (PCP), specialty physician(s) including:
 - The clinical reviewer will look for a summary of findings or discharge summary in the medical record; examples include, but are not limited to: Progress notes / reports from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing / Provider reports

Preventive Care & Advance Directives

- Age appropriate routine preventive services / risk screenings are consistently noted (e.g. childhood immunizations, adult immunizations, mammograms, pap tests) or the refusal by the patient, parent or legal guardian, of such screenings/immunizations in the medical record
- Documentation of Advance Directive or Living Will or Power of Attorney discussion in a prominent part of the medical record for adult patients is encouraged



- Should the member decline an Advance Directive, documentation of the member decision shall be documented

Privacy, Security & Member Rights

- Medical records are stored securely and only authorized personnel have access.
- There is evidence of annual staff confidentiality training.
- Evidence that the member was informed of their rights and responsibilities as a member.

Claims and Payment

Overview

This section explains how to submit claims, how Oscar processes claims, and how payment or denial decisions are communicated.

Electronic Claims Status and Claim Inquiry

Oscar offers electronic claims status transactions via a clearinghouse, and with this partnership, you can receive electronic claims status information faster than before.

This claims status solution is utilized across the industry, to get claims status answers quickly, without making any new connections. When working with your clearinghouse, please use payor ID: OSCAR.

Payor Name: Oscar Health
Payor ID: OSCAR
Claims CPIDs: 9638, 7468
Enrollment Required: No

If necessary, Providers who would like to make a claims inquiry may contact Oscar via phone, web, email, fax, or letter sent to the address specified on the Explanation of Payment (EOP). Inquiries leading to the submission of adjusted claims or late submissions will be reviewed according to the timelines established in the claim submission section.

Payment and Remittance Options

Oscar partners with Optum Financial, Inc. and ECHO Health, Inc for payment and remittance options. By default, Provider payments will be sent via Virtual Credit Card along with an Explanation of Payment (EOP).

To enroll in electronic payments (ACH) and remittance (ERA), please visit enrollments.echohealthinc.com/eftdirect/OscarManagementCorp.



To enroll in paper checks and paper Explanation of Payment EOPs, please visit echovcards.com/letter.

Credit card processing fees may apply to virtual cards. Contact your merchant processor or financial institution for information on specific costs. Unspent funds for VCPs are subject to state unclaimed property laws. Either Oscar or Oscar affiliated companies may receive transaction fees or other compensation related to some payment options.

For questions and additional payment or remittance options, please contact our partners at 888.686.3260.

Claims Submission

Providers may submit claims electronically or by mail. Oscar strongly encourages electronic submission through Availity using payer ID Oscar for faster, more efficient processing. Providers who submit paper claims must use the appropriate complete and compliant claim form and follow Oscar's mailing instructions.

Electronic Claim Submission

Oscar recommends electronic claims submission through Availity using payer ID OSCAR. If setup does not work, contact your billing vendor and confirm that OSCAR is loaded in the vendor's system.

Mailing Claim Submission

For paper claims, submit a complete and compliant CMS-1500 for professional services and UB-04 for facility services. Use ICD-10 diagnosis codes and HCPCS/CPT procedure codes where required. All field information is required unless otherwise noted. Mail claims to the address listed in this section.

For all claims submitted via mail, please send to the mailing address below:

Oscar Health
P.O. Box 52146
Phoenix, AZ 85072-2146

Delegated Vendor Claims Submission

Submit transplant claims to the vendor assigned to the member's plan using that vendor's designated claims address. All Providers for these services must be in the vendor's network. For prior approvals and review rules, please view the Utilization Management section.



National Uniform Claim Committee and Provider Taxonomy Codes

Pursuant to Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards, a valid taxonomy code must be submitted on all claims, unless applicable state law states otherwise. Oscar reserves the right to deny claims that fail to meet this requirement. For detailed information, please refer to the Reimbursement Requirements and Policies section of the Provider Manual.

Timely Filing of Claims

Submit a properly complete Clean Claim itemizing the services or supplies received and the charges within the deadline required by state law or your Agreement. Oscar is not responsible for payment if it does not receive a complete claim by the deadline. Canceled checks and receipts are not claim forms.

Requests for Additional Information

During claim review, Oscar or a delegated vendor may ask you for more information, such as medical records, invoices, or itemized bills. Submit the requested information by the deadline in your Agreement or the applicable state law. If no different deadline applies, submit it within 90 calendar days after receiving the request, unless state law states otherwise.

When submitting requests for additional information documents by fax or mail:

- Resource: Cover forms can be found at <https://www.hioscar.com/for-providers/cover-forms>
- Best Practice: We highly recommend using these cover forms to ensure faster and more streamlined processing.

Guidelines for Additional Information

The following content guidelines for medical records and itemized bills will ensure timely processing of claims requiring additional information. To avoid delays, make sure all requested documents are legible, complete, and easy to interpret. Oscar's claim processing timeframe starts when the request is properly satisfied.

Medical Record Content

Complete medical records requested for the purpose of claim payment must include the content outlined below only for the requested dates of service. Additionally, in accordance with CMS signature requirements, medical records must be signed in a reasonable time by the appropriate medical professional.

A member cannot be held financially responsible for claims denied due to the Provider's failure to



submit requested documentation.

Oscar will not be liable for interest or penalties when payment is denied or recouped as a result of failure to submit required or requested documentation for claims.

These records may include items such as:

- Member demographics
- Biographical Information
- Consultation reports including specialist consultations
- History and physical examination
- Daily clinician notes
- Physician's Orders
- Laboratory reports
- Vitals
- Medication list
- Diagnostic tests
- Imaging results, if applicable
- Preventative health records including immunizations
- Operative notes, if applicable
- Inpatient/ER discharge summary reports, if applicable
- Progress or office visit notes, if applicable
- All medical records must be signed by the appropriate medical professional

Itemized Bill Content

An itemized bill must show each line item, supply, and service billed under the applicable revenue code. A complete itemized bill must contain the following information:

- Member demographics
- Admit date / discharge date
- Revenue codes
- Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes, if applicable
- Date of service per item
- Description of service per item
- Quantities per item
- Amount billed per item
- Total billed charges

Timely Processing of Claims

Oscar and delegated Provider organizations must process claims within the timelines required by state law or your Provider contract.

Incomplete Claims

Claims that are determined to be incomplete due to incorrect or missing required information (e.g. invalid CPT codes) will be denied. Providers will need to re-submit these claims with the appropriate information for the claims to be adjudicated. Unless otherwise required by applicable law or regulation, a complete claim:

- Includes detailed and descriptive medical and patient data
- Includes all the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to member identification number, National Provider Identifier (NPI), date(s) of service, and a complete and accurate breakdown of services)
- Does not involve coordination of benefits
- Contains no errors or missing details that stop or delay payment. This includes new procedures without CPT codes, experimental treatments, or other situations not covered in your contract

Excessive or Egregious Charges

Oscar reserves the right to review any claim or charge that appears excessive, unreasonable, or materially inconsistent with generally accepted reimbursement or billing practices. In determining whether a charge is excessive or egregious, Oscar may consider, as applicable, one or more of the following: (i) the applicable Medicare or other governmental reimbursement rate for the same or substantially similar service; (ii) prevailing commercial reimbursement rates for the same or substantially similar service in the applicable geographic market; (iii) the Provider's usual, customary, or historical charges or reimbursement for the service; (iv) charges or reimbursement for comparable services by similarly situated Providers; (v) the nature, complexity, and circumstances of the service provided; and (vi) other reasonably applicable industry-standard reimbursement benchmarks. Following such review, Oscar may deny or adjust payment for any service or claim determined to contain an egregious charge.

Claim Denials

If a denied claim could make the member financially responsible, Oscar will send the member an Explanation of Benefits. The notice will explain the denial reason and appeal rights.

Claim Corrections and Late Charges

Providers who believe they have submitted an incorrect or incomplete claim may submit a corrected claim within the same time frame as the timely filing limit established in the "Timely Filing of Claims" section above).

Providers must submit a corrected claim when previously submitted claim information has changed (e.g. procedure codes, diagnosis codes, dates of service, etc.). When a claim is submitted as a correction or replacement, the entire claim must be submitted.

Updated claim submissions that do not have these codes may be denied as duplicate submissions:

Corrected Claim Type	Field Requirements
Paper CMS 1500 corrected claim submissions	• Include "Corrected Claim" on the re-submission • Use Frequency Code 7 under Item 22 (Resubmission Code) • Use the corresponding original reference code field • Must list the original payor claim ID
UB-04 corrected claim submissions	• Include "Corrected Claim" on the re-submission • Use Frequency Type 7 as the third digit under Type of Bill (Form Locator 04) • Use the corresponding original reference code field • Must list the original payor claim ID
Electronic corrected claim submissions	• Include "Corrected Claim" on the re-submission • Use frequency code 7 in Element CLM05-3 (Claim Frequency Type Code) • Use the corresponding original reference code field • Must list the original payor claim ID

If it is determined that Oscar made a claim-processing error, Oscar will send the claim for correction and no additional action is required. If it is determined that there was an omission or incorrect information was submitted on the claim (e.g. missing field or missing modifier), you will be asked to submit a corrected claim to the address on the participant's Oscar ID card. Include "Corrected Claim" on the re-submission. The claim will be re-evaluated with this new information.

Claims for Emergency Services

Post-stabilization services require notice and may be reviewed during or after care, and for



medical necessity. Failure to notify Oscar may cause such services to be reimbursed at a lesser rate and/or denied. In such circumstances members may not be billed.

Oscar abides by all state and federal laws and regulations related to surprise billing.

In-Network Providers and Multiple Contracted Rates

In-network Providers will be reimbursed according to the rates established in their Provider Agreements. In the event that multiple contracted rates apply to a claim (including scenarios in which a Provider is both directly contracted with Oscar and part of a leased network or contracted Provider organization), or that contracted rates exceed billed charges, Oscar, in its sole discretion, may pay the claim at billed charges or the lower applicable contracted rate, as allowed by the agreement.

Collection of Cost Share

Covered Services provided to Oscar members may be subject to a deductible, a coinsurance amount, and/or a copayment amount. In these cases, the member will be liable for reimbursing the Provider the relevant amount.

Oscar encourages Providers to collect copayments at the time of service. Oscar encourages Providers to wait to collect coinsurance and deductible amounts until the claim is adjudicated and the EOP or 835 remittance is received. If you collect cost share upfront, do not collect more than the member's Schedule of Benefits and negotiated rate allow.

Oscar encourages Providers to check with the member whether the member expects other medical or prescription spending to occur on that day. If the member anticipates further spending, Oscar encourages the Provider to account for those amounts in the upfront collection.

If you collect more than the cost share shown on the EOP, refund the extra amount to the member within 30 days after receiving the EOP.

Copayment and coinsurance amounts for the most common services are indicated on a member's ID card. Providers can also check a member's outstanding copayment amount, coinsurance amount, or deductible by calling Oscar Provider Services at 1-855-672-2755 (Option 4) or logging onto <https://www.hioscar.com/for-providers/resources>.

Claims Payment Audits

Oscar has the right to access confidential medical and billing records for the purpose of claims payment, assessing quality of care (including medical evaluations and audits), and performing utilization management functions.

Oscar conducts claims audits to ensure that billing is in accordance with Current Procedural



Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and International Classification of Disease (ICD) guidelines, Oscar's Reimbursement Policies, benefit policies, medical policies (including authorization requirements), and Provider agreement terms.

At any time, Oscar or its contracted reviewers may request on-site, electronic or hard copy medical records, utilization review sheets and/or itemized bills related to claims for the purposes of conducting audits and reviews to determine medical necessity, diagnosis and other coding and documentation of services rendered.

Claim audits may be performed on a prepayment or post-payment basis, subject to the terms of the Provider Agreement. Claim audits involve review of claims data, claims payments, and medical records, and are performed on areas including, but not limited to:

- Billing with incorrect coding; CPT, HCPCS, ICD-10, modifiers, bundling/unbundling services
- Billing with incorrect or above the recommended units/frequency
- DRG validation
- Duplicate billing / services
- Prior authorizations not received/denied
- Historical claims review
- Coordination of Benefits (COB)
- Insurance liability and recovery
- Potential fraud, waste or abuse

Post-payment reviews may involve a sampling and extrapolation methodology, where applicable, and may involve any amount of claims with no specified minimum amount involved or potential recovery probability. The estimated error rate may be projected across all claims to determine overpayment. Providers must supply all requested documentation including, but not limited to, medical records or itemized bills. Failure to do so may result in denial of the entire sample and apply to all claims within the review.

Oscar reserves the right to audit and adjust or deny payment for any medical claim or individual charge deemed excessive, unreasonable, or inconsistent with standard billing practices. To determine whether a charge is egregious, Oscar evaluates specific industry benchmarks, including Medicare and government reimbursement rates, local commercial market averages for similar services, the Provider's historical billing patterns, and charge comparisons among peer facilities. Additional factors such as the nature, complexity, and clinical context of the service provided are also taken into account.

If an internal or contracted reviewer identifies an overpayment for any reviewed claims, Oscar will



make appropriate adjustments to the payments. If the reviewer is unable to review the records, Oscar will make adjustments to payments based upon the information available to us at that time. Any denials will be subject to the Provider dispute or appeal rights process, depending on the denial reason, specified herein and in the terms of the Provider's Agreement.

Complaints, Grievances and Appeals

Overview

As an Oscar Participating Provider when a complaint, grievance, or appeal is brought to your attention by the member, you are required to assist the member with filing a complaint, grievance, or appeal upon request from the member. An Oscar Grievance and Appeal Form is available at <https://www.hioscar.com/for-providers/cover-forms>, or these forms can be attained at the contact addresses listed above.

Complaints and Grievances

Oscar has a process for timely hearing and resolution of member complaints and grievances in accordance with state and federal laws and regulations. Oscar performs ongoing review and analysis of complaints and grievances in order to track and trend issues. Analyses are reviewed by the Quality Management Committee and the Quality Improvement Committee, and recommendations are made to improve plan policies and procedures.

Oscar provides assistance as needed to members filing complaints or grievances and maintains a toll-free number for the filing of complaints or grievances. Complaints or grievance forms and a description of the complaints or grievance procedure are made available on the Oscar website (www.hioscar.com/forms).

Members may submit complaints or grievances via mail, fax, member Services, or email according to applicable state or federal laws or regulations using Oscar's Grievance and Appeal Form, by requesting through the member portal, or by calling member Services. A written record is made for each complaint or grievance received by Oscar including the date received, the plan representative recording the complaint or grievance, a summary or other document describing the complaint or grievance, and its disposition. Please see below for methods of submission:

Mail:

Oscar Health
P.O. Box 52146
Phoenix, AZ 85072-2146



Phone: 1-855-672-2755

Email: help@hioscar.com

Fax: 1-888-977-2062

Oscar's complaints and grievance system addresses the linguistic and cultural needs of its member population as well as the needs of members with disabilities. Oscar ensures there is no discrimination against an enrollee or member (including cancellation of the contract) on the grounds that the complainant filed a grievance. Complaints and grievances will be addressed and resolved according to applicable state and federal laws and regulations.

Appeals

Denied authorization requests are handled through a formal appeal process. An independent, licensed doctor who was not involved in the original denial will review the appeal if it is upheld.

Who May Appeal

- The plan member
- An authorized representative chosen by the member
- The healthcare Provider

What Form to Use

- Use Oscar's Clinical Appeals Provider Form, available online at hioscar.com/providers/cover-forms. Completing this form helps us process your request faster.
- State clearly that you are filing an appeal for a denied utilization review decision with the Clinical Review team (whether applying by phone or in writing).

Where to Submit

- Send all appeal requests directly to the specific phone numbers, fax lines, or mailing addresses listed on the Clinical Appeals Provider Form.

Deadline to File

- Submit the appeal within 180 days from the date you received the denial notice (unless state law or your Provider agreement gives a different timeframe).

What Oscar Will Send Back



- Independent Review: A licensed doctor who had no part in the original denial will review the appeal.
- Resolution Letter: After reviewing the appeal, Oscar sends a decision letter to the member. If the denial stands, the letter explains further appeal options and next steps.
- Provider Notice: Oscar faxes a copy of the decision letter to the Provider and any appointed representative.

Requesting an Independent Medical Review

- Members or their chosen representatives may request an Independent Medical Review (IMR) from an outside state reviewer if they believe care was improperly denied, changed, or delayed by Oscar or a network Provider.

Response Details

If the claim then requires an additional payment, the Explanation of Benefit (EOB) or Provider Remittance Advice (PRA) will serve as notification of the outcome of the review. If the original claim status is upheld, you will be sent a letter outlining the details of the review.

As an Oscar Provider panel member, you are required to cooperate with our review of claims and payments. We may request access to claim information and supporting documentation.

Provider Disputes

Overview

A dispute is a contracted Provider's written request asking Oscar to review a claim decision, payment issue, contract issue, or administrative matter. Oscar defines a dispute as a contracted Provider's written notice to Oscar of the following: Challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested.

Dispute Submissions

Payment disputes require a dispute submission form. This form is mandatory for initiating the dispute resolution process, and the form is available for download for faxed or mailed dispute submissions at hioscar.com/providers/cover-forms.



Requirements for Valid Payment Dispute Submissions

- Use of Oscar's Claims Disputes Provider Form is required for all submissions. A completed submission of the Claims Disputes Provider Form will trigger Oscar's Dispute Resolution Process.
- Submission Guidance
 - Provider Portal: Oscar encourages submission of claims disputes using Oscar's electronic Provider portal, where a streamlined version of the required form is available for electronic submission.
 - For fax and mail: Please access the form as noted, and submit the form with any supporting documentation.
- Incomplete forms will be returned for additional information.

For all states except Florida, and Texas

Your dispute must be submitted within 180 days of Explanation of Payment (EOP) receipt for the claim in dispute, unless other timelines are required in your Provider Agreement.

For Florida, and Texas

Your dispute must be submitted within 365 days of Explanation of Payment (EOP) receipt for the claim in dispute, unless other timelines are required in your Provider Agreement.

Methods of Submission:

Electronic Provider Portal Submission:

<https://www.hioscar.com/for-providers/resources>

Fax: 1-888-977-2062

By mail:

Oscar Health, Inc.

P.O. Box 52146

Phoenix AZ, 85072-2146

Inquiries for Administrative Process

Use this process for administrative questions that are not payment disputes. For payment disputes, use the Dispute Resolution Form and the dispute process in your Agreement.

For inquiries about an administrative process (as distinct from a payment dispute), Providers should call Oscar's Provider Services (1-855-672-2755) (Option 4).

Third Party Liability

Coordination of Benefits (COB)

Coordination of Benefits (COB) decides which plan pays first when a member has more than one coverage source. If Oscar is not the primary payer, submit the claim to the primary payer first and follow Oscar's COB instructions. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense. To maximize efficient and accurate payment of your claims and to avoid recoupment requests, you should assist Oscar and bill services to the responsible primary plan first.

Billing Instructions for Providers To help ensure fast, accurate payments and prevent future payment takes back (recoupments):

- **Bill the Primary Plan First:** Always send claims to the member's primary insurance plan before billing Oscar as secondary.
- **Include Primary EOP:** If Oscar is the secondary payer, you must submit the primary plan's Explanation of Payment (EOP) with the claim.
- **Missing EOP Denials:** Claims sent to Oscar without the primary EOP will be denied. (See the "Incomplete Claims" section of this Manual for complete submission rules.)

Electronic Claim Submission

- **Electronic COB Claims:** Oscar accepts electronic COB claims. Contact your billing software vendor to set up electronic secondary billing using the Oscar Payor ID: OSCAR.
- **More Details:** Refer to the "Claims Submission" section of this Manual for additional guidance on electronic claims.

For more information about requirements for complete claims, go to the "Incomplete Claims" section of this Manual.

When Oscar is not primary payor

How to Submit Secondary Claims

- **Bill Primary First:** Always send your claim to the primary insurance plan first.
- **Submit to Oscar:** After receiving payment or a denial notice from the primary plan, submit the claim to Oscar.
- **Include the Primary EOP:** Include a copy of the primary plan's Explanation of Payment (EOP).

- Electronic Claims (EDI): If you submit electronic claims following standard HIPAA rules, you do not need to send paper copies.

Overpayments and Money Take-Backs (Recoupments)

- Full Payment Corrections: If Oscar pays full price on a claim where another plan is primary, Oscar will ask for a refund for the overpaid amount.
- Vendor Outreach: Oscar or an authorized vendor may handle this overpayment process.
- Proof of Payment Needed: Oscar or its vendor may ask for an updated electronic claim with the primary plan's payment details or a paper copy of the primary EOP.
- Full Recoupment: If you do not send the primary EOP when requested, Oscar may take back the full payment as an overpayment

You can use the Claims-Related Documents form to submit a primary insurer's Explanation of Payment (EOP). Download this form at hioscar.com/providers/cover-forms. We strongly recommend using this cover form to ensure faster claim processing.

Workers' Compensation

All claims paid by Oscar are reviewed post-payment to identify any claims that may qualify for workers' compensation coverage. Oscar may review whether a claim should be paid by workers' compensation. Oscar or a vendor may contact the patient for information. If Oscar paid a claim that should have been paid by workers' compensation, Oscar may request a refund. You should then submit the claim to the responsible workers' compensation carrier.

The coverage provided under the member's policy is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law. Workers' compensation claims that are not a benefit under the member's policy are not payable by Oscar.

Reimbursement Requirements and Policies

Oscar reimburses Providers under this Manual, your Agreement, and the applicable policies. Oscar may modify its reimbursement policies at any time by publishing new versions by providing advance notice. Oscar's Reimbursement Policies can be found at provider.hioscar.com/resources.

For reimbursement claim denials, and how to determine disputes versus correct claim information and requirements, please refer to the appropriate section within the Provider Manual.



Balance Billing Reimbursement

Providers must not invoice or balance bill Oscar members for the difference between the Provider's billed charges and the reimbursement paid by Oscar for Covered Services. Additionally, if Providers do not comply with rules laid out in their Agreements, in this Manual, or by state regulators (e.g. timely filing, surprise bills, pre-authorization checks, etc.), Providers cannot hold members liable for payment.

Interim Billing

Interim claims policy sets clear rules for how often interim claims may be submitted, the order in which claims must be billed, and when a final claim is required. These rules follow recognized billing standards and help ensure claims are processed correctly, payments are accurate, and duplicate or improper payments are prevented. Oscar's policy on interim claims billing is located within Oscar's Reimbursement Policy library at provider.hioscar.com/resources.

Unlisted or Miscellaneous Code Usage

If you use unlisted or miscellaneous codes, include notes or a service description with the claim. These codes can delay payment. Oscar may deny claims that use these codes without supporting documentation, and the member may not be billed.

Interest on Late Payments

Oscar and its delegated Provider organizations will pay interest on clean claims when required by state or federal law. Interest is calculated from the date Oscar had the information needed to adjudicate the claim. Interest for these applicable claims will be calculated based off of the date at which Oscar had the information necessary for adjudication.

Good Faith Payments

If Oscar determines (in its sole discretion) that a claim was denied or reimbursed correctly, however, agrees to overturn the denial or issue additional payment in the interest of the member, this additional payment is a good faith payment, and will not be eligible for any interest or penalties related to the payment.

Claims Overpayment

If Oscar determines that it overpaid a claim, Oscar will send a refund request to the Provider. The request will explain the overpayment and include the patient name, dates of service, amount, and



reason. Within 30 calendar days after receiving the notice, unless applicable law states otherwise, you must refund the amount or send a written explanation contesting the request.

Refund Request Timeframes

Oscar will make refund requests within either 1) the timeframe required by applicable state or federal laws and regulations, or 2) the timeframe specified in the Agreement.

Remittance of a Refund Request

The "Claims-Related Documents" cover form is encouraged to be mailed with refund checks. Forms are available at hioscar.com/providers/cover-forms.

Providers should send refund checks to the mailing address listed below:

Oscar Management Corporation
RE: Provider Refunds
P.O. Box 412410
Boston, MA 02241-2410

Contesting a Refund Request

The Provider must submit a clear, written explanation of why the refund request is being contested within 30 calendar days of the date the notice of overpayment was received unless applicable law states otherwise.

If the Provider contests the refund request, the Provider must identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment. Please refer to the Provider Disputes section of the Provider Manual to contest the refund request

Failure to Issue Refund or Intent to Contest

If you do not refund or contest the overpayment within the allowable time, Oscar may deduct the amount from future claim payments until the overpayment is recovered, unless your Agreement says otherwise. Oscar will send a written explanation with each deduction.

Indirect Medical Education, Direct Graduate Medical Education, and Nursing & Allied Health Payment

Since Operating Indirect Medical Education (IME), DGME (Direct Graduate Medical Education) and Nursing & Allied Health payments amounts for inpatient stays are paid by Medicare Administrative Contractors on behalf of Medicare Advantage members, they are not included in our payments.

Clinical Criteria

Oscar develops and approves written clinical criteria and protocols to determine the medical necessity and clinical appropriateness of healthcare procedures and services under the direction of the Chief Health Officer (CHO), designated Medical Directors, and Quality Subcommittees. These clinical criteria and guidelines are systematically reviewed and updated to reflect current evidence based medicine.

Evidence-based Clinical Criteria and Resources

Oscar may cite current clinical evidence from established and reliable sources, in addition to evaluating the adoption of new medical technologies for medical/surgical procedures, behavioral health, pharmaceuticals, and medical devices to be used in the utilization decision process.

Evidence-based clinical resources and/or criteria used by Oscar include, but not limited to:

- Oscar's Clinical Guidelines
- The World Professional Association for Transgender Health Standards of Care
- CVS Criteria, Pharmacy Clinical Guidelines or Exceptions
- SympIir
- Up-to-Date
- Authoritative peer-reviewed textbooks and journals
- National society guidelines
- Agency for Healthcare Research and Quality
- National Institute of Health Consensus Statements
- Milliman Care Guidelines*
- National Comprehensive Cancer Network

**Note:* Milliman Care Guidelines criteria are national, standardized benchmark criteria developed with input and involvement from physicians and other licensed healthcare Providers and based upon generally accepted medical standards. Oscar uses the most recently released version of Milliman Care Guidelines criteria. Milliman Care Guidelines criteria are reviewed and updated annually.

Medical and Pharmacy Clinical Criteria

You may reference the plan adopted guidelines and full details of both the monthly Pharmacy & Therapeutics (P&T) Summary of Changes, and quarterly Clinical Advisory Subcommittee (CAS) Summary of Changes.

Clinical criteria, adopted criteria, current guidelines, summary of changes, and advanced versions of changes can be found on <https://www.hioscar.com/clinical-guidelines> and are:

- Developed in accordance with the current standards of national accreditation entities



- Developed to ensure quality of care and access to needed healthcare services
- Evidence-based
- Reviewed and updated at least annually, or more frequently as appropriate, based on a review of new evidence, research, developed treatments or guidance.

Please utilize following links to view the full policies and respective effective date:

Medical: <https://www.hioscar.com/clinical-guidelines/medical>

Pharmacy: <https://www.hioscar.com/clinical-guidelines/pharmacy>

We encourage you to bookmark the clinical guidelines page and integrate regular reviews into your practice operations.

- Hard copies of Oscar's Clinical Criteria is available upon request by calling 1-855-672-2755
- Additional clinical criteria (e.g. MCG) used by Oscar are made available to members and Providers upon request. In the case of an adverse determination, the clinical criteria relevant to the review are summarized in a letter to the Provider and member.

Utilization Management

Overview

Oscar's Utilization Management (UM) Program makes sure members get high-quality, necessary, and affordable healthcare. The utilization management program outlines policies and procedures by which Oscar determines medical necessity, access, availability, appropriateness, and efficiency for clinical services and procedures based on a member's health benefits.

Oscar's Utilization Review (UR) activities include pre-service (prior authorization), concurrent, and post-service (retrospective) reviews. Prior authorization and notification are not required for Emergent or Urgent Care. Post-emergent inpatient admissions do require authorization.

Oscar's utilization review process gathers needed clinical information, applies case-specific criteria based on the member's health factors, and sends decisions within required timeframes.

Oscar maintains a utilization review process to:

- Gather pertinent clinical information for each case
- Apply case specific criteria based on an individual's characteristics (e.g. age, comorbidities, family health history, and other factors)
- Notify Providers and members of the utilization decision according to the timeframes required by National Committee for Quality Assurance (NCQA) or state and/or federal regulations



Authorization is provided when a requested service is a covered benefit, deemed medically necessary, and provided in the most efficient and cost-effective manner without compromising quality of care. Benefits are provided only for services that are medically necessary. If care can be safely provided in a lower-cost setting, Oscar may not find a higher-cost setting medically necessary.

In addition to medical necessity, Oscar considers the local network and delivery system available to members. This may include skilled nursing facilities, subacute facilities, and home health agencies. Oscar reviews each member's situation and gives guidance based on the member's needs.

Oscar may use vendors with clinical expertise to review certain services. Oscar oversees those vendors as described in the Delegation and Oversight section. For these cases, the Utilization Management Program includes the management and oversight of these vendors as detailed in the "Delegation and Oversight" section of this Manual.

Program Staff

Oscar's Chief Health Officer and designated Medical Director are ultimately responsible for the Utilization Management Program. With a full, unrestricted license to practice medicine issued by their respective states, the designated Medical Directors maintain authority over all utilization management activities, including implementation, supervision, oversight, and evaluation of the Program. This includes ultimate oversight and accountability for all adverse determinations relating to members in an Oscar plan, whether made by an Oscar employee or delegated utilization review agent. Any adverse determinations (medical necessity denials) are reviewed and ultimately made by a physician, pharmacist or psychologist with an active license issued by a state licensing agency in the United States.

Table 1. Oscar Utilization Management staff

Staff	Participation in Utilization Management Program	Authority to issue Adverse Determination?
Licensed Physicians	Review, approve, and/or deny utilization management requests based on Oscar documents, policies and procedures, and established Clinical Criteria; communicate with Providers	Yes
Licensed Pharmacists	Review and approve utilization management pharmaceutical requests based on Oscar documents, policies, procedures, and established Clinical Criteria;	Yes (except AZ, NJ, NY, NC, PA, and TX)

	deny initial requests and escalate non-approval appeals for physician review; communicate with Providers	
Licensed Nurses	Review and approve utilization management requests based on Oscar documents, policies, procedures, and established Clinical Criteria; escalate non-approvals for physician review; communicate with Providers	No
Clinical Operations Staff	Oversee utilization management operations to ensure compliance and that all necessary resources are available to clinical staff; contribute to quality oversight and reporting	No
Board-Certified Physician Consultants	Apply domain expertise where a specialty review is required; provide determination recommendation to Oscar licensed physician	No
Non-licensed Staff - Processors	Provide clerical support for Inpatient Services, Outpatient Services, and case management areas including: data entry, creation of letters, reports and files, verification of member eligibility and benefits, and serving as the initial point of contact for members and Providers regarding utilization management activities. Review and approve certain utilization management requests when no clinical judgment is required using explicit utilization management criteria. Escalate non-approvals for review by a clinician.	No

Oscar promotes consistent application of review criteria across its utilization management staff by conducting regular internal audits of determinations made by all clinical utilization management staff as well as annual inter-rater reliability testing (IRR). In IRR testing, clinicians are given the same clinical scenario and asked to demonstrate their decision making so that differences in determinations can be used as the basis for remediation and training.

Oscar staff are available at least eight (8) hours per day during normal business hours, and outside normal business hours for urgent requests. TDD/TTY services and language assistance are available (via the main Oscar phone number: 1-855-672-2755) for callers as well. Please refer to the Language Assistance for Limited English Proficiency (LEP) section for details.

Oscar's Utilization Management Program affirms the following:

- Utilization management decision-making is based only on appropriateness of care at the requested location and service and existence of coverage



- Oscar does not reward practitioners or other individuals for issuing denials of coverage
- Financial incentives for utilization management decision-makers do not encourage decisions that result in under utilization

Same or Similar Specialty Review

Where required by law, Providers may request a review of a prior authorization by a physician or pharmacist in the same specialty or a similar appropriate specialty.

Prior Authorization

Covered Benefits and Prior Authorization Requirements

Please be aware that some benefit plans require prior authorization through a pre-service clinical coverage review. Once you notify us of any planned service, item or drug that requires prior authorization, Oscar will inform your office of any required information necessary to complete the clinical coverage review as part of Oscar's prior authorization process. Oscar will notify you of the coverage decision within the time frame required by applicable law.

Providers and members should know the coverage decision before covered services are provided. If you provide a service before a required decision is made, and Oscar later finds the service not medically necessary or experimental/investigational, benefits may be denied or reduced and the member may not be billed.

If you provide services prior to our decision, the member cannot make an informed decision about whether to pay for and receive the non-covered service. Other prior authorization and gate-keeping requirements are noted in this manual.

Services Requiring Authorization

The Utilization Management Program maintains a prior authorization list of medical procedures and services which require utilization review. The prior authorization list is reviewed annually by the Chief Health Officer and designated Medical Directors as well as by the Utilization Management Subcommittee.

The factors considered when developing the prior authorization list include, but are not limited to:

- Risk of fraud, waste, and abuse (including overuse and misuse)
- Availability of alternatives that may be a more appropriate first course of treatment
- Whether coverage of a given benefit is contingent on medical necessity



The list of services subject to prior authorization can be accessed online: www.hioscar.com/prior-authorization or through Availity Essentials at essentials.availity.com.

The Authorization List may not include every service in a category. Being listed does not guarantee coverage. Coverage can vary by plan, and the list may change. Use the authorization tool or call Oscar to confirm requirements for a specific code or service. Please refer to your specific State Supplement as applicable.

Authorization Request Requirements

In general, the following information is required when submitting an authorization request:

- Member information including first and last name, Oscar ID, and date of birth
- Referring/ordering Provider name information National Provider Identifier (NPI), Tax Identification Number (TIN), and contact information
- Attending/servicing (billing) Provider name information (NPI, TIN, and contact information)
- Level of Care (Inpatient, Outpatient Status)
- Facility, if applicable, (NPI, TIN, and contact information)
- Requestor's contact information (phone and fax number)
- The healthcare service being requested including procedure codes, requested number of units or visits, and length of treatment(s).
 - For pharmacy reviews: Drug name, strength, and dosing
- Diagnostic codes
- Clinical information relevant to the authorization request which may include clinical notes including consultation notes, labs, radiology, and other health pertinent information

To check if a specific code or service needs approval, or to submit a new authorization request, visit Availity Essentials at essentials.availity.com. Submitting authorization requests through Availity Essentials is the fastest way to get your request processed, check its current status, and receive updates from Oscar.

Non-digital Authorization Request Requirements

Any Provider wishing to submit an authorization non-digitally, must submit using Oscar's Authorization Request Form (copies of Oscar's Authorization Request Form, by state, can be found at www.hioscar.com/forms). Faxes of forms should be sent to the number provided on the form, or the Provider must call 1-855-672-2755. For services where Oscar delegates utilization review, you will be transferred to or instructed to contact the appropriate vendor.



Extension Requests

Until capabilities are available in Availity Essentials, extension requests will be submitted to Oscar via fax with Authorization Request Form attached.

Information Necessary for Authorization Intake

If information necessary for an authorization is missing, Oscar will tell you what is needed. If information needed for a utilization review decision is missing, Oscar may deny the request for not meeting medical necessity. Submit complete clinical information with the first request to avoid delays.

Urgent Authorization Requests

Providers may ask for an urgent authorization if waiting for a standard approval could seriously harm the member's life, health, or ability to recover fully. Urgent authorization requests may require a doctor to confirm that the situation is an emergency. Do not use urgent requests just to get a faster response or quicker processing time.

Elective Authorization Requests

It is important to submit any elective or prior authorization requests in advance to ensure everything is in place for your patients to get the right care. If prior authorization is not obtained, the member cannot be billed and claim payments may be reduced or denied. Please refer to the delegated vendor list for state-by-state submission requirements.

Delegated Vendor Criteria

For certain services, Oscar has partnered with outside vendors for utilization review activities. These vendors have adopted their own specialty criteria, which are reviewed and approved annually. These vendors are overseen by Oscar's utilization management staff. Please reference the "Delegation and Oversight" section of the Provider Manual for utilization management vendors and the associated service categories they manage.

Delegated Vendors:

Optum: Behavioral health and substance abuse

Review requirements, including prior authorization, concurrent, and/or retrospective review for behavioral health and substance abuse are subject to the policies and procedures of Optum.

EviCore Healthcare: Certain services are delegated to EviCore.

For a list of review types, please see "Our Delegated Vendors" section. For access to the



clinical criteria used by EviCore and authorization request forms, please visit:

<https://www.evicore.com/provider/clinical-guidelines>.

American Specialty Health (ASH): Physical and Occupational Therapy

Reviews for physical therapy and occupational therapy services are delegated to American Specialty Health (ASH).

Progeny: Neonatal Intensive Care Unit

Reviews for Neonatal Intensive Care Unit (NICU) admissions are delegated to Progeny Health. For any other services not indicated in these resources, you can call 1-855-672-2755 (Option 4) or follow the instructions on the Oscar Authorization Request Form available at www.hioscar.com/forms.

Authorization Request Communication

All authorizations or requests for more information for initial utilization review must be made in a timely fashion appropriate for the member's specific condition. Requests for information shall not exceed the timeframes required by National Committee for Quality Assurance (NCQA) or state and/or federal regulations.

Authorizations will be communicated verbally and/or in writing to either members and/or Providers as required by applicable regulations.

Oscar will not reverse an authorization when prohibited by law or after a service has been rendered consistent with the authorization except in cases where there is material misrepresentation or suspected fraud.

Emergency and Ambulance Services

No prior authorization is required for emergent services, including emergency ambulance. Members who reasonably believe they have an emergent medical condition that requires an emergency response are encouraged to appropriately use the 911 emergency response system where available. Emergency ambulance services are covered from the site of the medical emergency to the nearest appropriate facility or between facilities when a higher level of care is required to stabilize and treat an emergency medical condition.

Oscar participating hospitals are responsible for notifying Oscar of an emergent/inpatient admission within 24 hours, unless otherwise specified in either applicable state or federal law or your Agreement. Non-participating hospitals are required to notify Oscar prior to any emergent/urgent inpatient admission when further care or treatment is needed following



stabilization of an emergent/urgent condition. Failure to comply with Oscar's notification requirements will result in an administrative denial of the claim payment. Members cannot be held liable for claims denied for failure to notify. Notification may be communicated by fax (see the Authorization Request Form at www.hioscar.com/forms for fax number) or phone (1-855-672-2755) to speak with Oscar's Clinical Review Team.

Oscar abides by all state and federal laws and regulations related to surprise billing.

Peer-to-Peer Process

In the case of an Initial Adverse Determination, excluding denials for non-covered benefits and lack of information, the Provider of record is notified in the denial notification of the opportunity to discuss a medical necessity denial with an Oscar utilization management physician. The Provider must ask for a peer-to-peer review within 7 business days from the date on the denial letter. Scheduling and decisions will happen quickly based on the member's health needs and state legal deadlines. If a state requires a peer-to-peer discussion *before* a denial is made, Oscar follows those specific state rules.

Denials for non-covered benefits and lack of information are not eligible for the peer-to-peer reconsideration process. Providers who wish to dispute a denial for non-covered benefits may do so via the appeal process outlined in the adverse determination letter.

Post-Stabilization

Post-stabilization services require notice and may be reviewed during or after care, and for medical necessity. Failure to notify Oscar may cause such services to be reimbursed at a lesser rate and/or denied. In such circumstances members may not be billed.

Oscar will comply with any state specific post-stabilization requirements in accordance with applicable state and federal law and regulations. Oscar abides by all state and federal laws and regulations related to surprise billing.

Second Medical Opinion Coverage

Second Cancer Opinion

We cover a second medical opinion by an appropriate specialist, including, but not limited to, a specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.

Second Surgical Opinion

We cover a second surgical opinion by a qualified physician on the need for surgery.



Required Second Surgical Opinion

We may require a second opinion before we preauthorize a surgical procedure. There is no cost to the member when we request a second opinion.

- The second opinion must be given by a board-certified specialist who personally examines the member.
- If the first and second opinions do not agree, the member may obtain a third opinion.
- The second and third opinion consultants may not perform the surgery on the member.

Second opinion services must be obtained by an in-network Provider. In cases where there is not an in-network Provider with the appropriate specialization to conduct the second opinion, we may authorize the member to obtain a second opinion from an out-of-network Provider. Please refer to the "Authorizing an Out-Of-Network Provider" section of this Manual for more detail.

Experimental and Investigational Treatments

Oscar may deny coverage for services that are experimental or investigational under the member's plan and applicable criteria. Oscar reserves the right to deny benefits as experimental, investigational, or unproven for any service, treatment, therapy, procedure, device, or drug that is utilized in a manner contrary to standard medical practice or that has not been demonstrated through medical research to have a beneficial impact on health outcomes. If coverage is denied, an appeal may be submitted, including any pertinent medical records and/or supporting medical evidence.

If applicable, any exceptions to Oscar's decision-making on experimental and investigational treatments can be found in the State Specific Supplement(s).

Monitoring and Reporting of Utilization Management

Oscar retains documented utilization management policies and procedures as required by federal and state regulation. Contact Oscar Provider Services (1-855-672-2755) (Option 4) with questions about utilization management documentation, including but not limited to:

- Policies and procedures, including clinical criteria and guidelines
- Utilization records including prior authorization approvals and denial letters
- Evidence of appropriate licensure, including of physician and other clinical reviewers responsible for conducting utilization reviews

Oscar has utilization and claims management systems to identify, track, and monitor care provided to members and to ensure its appropriateness. Oscar does not reward Providers, practitioners, employees, or reviewers for denying coverage or encouraging underutilization. Utilization management decisions are based on medical necessity and benefit eligibility.



Pharmacy Services

Overview

Oscar provides access to generic, brand, and specialty drugs through a network of pharmacies, infusion centers, hospitals, and outpatient Provider sites. CVS/Caremark manages the pharmacy network, claims processing, and pharmacy benefit operations. Oscar maintains the drug formulary through the Pharmacy and Therapeutics Committee (P&T) (composed of healthcare Providers in various settings), and reviews prior authorizations, peer-to-peer requests, appeals, and non-formulary requests submitted by Providers.

Providers must check member benefits for medications that must be billed under the pharmacy benefit.

Pharmacy Sourcing for Select Provider-Administered Drugs

For select Provider-administered drugs, Participating Providers must use an in-network specialty pharmacy unless Oscar authorizes another source. This requirement applies to the following states: FL, GA, AZ, IL, IA, VA, KS, MI, MO, NE, NJ, NC, OH, PA, and TN.

For these drugs, Providers may not request reimbursement for the drug cost or bill the member for the drug cost. Providers may request reimbursement only for administering the medication.

- Providers may not request reimbursement from the health plan for the cost of the drug, or bill the member for the cost of the drug.
- Providers may only request reimbursement for administration of the medication.

Please reference the Pharmacy Sourcing for Select Provider-Administered Drugs policy located within Reimbursement Requirements and Policies section for guidelines on reimbursement eligibility.

Formulary Management

Oscar maintains a list of covered medications, called the Formulary. The Formulary is reviewed and updated regularly. The Formulary includes medications in most therapeutic classes but may not necessarily include all dosage forms of a given prescription drug (e.g. oral tablets, liquids, topical). The Pharmacy & Therapeutics (P&T) committee gives clinical input on how drugs are used, standard of care, and patient-centered outcomes. The committee meets regularly and oversees the drug review process to ensure that clinical efficacy, safety, and quality are appropriately considered for all drugs.



Oscar may add or remove medications each year, and coverage rules may change. Oscar always ensures uniformity among all individuals in a given plan type when changes occur. When required, Oscar gives advance notice to members, Providers, and the Insurance Commissioner in accordance with federal and state specific law. A medication must be prescribed by a healthcare Provider and found medically necessary by Oscar unless otherwise specified by applicable state or federal law or regulation.

The Formulary may include rules such as prior authorization, step therapy, and quantity limits. If a medication is not on the Formulary, the member or Provider may request coverage. Check the current Formulary online before submitting a request. Please see the most updated version of the Formulary here: <https://www.hioscar.com/search-documents/drug-formularies/>.

Prior Authorizations and Non-Formulary Exceptions

Some Formulary drugs need prior authorization before Oscar will pay at the pharmacy. Pharmacists and physicians review these requests to confirm that the prescribed drug is clinically appropriate and cost-effective. When a pharmacy notifies you that a drug requires prior authorization, you can initiate the authorization through one of the methods listed at the end of this section.

Before requesting a non-Formulary exception, check whether a Formulary alternative is clinically appropriate. If not, submit a non-Formulary exception request with medical records. Medical records are required to verify the information attested to on the prior authorization form. If more information is needed, Oscar will contact your office. If the request is denied, you may request a peer-to-peer discussion, an appeal, or an external appeal when available. You may also request the benefit provision, guideline, protocol, criterion, and case documents used in the decision. If you disagree with this decision, you may request an appeal to have the decision re-reviewed by a different reviewer, or you may request an external appeal to have the case reviewed by a state assigned reviewer. You may always request a free copy of the actual benefit provision, guideline, protocol or other similar criterion on which our decision was based. You may also request reasonable access to, and copies of, all of the case documents.

To submit a prior authorization, non-Formulary exception, or appeal, download the form at www.hioscar.com/forms and send it using one of the methods below.

Electronically:

CoverMyMeds:

<http://www.covermymeds.health/prior-authorization-forms/oscar-health-prior-authorization-forms>

Fax:



1-855-211-0731

Phone:

1-855-672-2755

Credentialing

Overview

Oscar's credentialing process performs initial and ongoing reviews on whether Providers are qualified to provide specific patient care and treatment within limits defined by licensure, certification and/or accreditation. Oscar verifies Provider information and looks for issues that may affect participation in the network. Oscar performs or provides oversight for all aspects of the credentialing process, including primary source verification of Provider information and identification of potentially problematic Providers.

As a potential Oscar network panel member, you are responsible for verifying your clinical staff have required licenses and other credentials.

Oscar reserves the right to also choose to include health care Providers in our network because they meet certain demographic, specialty or cultural needs of our members.

When Oscar reviews to approve or deny an application or reapplication, Oscar considers network needs, business needs, and the Provider's credentials and qualifications.

Providers that meet requirements go to the Medical Director for review and final approval. The Medical Director has the authority to refer any Providers for further review to the Credentialing and Peer Review Committee for final approval. If a reportable quality issue or trend is identified, the Credentialing and Peer Review Committee takes appropriate action in accordance with Oscar's policies and procedures. Oscar Providers have the right to formal fair hearing and appeal if Oscar decides to alter the conditions of a practitioner's participation based on quality and/or service issues. Oscar complies with applicable state and federal requirements and National Committee for Quality Assurance (NCQA) standards in credentialing and recredentialing its Providers.

Non-discrimination

Oscar does not make credentialing or recredentialing decisions based on race, ethnic or national identity, gender, age, sexual orientation, types of procedures specialized in, or specialty serving high-risk or high-cost populations.

Practitioner Rights

Practitioners may review outside-source information, correct errors within 30 days, and check application status online. If an appeal right applies, Oscar will send a notice explaining the recommendation, proposed effective date, basis, and appeal process. All practitioners have the right to:

- Review the information Oscar obtains from outside sources (e.g. malpractice insurance carriers, state licensing boards) to support their credentialing applications
- Correct erroneous information from outside sources within 30 days of identification
- Check the status of their credentialing or recredentialing application here: provider.hioscar.com/provider-credentialing-status

If the Peer Review and Credentialing Committee makes a professional competence, conduct, business, or administrative decision with regard to a practitioner's participation status and the Committee offers such participating practitioner an opportunity to appeal the recommendation, the Peer Review and Credentialing Committee will provide the participating practitioner notice of the recommendation, that:

- States the specific criteria, facts and circumstances that the Peer Review and Credentialing Committee considered in making its recommendation
- Specifies the proposed effective date of its recommendation
- Summarizes the basis for the Peer Review and Credentialing Committee's recommendation
- Describes the participating practitioners right to request a hearing or meeting to appeal the recommendation
- Sets forth the time limit within which to request such a hearing/meeting
- Generally, describes the appeal process and summarizes the participating practitioner's rights during the hearing / meeting

These rights to appeal apply exclusively to participating practitioners and organizational Providers. An applicant who does not have a Participation Agreement in place with Oscar at the time of application has no appeal rights under this plan.

Practitioner Obligations

Every 120 days, Participating Providers must review, update, and attest to the Provider information in CAQH, and changes must be reported to Oscar at least 30 days before they take effect. Failure to update the CAQH application or to provide such notification to Oscar will constitute withdrawal of the recredentialing application for nonresponsiveness to outreach for missing information and termination of Participating Practitioner's participation status may occur.

Active Panel Participation

Credentialing approval does not always mean you are active in Oscar's panel. Unless state law allows otherwise, do not see Oscar members until your credentialing application is approved and Oscar gives you written notice of your effective active date. In addition, once the Provider has completed the process of contract load and credentialing approval, the Provider will receive notification in writing the effective date of their active status.

Ongoing Monitoring of Oscar Providers and Healthcare Professionals

Oscar performs ongoing monitoring of sanction activity from state licensing boards, CMS, Office of Inspector General (OIG) and other regulatory bodies. If a sanction or pending sanction affects licensure or government authorization, Oscar may terminate the Provider from the network.

Provider Office Location Onsite Quality Reviews

Oscar may perform an onsite quality review of any Provider office being considered for the network. Quality standards may include accessibility, cleanliness, room space, appointment availability, and medical record security. Quality standards include, but may not be limited to:

- Physical accessibility, such as handicapped accessible.
- Physical appearance and cleanliness of the site.
- Adequacy of waiting and examining room space.
- Availability of appointments.
- Adequacy of medical record keeping (e.g., secure/confidential filing system).

Credentialing Delegation and Oversight

Oscar may delegate credentialing activities to contracted Provider organizations that can meet delegation requirements. Oscar confirms this through a pre-delegation review. Delegated partners must meet or exceed National Committee for Quality Assurance (NCQA) accreditation standards when required in order to perform credentialing activities as a delegate of Oscar. If applicable, please see your Delegated Credentialing Agreement for additional information regarding delegated entities.

Oscar performs, and requires delegated entities to perform, ongoing internal audits to ensure the credentialing status of its Providers remains current at all times. Audits include validation of licensure, malpractice, DEA, Office of Inspector General (OIG) and other sanctions, and current status of applicable certification and / or accreditation.

Re-credentialing Process for Practitioners

Oscar recredentials Providers every three years or 36 months. Provider status and performance is continuously monitored between recredentialing cycles. Oscar may review utilization management, member services, appeals and grievances, sanctions, licensure limits, and complaints during and between recredentialing cycles by Oscar or its delegated entity. Ongoing monitoring of reports by regulatory agencies of sanctions, limitations on licensure, and complaints are also performed between re-credentialing cycles.

Our Members

A Better Member Experience

In addition to great benefits, Oscar's unique experience offers individuals and families virtual care options, support from Care Guides, digital tools such as the member Portal and mobile application.

Member's Rights and Responsibilities

Oscar ensures the following rights and responsibilities for Oscar members.

Rights

- Private Health Records: Keep all medical records and personal health information confidential and secure.
- Plan and Provider Information: Access clear details about Oscar, available services, network doctors, care Providers, and rights and responsibilities. (Visit www.hioscar.com or call Member Services at 1-855-672-2755, option 2, to learn more.)
- Respect and Privacy: Receive respectful, dignified treatment and full privacy protection from all doctors, care Providers, vendors, and Oscar staff.
- Care Decisions: Partner directly with doctors and care Providers to make decisions about medical care and treatment.
- Open Discussion: Have honest, open talks with doctors and care Providers about all appropriate or necessary treatment options, no matter the cost or insurance coverage.
- Complaints and Appeals: Voice complaints, grievances, or appeals about Oscar, contracted doctors, or care Providers regarding services received. (See the "Complaints, Grievances, and Appeals" section of this Manual for instructions on helping a patient submit a request.)



- Policy Feedback: Suggest changes or recommendations regarding Oscar's rights and responsibilities policy.

Responsibilities

- Share Information: Provide complete health details whenever possible so doctors, care Providers, and Oscar can deliver quality care.
- Follow Care Plans: Stick to the treatment plans and care instructions agreed upon with healthcare Providers.
- Set Health Goals: Work together with doctors to understand medical conditions and set shared health targets.
- Pay Plan Costs: Pay required copays, coinsurance, and deductibles according to plan benefits.

Designation of an Authorized Representative

Members may name an Authorized Representative. To do this, they must complete and sign the Authorized Representative form. Members can find the form online, request it through the Member Portal, or call Member Services.

- Member Portal: www.hioscar.com/forms
- Member Services at 1-855-672-2755 (option 2).

Premium Grace Periods

Oscar's grace period policy is as follows, unless otherwise specified by applicable state or federal law or regulation:

For members *not* receiving subsidies advance premium tax credit

Oscar provides a grace period of up to 31 days to members who are not receiving advanced premium tax credit (APTC) and who have previously paid at least one full month's premium during the benefit year.

- During the grace period, the policy will remain active. Oscar will pend claims for services rendered to the enrollee in the grace period.
- If any premium is not paid by the end of the grace period, coverage will be terminated as of the end of the period for which premium has been paid.
- After confirming the grace period has expired without full premium payment, Oscar will deny any unprocessed claims with dates of service after the last month of premium payment.
- Providers must refund Oscar for any payments made on behalf of members who

ultimately lose coverage due to non-payment of premiums. The Provider must issue the refund within forty-five (45) days after receiving Oscar's written request.

- Any amounts not paid within forty-five (45) days of receipt of notice from Oscar may be offset by Oscar from amounts otherwise owed to the Provider without any further action required.

For members receiving APTC

Oscar provides a grace period of three months to members receiving APTC who have previously paid at least one full month's premium during the benefit year.

- During the grace period, Oscar will pay all appropriate claims for services rendered to the member during the first month of the grace period and pend and/or deny claims for services rendered to the enrollee in the second and third month of the grace period.
- Request a refund of any payments made in the second or third month of the grace period if the member is ultimately terminated.
- If a member receiving APTC exhausts the three-month grace period without paying all outstanding premiums, Oscar will terminate the member's coverage on the last day of the first month of the three-month grace period and deny claims incurred during the second and third months of the grace period.
- Providers must refund Oscar for any payments made on behalf of members who ultimately lose coverage due to non-payment of premiums. This provision applies to payments for dates of service after the first month of the three-month grace period. The Provider must issue the refund within forty-five (45) days after receiving Oscar's written request.
- Any amounts not paid within forty-five (45) days of receipt of notice from Oscar may be offset by Oscar from amounts otherwise owed to the Provider without any further action required.
- After confirming the grace period has expired without full premium payment, Oscar will deny any unprocessed claims with dates of service after the end of the first month of the 3-month grace period.
- If the member pays in full during the three-month grace period, claims will be processed as usual.

Fraud, Waste, and Abuse

Overview

Oscar maintains a strong commitment to identifying and addressing fraud, waste, and abuse (FWA). Oscar's Special Investigations Unit (SIU) is responsible for detecting, preventing, and investigating suspected FWA in connection with the delivery of healthcare services. Fraud, waste, and abuse include improper practices that lead to inappropriate or unnecessary healthcare

expenditures:

- Fraud means intentionally giving false or incomplete information to get a benefit, and knowingly or willfully making a material misrepresentation or omitting material information with the intent to deceive and obtain a benefit.
- Waste is the excessive or unnecessary use of healthcare benefits, services, or resources, often resulting from inefficient practices, poor organization, or resource mismanagement.
- Abuse means practices outside accepted standards that result in unnecessary services or payment. Abuse refers to practices that are inconsistent with sound fiscal, business, or medical standards and that result in unnecessary healthcare costs, improper payments, reimbursement for medically unnecessary services, or services that fail to meet professionally recognized standards of care.

Detection

Oscar uses a number of sources as well as proactive and reactive processes to detect FWA, including but not limited to: Hotline reports, internal employee escalation, external industry sources, prior to payment and post-payment claim review, claim edits, and data analysis. Any report, regardless of source, may result in an investigation.

Prevention and Investigation

Oscar's SIU may investigate suspected FWA. The investigation may include a review and audit of Provider records. Oscar may review claims before payment or after payment when there is a reason to suspect inappropriate billing or services.

- Pre-payment review may be applied to the claims of a Provider or member for whom there is a basis to suggest inappropriate billing or services may be occurring.
- Post-payment review may be conducted when there is a basis to suggest inappropriate billing or services relating to a Provider or member after claims have previously been processed and paid.

Prior to payment and post-pay claims reviews

Prior to payment and post-pay claims reviews entail a thorough assessment of submitted claims, and all available information including requested information, to determine whether the data submitted on the claim is accurately and appropriately supported. Providers are notified formally in writing when a preliminary review of medical records for claims billed is required. At times, reviews may be conducted at the Provider's location. Information requested or reviewed onsite may include but is not limited to: medical records, billing statements, evidence of member cost share collection, invoices, administration records, test results, progress notes, audit logs, Provider's orders, lab requisitions, certificates of medical necessity as well as the medical record



documentation that supports each of these. If faxed or mailed, applicable documents (e.g., medical records, acquisition invoices) are encouraged to be submitted with the "Claims-Related Documents" cover form, which will be available at hioscar.com/providers/cover-forms. Providers are responsible to ensure that their available documentation fully supports the data, and medical necessity of the procedures, services, and supplies, submitted on the claim. Medicare's Medical Record Documentation standards in the absence of others, as well as compliance with national coding and billing standards (e.g. CPT, HCPCS, ICD-10). Reviews may result in full denial of the claim or specific claim lines if documentation is insufficient or does not substantiate data submitted. Records that contain cloned documentation, conflicting information or other such irregularities may be disallowed for reimbursement.

Preliminary review of medical records against claims billed or prior to payment reviews will remain in place at the discretion of Oscar to mitigate risk to Oscar and its members. Following its review, and subject to applicable law and the terms of the governing agreement or benefit plan, Oscar may adjust or deny payment for any claim or charge determined to be excessive, egregious, unsupported, improperly billed, or otherwise inconsistent with applicable reimbursement or billing standards.

Additionally, where permitted, a post-payment review may use sampling and extrapolation methodologies or require the Provider to cooperate in conducting a self-audit to address identified concerns. Investigations may include a review of contemporaneous treatment records and interviews with relevant parties, including members and Providers. During an Special Investigations Unit (SIU) review or investigation, the Provider is prohibited from submitting corrected claims or resubmitting denied claims related to the matter under review unless expressly instructed to do so by the SIU Department.

SIU Action		Provider Notification
1	Records Request	Medical Records Request Letter
2	Medical Records Audit	Finding & Overpayment Letter
3	Provider Dispute Review	Final Determination Letter
4	Preliminary Review of Medical Records	Notification of Performance Letter

Investigative Actions & Provider Notification

Documentation Requirements

Providers must keep documentation that fully supports the claim data, medical necessity, services, supplies, and billing codes submitted to Oscar.

- When time is used to support a service, including but not limited to Evaluation and Management services, documentation must include sufficient information to support the amount of time reported. This includes a description of the activities personally performed by the rendering Provider(s) on the date of service of the visit.
- When time is used to support a billed service, the medical record must document the service's specific start and end times. Estimated times, time ranges, and total duration alone are insufficient to support payment. All timestamps must be clearly documented and readily accessible within the medical record.
- In addition to the patient name, a total of at least two (2) patient identifiers must be documented on each page and readily accessible in the medical records. Identifiers may include patient name, date of birth, Oscar ID Number or address.
- The medical record must clearly identify the individual who personally rendered the service. Each entry must include the rendering individual's full name, applicable credentials, signature, and date of authentication. The billing Provider must also sign and

date the medical record. If the rendering individual and billing Provider are different, the record must clearly identify both parties and include each individual's signature and corresponding date of authentication.

- Providers must submit all requested medical records and supporting documentation necessary to determine coverage and payment for the claim. If the requested records are not submitted within the specified timeframe, the claim will be denied due to insufficient documentation.

Resolution

Based on the findings of an investigation, Special Investigations Unit (SIU) may pursue corrective actions including but not limited to: Provider placement or continuation on prior to payment review, Provider education, recovery of overpaid funds including claims offsets, repayment demands, legal action, termination of contract, and reporting to state and federal regulators and / or law enforcement.

Providers may submit a dispute for claims denied on prepay review within the timeframe outlined in the applicable state statute or CMS guidelines. Providers disputing a claim denied on prepay review must follow the policies outlined in section "Provider Disputes". Post pay disputes and timelines are outlined in the SIU's notification letters sent directly to the Provider detailing the findings of the investigation. Any dispute submitted for review may not include documentation that was already submitted and considered as part of the initial review's determination. For post pay reviews, where medical records or other documentation was not initially submitted for review, records will be considered as a reconsideration and final determination.

Reporting Fraud, Waste, and Abuse

If you suspect FWA relating to Oscar, report it immediately. Use the online portal, mail, email, or compliance hotline listed in this section. To report, you can contact Oscar's Special Investigations Unit (SIU) in the following ways:

Online Portal: www.hioscar.ethicspoint.com

Mail:

Oscar Health
Special Investigations Unit
75 Varick Street, 5th Floor
New York, NY 10013



Email: fraud@hioscar.com

Compliance Hotline: 1-844-392-7589

Please call the Compliance Hotline or submit through the Online Portal to report any general compliance-related concerns (including reporting violations of law, regulations, policies, or procedures) and questions about Oscar's Compliance Program, or to seek advice about how to handle compliance-related situations at work. All calls are treated confidentially, and callers can remain anonymous if they so choose. Callers may be asked whether they are willing to identify themselves so that an issue may be followed up with the caller after the call ends. Retaliation against anyone who raises a concern is prohibited.

Regulatory Compliance

Providers must comply with all applicable federal and state laws and regulations regarding the prevention, detection, and correction of Fraud, Waste, and Abuse (FWA), including but not limited to all applicable Federal and State False Claims Acts, Federal and State Anti-Kickback Statutes, and the requirements of 45 CFR § 156.715. Providers must also comply with Oscar's FWA Compliance Plan and all FWA protocols which govern both medical/surgical (M/S) and behavioral health (MH/SUD) services.

Quality and Population Health Management

Overview

Oscar is dedicated to providing best-in-class experience and quality of healthcare for our members. Oscar's vision is to reinvent how a health plan functions and its role in the lives of its members, and our quality strategy and structure provides the foundation to achieve that vision. We are focused on improving outcomes with innovative quality reporting, case management, care coordination, population health programs, compliance activities, and programs to reduce hospital admissions, improve patient safety, reduce medical errors, and minimize health disparities.

Contracted Provider organizations and their downstream Providers are required to participate in Oscar's Quality Management and Quality Improvement (QI) Programs. Participation includes submission of encounter data, accurate and complete coding, and participation in review of potential quality issues (PQI) and programs.

Quality and Performance Improvement

The Quality Improvement (QI) Program is to improve health outcomes of members by providing access to affordable, appropriate and timely healthcare and services, with established, evidence-based standards. This is accomplished by accessing pertinent data, utilizing proven management and measurement methodologies, and continuously evaluating and improving organizational service processes that are either directly or indirectly related to the delivery of care.

QI Program Framework

The QI Program framework is based upon the philosophy of continuous quality improvement and includes the following considerations:

- Quality issue identification, oversight, corrective action plan assignment, and follow-up
- Oversight and monitoring of internal programs
- Tracking and trending identified plan and Provider issues
- Utilization and medical management plans
- Management of Protected Health Information (PHI)
- Credentialing of practitioners and other Providers
- Oversight of delegated entities for quality and medical management
- Population health
- Case management
- Clinical practice guidelines
- Member rights and responsibilities

QI Program Oversight

The QI Committee of the Board oversees the QI Program.. In order to foster communication with the practitioner and Provider networks, Oscar may invite practitioners and behavioral healthcare practitioners to help plan, design, implement, or review QI activities.

If you are a practitioner or behavioral healthcare provider and are interested in participating in the QI Program or attending a subcommittee meeting you can send an email to quality@hioscar.com.

Oscar does not delegate its QI Program. Oscar may delegate certain QI activities. If activities are delegated to an approved entity, Oscar will:

- Create a formal written delegation agreement that clearly explains what tasks the delegate is responsible for and how Oscar will monitor the plan.
- Perform pre delegation audit and annual oversight audit to ensure the delegate has the staff, technology, and funds to fulfil the responsibilities.
- Keep written rules in place to make sure delegates and Providers are fulfilling responsibilities.
- Delegates and Providers must share quality metrics with the Quality Improvement

Committee, including, but not limited to:

- Complex case management summaries
- Utilization management (UM)
- Performance improvement initiatives, findings, and corrective actions

Preventive Health and Wellness Initiatives

Oscar's goal is to meet and exceed all the highest clinical and customer quality standards and reporting requirements, specifically the utilization and quality measures of Healthcare Effectiveness Data and Information Set (HEDIS) and the CAHPS/QHP Enrollee Experience survey.

HEDIS®

HEDIS is a set of standardized performance measures designed to evaluate health plan performance across clinical areas and patient populations. It is updated annually to reflect changes in healthcare practices and priorities. The National Committee for Quality Assurance (NCQA) is responsible for developing, maintaining, and updating the HEDIS measures. The Centers for Medicare & Medicaid Services (CMS) uses HEDIS scores to monitor a health plan's performance. More than 90% of US Health Plans use this data set. [Discover how CMS utilizes HEDIS for its annual Star Rating program, evaluating health plans.](#)

Achieving HEDIS success hinges on these key practices:

- **Accurate and Complete Data Submission:** Submission of precise and comprehensive CPT/ICD-10 codes on claims.
 - The HEDIS Resource Guides, [Adult Population](#) and [Pediatric Population](#), offer guidance in coding by measure.
- **Sending Supplemental Clinical Care Data:** Monthly supplemental file captures specific patient encounters and procedures, to bridge care gaps that might be missed during claims processing. It also utilizes diagnosis codes to address Risk Adjustment (RA) gaps.
 - [Learn how to set up a supplemental file here.](#)
- **EMR Access for Compliance:** Giving authorized Oscar staff access to Oscar members' electronic medical records systems helps ensure accurate RA coding and allows for the review of patient history to demonstrate HEDIS compliance.

Oscar offers Providers a monthly report detailing HEDIS care gaps for patients by practice. This report can help Providers proactively schedule patient appointments and optimize clinic workflows based on identified trends. To learn how to set up this report, please contact your Oscar Market Representative.



Population Health Management

Oscar offers programs to keep members healthy and support members with clinical risk or chronic illness. Programs may include prevention and screening, case management, discharge planning, and Complex Case Management (CCM).

Our Complex Case Management (CCM) program supports Oscar members in managing chronic conditions and assists them in minimizing barriers and navigating the healthcare system. Enrollment into Oscar's CCM program involves a comprehensive assessment of the member's condition, determination of available benefits and resources, and development and implementation of a case management plan with performance goals, monitoring and follow-up. Depending on the needs of your patient, they may qualify for a number of Oscar's Population Health Programs. To refer an Oscar member to our Complex Case Management program or obtain more information on Oscar's Population Health programs, call 1-855-672-2755. Depending on the individual member's needs and personal preference, Oscar may reach out to a Provider to collaborate with them to support our member's case management needs.

Health Management and Education

Oscar delivers health education via telephone outreach, targeted online content, Oscar's mobile app and website, and other tactics. This equips members with tools and resources to stay healthy. Program evaluation and impact measures include, but not limited to:

- HEDIS measures and clinical utilization data
- Pharmacy data and participant survey feedback

Member and Provider Satisfaction

Measuring member and Provider satisfaction is essential to maintaining high service standards across our network. Oscar tracks feedback through structured surveys, direct input, and operational metrics to address issues and enhance network performance.

- **Member satisfaction:** Member satisfaction is a high priority and may be assessed by several sources, including but not limited to: Satisfaction surveys and complaints, grievances, and appeals. Member complaints, grievances, and appeals are assessed by reason category, Provider, region, and delivery system.
- **Provider satisfaction:** Provider satisfaction may be assessed by satisfaction surveys and direct feedback offered by Provider organizations. Satisfaction issues are categorized and

assessed by severity and prevalence of the issue. Issues not meeting standards or performance benchmarks are identified and a Corrective Action Plan (CAP) for resolution and correction is implemented.

Potential Quality Issues

Definitions

- Potential Quality Issue (PQI): A suspected deviation from Provider performance, clinical care, or outcome of care which requires further investigation to determine if an actual quality of care issue exists.
- Quality of Care (QOC) Issue: A confirmed adverse variation from expected clinician performance, clinical care, or outcome of care, as determined through the PQI process.
- Quality of Service (QOS) Issue: A confirmed adverse variation that causes dissatisfaction and a poor experience in the delivery of healthcare services. A clinician or Provider is any individual or entity engaged in the delivery of healthcare services licensed or certified by the state to engage in that activity, if licensure or certification is required by state law or regulation.
- Corrective Action Plan (CAP): A plan approved by the appropriate quality improvement committee to help ensure that a related quality issue does not occur in the future. CAPs contain clearly stated goals and timeframes for completion.

Process

Oscar uses a standard process to identify, report, and review PQIs. Oscar reviews PQIs to find improvement opportunities for services and provision of care to Oscar members, and decide what actions are needed based on the frequency and severity of the issue.

It is our policy to accept a PQI referral through a variety of sources. Potential sources for PQI referrals include, but are not limited to:

- Member-facing departments (e.g., Complaints, Grievances, Appeals, and Clinical Care)
- Oscar members
- Providers or facility staff members
- Other authorized affiliates

Oscar tracks all identified PQIs to monitor patterns, trends, and significant sentinel events. Oscar keeps information from quality of care investigations confidential under Plan confidentiality policies and applicable state and federal peer review laws and regulations.

A designated medical professional reviews all referred PQIs to identify whether a true Quality of Care or Quality of Service issue exists and assigns a severity score. Some cases will be referred to the Peer Review and Credentialing Subcommittee. The Provider may be placed on a corrective



action plan (CAP), or may be required to submit a CAP. The CAP will require follow up to show evidence that corrective actions were complete.

Depending on the severity of the issue and the outcome of the CAP, the Provider in question may be subject to termination from the Health Plan network and reporting to the appropriate state licensing board or the National Practitioner Data Bank. Should the Peer Review and Credentialing subcommittee make a recommendation for termination from the network, the practitioner may deploy their right for a fair hearing.

Potential Quality Issue Outcomes

Oscar trends potential and actual quality outcomes over a continuous 36-month period. Oscar refers identifiable trends, regardless of outcome to the member, will be referred to the Quality Improvement Committee quarterly for possible action or educational opportunities

Reporting

To submit a Potential Quality Issue (PQI), please reach out via:

Fax: 1-888-732-0625

Email: quality@hioscar.com

Mail:

Oscar Health, Inc. Quality Improvement Program

P.O. Box 52146

Phoenix AZ, 85072-2146

Clinical Practice and Preventive Health Guidelines

Overview

Clinical practice guidelines, preventive health guidelines, and other internal criteria guide preventive, acute, and chronic care for Oscar members. Clinical practice guidelines are reviewed against utilization management criteria and member education materials for consistency and alignment with appropriate medical recommendations.

Oscar uses evidence-based guidelines because they can improve health outcomes. Oscar has compiled a group of recognized resources that publish evidence-based clinical practice guidelines.

Preventive Care Resource Guidelines

Resource	Description	Guideline	Resource Details
U.S. Preventive Services Task Force (USPSTF)	Issues recommendations on screening, counseling, and preventive medication topics and includes clinical considerations for each topic.	For adults 20-64 and 65+ years as well as children 2-19 years	www.uspreventiveservicestaskforce.org
Advisory Committee on Immunization Practices (ACIP)	Medical and public health experts who develop recommendations on the use of vaccines in the civilian population of the United States. The recommendations stand as public health guidance for safe use of vaccines and related biological products.	For children under 24 months	www.cdc.gov/vaccines/hcp/acip-recs/index.html
The American College of Obstetricians and Gynecologists (ACOG)	Decision support resources grounded in scientific evidence from the premier professional organization dedicated to the improvement of women's health.	n/a	www.acco.org/guidelines .
American Academy of Pediatrics	Evidence-based decision-making tools for managing common pediatric conditions.	For children from birth to 19 years	https://healthychildren.org/English/Pages/default.aspx .

Acute / Chronic Medical Condition Resource Guidelines

Resource	Description	Resource Detail
American	Framework of evidence-based clinical	www.acco.org/guidelines

College of Cardiology	statements and guidelines developed by leaders in the field of cardiovascular medicine.	
American Diabetes Association	Standards, guidelines and clinical practice recommendations for healthcare professionals who care for people with diabetes.	www.professional.diabetes.org/content-page/practice-guidelines-resources
American College of Physicians	American College of Physicians resource for clinical practice guidelines addressing screening, diagnosis and treatment of diseases relevant to internal medicine and its subspecialties.	www.acponline.org/clinical-information/guidelines

Behavioral Health Guidelines

Optum is Oscar's contracted Managed Behavioral Health Organization. Optum provides guidelines for screening, diagnosis, and treatment of mental health conditions and substance use disorders.

For details: www.providerexpress.com/content/ope-provexpr/us/en/clinical-resources.html.

Qualified Health Plan Exchange Requirements

Overview

As a participant on Oscar's Exchange product network, you understand and agree that Oscar, as a Qualified Health Plan (QHP) issuer may delegate some of Oscar's responsibilities to your practice or facility as part of your duties set forth in your Agreement. In the event that Oscar delegates any of its responsibilities to you, the delegation requirements set forth in 45 CFR 156.340 and those set forth in your Exchange Regulatory Exhibit will be incorporated into your Agreement.

Delegation Duties

Notwithstanding any relationship(s) that Oscar may have with your office or facility, Oscar maintains responsibility for its compliance and the compliance of any of its network Providers with all applicable Federal standards related to Exchanges. The applicable standards depend on the Exchange model type in which the Qualified Health Plan (QHP) is offered. Please refer to your Exchange Regulatory Exhibit for additional requirements.

For Hospitals with Greater Than 50 Beds

If your facility is a licensed hospital, with fifty (50) beds or more, as defined under 42 CFR § 124.2 your facility is required to be compliant with the patient safety standards in 45 CFR § 156.1110 and section 1311(h) of the Affordable Care Act for plan years beginning on or after January 1, 2017. Continued participation in Oscar's Exchange product network requires the following actions:

- Use a patient safety evaluation system as defined in 42 CFR § 3.20; and
- Implement a mechanism for comprehensive person-centered hospital discharge process to improve care coordination and health care quality for each of its patients
- Implement an evidence-based initiative, to improve health care quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmission, or improves care coordination.

If applicable, you understand that Oscar may rely on your affirmations to demonstrate its compliance with its federal and state requirements as a Qualified Health Plan and may make this certification available to CMS and applicable state regulators to demonstrate compliance with these requirements.

Consolidated Appropriations Act, 2021 Requirements

Prohibition on Gag Clauses.

Your Agreement may include a confidentiality provision that describes information that neither party may disclose to a member, other health care Provider or other third party except as required by an agency of the government, court order or other third party. You agree the Consolidated Appropriations Act (CAA) constitutes such a requirement by an agency of the government, and nothing in your participation agreement will be interpreted to supersede or conflict with the CAA. Specifically, your participation agreement will not be interpreted to directly or indirectly restrict us (as a health insurance issuer offering group and individual health insurance coverage) or a group health plan from:

- Providing Provider-specific cost or quality of care information to referring health care Providers or current and potential members.
- Electronically accessing de-identified claims and encounter information for each member in the plan or coverage, upon request and consistent with the privacy regulations related to section 264(c) of the Health Insurance Portability and Accountability Act (HIPAA), the amendments made by the Genetic Information Nondiscrimination Act of 2008 and American with Disabilities Act of 1990. This includes, on a per claim basis, the following:
 - Financial information

- Provider information
 - Service codes
 - Any other data included in claim or encounter transactions
- Sharing information with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with HIPAA, the amendments made by the Genetic Information Nondiscrimination Act of 2008 and the Americans with Disabilities Act of 1990.

Continuity of Care

Health insurance issuers, plan sponsors and/or health care Providers are required to comply with the Continuity of Care requirements under the Consolidated Appropriations Act (CAA) unless your participation agreement states otherwise.

Continuity of Care is provided in the following circumstances:

- Your participation agreement with us or between you and a downstream Provider is terminated by us, a payor, you or a downstream Provider.
- The terms of your network participation with us or a payor changed, and that change leads to certain members no longer receiving in-network coverage for your care.
- A fully insured group contract between us and a group health plan terminated and that termination leads to members no longer receiving in-network coverage for your care.

Under the CAA, Continuity of Care must be offered to members under your care, or under the care of your downstream contracted Providers when one of the listed conditions apply:

- Treatment for a serious and complex medical condition.
- Undergoing inpatient or institutional treatment.
- Scheduled nonelective surgery, including receipt of postoperative care with respect to such a surgery.
- Pregnant and receiving treatment related to the pregnancy.
- Terminally ill per the Social Security Act and receiving treatment for the terminal illness.

In accordance with the CAA, you must accept payment from us or a payor based on your participation agreement and negotiated rates for any services rendered pursuant to the Continuity of Care requirements under the CAA. Any care you render to a member under Continuity of Care is subject to our or any payor's applicable policies, procedures and quality standards.

You also acknowledge additional rights for Continuity of Care may be required under state or local law or as specifically required in your participation agreement with us.

State Law Privacy Requirements

You must follow all applicable state privacy laws. Review the state supplements in the manual as applicable.



Offshoring

Unless previously authorized by Oscar in writing, all Provider services, including those of an administrative nature, provided pursuant to the Agreement must be performed within the United States, the District of Columbia, or the United States territories, with the exceptions of India, the Philippines, Mexico, Colombia, United Kingdom, and Ireland.