oscar

2025
Oscar Health
Provider Manual

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Introduction

Overview

Welcome to Oscar Health, Inc. 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 document includes useful information regarding our health plans, including topics such as claims and prior authorizations as well as contact information, and are part of the conditions of your Agreement. This Manual is meant to be read in conjunction with your Provider Agreement and the State Specific Supplements (if applicable), which are available on our website (www.hioscar.com/providers/resources).

This Manual is effective January 1, 2025 and applies to covered services you provide to our members or the members through our benefit plans insured by or receiving administrative services from us, unless otherwise noted. This Manual is subject to change; the content is updated periodically to better support our health care provider networks.

Our Philosophy

Great health insurance starts with a great network. We’re partnering with forward-thinking providers and world-class health systems to change healthcare for the better. We want to make it simple for you to manage your practice so that you can focus on providing care. And - we’re here when you need us.

Terms and definitions as used in this guide

The defined terms in this Provider Manual shall have the meaning set forth in the Provider Agreement unless otherwise defined below.

- “Covered Services” refers to services that Oscar members are entitled to receive via benefits of their qualified health plan.
- “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” refers to a person eligible and enrolled to receive coverage from Oscar for covered services.
- “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 (provider.hioscar.com).
- "Subscriber" refers to the person who is responsible for a contract with a health insurance plan.
- "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!

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 • *Provider Services Hours:* Mon-Fri, 8:00am-6:00pm (local time across markets) (Provider Services is Option 4)

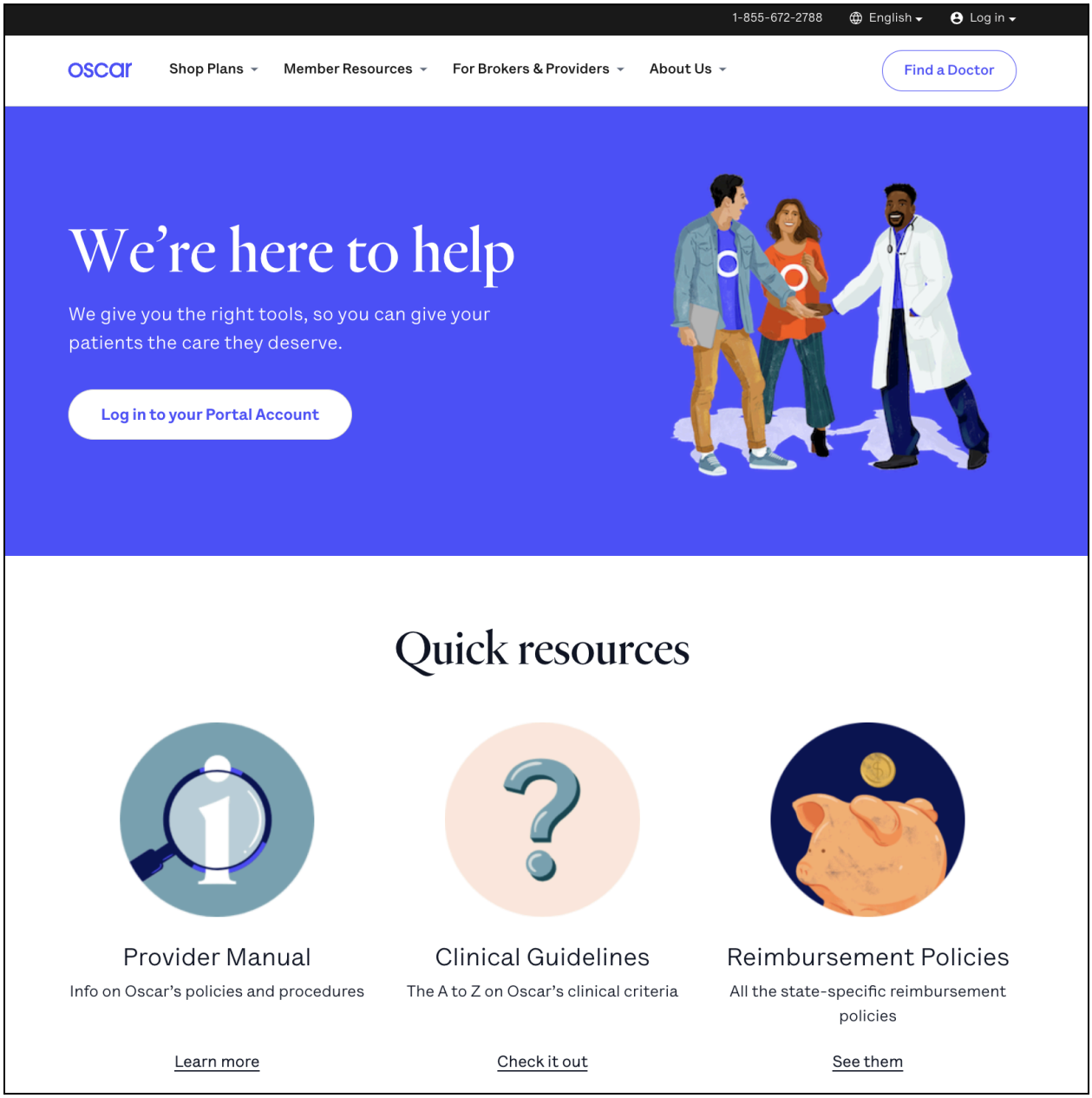
Utilization Management	(855) 672-2755 • *Utilization Management Hours:* Mon-Fri, 8:30am-5:00pm (local time across markets)
Oscar's Website	hioscar.com
Oscar's Provider Portal	provider.hioscar.com
Referral Submissions (where applicable)	provider.hioscar.com
State Specific Provider Resources	hioscar.com/providers/resources
Forms	hioscar.com/forms
Policies	provider.hioscar.com/resources

Our Products Referenced in this Manual

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**	No*
EPO Plans Offered		
Product Type	States Offered	OON Coverage
EPO	FL, IA, KS, MI, MO, NE, NJ, NY, TN, TX, VA	No*
PPO Plans Offered		
Product Type	States Offered	OON Coverage
PPO	OK	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 applicable State Supplement.		

Provider Resources Site and Portal



Resources Site

You can use Oscar's Provider Resources site (hioscar.com/providers/resources) and Provider Portal to find everything you need to work with Oscar. We built these sites to simplify your team's workflows so that you can focus on delivering great care to members.

Go to hioscar.com/providers/resources and request to join the network

- Browse resources such as:
    - Provider Manuals for all markets

  - Policies (clinical guidelines, reimbursement policies, etc.) and forms
  - Tutorials and how-to-guides on using the Provider Portal
- Search our Provider directory for in-network specialists, lab facilities and more
- Search our drug Formulary to find out what medications Oscar covers
- Training videos and other quick FAQ's

Portal

Connect your staff to your portal account and grant permission to complete tasks in the Portal. When you create a Provider Portal account you may complete the following tasks online:

- Check member eligibility
- Check status of claims
- Submit prior authorizations
- Submit referrals electronically
- Edit your provider data information
- Review members' clinical information

Our Providers

Overview

We're so glad to have you in our network! To help make working with Oscar simple, we have created this Provider Manual with direction and guidance around the basic operational processes of Providers and Provider organizations. Please note that Provider organizations are responsible for distributing copies of this Provider Manual to their in-network Providers.

Provider Training

All contracted Providers and Provider organizations are required to provide appropriate training for employees and applicable subcontractors within 90 days of hire and annually. Such training shall cover compliance programs that include, but are not limited to, Fraud, Waste, and Abuse (FWA), Potential Quality Issues (PQI), and the Health Insurance Portability and Accountability Act (HIPAA).

Provider's Notification of Important Changes

Oscar is committed to providing our members with accurate Provider information. You are required to provide the Oscar team with an updated roster every 30 calendar days. This is to help ensure any changes to your information (e.g., new Providers in your group, name changes of

Providers, address changes, whether a Provider is no longer accepting new patients, etc.) is continuously updated in our system and published in Oscar's online directory.

Oscar is required by applicable regulations to have accurate Provider directory information to ensure that our members have access to care under their benefit. Because Oscar is subject to Provider and Provider Directory accuracy requirements, we request that you be as proactive as possible concerning notification of changes to your practice, office, or Provider entities.

In addition to those requirements in your Agreement, every quarter, you, or an entity delegated to handle activities on behalf of us (a "delegate"), are expected to review, update and attest to the health care Provider information available to our members. If you or the delegate cannot attest to the information, you must correct it online or through Oscar's Provider portal. You or the delegate must tell us of changes to the information at least 30 calendar days before the change is effective. This includes adding new information and removing outdated information, as well as updating the information listed in the section below.

- You may access the most current Provider information we have by searching our online Provider directory, which is available at hioscar.com/search.
- Full Provider roster files should be submitted to rosters@hioscar.com.

Information Subject to Accuracy Requirements

You and the delegates are required to update all health care Provider information, such as the following:

- 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
- NPI(s)
- Languages spoken/written by staff
- Ages/genders served
- Office hours
- ADA Accessible
- Use of telehealth by office, including, but not limited to:

- whether the Provider offers the use of telehealth or telemedicine to deliver services to patients as clinically appropriate;
- outline what types of services may be provided via telehealth or telemedicine; and
- whether the Provider can perform telehealth or telemedicine with a family caregiver who is in a separate location than the patient (with patient consent).

Invalid Information and/or Practice Inactivity

Please be aware that Oscar may reach out to validate your demographic information and whether you are accepting new patients. Prompt responses to this outreach will allow us to ensure your information is up-to-date. Consequently, because we must ensure accurate Provider directories, Oscar, in addition to those termination rights listed in the Provider Agreement, at its discretion, may:

- Administratively terminate a Participation Agreement or a Participating Provider if there have not been claims submitted for over 1 year.
- Deactivate any 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. Should this occur,

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.

General Provider Requirements

On Site Audits

Where applicable, and in addition to those requirements in the Provider Agreement, you must agree to permit Oscar or appropriate regulatory bodies, as required, to conduct on-site evaluations periodically in accordance with the current state and federal laws and regulations and

to comply with recommendations, if any. You and your applicable facility must give Oscar, Health and Human Services (HHS), the General Accounting Office (GAO), any Peer Review Organization (PRO) or accrediting organizations, their designees, and other representatives of regulatory or accrediting organizations the right to audit, evaluate, or inspect books, contracts, medical records, patient care documentation, other records or contractors, subcontractors, or related entities for services provided on behalf of Oscar during the term of the Participation Agreement, and, also, for the time period required by applicable law following the termination of the Participation Agreement or the completion of an audit, whichever is later.

Provision of Covered Services

You must provide covered services according to the terms of your Participation Agreement, consistent with Oscar's policies and procedures as mentioned in the Participation Agreement and this Provider Manual, and within the professional standards of practice for care generally recognized within the health care community in which you operate.

As an Oscar Provider, you must treat all Oscar members equally and may not refuse to provide covered services unless you are unable to provide such services according to the terms of your Participation Agreement. You are expected to provide covered services to Oscar members in the same manner, in accordance with the same standards, and with the same time availability, as provided to your other patients.

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 a malpractice, general liability, and any other insurance and 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 (ADA)

Oscar employees, business partners and contracted Providers must comply with ADA requirements, including compliance with Section 504 and Section 508 of the Rehabilitation Act which requires that electronic and information technology be 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 to members who are deaf or hard of hearing.

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

You must not discriminate against any patient with regard to quality of service or accessibility of services because they are our member. You must not discriminate against any patient on the basis of including but not limited to the following:

- Type of health insurance

- Race
- Ethnicity
- Color
- National origin
- Religion
- Sex or gender
- Age
- Mental or physical disability or medical condition
- Sexual orientation
- Gender identity
- Claims experience
- Medical history
- Genetic information
- Type of payment

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

Including those requirements set forth on your Provider Agreement, you are required to follow Oscar's quality improvement and patient safety activities and programs. These include:

- Quick access to medical records when requested.
- Timely responses to queries and/or completion of improvement action plans during quality of care investigations.
- Participation in quality audits, including site visits and medical record standards reviews, and Healthcare Effectiveness Data and Information Set (HEDIS®) record review.
- Allowing use of practitioner and health care Provider performance data.
- Notifying us when you become aware of a patient safety issue or concern.

Retroactive Eligibility Changes

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.

Access to Care

Overview

Oscar is dedicated to providing access to high-quality Providers and strives to ensure strong network coverage for all Oscar members' needs. Oscar will work with members and Providers to ensure members have access to appropriate, timely, and continued care. Providers may freely communicate with patients about treatment options, regardless of benefit coverage limitations. Please encourage the member to call Oscar to discuss benefit coverage.

Availability Standards

Oscar expects to offer access to covered services by an in-network Provider, mental health professional, and facilities in accordance with applicable state and federal law, regulation and NCQA guidelines. Oscar has adopted quantifiable and measurable network access standards consistent with applicable regulations and NCQA guidelines, including timeliness of appointments for preventive care, routine primary care, specialty care, and access to urgent care, emergency care, after hours care, and waiting time in the Provider office. Providers must offer Oscar members access to appointments and provide office wait times comparable to other commercial members.

As a member's Primary Care Provider "PCP" you must arrange for 24 hours a day, 7 days per week coverage of our members. If you are arranging a substitute health care Provider, Oscar plans require the use of Providers who are in-network with the member's benefit plan. In-network Providers are listed in Oscar online directory.

Office Appointment Standards

Type of Service	Appointment Requirement
Preventative care	Within 15 business days
Regular or routine care	Within 15 business days
Urgent care	Same day
Emergency care	Immediate
After hour services	24 hours/ 7 days a week for PCPs

The above appointment standards are general guidelines. State or federal regulations including Qualified Health Plan regulations may require standards that are more stringent.

Message recording suggestions for after hour messages

While not a set requirement, Oscar generally suggests the following information be included in after hour messages.

For members with medical emergencies:

- The caller should be directed to hang up and dial 911 or local equivalent.
- 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.

Referrals

Some benefit plans subject to this Manual require referrals for specialist visits, which must be submitted by the member's PCP or by a PCP in accordance with the member's benefit plan. Referrals may be submitted and viewed on our portal at provider.hioscar.com. Reference the member plan details as to whether referrals are required and the State Specific Supplement for referral requirements.

Authorizing an Out-of-Network Provider

An approved prior authorization is required before an out-of-network Provider's services will be covered. If it is determined that Oscar does not have an in-network Provider with the appropriate training and experience needed to treat a member's condition, Oscar may approve an out-of-network authorization for covered services. Forms to submit a request can be found at https://www.hioscar.com/form/oon-request-form.

Please note: Approvals are based on the medical necessity of the service being requested and the availability of an in-network Provider with the appropriate experience to provide the requested service in a timely manner. Approvals will not be made on the basis of convenience for either a member or a Provider, and Oscar may not approve the particular out-of-network Provider requested. If Oscar approves the authorization, all 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. All 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. In the event that we do not approve an authorization, any services rendered by the out-of-network Provider will not be covered.

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. Qualification requirements are documented in Oscar's Continuity and Transition of Care Guidelines available at www.hioscar.com/forms. Oscar encourages Providers to submit these requests on behalf of our members. Members may also submit these requests by contacting Member Services (1-855-672-2755).

Please note: Continuity of Care or Transition of Care must be authorized prior to service. Formerly in-network Providers must agree to accept as payment the negotiated fee that was in effect just prior to the termination. Additionally, the Provider must agree to provide Oscar with necessary medical information related to the member's care and 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, imminent harm to patients, or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

Language Assistance for Limited English Proficiency (LEP)

Oscar assesses the linguistic needs of its enrollee population to ensure members have access to translation and interpretation services for medical services, customer service, and health plan administrative documentation, as needed and according to state regulations. Oscar also ensures member access to translated or alternative format documents and communication as necessary, including for the visually and hearing impaired. Members requiring interpreter services can contact Oscar's Member Services at 1-855-672-2755 to access, free of charge, Oscar's language services.

Understanding & Adhering to Culturally and Linguistically Appropriate Services (CLAS) Standards

Contracted Providers are required to follow all state and federal requirements that align with the principles of 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 Services for Members

Oscar is dedicated to ensuring that members with limited English proficiency (LEP) have access to quality healthcare services. To achieve this, we provide the following language assistance services:

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

Oscar requires Providers to comply with state and/or federal regulations regarding language assistance for LEP members. Providers are equally required to provide qualified interpreters and translators, both in-person and remote, as needed by an LEP member, and at no cost to said 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

If you have questions about how to use the language service or general questions about Oscar's approach to cultural competency, please call 1-855-672-2755.

Oscar also encourages Providers to share their experiences and suggestions for improving language assistance services 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.

Oscar's Commitment to Cultural Competency

Oscar believes cultural competency in healthcare is the ability of Providers to deliver high quality services taking into account how social, ethnic, religious, and/or linguistic characteristics of members may impact their delivery of care or clinical 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.

What cultural competency means for our members: Demographic, identity, socioeconomic, and/or cultural differences between members and healthcare professionals can influence many aspects of the medical encounter that can impact patient satisfaction, adherence to medical advice, and health outcomes. For example, members respond better when care instructions are delivered in their own language. Moreover, knowledge of, and sensitivity to, cultural and/or sexual orientation and gender identity beliefs can impact the way members communicate their medical needs, and how physicians, nurses or other healthcare Providers can enhance diagnosis and treatment. 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.

Cultural competency resources

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) provides free resources to healthcare professionals via e-learning modules that can be found at: https://

thinkculturalhealth.hhs.gov/education or by visiting the HHS web homepage and searching for keyword “education”. These HHS resources equip healthcare Providers to better administer culturally and linguistically appropriate services and improve the quality of their treatment and/or the experience for Oscar’s diverse member population. We encourage all our Providers to utilize these HHS resources to learn more about how to improve their interactions with members who have specific language and/or ethnic preferences.

Confidentiality and Protected Health Information (PHI)

Oscar and its Providers are considered “Covered Entities” under the Privacy Rule, implemented pursuant to HIPAA, and must comply with the strictest applicable federal and state standards for the use and disclosure of 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; it is important that any Provider and its delegated entities maintain these safeguards of PHI as well. To discuss any known or suspected breaches of the privacy of our members, please immediately contact our HIPAA Privacy Officer at privacy@hioscar.com. 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).

Provider Disputes

Overview

Oscar defines a dispute as a contracted Provider’s written notice to Oscar or to Oscar’s capitated Provider:

- 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
- Seeking resolution of a billing determination or other contract dispute (or a bundled group of substantially similar multiple billing or other contractual disputes that are individually numbered)
- Disputing a request for reimbursement of an overpayment of a claim.

For payment dispute submissions:

For payment dispute submissions to be considered valid and complete: A Provider wishing to submit a payment dispute must do so using Oscar’s Dispute Resolution Form (copies of Oscar's Dispute Resolution Form, by state, can be found at Provider.hioscar.com/resources) submitted by

mail, through Oscar's electronic Provider portal, or via fax. Submission of this form will trigger Oscar's Dispute Resolution Process.

For all states except FL, and TX

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 FL, and TX

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.

Please see below for methods of submission:

Electronic Provider Portal Submission:
provider.hioscar.com

Fax:
1-888-977-2062

By mail:
Oscar Health, Inc.
P.O. Box 52146
Phoenix AZ, 85072–2146

You must complete the Dispute Resolution Form before you can initiate the dispute resolution process set forth in your Agreement.

Inquiries for administrative process

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).

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

Our Network

Network Overview

In certain markets, Oscar may operate multiple Provider networks in the same service area. Providers can confirm their in-network status via Provider directories on Oscar's website

(www.hioscar.com/care-options). More information on Oscar's network choices may be found in the State Specific Supplement, if applicable. A members' chosen network, if applicable, will be reflected in the plan name. Providers should make best efforts to refer to other Providers that participate in the member's specific network.

Our Delegated Vendors

See below for a list of our nationally delegated vendors.

Service	Partner	Contact Information	States
Behavioral Health and Substance Abuse Services	Optum	Phone: (877) 620-6194 Fax: 866-322-0051 Electronic Payor ID: 87726 Claims Submission Address: Optum P.O. Box 30757 Salt Lake City, UT 84130-0757	All States
Dental (Pediatric)	DentaQuest	Provider Customer Service: 855-418-1624 Systems Operations Support: 888-560-8135 Electronic Submission www.dentaquest.com Payor ID: CX014 Payor Address: PO Box 2906 Milwaukee, WI 53201-2906 Paper Claims Submission Fax: 262-834-3589 Address: PO Box 2906 Milwaukee, WI 53201-2906	States: AZ, CA, CT, GA, KS, MO, PA, TN, NY and NJ
Pediatric Vision	Davis Vision (Versant Health)	Fax: 888-343-3475 Claims Submission Address: Davis Vision	All States

		Vision Care Processing: P.O. Box 1525 Latham, NY 12110	
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 Oscar's prescription authorization line: Fax Standard: 844-814-2258 Fax Specialty: 844-814-2259 Claims Submission Address: CVS/Caremark Claims Department PO Box 52136 Phoenix, AZ 85072-2136	All States
Utilization Management: -Radiology/Advanced Imaging -Cardiology/Cardiac Imaging -Sleep -Lab -Interventional Pain -Outpatient Joint Surgery -Outpatient Spine Surgery -Radiation Oncology -Medical Oncology -Chiropractic	Evicore healthcare	Phone: 855-252-1118 Fax: 800-540-2406 Mailing Address: eviCore healthcare 400 Buckwalter Place Blvd. Bluffton, SC 29910	All States except for MI and AR
Utilization Management: -Physical Therapy (PT) & -Occupational Therapy (OT)	American Specialty Health (ASH)	Phone: (800) 848-3555 Fax: 877-248-2746 Mailing Address: American Specialty Health (ASH) P.O. Box 509077, San Diego, CA 92150-9077	KS, MO, IA, OK, FL, MI, OH, TN, NY, TX
Utilization Management: -NICU Admissions	Progeny	Phone: (610) 832-2001 Fax: 1-866-465-8926 Mailing Address: Progeny Health 450 Plymouth Rd, Plymouth Meeting, PA 19462	AZ, CO, FL, IA, KS, MI, MO, NE, NY, OH, OK, PA, VA, TN, TX, IL, NJ

Providers of these services must be in the respective partner's networks, and claims must be submitted to the address listed. For more information on the vendors Oscar uses for utilization management and reviews, please see the Utilization Management section of this manual.

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, and market differentiating 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:

- Receive information about the member rights and responsibilities
- The right to the privacy of medical records and personal health information
- A right to receive information about Oscar, its services, its practitioners and Providers and member rights and responsibilities; for more information please see our website at www.hioscar.com or call Member Services at 1-855-672-2755
- A right to be treated with respect and recognition of their dignity and their right to privacy by all Providers, practitioners, Oscar-contracted vendors and Oscar staff
- A right to participate with practitioners and Providers in making decisions about their healthcare
- A right to a candid discussion with their practitioners and Providers of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage
- A right to voice complaints, grievances, or appeals about Oscar and its contracted Providers and practitioners regarding the care or services they provide. Please refer to the "Complaints, Grievances, and Appeals" section of this Manual for directions on how to assist a member in submitting a grievance or appeal
- A right to make recommendations regarding Oscar's member rights and responsibilities policy
- A responsibility to supply information (to the extent possible) that Oscar and its practitioners and Providers need in order to provide care
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners

- A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible
- A responsibility to pay the appropriate cost share in accordance with their Oscar plan

Designation of an Authorized Representative

Members have the right to designate an Authorized Representative. If they wish to do so, they must complete and sign an Authorized Representative form, found on: www.hioscar.com/forms, by requesting through the Member Portal or calling the Member Services at 1-855-672-2755.

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 (APTC): Oscar provides a grace period of up to 31 days to members who are not receiving 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.
- 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.
- Oscar will deny claims that are received and not processed with dates of service beginning on the day following the last day the premium was paid after Oscar has confirmed that the grace period expired without premiums being paid in full.
- Any payments made to a Provider on behalf of a member who ultimately loses coverage due to non-payment of premiums will be refunded to Oscar by the Provider within forty-five (45) days of receipt of written request by Oscar.
- 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; and,
- 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.

- Any payments made to Providers on behalf of members who ultimately lose coverage due to non-payment of premium with dates of service beginning after the first month of the three-month grace period will be refunded to Oscar by the Provider within forty five (45) days of receipt of written request by Oscar.
- 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.
- Oscar will deny claims that are received and not processed with dates of service beginning after the last day of the first month of the three-month grace period after Oscar has confirmed that the grace period has expired without premiums being paid in full.
- If the member pays in full during the three-month grace period, claims will be processed as usual.

Eligibility

Verifying Eligibility

While Providers are responsible for verifying member coverage and benefits prior to rendering any non-emergency services or treatments, we've made it easy for you to identify our members.

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.

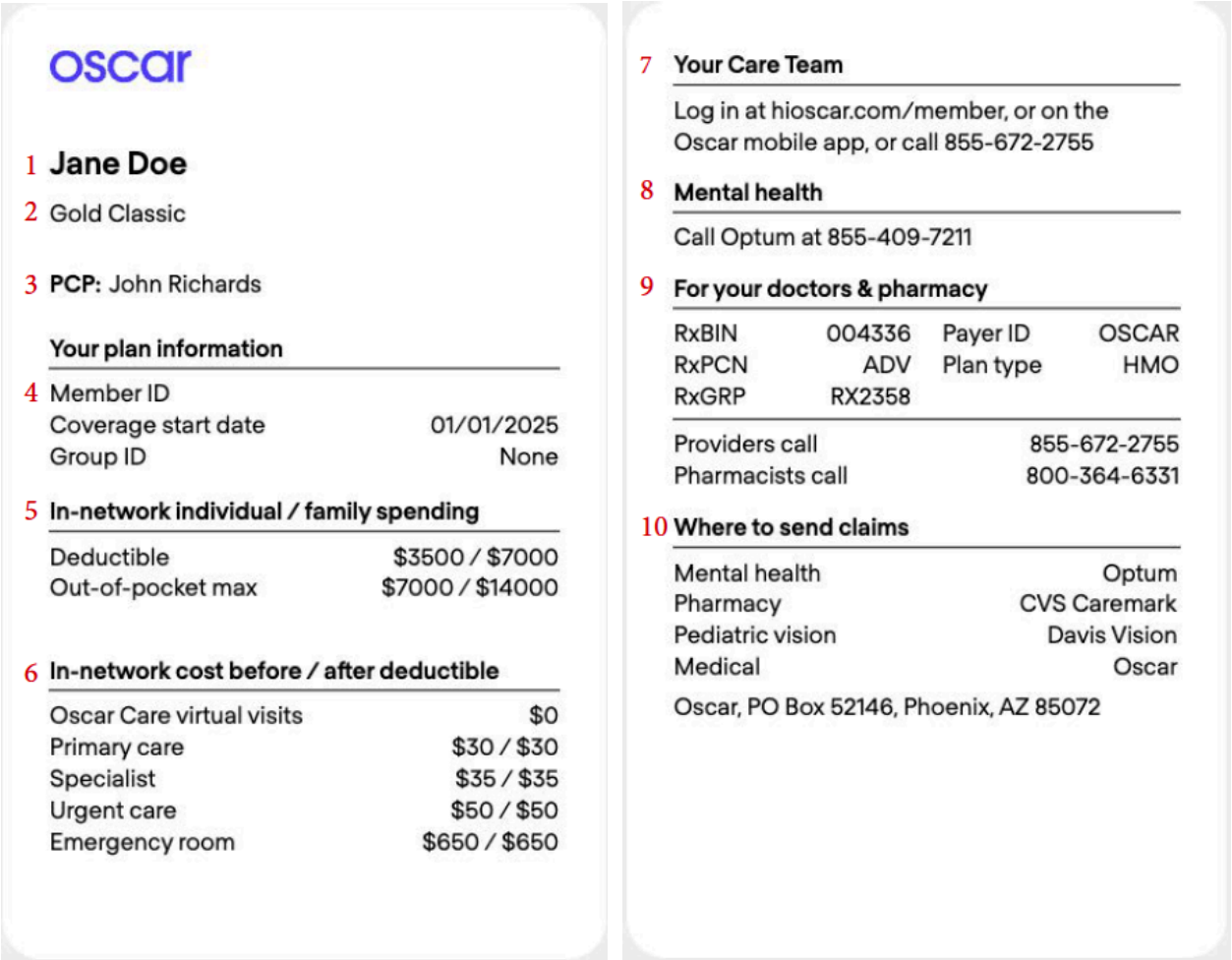
Newborn Eligibility

Newborns are always covered for the first 48 hours (vaginal delivery) or 96 hours (cesarean delivery) for the birth itself on the mother's plan as part of the federal ACA requirement.

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

Member ID Cards

All Oscar members should receive a member Identification (ID) Card . The following information can be found on the most common Oscar ID Cards:



1. Member first and last name
2. Name of the member's plan
3. Member's primary care Provider (where applicable)@
4. Member ID
5. Deductible and maximum out of pocket amounts, Individual & Family
6. Cost to the member, before and after, deductibles
7. Oscar Customer Service contact information

8. Behavioral Health services contact information
9. Pharmacy Information
10. Claims Information (where to send claims based on services provided)

Please note that there may be differences between Oscar member IDs based on market and / or the Oscar member's individual plan.

Verifying Benefits

We have a partnership with Change Healthcare for Real Time Eligibility (RTE) transactions.

With this partnership, you can receive benefit and eligibility information faster than before. Our collaboration with Change Healthcare supports an increase in the quality and speed of eligibility transactions, which will ultimately improve the patient experience.

This RTE solution is utilized across the industry, giving you the option to connect directly with Change Healthcare or utilize your current clearinghouse to get eligibility 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

Providers can verify Oscar benefits by logging in to Oscar's Provider Portal (provider.hioscar.com) or call Oscar Provider Services at (855) 672-2755 (Option 4) and request assistance with benefit verification.

For fastest service, we strongly encourage you to utilize RTE for benefit and eligibility questions.

Tiered benefit plans and tiered networks

Certain Oscar plans have defined tiered health care providers. Check for tier participation status on Oscar's provider portal when verifying members' eligibility and benefits. Members may have lower out-of-pocket costs for services provided by a tier health care provider or facility.

Non-Covered Benefits

If you provide non-covered services to Oscar members you may collect payment from Oscar's members for services not covered under their Oscar benefit plan if you first get:
The member's written consent.

The member must sign and date the consent before the service is done.
You must keep a copy in the member's medical record.

If you know or have reason to suspect the member's benefits do not cover the service, 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.

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

Plan Design Details

Overview

Oscar offers a variety of plan designs and benefits. Qualified Health Plans are offered by Oscar to Qualified Individuals as a Qualified Health Plan Issuer through a State-Based Exchange or Federally-Facilitated Marketplace/Exchange or Off Exchange. 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. Please review this manual for plan specifics.

Understanding Your Network Participation Status

Unless you have designated otherwise in your Agreement, you are contracted to see all members who are participating in an Oscar Health plan. Currently, Oscar Health plans are offered by Oscar's insurance affiliates. Oscar Health consists of the following insurance affiliates:

- Oscar Insurance Corporation
- Oscar Insurance Company
- Oscar Garden State Insurance Corporation
- Oscar Insurance Corporation of Ohio
- Oscar Health Plan, Inc.
- Oscar Insurance Company of Florida
- Oscar Managed Care of South Florida Inc.
- Oscar Buckeye State Insurance Corporation
- Oscar Health Plan of Pennsylvania, Inc.

- Oscar Health Plan of Georgia
- Oscar Health Plan of North Carolina, Inc.
- Oscar Health Plan of New York, Inc.

There may be an occasion due to medical circumstances that you render services to an individual enrolled with an Affiliate of Oscar listed above. Oscar is required by Law to compensate you for such services or services that Oscar has authorized. Oscar will reimburse you in the amount set forth in the compensation section of your Agreement.

Primary Care Provider (PCP)

A provider such as a family practitioner, pediatrician, internist, general practitioner or obstetrician, who oversees care for their assigned members'. Other Providers may be included as primary care Providers such as nurse practitioners and physician assistants as allowed by state mandates.

To be designated as a PCP, you must meet the PCP eligible specialty, and complete an attestation of service locations, and group affiliations in which the physician provides services in a PCP capacity. The attestation should be completed through the PCP flag on your roster.

Claims and Payment

Overview

This section outlines Oscar's claims policies and processes.

In-Network Providers

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 in accordance with the agreement with the lesser reimbursement rate.

Claims Submission

Providers may submit claims electronically or by mail.

Electronic Claim Submission

Oscar highly recommends that Providers submit claims electronically via Availity using Oscar's payor ID: OSCAR. If you are having any issues setting up the ability to submit claims

electronically, please contact your billing vendor to ensure they have Oscar's payor ID in their system.

Mailing Claim Submission

For all claims submitted via mail, Oscar requires the CMS-1500 Form for professional services and the UB-04 Form for facility services. These forms are available for download on the Forms section of provider.hioscar.com/resources.

- **CMS-1500 Claim Form:** Required for all Provider services claims, including internal medicine, gynecology and psychiatry. The International Classification of Diseases Tenth Revision (ICD-10) diagnosis codes and HCPCS/CPT procedure codes must be used. All field information is required unless otherwise noted.
- **UB-04 Claim Form:** Required for all institutional services claims. All field information is required unless otherwise noted.

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

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

Unlisted or Miscellaneous Code Usage

If unlisted or miscellaneous codes are used, notes and/or a description of services rendered must accompany the claim. Using unlisted or miscellaneous codes will delay claims payment and should be avoided whenever possible. Claims received with unlisted or miscellaneous codes that have no supporting documentation may result in a claim denial, and the member may not be held liable for payment.

Delegated Vendor Claims

Please consult the "Our Delegated Vendors" section of the Provider Manual for additional and/or required electronic and paper claims submission guidance for behavioral health and substance abuse, pediatric dental, pediatric vision, and prescription/specialty pharmacy services.

Please note that Oscar does not offer routine dental or vision coverage for adults.

Timely Filing of Claims

Providers must claim benefits by sending Oscar properly completed Clean Claim forms itemizing the services or supplies received and the charges within the timeline specified by applicable state

law unless stated otherwise in your Agreement. Oscar will not be liable for benefits if Oscar does not receive a completed claim form within this time period. Claim forms must be used; canceled checks or receipts are not acceptable.

Requests for Additional Information

During the claim's adjudication process, Oscar or delegated vendors may request additional information—such as medical records, acquisition invoices, or itemized bills— from the Provider in order to better ascertain financial liability and whether the services on the claim should be reimbursed. Oscar will make any requests for more information within timelines set by applicable state law or the Provider Agreement. Providers should refer to their respective Agreements for timelines when submitting requested additional information for claims. Unless a different timeline is specified in the Agreement, Providers must submit the requested information to Oscar, along with the associated Explanation of Payment (EOP) and / or a copy of the information request letter, within ninety (90) calendar days of receipt of the initial request. 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.

Guidelines for Additional Information

The following content guidelines for medical records and itemized bills will ensure timely processing of claims requiring additional information. All requested documents must be legible and must present the information in a way that can be reasonably interpreted.

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. The content is as follows but is not limited to:

- 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

Itemized Bill Content

An itemized bill will appropriately reflect line items, supplies, and services billed under the applicable revenue codes. A complete itemized bill must contain the following information:

- Member demographics
- Admit date / discharge date
- Revenue codes
- CPT and HCPCS codes, if applicable
- Date of service per item
- Description of service per item
- Quantities per item
- Amount billed per item
- Total billed charges

If the requested required documentation is not received within the applicable timeframe, Oscar may deny the claim.

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.

If the requested documentation received from the Provider is insufficient or incomplete, Oscar will send additional requests to the Provider detailing what information is still outstanding. All requests must be fulfilled within ninety (90) days of the initial request unless applicable state law states otherwise**.** Oscar will not be liable for claim payment or interest unless and until the documentation request has been properly satisfied, at which time the applicable timeframe for processing the claim will commence.

Timely Processing of Claims

Oscar and its delegated Provider organizations and hospitals are required to meet the claims timeliness standards established by state law.

Payment and Remittance Options

Oscar partners with Optum Financial, Inc. and ECHO Health, Inc to offer multiple 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/efteradirect/OscarManagementCorp.

To enroll in paper checks and paper 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.

Incomplete Claims

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
- Has no defect or error (including any new procedures with no CPT codes, experimental procedures, or other circumstances not contemplated at the time of execution of your Agreement) that prevents timely adjudication.

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.

Claim Denials

Oscar will send an Explanation of Benefits to members in situations where a denied claim could lead to member financial responsibility. The Explanation of Benefits will include the reason for denial as well as an explanation of 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.

Paper CMS 1500 corrected claim submissions must use Frequency Code 7 under Item 22 (Resubmission Code) and the corresponding original reference code field must list the original payor claim ID. Paper
UB-04 corrected claims must be submitted with Claim Frequency Type 7 as the third digit under Type of Bill (Form Locator 04) and the corresponding original reference code field must list the original payor claim ID. Electronic corrected claims must be submitted with frequency code 7 in Element CLM05-3 (Claim Frequency Type Code) and the corresponding original reference code field must list the original payor claim ID. Updated claim submissions that do not have these codes may be denied as duplicate submissions.

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

Emergency services do not require prior authorization or referrals. However, post-stabilization services require notification and may be subject to concurrent or retrospective review and medical necessity determination.

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

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 upfront but to defer the collection of coinsurance and deductible amounts until Oscar has adjudicated the claim and an Explanation of Payment (EOP) or 835 electronic remittance notice has been received. If a Provider prefers to collect member cost share upfront, the Provider is expected to collect the cost share as outlined in the member's Schedule of Benefits (found at www.hioscar.com/forms), never exceeding the full

negotiated rate for the services rendered.

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 a Provider collects an upfront amount that exceeds the member's cost share indicated in the EOP, Oscar requires the Provider to issue a refund to the member within 30 days of receipt of 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 provider.hioscar.com/.

Provider 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 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.

Complaints, Grievances and Appeals

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 subscriber (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

In cases where an authorization request is denied, the enrollee or the enrollee's authorized representative will have an opportunity to appeal the decision. The appeal will be handled through a structured appeal process and a licensed physician not involved in the initial coverage decision will review the appeal. Upon resolution of every internal appeal, a resolution letter is sent to the member, which, in the case of an adverse determination, will include information regarding any additional appeal rights the member might have and instructions on how to dispute the

determination. A copy of this letter will also be faxed to the Provider and the member's authorized representative, if applicable.

Members or Providers must submit an appeal of an adverse determination within 180 days after the date of receipt of a notice of an adverse benefit determination unless applicable law states otherwise. Appeals must be sent to the appropriate addresses on the appropriate forms noted below.

In order to request an appeal, please specify that you are seeking to file an appeal of a denied UR decision with the Clinical Review team, whether you submit your request via telephone, or in writing. An Oscar Grievance and Appeal Form is available at www.hioscar.com/forms, which the member may submit along with additional clinical information, to initiate an appeal request.

Members or their authorized representatives may request an independent medical review of disputed healthcare services if they believe that healthcare services have been improperly denied, modified, or delayed by Oscar or one of its contracting practitioners.

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 www.hioscar.com/forms, or these forms can be attained at the contact addresses listed above.

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.

Third Party Liability

Coordination of Benefits (COB)

The Coordination of Benefits (COB) applies when a person has health care coverage under more than one plan. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. 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.

If COB information is not included with the electronic claim or a copy of the primary EOP is not included with the paper claim, when not received, Oscar will deny the claim for primary carrier EOB. For more information about requirements for complete claims, go to the “Incomplete Claims” section of this Manual.

Oscar Payor ID: OSCAR is able to receive COB claims electronically; please contact your billing vendor for information on how to submit these claims. For more information about electronic claims, go to the “Claims Submission” section of this Manual.

When Oscar is not primary payor

When the Oscar plan is secondary, tertiary, or other non-primary payor, first submit the claim to the primary plan. After receiving a payment or denial notice from the primary plan, submit the claim to Oscar, along with a copy of the primary plan EOP. Paper copies are not required if you submit HIPAA-compliant COB content electronically through an EDI claims submission.

In the event that Oscar pays the full contracted rate on a claim for which Oscar is not the primary payor, a refund may be requested for the overpaid amount. This recoupment may be pursued by Oscar or by a vendor on Oscar’s behalf. Oscar or its vendor may request a copy of the primary insurer’s EOP to calculate Oscar’s responsibility as secondary payor. If the primary EOP is not provided upon request, Oscar may recoup the entire claim as an overpayment.

Workers’ Compensation

All claims paid by Oscar are reviewed post-payment to identify any claims that may qualify for workers’ compensation coverage. Part of this review process may include an Oscar vendor contacting the patient for information about the case. If it is determined that we have made a medical payment on a valid workers’ compensation case, we may require a refund. The vendor will provide information about that process. In this case, you should then resubmit the claim to the workers’ compensation carrier responsible for payment and submit the full refund to Oscar’s vendor or Oscar directly.

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.

Provider Member Medical Records Requirements

Access to Oscar Member medical records

As an Oscar Provider, unless otherwise stated in your Agreement, you are required to:

- Send copies of our Members' medical, financial, administrative, or purchasing and leasing records.
- Provide electronic medical records (EMR) access to Oscar on a 24 hours a day, 7 days per week basis.
- Maintain and protect records for 10 years.
- Give access to records for all dates of service that occurred when you were a contracted Provider.
- Assist us, or our designee, in completing chart reviews for Oscar members.

Medical record standards

Documenting a point of care improves quality of care, reduces risk of medical errors, and provides better communication between Providers, and supports better health outcomes.

Member point of care documentation for each visit:

- Member's complaint or reason for the visit.
- Physical assessment.
- Unresolved 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.
- Review by the PCP (initialed) on consultation, lab, imaging and special studies, as well as ancillary, outpatient and inpatient records.
- Follow-up care plans.

When coding the member's point of care, pick the Evaluation and Management level that reflects the member's condition at the time of the visit.

Monitoring the quality of medical care through review of medical records:

A well-documented medical record reflects the quality of care delivered to patients. Accreditation and regulatory groups review medical records as part of their oversight activities. Maintain your medical records in a manner that is current, detailed and organized. This allows for effective and confidential patient care and quality reviews. Correspondence from Oscar's Clinical or Quality of Care Department is considered privileged and confidential. The involved health care Providers cannot share or discuss correspondence with the patient, member or any member representative. You may not file the communication in the patient's medical record.

Medical records duplication

Medical records requests procedures for specialty referrals, member transfer, and member request guidelines for the following:

- Medical Record Copies for Specialist Referrals. The PCP office pays for the cost of duplicating and shipping the records due to a referral. You cannot charge the member for records used during the member's course of treatment.
- Member Transfer to Another PCP. Do not charge the member if they need records sent to another PCP.
- Member Request for Medical Records. The member, or member's representative, may request copies of records from your office.

Medical record guidelines

Medical records must have all information necessary to support claims for your services. You are expected to have written policies for the following:

- Medical records guidelines including maintenance of a single, permanent medical record that is legible, current and detailed
- Process for handling missed appointments
- Non-discrimination of health care delivery
- Staff training on confidentiality and safe record keeping
- Release of information
- Medical record retention
- Availability of medical records if housed in a different location
- Coordination of care between medical and behavioral health care Providers
- Process for notifying Oscar upon becoming aware of a patient safety issue or concern

General documentation guidelines

We expect you to follow guidelines for medical record information and documentation including the following:

- 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 and date of change. You must keep a copy of the original entry.
- 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.

- Medical records must be signed within 72 hours of the order date or date of service by the ordering (or) rendering Provider.
- Gather demographic information including name, gender, date of birth, member number, emergency contact name, relationship, phone numbers and insurance information.
- Transcribe family and social history, including marital status and occupational status or history.
- Prominently place information on whether the member has executed an advance directive. This is critical.
- List medical history, chronic conditions and significant illnesses, accidents and operations. Include the chief complaint, diagnosis and treatment plan at each visit.
- List medication allergies and adverse reactions. Also note if the member has no known allergies or adverse reactions. This is critical.
- Include name of current medications, dosages and over-the-counter drugs.
- Reflect all services provided, ancillary services/tests ordered and all diagnostic/therapeutic services referred by the health care Provider.

Document member history and health behaviors such as:

- Tobacco habits, including advice to quit, alcohol use and substance use (age 11 and older).
- Immunization record.
- Preventive screenings/services and risk screenings.
- Screenings for depression and evidence of coordination with behavioral health care Providers.
- 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."

Clinical decision and safety support tools are in place to help ensure evidence-based care and follow-up care. Examples include: Lab, X-ray, consultation reports, behavioral health reports, ancillary health care Providers' reports, facility records and outpatient records show health care provider review by signature or initials.

Reimbursement Requirements and Policies

Reimbursement Requirements and Policies

Oscar conducts Provider reimbursement according to its Manual and applicable policies listed in the policies section of the Provider Portal: provider.hioscar.com/resources.

Balance Billing Reimbursement

Except for cost share (copayments, coinsurance, deductibles), 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 under an Oscar Plan. 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

Oscar does not accept interim claims for inpatient services. Claims may only be billed upon patient discharge.

Interest on Late Payments

Oscar and its delegated Provider organizations will pay interest on any clean claim not paid according to applicable state and federal laws and regulations. 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, in its sole discretion, determines that it has denied or reimbursed a claim correctly but agrees to overturn the denial or issue additional payment in the interest of the member, these “Good Faith Payments” will not be eligible for any interest or penalties related to late payment.

Reimbursement Policies

Oscar reimburses in-network Providers according to the policies listed in the policies section of the Provider Portal. Oscar may modify its reimbursement policies at any time by publishing new versions to the Portal and providing advance notice to Providers of expected changes in accordance with state law, if applicable. Oscar’s Reimbursement Policies can be found in the Policies section of the Provider Portal: provider.hioscar.com/resources.

Claims Overpayment

In instances where Oscar has determined it has overpaid a claim, Oscar will submit a refund request to the Provider. This request will include the patient’s name, date(s) of service, amount of overpayment, and an explanation of how Oscar determined that an overpayment had been made. Oscar will make any refund requests within either 1) the timeframe required by applicable state or federal laws and regulations, or 2) the timeframe specified in the Agreement.

Upon receiving this request, the Provider must issue the refund or 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.

Providers should send refund checks or written notices contesting refund requests to the mailing address listed below:

Oscar Health
ATTN: Provider Refunds
615 S. River Drive
Tempe, AZ 85281

In instances where Provider either fails to issue a refund of overpayment, or notify Oscar of Provider's intent to contest an overpayment within the allowable time frame, Oscar may deduct the amount of overpayment from future claims payments until Oscar has been fully reimbursed unless otherwise specified in the Agreement. A written explanation will accompany all deductions made from future claims payments.

Utilization Management

Overview

Oscar's Utilization Management (UM) Program promotes the delivery of high-quality, medically necessary, cost efficient care for members. The UM Plan 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 (precertification or prior authorization), concurrent, and post-service (retrospective) reviews. It is important to note that neither prior authorization nor notification is required for Emergent or Urgent Care; however, post-emergent inpatient admissions do require authorization.

Oscar maintains a UR 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 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. When a setting, place of service, or level of care is part of a review, services that can be safely provided in a lower-cost setting will not be deemed medically necessary if they are performed in a higher-cost setting. For example, Oscar will not approve an inpatient admission for surgery if the surgery could have been performed on an outpatient basis, or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug can be provided in a physician's office or the home setting.

In some cases, Oscar uses vendors with expertise in particular clinical functions to oversee utilization and coverage determinations. For these cases, the UM Program includes the management and oversight of these vendors as detailed in the "Delegation and Oversight" section of this Manual.

Authorization Request Requirements

In general, the following information is required to submit an authorization request:

- Member information including first and last name, Oscar ID, and date of birth
- Referring/ordering Provider name information (NPI, TIN, and contact information)
- Attending/billing Provider name information (NPI, TIN, and contact information)
- 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 confirm authorization requirements for a specific code or service or to submit an authorization request, use Oscar's Provider Portal at provider.hioscar.com. Providers should submit authorizations through Oscar's Provider Portal for more expedient processing and communication, or check the status of an authorization. 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. In some states, Providers may be entitled to use other methods to submit an

authorization request. When relevant, this is indicated in the State Specific Supplement(s). For services where Oscar delegates utilization review, you will be transferred to or instructed to contact the appropriate vendor.

If we do not receive the information necessary to intake your authorization, you will be notified of the missing elements and asked to provide the required information. If any of the clinical information necessary to render a UR determination is missing, Oscar may issue a denial for not meeting medical necessity. To avoid processing delays, Oscar encourages initial submission of complete requests including the clinical information necessary for review.

An expedited / urgent authorization may be available if the time needed to complete a standard authorization could seriously jeopardize the member's life, health or ability to regain maximum function. Urgent authorizations may require physician attestation and should not be requested due to Provider desire for more timely communication or processing.

Authorization Request Communication

All determinations or requests for more information in order to make an initial UR determination are made in a timely fashion appropriate for the member's specific condition, not to exceed the timeframes required by NCQA or state and/or federal regulations. Decisions are communicated verbally and/or in writing to members and Providers as required by regulations.

Oscar will not reverse a UM approval where the Provider relied upon written or oral authorization of Oscar (or its agents) prior to providing the service to the covered person, except in cases where there is material misrepresentation or suspected fraud.

Same or Similar Specialty Review

In some states, Providers may request that a prior authorization request be reviewed by a physician in the same specialty as theirs, or by a physician in another appropriate specialty, or by a pharmacologist.

Clinical Criteria

The UM Program, under the direction of the Chief Medical Officer (CMO) and the designated Medical Directors, and with input and review by a quality subcommittee, develops and approves written clinical criteria and protocols for the determination of medical necessity and appropriateness of healthcare procedures and services. Clinical criteria and adopted criteria can be found on provider.hioscar.com/resources, and are:

- Based on nationally recognized standards
- 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
- Evaluated and updated at least annually

Current 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, CVS Speciality Exceptions Criteria
- Hayes, Inc.
- Up-to-Date
- American Society of Addiction Medicine
- Authoritative peer-reviewed textbooks and journals
- National society guidelines
- Agency for Healthcare Research and Quality
- National Institute of Health Consensus Statements
- Milliman Care Guidelines*

*Note: MCG 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 MCG criteria. MCG criteria are reviewed and updated annually.

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

For certain services, Oscar has partnered with outside vendors for UR activities. These vendors have adopted their own specialty criteria, which are reviewed and approved annually. These vendors are overseen by Oscar's UM staff as explained in the "Delegation and Oversight" section of this Manual. See the "Delegation and Oversight" section of the State Specific Supplement(s) for UM vendors and the associated service categories they manage.

In addition to medical necessity, Oscar also considers the local network and delivery system available to members with specific needs, e.g. for services rendered by skilled nursing facilities, subacute facilities, and home health agencies. Oscar reviews an individual member's unique situation and provides specific guidance tailored to the member and any special circumstance.

The UM Program maintains a list of medical procedures and services that require utilization review, which is shared on the Oscar website (https://www.hioscar.com/prior-authorization). This list is reviewed annually by the Chief Medical Officer and the designated Medical Directors as well

as by the Utilization Management Subcommittee.

The following factors are considered when building this list:

- 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

Oscar's Clinical Criteria are made available to enrollees and Providers act www.hioscar.com/clinical-guidelines. A hard copy of Oscar's Clinical Criteria is also 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.

Program Staff

Oscar's Chief Medical Officer and designated Medical Director are ultimately responsible for the UM Program. With a full, unrestricted license to practice medicine issued by their respective states, the designated Medical Directors maintain authority over all UM 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.

Table 1. Oscar Utilization Management staff

Staff	Participation in UM program	Authority to issue Adverse Determination?
Licensed Physicians	Review, approve, and/or deny UM requests based on Oscar documents, policies and procedures, and established Clinical Criteria; communicate with Providers	Yes
Licensed Pharmacists	Review and approve UM pharmaceutical requests based on Oscar documents, policies, procedures, and established Clinical Criteria; deny initial requests and escalate non-approval appeals for physician review; communicate with Providers	Yes (except AZ, NJ, NY, NC, PA, and TX)
Licensed Nurses	Review and approve UM 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 UM 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 UM activities. Review and approve certain UM requests when no clinical judgment is required using explicit UM criteria. Escalate non-approvals for review by a clinician.	No

Any adverse determinations (medical necessity denials) are reviewed and ultimately made by a physician or psychologist with an active license issued by a state licensing agency in the United States.

Oscar promotes consistent application of review criteria across its UM staff by conducting regular internal audits of determinations made by all clinical UM 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. Staff are identified by name, title, and organization name when initiating or returning calls regarding UM issues. 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 Language Assistance for Limited English Proficiency (LEP) section for details.

Oscar's UM Program affirms the following:

- UM decision-making is based only on appropriateness of care and service and existence of coverage

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

Services Requiring Authorization

The list of services subject to pre-authorization can be accessed online: www.hioscar.com/prior-authorization. Review requirements (prior authorization, concurrent, and/or retrospective review) for Behavioral Health & Substance Abuse are subject to the policies and procedures of Optum. It is important to submit any elective or pre-service requests in advance to ensure everything is in place for your patients to get the right care. If prior authorization is not obtained, they are subject to post-service (retrospective) review. Some services that may be a part of an ongoing course of treatment may also be subject to concurrent review.

Please note that the list of services within each category might not be exhaustive and inclusion of a benefit in the Oscar Authorization List is not a guarantee of coverage. Coverage of these benefits may vary by plan, and the Authorization List is subject to change. To confirm requirements for a specific code or service, request authorization, or check the status of an existing authorization, reference the authorization tool at provider.hioscar.com or call 1-855-672-2755. Authorization requests may also be submitted by faxing the Authorization Request Form found on www.hioscar.com/forms to the number provided on that form. For state specific options and additional details, refer to the "Authorization Request Requirements" section of your State Specific Supplement(s).

Review for certain services is delegated to eviCore healthcare. For access to the clinical criteria used by eviCore and authorization request forms, please visit: https://www.evicore.com/provider/clinical-guidelines. Reviews for Physical Therapy & Occupational Therapy services are delegated to American Specialty Health (ASH). Reviews for NICU admissions are delegated to Progeny Health. For any other services not indicated in these resources, you can call 1-855-672-2755 or follow the instructions on the Oscar Authorization Request Form available at www.hioscar.com/forms.

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.

We require that both you and the Oscar treated member must be aware of coverage decisions before covered services are rendered. If you provide the service before a coverage decision is made, or If any treatment or service described above is not pre-authorized and it is determined that the treatment, service, or extension was not medically necessary or experimental / investigational, the member cannot be billed and benefits may be reduced or denied.

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.

Emergency, Urgent, and Ambulance Services

No prior authorization is required for emergent or urgent 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/urgent inpatient admission within 48 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.

Post-Stabilization

Oscar will comply with any state specific post-stabilization requirements in accordance with applicable state and federal law and regulations.

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 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).

Delegation and Oversight

Oscar contracts with vendors to conduct UR for certain service categories. In these cases, Oscar UM staff is responsible for oversight of the delegated vendor for both clinical and operational purposes. The vendors Oscar utilizes nationally for UR are listed below.

Delegate	Service Categories Delegated for UR	Review Type	States / Markets
Optum	Behavioral health	Authorizations	All states / markets

		Reconsiderations and First Level Member and Provider Appeals	
American Specialty Health (ASH)	Physical Therapy & Occupational Therapy	Authorizations, Reconsiderations and First Level Member and Provider Appeals	KS, MO, IA, OK, FL, MI, OH, TN, NY, TX (Only Oscar IFP)
Progeny	UM and CM services from date of NICU and SCN admissions through discharge, continuing through the first year of life (365 days after birth)	Authorizations and Reconsiderations	AZ, CO, FL, IA, KS, MI, MO, NE, NY, OH, OK, PA, VA, TN, TX, IL, NJ
Evicore	- Radiology/Advanced Imaging - Cardiology/Cardiac Imaging - Sleep - Lab - Interventional Pain - Outpatient Joint Surgery - Outpatient Spine Surgery - Radiation Oncology - Medical Oncology - Chiropractic	Authorizations, Reconsiderations and First Level Member and Provider Appeals	All states except for MI and AR

Monitoring and Reporting of Utilization Management

Oscar retains documented UM policies and procedures as required by federal and state regulation. You may contact Oscar Provider Services (1-855-672-2755) (Option 4) with any questions about UM 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 practitioners, Providers, or employees who perform utilization reviews for issuing denials of coverage or for encouraging underutilization. Utilization review decisions are based on medical necessity and benefit eligibility.

Peer-to-Peer Process

In the case of an Initial Adverse Determination, excluding denials for non-covered benefits, the Provider of record is notified in the denial notification of the opportunity to discuss a medical necessity denial with an Oscar UM physician. If a request to schedule a peer-to-peer is received, scheduling and decisions will occur in a timely fashion appropriate for the member's specific condition, not to exceed timeframes required by applicable state regulations. A request for a peer-to-peer review must be submitted within seven business days of the date the prior authorization request was denied as indicated in the denial letter. The Oscar physician will make one attempt to contact the Provider of record during the scheduled time. If the Provider is unreachable, the Oscar physician will supply their name, position, and contact information for Oscar Clinical Review to reschedule the peer-to-peer. If applicable, pre-denial peer to peer procedures and/or requirements are provided in accordance with applicable state law or guidelines. Denials for non-covered benefits are not eligible for the 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.

Audits

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 contract 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
- Medical records signed within 72 hours of the order date or date of service by the ordering (or) rendering Provider.
- 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.

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.

Credentialing

Overview

The Oscar network credentialing process is designed to provide initial and ongoing assessment of the Provider's ability to render specific patient care and treatment within limits defined by licensure, certification and/or accreditation. 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.

Network Providers and business needs:
When we decide to approve or deny an application/reapplication, we consider:

- Our current network of healthcare Providers.
- Our business needs.
- The health care Provider's credentials and qualifications.

All Providers that meet requirements are referred 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 NCQA standards in credentialing and recredentialing its Providers.

Non-discrimination

Oscar's credentialing and recredentialing decisions are not based on a health care Providers or professional's:

- Race or ethnic/national identity.
- Gender.
- Age.
- Sexual orientation.
- Types of procedures they specialize in.
- Specialties that serve high-risk populations or conditions that require costly treatment.

Practitioner Rights

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

A Participating Practitioner has the obligation to update their CAQH (Council for Affordable Quality Health) application in accordance with the specified timelines with the most current information available and to notify Oscar immediately upon updates being attested to in the CAQH repository.s. 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, or approval for Oscar panel participation, by the Credentialing Committee does not necessarily mean "active" Oscar panel member. Unless allowed under applicable state law, a Provider may not begin seeing Oscar members until the credentialing application is approved. 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. In instances where Providers are sanctioned, or are in the process of being sanctioned, that result in a loss of license or

governmental authorization, Oscar reserves the right to terminate the Provider from Oscar's network.

Provider office location onsite quality review

Oscar retains the right to perform an onsite quality review of any Provider office location being considered for the Oscar network. 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 have administrative capacity to provide such services and meet delegation requirements as demonstrated in a pre-delegation review. At a minimum it is expected that these delegated partners meet or exceed NCQA accreditation standards in order to perform credentialing activities as a delegate of Oscar. See State Specific Supplement(s) 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, OIG and other sanctions, and current status of applicable certification and / or accreditation.

Re-credentialing Process for Practitioners

Re-credentialing of Providers occurs every three (3) years or 36 months. Review of Utilization Management (UM), Member Services, and Appeals & Grievances is considered at the time of recredentialing. Provider status and performance is continuously monitored 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.

Fraud, Waste, and Abuse

Overview

Oscar takes Fraud, Waste and Abuse (FWA) very seriously. Oscar's Special Investigations Unit

(SIU) is tasked with the detection, prevention, and investigation of FWA in the delivery of healthcare services. Fraud, Waste, and Abuse are improper actions that result in inappropriate and unnecessary spending:

- **Fraud** is distinguished from waste or abuse in that it is committed when one knowingly or willfully makes a material misrepresentation or omission with the intent to defraud and obtain a benefit
- **Waste** refers to overutilization, extravagant, careless or needless expenditure of healthcare benefits or services often caused by disorganization or a misuse of resources
- **Abuse** describes practices that are inconsistent, or outside the bounds of generally accepted practices in the industry, which result in unnecessary services and payment

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, prepayment and post-payment claim review, claim edits, and data analysis. Any report, regardless of source, may result in an investigation.

Prevention and Investigation

As part of its prevention and investigative efforts, Oscar's SIU initiates investigations which may include but are not limited to an audit of a Provider's records. 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.

Pre and post-pay claims reviews

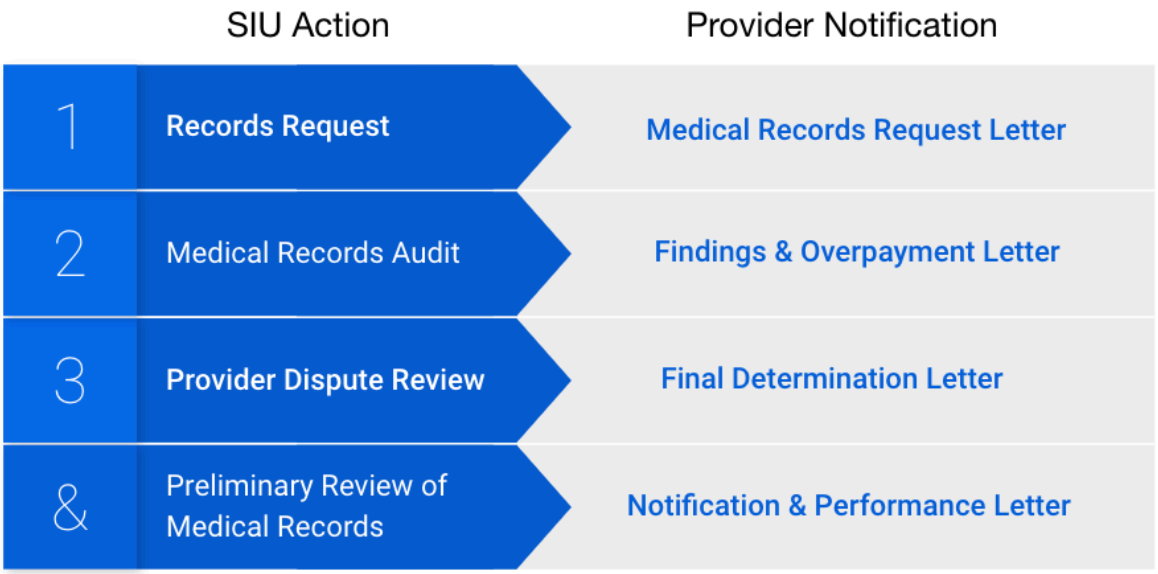
Pre and post-pay claims reviews entail a thorough review of submitted claims, and all available information including requested information, to determine whether the data submitted on the claim is accurately and appropriately supported. Providers are notified formally in writing when a preliminary review 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. 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. This includes, but is not limited to, compliance with the most stringent medical record documentation standards that would apply, and 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 prepay reviews will remain in place at the discretion of Oscar to mitigate risk to Oscar and its members. Oscar reserves the right to deny services or claims when review findings identified are egregious.

Additionally, a post-payment review may involve a sampling and extrapolation methodology, where allowed, or may require the Provider to cooperate in the performance of a self-audit to resolve identified issues. Investigations may involve review of contemporaneous treatment records as well as interviews with associated parties including members and Providers.

Investigative Actions & Provider Notification



Documentation Requirements

In addition to the medical record and documentation standards outlined throughout this manual, the following are also required:

- 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 being used to support a service, time must be documented with both an in and out time. Approximate time, ranges or total time will not be considered eligible for payment. Timestamps must be readily accessible in the medical record.

- In addition to the patient name, a total of at least two (2) patient identifiers must be documented and readily accessible in the medical records. Identifiers may include patient name, date of birth, Oscar ID Number or address.

- Provider name and signature must clearly identify the individual who rendered the service. If it is someone other than the billing Provider, indicate the name, credential and date with a signature. Authentication of medical records requires a date to coincide with the rendering Provider's name and signature.

Resolution

Based on the findings of an investigation, SIU may pursue corrective actions including but not limited to: Provider placement or continuation on pre-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. 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 Provider or Provider organizations suspect potential FWA relating to Oscar in any form, they must report it to Oscar immediately. To report, you can contact Oscar’s 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.

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.

All contracted Provider organizations and their downstream Providers are required to participate in Oscar's Quality Management and Quality Improvement (QI) Program. 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 purpose of the Quality Improvement (QI) Program is to improve health outcomes of members by providing access to affordable, appropriate and timely healthcare and services, which is routinely measured for compliance with established, evidence-based standards. This objective 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.

The QI Program also provides a framework to evaluate the delivery of healthcare and services provided to members. This 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

The responsibility for developing and providing oversight of the QI Program rests with the QI Committee of the Board. In order to foster communication with the practitioner and Provider networks, as appropriate, practitioners and designated behavioral healthcare practitioners are invited to participate in the QI Program through planning, design, implementation or review. Any network practitioner may be involved in the QI Program and / or attend and advise through involvement in various clinical subcommittees. If you are interested in participating further 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 does delegate certain QI activities. If activities are delegated to an approved entity, Oscar will:

- Establish a written delegation agreement outlining the scope of that delegate's responsibilities and how it will be monitored by the plan
- Through a pre-delegation audit and annual oversight audits thereafter, assess the delegate's ability to fulfill its responsibilities, including administrative capacity, technical expertise, and budgetary resources
- Maintain written oversight procedures in place to ensure Providers are fulfilling all delegated responsibilities; delegated organizations and Providers must provide quality metrics for review by the QI Committee, including but not limited to periodic reporting of:
    - Complex case management summary
    - 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 HEDIS and the CAHPS survey.

Population Health Management

Oscar offers a variety of programs designed to keep members healthy, improve clinical outcomes across settings, support members with emerging clinical risk and support members with multiple chronic illnesses. These programs cover a range of areas such as: Prevention and Screening, Concierge Case Management, Discharge Planning and Complex Case Management. 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.

Health Management and Education

Oscar engages in health education to equip members with tools and resources to stay healthy, improve knowledge about chronic conditions and their treatment, learn behaviors for better self-management, and promote prevention and early detection of illnesses. Education efforts include telephone outreach, targeted online content, member engagement through Oscar's mobile app and website, and other tactics. We evaluate outcomes using several mechanisms, including but not limited to HEDIS measures, utilization statistics, pharmacy data, and program participant surveys.

Member and Provider 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 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. 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 has a systematic method for the identification, reporting, and processing of PQIs to determine opportunities for improvement in the provision of care and services to Oscar members and to direct actions for improvement based upon the frequency and severity of the PQI.
It is our policy to accept a PQI referral through a variety of sources. These include but are not limited to: Internal referrals from Complaints, Grievances, and Appeals; an Oscar member; an Oscar Provider; an Oscar staff member; an affiliate.

- All PQIs that are identified are tracked for the purposes of monitoring patterns to identify any potential trends or any significant sentinel events.

- All information obtained during and used in a quality of care investigation will be held in strict confidence, according to the Plan confidentiality policies and in accordance with all relevant 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 after which the case will be assigned a severity score. Some cases will be referred to the Peer Review and Credentialing Subcommittee based on our policy. Based on review by the Peer Review and Credentialing Subcommittee, a Provider may be

placed on a corrective action plan (CAP) or may be required to submit a CAP. The CAP will require follow-up and evidence from the Provider in question to demonstrate that the corrective actions have been implemented as specified. 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.

PQI Outcomes

All PQI outcomes are trended on a continuous 36 month basis. Any identifiable trends, regardless of outcome to the member, will be referred to the Quality Improvement Committee on a quarterly basis for potential 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 provide direction and standards for preventive, acute, and chronic care health services relevant to Oscar's enrolled membership. Clinical practice guidelines are reviewed against UM criteria and member education materials to ensure consistency and alignment with appropriate medical recommendations.

Oscar is committed to the philosophy that evidence-based guidelines are known to be effective in improving health outcomes. Oscar compiled a group of recognized resources that promulgate evidence-based clinical practice guidelines (see below).

Preventive Care Guidelines

U.S. Preventive Services Task Force: The U.S. Preventive Services Task Force (USPSTF) issues recommendations on screening, counseling, and preventive medication topics and includes clinical considerations for each topic. Includes guidelines for adults 20-64 and 65+ years as well as children 2-19 years. For details: www.uspreventiveservicestaskforce.org.

Advisory Committee on Immunization Practices (AICP): 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. Includes guidelines for children under 24 months. For details: 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. For details: www.acc.org/guidelines.

American Academy of Pediatrics: Evidence-based decision-making tools for managing common pediatric conditions. Includes guidelines for children from birth to 19 years. For details: https://healthychildren.org/English/Pages/default.aspx.

Acute / Chronic Medical Condition Guidelines

American College of Cardiology: Framework of evidence-based clinical statements and guidelines developed by leaders in the field of cardiovascular medicine. For details: www.acc.org/guidelines.

American Diabetes Association: Standards, guidelines and clinical practice recommendations for healthcare professionals who care for people with diabetes. For details: 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. For details: www.acponline.org/clinical-information/guidelines.

Behavioral Health Guidelines

Professional Resources for Behavioral Health: Optum is the contracted Managed Behavioral Health Organization for Oscar. Optum provides best practice guidelines for the

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.

Medical Records and Standards

Access to Oscar Member Medical Records

Unless otherwise stated in your Agreement, you are required to:

- Supply member records to Oscar within 14 days upon request, free of charge.
- Provide electronic medical records (EMR) access to Oscar on a 24 hours a day, 7 days per week basis.
- Supply medical records faster in certain circumstances.
- Maintain and protect medical records for 10 years.
- Give access to member records for all dates of service that occurred when you were a Participating Provider.

Chart assessments and Provider failure to comply

Oscar has the right to assess its member's medical records in order to determine the accuracy of ICD-10-CM and CPT coding. Oscar will notify you of the results. We may charge a penalty if you fail to submit the information.

Risk adjustment and medical records

Medical records are important for both CMS reimbursement for Oscar's members and to accurately calculate an annual patient risk score that represents the specific patient's disease burden for the Department of Health and Human Services (DHHS). Every year, CMS and HHS require information about the demographic and health of our members. Diagnoses do not carry forward to the following year and must be assessed and reported every year. Records must show all conditions evaluated during the visit. It is important to evaluate all medical conditions, both chronic and acute, 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.

For accurate reporting on ICD-10-CM diagnosis codes, the medical record documentation must describe the Oscar member's condition. This should 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. Oscar may review the charts to identify conditions not coded on claims.

Medical Record Content

Complete medical records requested for the purpose of claim payment must include the content outlined in the earlier “Requests for Additional Information” section in this manual.

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 (PCPs) are compliant with current medical record standards:

- Every page in the record contains the patient name or ID number
- Documentation of allergies or No Known Drug Allergies (NKDA) and adverse reactions are prominently displayed in a consistent location
- All presenting symptom 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
- The important diagnoses are summarized and highlighted
- A problem list is maintained and updated for significant illnesses and medical conditions
- 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
- 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
- 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

- Continuity and coordination of care between the 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
- 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
- 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
- Evidence that the record was created contemporaneously with submission of the claim and include dates and signatures on any late entries, addendums, or corrections

Pharmacy Services

Overview

Oscar provides access to generic, brand, and specialty drugs through a network of pharmacies, infusion centers, hospitals, and outpatient Provider sites. We partner with Pharmacy Benefit Manager (PBM) CVS/Caremark to manage the pharmacy network, process claims, and support general pharmacy benefit operations. Oscar retains responsibility for maintaining the drug formulary through a Pharmacy and Therapeutics Committee (P&T) committee composed of healthcare Providers in various settings. Oscar also reviews all prior authorizations, peer-to-peer requests, appeals, and non-formulary requests submitted by Providers. Please see below for information on how to navigate formulary management, and submit a prior authorization, appeal, or non-formulary exception.

Formulary Management

Oscar maintains a list of covered medications, called the Formulary, that is reviewed and updated on a regular cycle. 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 P&T committee provides clinical expertise when determining a drug's place in therapy and provides input on standard of care and real-world 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.

While Oscar's Formulary generally stays consistent between plan years, medications are added or

removed on an annual basis and rules for coverage may change as well. Oscar always ensures uniformity among all individuals in a given plan type when changes occur. When a change does occur, advanced notice is provided to members, healthcare Providers, and the Insurance Commissioner in accordance with federal and state specific law. To receive coverage for a formulary medication, members must have a health care Provider prescribe the medication and the medication must be determined by Oscar to be medically necessary, unless otherwise specified by applicable state or federal law or regulation.

The Formulary contains utilization management rules for coverage such as prior authorization, step therapy and quantity limits. To request coverage for a medication not listed on the Oscar Formulary, members or their health care Providers may submit a request to us. If you have a question regarding whether a drug is on the Formulary, please see the most updated version of the Formulary here: www.hioscar.com/forms or call us at 1-855-672-2755.

Prior Authorizations and Non-Formulary Exceptions

Some drugs on Oscar's Formulary require prior authorization before Oscar will pay for the drug at the pharmacy. A team of pharmacists and physicians review these requests to ensure that the most clinically appropriate and cost-effective drugs are being prescribed. 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.

If you are prescribing a drug that is not on Oscar's Formulary, please review the Formulary first to determine if an alternative drug is clinically appropriate. If not, you can submit a non-Formulary exception request via the methods below. For all prior authorization and non-Formulary exceptions, medical records are required to verify the information attested to on the prior authorization form. If Oscar's clinical reviewer needs additional information, they will reach out to your office with the specific information needed to render a decision. If your request is denied, you may have a peer to peer discussion regarding the decision with a clinical reviewer at Oscar. 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.

You can submit a prior authorization, non-Formulary exception, or appeal request by downloading a form here: www.hioscar.com/forms and submitting through the following methods:

Electronically:
CoverMyMeds: www.covermymeds.com

Fax:

1-844-814-2259 (Specialty Drugs)
1-844-814-2258 (Non Specialty Drugs)

Phone:
1-855-672-2755

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 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, as defined under 42 CFR § 124.2 with fifty (50) beds or more, your facility is required to be in compliance with the patient safety standards as articulated in 45 CFR § 156.1110 and in accordance with section 131l(h) of the Affordable Care Act for plan years beginning on or after January 1, 2017. Your continued participation in Oscar's Exchange product network requires you to:

- Utilizes a patient safety evaluation system as defined in 42 CFR § 3.20; and
- Implement a mechanism for comprehensive person-centered hospital discharge to improve care coordination and health care quality for each of its patients; or you
- 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 as to these requirements in order 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 its compliance with these requirements.

Consolidated Appropriations Act, 2021 (CAA) 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 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 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 in your care or the care of your downstream contracted Providers who are:

- Undergoing treatment for a serious and complex medical condition.
- Undergoing inpatient or institutional treatment.
- Scheduled to undergo 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

Please refer to the applicable state supplements in the manual.