2025 Annual
Members' Needs and Preferences Report

National

Completed: 1/20/2026
Lookback Period: 1/1/2025-12/31/2025
Confidential and Proprietary. Not To Be Reproduced Or Disclosed to Others Without Prior Written Approval.

Table of Contents

Member Cultural Needs and Preferences 3
- Racial, Ethnic, and Linguistic Needs1 3
  - Data Collection and Methodology 3
    - Available Member Data 4
    - Available Provider Data 5
    - Measures 6
  - Quantitative Analysis 7
    - Race: American Indian or Alaska Native 7
    - Race: Asian 9
    - Race: Black or African American 10
    - Race: Native Hawaiian or Other Pacific Islander 11
    - Race: White 12
    - Ethnicity: Hispanic or Latino 13
    - Preferred Languages 14
    - Availability of Office Staff Languages (Top 3) 15
    - Cultural Needs: Religion Breakdown 18
    - Cultural Needs: Nutritionists 19
    - Cultural Needs: OB/GYN 20
    - Cultural Needs: Gender 23
    - Member Experience with Cultural Competency 24
  - Summary of Misses 25
  - Qualitative Analysis 26
- Prioritized Improvement Opportunities 29
- Racial, Ethnic, and Linguistic Needs 29

Member Cultural Needs and Preferences

Racial, Ethnic, and Linguistic Needs

Oscar is committed to ensuring that members receive care that meets their racial, ethnic, cultural, and linguistic needs. The Plan strives to curate networks that provide its members with culturally sensitive treatment to help address ethnic disparities in healthcare.

Data Collection and Methodology

In order to measure network adequacy, Oscar collected and aggregated race, ethnicity, and language (R/E/L) data from members in order to assess needs. This member data is collected from exchange records as well as from health appraisal surveys and NCQA HEDIS measures.

The Plan also collected and aggregated R/E/L data from providers to assess whether or not Oscar's networks are meeting the needs of members. This provider data is collected during the credentialing process for internally credentialed providers as well as from the Plan's credentialing delegates via provider rosters. Currently Oscar does not have reliable data on practitioner race or ethnicity, as this data is "optional" (i.e. not required) on practitioner credentialing applications. Across all of Oscar's entities, only a few credentialing delegates collect data on provider race or ethnicity, allowing for Oscar to have a range of 6.1% - 20.1% for race data and 0.3% - 3.2% for ethnicity data in 2025 with similar reporting numbers in 2024. Although there is a lack of race and ethnicity data, Oscar does have a significant amount of language data for providers..

Additionally, Oscar assesses whether or not the cultural needs of its members are being met by tracking and trending complaints regarding cultural competency.Oscar also tracks gender for both members and providers as well as availability of OBGYN and Family Planning specialties.

Available Member Data

The below table shows how much R/E/L member data that is available for each entity. Overall availability of race data has increased from an average of 38.31% in 2024 to 41.34% in 2025. For Language, Oscar has >90.6% availability of data across all states. Membership estimated using "K" to represent "thousands" of members per recently available data (as of December 31, 2025). In comparison to 2024, membership has decreased across most states with the exception of FL, MI, NC, NE, NJ, TN, and TX. The availability of ethnicity data decreased from an average of 41.06% in 2024 to 29.23% in 2025, and language data remained at 98.9%.

Table 1	Available Member Data - 2025						
State	Membership	Race Data	Race YoY 2024 vs. 2025	Ethnicity Data	Ethnicity YoY 2024 vs. 2025	Language Data	Language YoY 2024 vs. 2025
AZ	13.27k	34.50%	-4.30%	41.50%	-7.10%	97.40%	-0.70%
FL	1.22M	28.60%	-0.30%	41.90%	-1.20%	100.00%	0.00%
GA	227.12k	36.40%	9.70%	28.20%	-3.40%	99.90%	-0.10%
IA	22.08k	27.70%	3.80%	43.00%	-2.60%	99.90%	0.00%
IL	2.49k	60.30%	28.10%	36.30%	-1.80%	98.90%	-0.30%
KS	15.27k	29.90%	1.30%	41.40%	-4.50%	99.90%	0.20%
MI	4.66k	33.30%	-4.50%	39.30%	-6.20%	99.70%	0.80%
MO	10.75k	30.20%	12.80%	37.90%	-0.50%	99.90%	0.00%
NC	16.31k	19.10%	-4.50%	28.60%	-8.00%	99.80%	0.30%
NE	1.75k	61.90%	1.80%	70.10%	-1.10%	99.40%	0.80%
NJ	36.98k	60.60%	-5.60%	15.30%	-2.60%	99.90%	0.00%
NY	9.46k	57.90%	-1.20%	48.90%	-0.30%	90.60%	-1.20%
OHB	57,920	33.20%	4.20%	43.00%	0.70%	100.00%	0.10%
OHC	9,310	61.80%	32.80%	63.20%	20.90%	99.80%	-0.10%
OK	4.62k	32.90%	4.20%	53.30%	2.60%	99.20%	-0.30%
PA	2.91k	71.50%	-3.40%	11.50%	-2.50%	99.40%	0.50%
TN	98.32k	26.40%	-1.60%	34.20%	-5.30%	99.90%	0.00%
TX	431.59k	19.10%	-10.00%	27.60%	-13.10%	99.90%	0.00%
VA	264	60.20%	-5.60%	40.20%	1.20%	95.50%	-0.40%
Average		41.34%		39.23%		98.89%	

Available Provider Data

The below table shows how much R/E/L provider data that is available for each entity. Oscar has <22.55% data for all states for race and ethnicity. NJ has the most data missing for race, with only 6.1% of race data available followed by GA with 8.6% of race data available. TN has the most missing data for ethnicity, with only 0.3% of ethnicity data available followed by IA, MO, OHB, and OHC at 0.4% of ethnicity data available. Oscar has 100% of Language collected across all of its providers inclusive of English. Network size per recently available data (as of December 31, 2025) has increased from an average of 38,192 in 2024 to 29,282 in 2025.

Table 2	Available Provider Data - 2025

State	Network Size	Race Data	Race YoY 2024 vs. 2025	Ethnicity Data	Ethnicity YoY 2024 vs. 2025	Language Data	Language YoY 2024 vs. 2025
AZ	25,889	13.40%	-0.40%	1.80%	0.00%	100.00%	0.00%
FL	87,984	13.20%	0.20%	5.30%	0.80%	100.00%	0.00%
GA	73,341	8.60%	-2.20%	0.50%	-0.20%	100.00%	0.00%
IA	12,840	13.80%	0.90%	0.40%	0.10%	100.00%	0.00%
IL	46,648	12.40%	-0.20%	1.30%	0.10%	100.00%	0.00%
KS	9,758	17.10%	-1.60%	0.70%	-0.10%	100.00%	0.00%
MI	21,675	20.10%	-0.10%	0.60%	0.00%	100.00%	0.00%
MO	19,971	15.50%	-1.50%	0.40%	0.10%	100.00%	0.00%
NC	30,793	16.90%	-1.40%	0.80%	0.00%	100.00%	0.00%
NE	16,962	10.10%	0.00%	0.50%	0.10%	100.00%	0.00%
NJ	50,804	6.10%	0.00%	0.80%	0.10%	100.00%	0.00%
NY	92,585	12.00%	-0.90%	1.50%	-0.40%	100.00%	0.00%
OHB	20,364	15.30%	3.00%	0.40%	0.00%	100.00%	0.00%
OHC	32,189	15.30%	3.00%	0.40%	0.00%	100.00%	0.00%
OK	8,601	22.50%	-1.10%	1.30%	0.00%	100.00%	0.00%
PA	43,693	15.80%	3.00%	0.60%	0.10%	100.00%	0.00%
TN	26,389	13.80%	-0.20%	0.30%	-0.10%	100.00%	0.00%
TX	98,465	13.80%	-0.20%	3.20%	0.00%	100.00%	0.00%
VA	27,407	19.80%	-0.50%	1.00%	0.10%	100.00%	0.00%
Average		14.50%		1.15%		100.00%	

Measures

Measure	Definition	Goal
Race	Based on the data available, Oscar calculates the percentage of members and of providers falling into the five OMB race categories: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White. The percentage of members falling into a category is compared to the percentage of providers falling into that same category.	*NEW Goal: 1:2000 provider (PCP) to member ratio*
Ethnicity	Based on the data available, Oscar calculates the percentage of members and of providers falling into the one OMB ethnicity category: Hispanic or Latino. The percentage of members falling under Hispanic or Latino is compared to the percentage of providers	*NEW Goal: 1:2000 provider (PCP) to member ratio*

	falling into that same category.	
Language	Based on the data available, Oscar calculates the percentage of members falling under each preferred language and reports languages preferred by >200 of members or >1% of members. The percentage of members falling under a reported language is compared to the percentage of providers who speak that same language.	*NEW Goal: 1:2000 provider (PCP) to member ratio*
Culture Competency	Oscar evaluates member experience with provider cultural competency by reporting the volume of complaints per 1000 members for complaints related to “Poor Cultural Competency” and “Allegation of discrimination based upon race, color, national origin, sex, age, or disability”.	1 per 1000 Members
Cultural Needs	Oscar evaluates for adequate provider volume by specialty based on cultural needs identified through external research.	Goals vary by metric. See Cultural Needs sections for specific goals.

Quantitative Analysis

Target Update:
For 2025, Oscar updated the metrics for Race and Ethnicity. In prior years (including 2023 and 2024) Oscar set the goal as greater than or equal to 500 providers per one thousand members. This included providers of all specialties. Per the Network team, this metric has been updated to a 1:2000 ratio of members: providers using only Primary Care Providers (PCP). Accordingly, no year over year data is included for 2025 since this is the first year of using the new target.

Race: American Indian or Alaska Native

Table 3	**Race: American Indian or Alaska Native - 2025** *NEW Goal: 1:2000 provider (PCP) to member ratio*		
State	**Member**	**Provider**	**Provider to Member Ratio**
AZ	56	0	NR
FL	860	5	1:172
GA	392	0	NR
IA	63	0	NR
IL	16	0	NR
KS	81	0	NR
MI	30	0	NR
MO	43	0	NR
NC	22	0	NR
NE	12	1	1:12
NJ	153	0	NR
NY	6	0	NR
OHB	96	0	NR
OHC	19	0	NR
OK	131	0	NR
PA	19	0	NR
TN	236	0	NR
TX	917	5	1:183
VA	2	0	NR

No gaps were identified for 2025 using the new metrics.

NR: No data reported or information available. NR states were not considered as deficient due to lack of data.

Race: Asian

Table 4	**Race: Asian - 2025** *NEW Goal: 1:2000 provider (PCP) to member ratio*		
State	**Member**	**Provider**	**Provider to Member Ratio**
AZ	315	20	1:16
FL	15,410	86	1:179
GA	92	423	1:0
IA	560	0	NR
IL	165	19	1:9
KS	397	3	1:132
MI	90	2	1:45
MO	454	4	1:114
NC	283	8	1:35
NE	63	0	NR
NJ	4,100	3	1:1,367
NY	671	50	1:13
OHB	2,180	4	1:545
OHC	294	1	1:294
OK	168	1	1:168
PA	160	14	1:11
TN	2,160	11	1:196
TX	10,380	151	1:69
VA	15	17	1:1

No gaps were identified for 2025 using the new metrics.

Race: Black or African American

Table 5	**Race: Black or African American - 2025** *NEW Goal: 1:2000 provider (PCP) to member ratio*		
State	**Member**	**Provider**	**Provider to Member Ratio**
AZ	225	1	1:225
FL	55,820	52	1:1,073
GA	23,980	73	1:328
IA	521	0	1:0
IL	267	5	1:53
KS	414	0	1:0
MI	120	0	1:0
MO	360	4	1:90
NC	586	4	1:147
NE	50	1	1:50
NJ	2,230	6	1:372
NY	177	11	1:16
OHB	4,470	1	1:4,470
OHC	261	0	1:0
OK	183	1	1:183
PA	185	5	1:37
TN	6,240	21	1:297
TX	7,490	65	1:115
VA	30	3	1:10

The only gap identified was the OHB market, with a ratio of 1:4,470. This misses the target of 1:2,000.

Race: Native Hawaiian or Other Pacific Islander

Table 6	**Race: Native Hawaiian or Other Pacific Islander - 2025** *NEW Goal: 1:2000 provider (PCP) to member ratio*		
State	**Member**	**Provider**	**Provider to Member Ratio**
AZ	12	0	1:0
FL	404	3	1:135
GA	97	1	1:97
IA	20	0	1:0
IL	4	0	1:0
KS	4	0	1:0
MI	3	0	1:0
MO	4	0	1:0
NC	8	0	1:0
NE	5	0	1:0
NJ	143	0	1:0
NY	7	0	1:0
OHB	21	0	1:0
OHC	4	0	1:0
OK	1	0	1:0
PA	4	1	1:4
TN	37	1	1:37
TX	174	0	1:0
VA	0	0	1:0

NR: No data reported or information available. NR states were not considered as deficient due to lack of data.

No gaps were identified for 2025 using the new metrics.

Race: White

Table 7	Race: White - 2025 *NEW Goal: 1:2000 provider (PCP) to member ratio*		
State	**Member**	**Provider**	**Provider to Member Ratio**
AZ	3,790	42	1:90
FL	256,400	235	1:1,091
GA	29,310	124	1:236
IA	4,870	5	1:974
IL	1,020	30	1:34
KS	3,640	16	1:228
MI	1,310	6	1:218
MO	2,380	26	1:92
NC	2,040	45	1:45
NE	974	36	1:27
NJ	13,760	11	1:1,251
NY	4,640	41	1:113
OHB	12,020	16	1:751
OHC	5,090	6	1:848
OK	1,050	12	1:88
PA	1,560	47	1:33
TN	16,020	99	1:162
TX	60,280	200	1:301
VA	107	23	1:5

No gaps were identified for 2025 using the new metrics.

Ethnicity: Hispanic or Latino

Table 8	Ethnicity: Hispanic or Latino - 2025 *NEW Goal: 1:2000 provider (PCP) to member ratio*		
State	**Member**	**Provider**	**Provider to Member Ratio**
AZ	1,330	6	1:222
FL	320,790	398	1:806
GA	18,800	26	1:723
IA	734	1	1:734
IL	318	32	1:10
KS	902	1	1:902
MI	166	0	1:0
MO	454	1	1:454
NC	1,370	2	1:685
NE	88	0	1:0
NJ	4,110	4	1:1,028
NY	374	5	1:75
OHB	2,840	175	1:16
OHC	138	170	1:1
OK	260	1	1:260
PA	237	3	1:79
TN	6,170	0	1:0
TX	63,450	164	1:387
VA	24	1	1:24

No gaps were identified for 2025 using the new metrics.

As Oscar continues to grow its Buena Salud program that specifically targets Hispanic and Latino populations, this will be an opportunity to showcase a focus on cultural competency by ensuring that we have providers of the ethnicity being marketed to.

Preferred Languages

For quality purposes, Oscar has chosen to identify threshold languages as languages preferred other than English by greater than or equal to 200 members or by greater than or equal to 1% of its membership, whichever is less. Due to stricter threshold criteria, please note that these

findings may differ from threshold languages identified in the tri-annual assessment of language preferences used to assess members' language needs. In 2027 the next assessment of language services will be conducted.

Table 9	Preferred Languages - 2025 *Goal: Providers per 1K Member >= 500*					
State	**Language**	**Member**	**Provider**	**Providers per 1K Members**	**Providers per 1K Members YoY 2024 vs. 2025**	**Member to Providers Ratio**
AZ	Spanish	17,006	2,784	164	-2,540	6:1
FL	Spanish	804,500	11,841	15	-29	68:1
	Portuguese	79,600	462	6	-151	172:1
	Creoles and Pidgins	89,600	451	5	NR	199:1
	Russian	2,590	351	136	-228	7:1
	Vietnamese	1,720	No Data	NR	NR	NR
	Chinese	1,070	No Data	NR	NR	NR
GA	Spanish	62,800	4,436	71	-44	14:1
IA	Spanish	2,680	275	103	-296	10:1
IL	Spanish	11,850	2,377	201	-515	5:1
KS	Spanish	2,450	174	71	-241	14:1
MI	Spanish	834	326	391	-3,771	3:1
MO	Spanish	1,680	338	201	-250	5:1
NC	Spanish	15,880	514	32	-941	31:1
NE	Spanish	264	441	1,670	-39,909	1:1
NJ	Spanish	34	12,094	355,706	353,050	0:1
NY	Spanish	1,040	6,723	6,464	NR	0:1
OHB	Spanish	13,880	375	27	-46	37:1
	Creoles and Pidgins	1,040	NR	NR	NR	NR
OHC	Spanish	14	375	27,017	26,939	0:1
	Creoles and Pidgins	1040	NR	NR	NR	NR
OK	Spanish	1,940	242	125	-242	8:1

PA	Spanish	1,030	1,425	1,383	-19,874	1:1
TN	Spanish	26,650	731	27	-484	36:1
TX	Spanish	181,390	6,169	34	-491	29:1
	Vietnamese	2,420	251	104	-876	10:1
	Chinese	806	No Data	ND	NR	NR
VA	Spanish	1,600	451	282	-33,375	4:1

Note: This table contains languages other than English preferred by >200 of members or >1% of members by entity. If no data is available meeting those thresholds, the next top language is included.Note: The providers per 1K member metric is based on the data available for language applied to the total membership and the total provider network.

NR: No data reported or information available. NR states were not considered as deficient due to lack of data.

Gap for Spanish-speaking providers were identified in NE, NJ and NY and PA. Also in FL, gaps for Portuguese and Russian speaking providers were identified. In Florida the following languages were not able to be trended due to lack of data, Creole and Pidgins, Vietnamese and Chinese.

This is a downward trend from both 2023 and 2024 creating a larger gap for Spanish speaking members.

The need for Spanish speaking providers is further amplified by Oscar's Spanish-First programs being implemented and expanded in 2025 which were created for Spanish speaking communities. Language barrier is cited as a main driver for not accessing healthcare needs. More can be found on these programs and opportunities can be found in the Opportunities for Improvement section.

Availability of Office Staff Languages (Top 3)

In January 2024, Oscar integrated the availability of office staff languages within the provider rosters so that we can assess the presence of bilingual staff in practitioners' offices. This was rolled out as a voluntary field where providers can list out all languages that are spoken in their respective offices. The "Offices" column is representative of the number of offices that responded to the new office staff language category. Since this data was first collected in 2024, 2025 is the first year Oscar is able to track this data year over year hence language goal benchmarks are still pending.

Table 10	Availability of Office Staff Languages (Top 3) - 2025			
State	**Offices**	**Languages Available**	**Percentage**	**YoY Changes 2024 vs. 2025**
AZ	558	English	69.89%	3.22%
		Spanish	27.96%	4.77%
		Chinese	0.72%	-1.11%
FL	1,591	English	68.76%	39.06%
		Spanish	28.22%	-35.96%
		French	2.33%	-3.04%
GA	427	English	95.78%	13.67%
		Spanish	3.51%	-0.37%
		Chinese	0.47%	-11.82%
IA	284	English	92.96%	5.27%
		Spanish	5.28%	-2.41%
		French	0.70%	-0.84%
IL	NR	NR	NR	NR
KS	448	English	79.46%	3.75%
		Spanish	18.30%	2.88%
		Arabic	0.67%	-6.89%
MI	395	English	90.38%	6.49%
		Spanish	5.82%	-2.71%
		Hindi	1.27%	-1.10%
MO	448	English	79.46%	3.75%
		Spanish	18.30%	2.88%
		Arabic	0.67%	-6.89%
NC	177	English	43.50%	20.37%
		Spanish	51.98%	-16.05%

		Hindi	1.69%	-3.07%
NE	NR	NR	NR	NR
		English	87.47%	24.97%
		Spanish	4.44%	-11.83%
NJ	11,680	Arabic	2.35%	-2.35%
		English	87.43%	24.36%
		Spanish	4.23%	-11.50%
NY	12,105	Arabic	2.59%	-2.12%
		English	85.68%	5.76%
		Spanish	11.17%	-3.40%
OHB	412	Arabic	0.97%	-0.21%
		English	88.70%	6.62%
		Spanish	8.52%	-4.20%
OHC	575	Arabic	0.70%	-0.46%
		English	89.53%	23.40%
		Spanish	6.98%	-17.21%
OK	86	Arabic	1.16%	-3.68%
		English	76.58%	7.97%
		Spanish	12.44%	4.64%
PA	474	Arabic	3.07%	-12.72%
		English	93.48%	9.38%
		Spanish	5.85%	0.21%
TN	559	Chinese	0.33%	-8.90%
		English	93.87%	1.42%
		Spanish	5.30%	-1.23%
TX	6591	French	0.29%	-0.11%
		English	82.06%	7.06%
		Spanish	12.69%	-4.18%
VA	457	French	2.72%	-1.50%

Overall, Spanish and English are the top 2 languages spoken by office staff. Across the board, the third language available is Arabic (KS, MO, NJ, NY, OHB, OHC, OK, PA), Chinese (AZ, GA, TN), French (FL, IA, TX, VA), or Hindi (MI, NC). Since 2024 is the first year this information has been requested from provider offices in addition to being a voluntary field, the data may be skewed and not representative of the market population. Once data has been trending for 3 or more years, Oscar can adequately assess the availability of provider office staff languages for members.

Cultural Needs: OB/GYN[1]

Based on results from the HEDIS Prenatal and Postpartum Care (PPC) Measure and the State of Healthcare Quality NCQA report as of May 2025:

- Nationally the highest performing prenatal group was white with a rate of 66.2% (35% of eligible population). The lowest performing group with more than 5% of eligible population is (Black/African American) BAA with a rate of 62.5% (8% of eligible population). The disparity between White and BAA is 3.7%.

- The postpartum measure's top performing group is white with a rate of 61.4% (35% of eligible population). The lowest performing group with more than 5% of eligible population is BAA, with a rate of 58.1% (8% of eligible population). The disparity between White and BAA is 3.3%.

- The disparity gap for both prenatal and postpartum care remains widest between White and BAA populations. Crucially, the "Unknown" or missing race/ethnicity data remains a significant hurdle for accuracy; currently, both populations have an unknown population of more than 58%. .

From these findings, Oscar has determined that OB/GYNs or Family Planning practitioners may fill a cultural healthcare need for the female membership which may or may not have restrictions around abortions and/or birth control. An OB/GYNs or Family Planner may assist and educate members on matters of reproductive health including birth control, childbirth, and any potential impacts on health, which can help members deal with personal and sensitive health issues in a way that meets both their cultural needs as well as their health needs.

In May 2024, Oscar also launched a maternal health program for low income mothers in an effort to close gaps in care. The program was launched in hopes to help alleviate two distinct issues, maternal health through encouraging prenatal visits and infant health post birth, specifically related to sleep. Both of these issues are exacerbated for families with low income, so we are choosing to focus on this cohort through our subsidized plans. The initiative involves sending mothers who go to a prenatal visit a package that includes a portable crib at no cost to them (~$150 value) available to all mothers within a CSR plan.

[1]Source: State of Health Care Quality Report - NCQA

Table 11	Cultural Needs: OB/GYN Ratio - 2025 Goal >= 1:100 (0.01)			
State	**Female Members**	**OB/GYN and Family Planning Practitioners**	**Ratio of Provider:Member**	**YoY Changes 2024 vs. 2025**
AZ	6,570	432	1:15 (0.06)	0.00
FL	651,710	1,408	1:463 (0)	0.00
GA	118,360	1,730	1:68 (0.01)	0.01
IA	10,510	267	1:39 (0.02)	0.00
IL	1,290	898	1:1 (0.69)	0.59
KS	7,630	111	1:69 (0.01)	0.00
MI	2,100	62	1:34 (0.02)	-0.02
MO	5,250	359	1:15 (0.06)	0.04
NE	7,610	438	1:17 (0.05)	-0.71
NC	963	544	1:2 (0.56)	0.51
NJ	19,560	1,749	1:11 (0.08)	-0.06
NY	5,030	1,229	1:4 (0.24)	0.08
OHB	45,380	646	1:70 (0.01)	0.01
OHC	5,760	413	1:14 (0.07)	0.07
OK	2,180	69	1:32 (0.03)	0.03
PA	1,470	645	1:2 (0.43)	-0.09
TN	48,820	589	1:83 (0.01)	-0.02
TX	214,460	1,787	1:120 (0)	-0.02
VA	134	389	1:0 (2.9)	1.09

With a Provider to Member ratio goal of 1:100 (or 0.01), gaps for OB/GYNs and Family Planning practitioners were identified in FL and TX. Thanks to the new initiative, there is significant improvement from 2024, where gaps were identified in 5 markets.

Cultural Needs: Gender

Oscar has determined that female practitioners may fill a cultural healthcare need for its female membership. The gender preferences among members, especially female members, may cause delays in the medical care they need. By ensuring that Oscar has adequate representation of female providers, the Plan can help meet its members' cultural needs as well as their health needs.

Table 12	Cultural Needs: Female Gender Ratio - 2025 Goal >= 1:5 (0.2)			
State	**Female Members**	**Female Providers**	**Ratio of Provider:Member**	**YoY Changes 2024 vs. 2025**
AZ	6,570	12,509	1:1 (1.9)	-0.51
FL	651,710	38,849	1:17 (0.05)	-0.04
GA	118,360	33,125	1:4 (0.27)	0.09
IA	10,510	6,462	1:2 (0.61)	0.1
IL	1,290	23,560	1:0 (18.26)	14.84
KS	7,630	4,843	1:2 (0.63)	-0.11
MI	2,100	11,918	1:0 (5.67)	-4.47
MO	5,250	10,185	1:1 (1.94)	1.09
NE	7,610	8,888	1:1 (1.16)	-16.66
NC	963	13,254	1:0 (13.76)	9.27
NJ	19,560	26,312	1:1 (1.34)	-0.95
NY	5,030	49,372	1:0 (9.81)	-0.58
OHB	45,380	30,684	1:1 (0.67)	0.3
OHC	5,760	32,808	1:0 (5.69)	5.24
OK	2,180	4,337	1:1 (1.98)	1.97
PA	1,470	21,341	1:0 (14.51)	14.15
TN	48,820	13,066	1:4 (0.26)	0.25
TX	214,460	46,016	1:5 (0.21)	0.17
VA	134	14,283	1:0 (106.58)	104.7

With a Provider to Member ratio goal of 1:5 (or 0.21), all entities except FL met the target for female providers. This is an improvement from 2024 where gaps were identified in 3 markets.

Member Experience with Cultural Competency

In order to identify potential issues with cultural competency amongst its provider network, Oscar evaluates member experience with provider cultural competency by assessing the volume of complaints per 1000 members against providers related to “Poor Cultural Competency” and “Allegation of discrimination based upon race, color, national origin, sex, age, or disability”.

Table 13	**Member Experience with Cultural Competency - 2025** *Goal: < 1 complaint per 1000 members*

State	Complaints per 1K	YoY Changes 2023 vs. 2024
AZ	0.00	0.00
FL	0.02	**0.02**
GA	0.02	**0.01**
IA	0.00	0.00
IL	0.40	**0.40**
KS	0.07	**0.07**
MI	0.00	0.00
MO	0.09	**0.09**
NC	0.00	0.00
NE	0.00	0.00
NJ	0.00	**-0.07**
NY	0.00	**-0.13**
OHB	0.00	**-0.01**
OHC	0.21	**0.18**
OK	0.00	**-0.04**
PA	0.00	0.00
TN	0.02	**0.00**
TX	0.01	**0.01**
VA	0.00	0.00

With a target of less than 1 complaint per 1000 members, all entities met the goal.

Measures

Measure	Definition	Goal
Race	Based on the data available, Oscar calculates the percentage of members and of providers falling into the five OMB race categories: American Indian or Alaska Native, Asian, Black or African American, Native Hawaiian or Other Pacific Islander, White. The percentage of members falling into a category is compared to the percentage of providers falling into that same category.	*NEW Goal: 1:2000 provider (PCP) to member ratio*
Ethnicity	Based on the data available, Oscar calculates the percentage of members and of providers falling into the one OMB ethnicity category: Hispanic or Latino. The percentage of members falling under Hispanic or Latino is compared to the percentage of providers falling into that same category.	*NEW Goal: 1:2000 provider (PCP) to member ratio*
Language	Based on the data available, Oscar calculates the percentage of members falling under each preferred language and reports languages preferred by >200 of members or >1% of members. The percentage of members falling under a reported language is compared to the percentage of providers who speak that same language.	*NEW Goal: 1:2000 provider (PCP) to member ratio*
Culture Competency	Oscar evaluates member experience with provider cultural competency by reporting the volume of complaints per 1000 members for complaints related to “Poor Cultural Competency” and “Allegation of discrimination based upon race, color, national origin, sex, age, or disability”.	1 per 1000 Members
Cultural Needs	Oscar evaluates for adequate provider volume by specialty based on cultural needs identified through external research.	Goals vary by metric. See Cultural Needs sections for specific goals.

Table 14	2025 Overall Goals - Ethnic, Race, Cultural and Linguistic NEW Goal: 1:2000 provider to member ratio 2025 Language goal: 1:500 provider to member ratio						
States	**American Indian or Alaska Native Providers**	**Asian Providers**	**Black or African American Providers**	**Native Hawaiian or Other Pacific Islander Providers**	**White Providers**	**Hispanic or Latino Providers**	**Language Needs**
AZ	Met	Met	Met	Met	Met	Met	Not Met
FL	Met	Met	Met	Met	Met	Met	Not Met
GA	Met	Met	Met	Met	Met	Met	Not Met
IA	Met	Met	Met	Met	Met	Met	Not Met
IL	Met	Met	Met	Met	Met	Met	Not Met
KS	Met	Met	Met	Met	Met	Met	Not Met
MI	Met	Met	Met	Met	Met	Met	Not Met
MO	Met	Met	Met	Met	Met	Met	Not Met
NC	Met	Met	Met	Met	Met	Met	Not Met
NE	Met	Met	Met	Met	Met	Met	Met
NJ	Met	Met	Met	Met	Met	Met	Met
NY	Met	Met	Met	Met	Met	Met	Met
OHB	Met	Met	Not Met	Met	Met	Met	Not Met
OHC	Met	Met	Met	Met	Met	Met	Met
OK	Met	Met	Met	Met	Met	Met	Not Met
PA	Met	Met	Met	Met	Met	Met	Met
TN	Met	Met	Met	Met	Met	Met	Not Met
TX	Met	Met	Met	Met	Met	Met	Not Met
VA	Met	Met	Met	Met	Met	Met	Not Met

Table 15	2025 Overall Goals - Cultural Needs		
States	OB/GYN and Family Planning Practitioners for Female Members Goal >= 1:100	Female Providers for Female Members Goal >= 1:5	Cultural Competency Complaints Goal: < 1 complaint per 1000 members
AZ	Met	Met	Met
FL	Not Met	Not Met	Met
GA	Met	Met	Met
IA	Met	Met	Met
IL	Met	Met	Met
KS	Met	Met	Met
MI	Met	Met	Met
MO	Met	Met	Met
NC	Met	Met	Met
NE	Met	Met	Met
NJ	Met	Met	Met
NY	Met	Met	Met
OHB	Met	Met	Met
OHC	Met	Met	Met
OK	Met	Met	Met
PA	Met	Met	Met
TN	Met	Met	Met
TX	Not Met	Met	Met
VA	Met	Met	Met

Qualitative Analysis

For reasons described in the Data Collection and Methodology section, obtaining data on race and ethnicity for providers continues to prove particularly challenging. Since these fields are typically not a "required" input for providers (i.e. they are optional data fields) in credentialing applications, often these data points are not available for Oscar data ingestion. Although to a much lesser extent (when compared to providers), member race and ethnicity data is also unavailable for similar reasons (i.e. the data element is not a required input during member enrollment).

With member race data, Oscar collected on average 3.04% more data than in comparison to 2024. However, for the second consecutive year Oscar collected less ethnicity data, decreasing an average of -1.84% for 2025. Oscar collects race and ethnicity data from members via two methods: 1) via the federal and state exchanges when members enroll, and 2) via the Health Risk Assessment (HRA), a survey that Oscar members can elect to take in the application.

Members creating digital accounts is a primary method Oscar uses to collect R/E/L data. As an example, in GA, there was a 13% increase of members having a digital account. In other words, 201.99K (53%) of our 2025 GA members have never made a web account in comparison to 2024, where 331.7K (66%) never made a digital account.

The main culprit is that we are getting less R/E data from the exchange when the member is enrolling and overall there are less members self-reporting this data, dragging our overall R/E data capture rate down. There were some fluctuations in the HRA completion rate, but the main driver is we are getting less data from the exchange. The team has confirmed that there are no data quality issues here, just less members self-reporting their R/E data.

Oscar has not historically collected and aggregated this type of data on providers until late 2020. In addition, with only a minimal amount of R/E/L data continuing to be available from credentialing delegates (and credentialing sources still being Oscar's primary source of race and ethnicity data for providers), it remains inadvisable and unfeasible to make a detailed, accurate, and/or conclusive assessments of Oscar's network adequacy along racial and/or ethnic dimensions. Because of this, it is possible that network gaps and/or other discrepancies (along racial and ethnic dimensions) may go unidentified. On the other hand, any misses, gaps and/or states not meeting threshold targets along race and/or ethnicity dimensions may be misleading or inaccurate, as there may be, for example, already enough providers of a certain race or ethnicity to meet the member population needs.

Oscar continues to broadly enhance its provider data collection strategy, to include strengthening efforts with third-party vendors, and in 2023 requested language to be included in Oscar's provider manuals and/or provider contracting documentation to allow Oscar to collect specific data from directories of network partners.

As outcomes of this report, the following Cultural Needs may warrant attention:

- Member Data - Since race and ethnicity are voluntary fields during collection, there is a gap in member data. Every market has decreased for race and ethnicity since 2023, with an average rate of 41.34% for race and 39.23% for ethnicity in 2025 in comparison to an average of 68% for both race and ethnicity in 2023. While race data increased slightly from 2024 to 2025, ethnicity data continued to decrease. It is recommended that Oscar initiate new campaigns and reminders for members to fill out this information so that there is better understanding of Oscar's network within the organization.

- Spanish Speaking Provider Gaps - Gaps for Spanish-speaking providers were identified in AZ, FL, GA, IA, IL, KS, MI, MO, NC, OHB, OK, TN, TX, VA. From a national perspective, Spanish is Oscar's second largest membership group (by language) and Spanish speakers constitute roughly a third of Oscar membership. It is recommended that Oscar takes steps to identify and/or contract additional Spanish speaking providers in its network. Additionally, from 2024 to 2025 an additional 5 markets failed to meet the

goal for Spanish speaking providers. This is still based on the ratio of 1:500 and is expected to change for the 2026 report using the updated 1:2,000 ratio.

- Language - Of the markets evaluated, only 5 met the target for language needs. The most substantial gaps were identified in FL, GA, KS, NC, OHB and TN. With a goal of at least 500 providers per 1,000 Spanish speaking members, these 5 markets feel below 100. It is recommended that Oscar takes steps to identify and/or contract additional providers to make progress towards closing gaps across all of the threshold languages.
    - Georgia: While GA met targets for cultural competency, OB/GYN and Family Planning Practitioners, and Female Providers for Female Members, Georgia failed to meet all race and ethnicity targets for 2025. Furthermore, with 62,800 Spanish speaking members and only 4,436 Spanish speaking providers, Georgia fell well below Oscar's goal of 500 providers for every 1,000 members.
    - **Note:** These findings are based on the 2024 targets and are not reflective of the updated metric for 2025 of 1:2,000. In 2026, Oscar will have trending data to effectively compare year over year data.

- Obstetrics & Gynecology (OB/GYN): Among all Oscar states, the state of Florida continues to have the largest discrepancy in this Provider:Member ratios. This is the third year that Florida failed to meet the goal in this category, and Florida is the only state to miss the target in 2025. With a target ratio of 1:5, Florida has a ratio of 1:17. Given that "provider specialty" should not be a relatively deficient data point for providers, it is possible that members in the state of Florida requiring OB/GYN and/or Family Planning services may experience access to care issues and/or related disparities. It is recommended Oscar pursue more contracting under this particular provider speciality in these states, prioritizing FL given the large gap, and/or also identify providers who may offer the service and have not indicated as such within our network.
    - Potential for 2026 to include female members of child bear age as an additional filter.

Opportunities for Improvement

Racial, Ethnic, and Linguistic Needs

The following are prioritized recommendations based on prior analysis and commentary. Oscar will continue to improve its provider network and member network experience in the following ways:

1. **Provider Data Collection:**

   To fulfill our 2025 third-party commitments, Oscar expanded its provider data collection strategy via third-party vendors, recognizing the limitations in data provided via rosters. This effort has increased the directory accuracy by 15% throughout 2025 and there is an anticipated improvement to Race, Ethnicity, and Language (R/E/L) data in 2026. Please note R/E/L remains a gap and will continue to benefit from these broader expansion efforts, the 2025 focus centers on integrating diverse sources—including credentialing vendors, third-party data-sharing agreements, and updated provider manual language—to meet our committed benchmarks for data breadth and accuracy.

2. **Language Insights-Driven Contracting:**

   Continue to inform and prioritize provider contracting efforts through internal network data visualization tools and/or other local market research and population insights to meet the needs of Oscar membership. These insights include the assessment of provider to member “ratios” (i.e. the number of providers vs. the number of members) for member spoken languages, and importantly representation of data at the state and county level. From these insights, prioritized efforts can be made at a county level (e.g. sorted by highest to lowest ratio) by the Network Management and Recruitment teams, who are responsible for provider contracting to address network opportunities. Where material opportunities exist, leverage publically available provider data, to identify and promote applicable provider prospects to the Network Recruitment team to consider adding to the network.

3. **Spanish-First Campaigns & Buena Salud:**

   Oscar continues to develop communications to engage with Spanish speaking membership, in particular “Spanish-first” campaigns that are guided by cultural competency and respect for the identity of members. Spanish-first campaigns are not translated content, they are purposely designed by Hispanic/Latino and/or Spanish speaking individuals, and/or guided by style guides, such as Oscar’s Voice & Tone for Spanish. These campaigns attempt to drive and influence healthy behavior for our members. In 2024, about 62% of all Oscar member-facing campaigns were launched with Spanish variants.

   Hola Oscar! was a program in Georgia launched in concert with the Georgia Office of the Commissioner of Insurance which launched in September of 2023 and ran through the first two weeks of Open Enrollment for PY24. The primary goal of the program was to encourage more Spanish speaking individuals in Georgia to enroll in ACA coverage. Hola Oscar! Resulted in 77% of the Hispanic market enrolling with Oscar in GA for PY24 (compared to 26% total market share in GA).

   For PY25, we are launching a more comprehensive Spanish-first product for Spanish speaking members in Georgia, called “Buena Salud Plateado Estandar Clasico” (Good Health Silver Standard Classic)
   This will continue building momentum in the Spanish-first market in these 4 key states and be a launching pad for a more comprehensive Spanish experience

   Oscar’s mission is to make a healthier life accessible and affordable for all. In support of this goal, we launched Hola Oscar: an immersive Spanish language program designed to better support our Hispanic and Latino members. The program, which is part of Oscar’s Culturally Competent Care (CCC) initiative, delivers socially and linguistically authentic experiences with cultural care matching and providers who speak the language.

   Hispanic and Latino communities are the fastest-growing populations in the ACA, and make up about one-third of Oscar’s membership. It was important to us to provide a culturally authentic experience for these members, who are navigating a system that often fails to accommodate non-English speakers. According to a Pew Research study, 44% of Hispanic adults cite communication problems due to language or cultural differences as a leading reason why Hispanic individuals generally have worse health outcomes than other adults in the US.

   We created Hola Oscar to offer Spanish speakers personalized health experiences that can better serve their unique needs. To build the program, our teams worked to understand how a Spanish speaker interacts with Oscar. The Hola Oscar program was developed based on internal research conducted with Oscar’s diverse employee base

and employee research groups, as well as focus groups with community partners. This approach aimed to understand the unique challenges faced by Hispanic and Latino communities and identify the most effective ways to connect with them.

Hola Oscar, which has an industry-leading NPS of 87, provides Spanish-speaking members with linguistically authentic experiences at every step of their healthcare journey. Our team created stylistic guides called “Voz y Tono” to ensure cultural and linguistic relevancy for all Spanish communications including: advertising and marketing with cultural signifiers, ongoing campaigns to influence healthy behavior, Spanish-first Welcome Kits, and resources to support Spanish-speaking brokers. We also built diverse provider networks to match members with Spanish-speaking providers, and support members with a Spanish-speaking Oscar Care Team made up of many native speakers.

In 2025, Oscar is introducing Buena Salud, a Spanish-first solution for Hispanic and Latino members, that builds on the Hola Oscar experience. Individuals meet Oscar in Español and are connected to an Oscar care team, primary care provider, and healthcare community that share their cultural heritage. The solution prioritizes the preferences of Hispanics and Latinos, who are more inclined to seek care when providers speak Spanish.

Oscar is committed to breaking down language and cultural barriers in healthcare through offerings like Hola Oscar and Buena Salud. By prioritizing culturally competent care and providing Spanish-first solutions, we aim to empower our Hispanic and Latino members with the resources and support they need for better health outcomes. As we continue to innovate and expand our offerings, Oscar remains dedicated to making healthcare more accessible and inclusive for all communities.

The company goals for Buena Salud encompasses the following:

1) Growth by picking up at least 1% of total addressable market in footprint offered
    a) Initial launch should occur in 2-5 states with rapid expansion
    b) Key provider partners (language-first PCPs) and new, innovative vendor partners (e.g. Parsley, Ovia) should provide key bi-directional referral channels
2) Increase Retention above the book average
3) Innovate & Differentiate with a portfolio that creates a specialized experience for myriad groups - Oscar is for *you*
    a) Create plans that meet members in a variety of personal and cultural positions
    b) Use rewards program innovation feedback loop to constantly evolve, add, and refine portfolio

For PY25, we launched a more comprehensive Spanish-first product for Spanish speaking members in Georgia, called “Buena Salud Plateado Estandar Clasico” (Good Health Silver Standard Classic).

Individuals meet Oscar in Español and are connected to an Oscar care team, primary care provider, and healthcare community that share their cultural heritage. The solution prioritizes the preferences of Hispanics and Latinos, who are more inclined to seek care when providers speak Spanish.

To expand on this progress for PY26, this plan will be offered in more markets and even target specific cohorts of members. There will be Buena Salud plans offered in TX, AZ, GA and IL for PY26. The TX plan will only be offered off exchange, which is targeting ICHRA members. In AZ, the Buena Salud plan is bronze diabetes focused plan. GA is expanding metals next year, adding a bronze offering alongside the current silver plan. IL will have a silver plan, similar to the current GA one.

4. **Maternal Health Program:**

The Maternal Health Program launched in August of 2024 and has seen success so far in terms of achieving the goal of giving low income families a safe space for their baby to sleep by encouraging the mothers to seek prenatal care. Oscar is targeting low income families by offering this program to members on a cost share reduction plan. To qualify for this type of plan, individuals have to be within 250% of the federal poverty level. We are able to get high level insights currently, but there is a need to get more detailed data. Lucas Sokol is working with the data team to get member-level data to give us insights into which markets are performing better than others and where the members who are claiming this reward reside. Right now we do know that 2,741 members qualified for the reward in 2024 and 131 of those members redeemed their reward. In addition to collecting better insights on this member population, we are working with the vendor we use to fulfill the cribs to make the redemption process easier. This should lead to more conversions and, hopefully, more pregnant people getting the prenatal care necessary.

It was our hope that these improvements would lead to more cribs getting into the hands of the mothers that need them. From 1/1 2025 through 6/30 2025, 3,825 members have qualified for the reward and 407 have redeemed their free crib. The process improvements appear to be working as our conversion percentage has increased from 4.7% to 10.6%. We will continue to monitor this program to look at ways to increase this number further to continue our mission of delivering a safe place to sleep for low income families.