TRANSPARENCY IN COVERAGE

Here at Oscar, We want to make it as easy as possible for You to understand how Your insurance coverage works. This document provides You with some basic information about the ideas, words, and documents that You might come across when You seek care. If You have questions about what's written below – or about Your Oscar health plan more generally – give Us a call at (855) 672-2755.

In the paragraphs that follow, Oscar and its affiliates are described as "We" or "Us," and our members and their enrolled dependents are described as "You."

OUT-OF-NETWORK LIABILITY AND BALANCE BILLING

What is a provider network?

Oscar's "provider network" is the full list of health care professionals, listed in our Provider Directory, who have agreed to provide services to Oscar members. An "in-network provider" is one of those providers – in other words, someone who has contracted with Us to provide services to members (like You) at specific, pre-negotiated rates. An "out-of-network provider" is any other provider. In most cases, receiving services from an in-network provider will be less expensive for You.

Why are services from out-of-network providers usually more expensive?

Generally, if You receive services from an out-of-network provider, these services are not covered under Your Oscar health plan (although We may authorize exceptions). Your health plan will not pay for these services and You are responsible for the out-of-network Provider's full costs. Charging any amount over what We pay and Your cost-sharing amount is called balance billing. Unless You receive prior authorization for out-of-network services, or the out-of-network service is covered by the Federal No Surprises Act or similar state law, You will be responsible for the full amount.

Are there any exceptions?

If You receive out-of-network services for a medical emergency, We will treat those services as if You received them at an in-network provider. Balance billing may be waived for emergency services received at an out-of-network facility. In other words, in cases of emergency, You will only owe the applicable in-network cost-sharing amounts for benefits described in Your policy documents. You may also seek specific authorization to pay in-network rates for out-of-network services, if medically necessary services are not available to You from an in-network provider within certain time/distance requirements. Precertification requirements apply (see below).

ENROLLEE CLAIM SUBMISSION

What is a claim?

A "claim" is a request that Oscar pay for health care services provided to a member like You. When We "process" (pay) claims that are "filed" (submitted to Us) for these services, We follow federal and state rules, as well as the policies described in Your health plan documents.

Who is responsible for filing a claim?

Usually, providers file claims with Us on Your behalf.

Before You seek services, We recommend that You confirm – by checking our Provider Directory or contacting Us at (855) 672-2755 – that the provider You want to see is an in-network provider. When You arrive at that provider and present Your Oscar identification card, the provider will confirm that they are an in-network provider with Oscar and that You are an Oscar member. After You receive these services, the provider will file a claim with Us, and We will make payment directly to them. Usually, the payment that We make does not include the cost-sharing for which You are responsible (such as copayments, deductibles, coinsurance amounts), any payment for non-covered or excluded expenses, or any amounts over specifically limited benefits.

Out-of-network providers – who may provide care to You because of a medical emergency, because We authorized such care, or because You elected to see them even though they are out-of-network – may or may not file claims directly with Us. If they do, We will process the claim as described above. If they do not, You may choose to file the claim with Us directly.

How can You file a claim with Us?

If You received services from an out-of-network Provider, and if that provider does not submit a claim to Us, You can file the claim directly. To do so, send Us a copy of Your paid, itemized bill, along with a completed claim form, which You may access on Our website, at hioscar.com/asset/member_claim_form_py26.

You can send the information by mail to:

Oscar Insurance Company
PO Box 52146
Phoenix AZ, 85072–2146

Alternatively, You can send the information by email to Help@hioscar.com or by fax to (844) 965-9054.

We will make payment to You of the billed expense amount for covered services as defined in Your policy documents, unless We are directed otherwise or as required by applicable state or federal law. You will be responsible for any applicable cost-sharing amounts (such as copayments, deductibles, and coinsurance amounts), any non- Covered or Excluded Expenses, and amounts over specifically limited benefits.

Please note that, in order to receive any payment to which You may be entitled, You must submit Your claim within 120 days of the date of the service in question, unless Your

health plan Evidence of Coverage provides a longer time to submit your out-of-network provider claim.

EXPLANATION OF BENEFITS

How can You find more information about a particular claim?

Every claim that We process for services You receive appears on an Explanation of Benefits (EOB) statement that We send You, after We pay Your claim. The EOB is not a bill. Instead, it explains what services We paid for, how much We paid under Your Oscar health plan, and any financial responsibility that You bear (which You would typically pay directly to the provider). The EOB also provides You with information about Your appeal rights if You disagree with how We processed the claim(s).

RETROACTIVE DENIALS

Can a claim be denied even after it was paid?

In certain situations – usually, when You are found no longer to be eligible for coverage by Oscar – a claim may be "reversed" (reprocessed and denied retroactively, even after it has been paid), meaning that You become responsible for payment to the provider. In most cases, You can prevent a retroactive denial by paying Your premiums on time and by promptly notifying Us or (if applicable) Your marketplace of changes in Your eligibility status.

How can You prevent retroactive denials?

You should talk to Your provider about whether the service performed is a covered benefit. You can also avoid retroactive denials by obtaining Your medical services from an in-network provider.

MEDICAL NECESSITY, PRIOR AUTHORIZATION TIMEFRAMES, AND ENROLLEE RESPONSIBILITIES

How do We decide whether to pay a particular claim?

We pay claims according to applicable law, the network status of the provider, and the relevant plan documents as described above – as well as whether We have determined that the services in question were medically necessary.

To determine medical necessity, in some cases, We require that You or Your treating provider Precertify the medical necessity of Your care. Precertification is sometimes called "preauthorization" or "prior authorization." Please note that precertification relates only to the medical necessity of care; it does not mean that Your care will be covered under the plan. Precertification also does not mean that We have been paid all monies (usually premiums) necessary for coverage to be in force on the date that services or supplies are rendered.

It is Your responsibility to ensure that You or Your provider obtains precertification. In some cases, Your provider will initiate the precertification process for You. You should be sure to check with Your provider to confirm whether precertification has been obtained. Generally, if precertification is required and not obtained, You may have to pay up to the full amount of the charges under the plan.

In order to minimize the potential for care delays, We recommend that Prior Authorization requests be received by phone, fax, or through our secure online portal within the following timeframes when feasible:

- At least five (5) days prior to an elective admission as an inpatient in a Hospital, extended care or rehabilitation facility, or hospice facility
- At least thirty (30) days prior to the initial evaluation for organ transplant services
- At least thirty (30) days prior to receiving clinical trial services
- At least five (5) days prior to a scheduled inpatient behavioral health or substance abuse treatment admission
- At least five (5) days prior to the start of home healthcare services

A decision on a request for urgent pre-service or concurrent review medical services will typically be made within 72 hours from receipt of all supporting information reasonably necessary to complete the review. For non-urgent pre-service or concurrent medical service requests, a decision will be made within 15 calendar days from receipt of Your request. For post-service requests, a decision will be made within 30 calendar days of receipt of all information necessary to complete the review. Except for medical emergencies, Prior Authorizations must be obtained before services are rendered or expenses are incurred.

COORDINATION OF BENEFITS

Who pays Your claims if You have more than one health insurance plan?

If You have more than one health insurance plan, those plans work together through a process called "coordination of benefits" to make sure You get the most from Your coverage. One plan is designated as Your primary plan and pays Your claims according to its rules, Your secondary plan then pays toward the remaining cost according to its rules, and so on. This process maximizes Your benefits and may lower Your out-of-pocket costs. Further information about Coordination of Benefits can be found in Your Evidence of Coverage under the Coordination of Benefits Section within the Order of Benefit Determination Rules provision.

GRACE PERIODS AND CLAIMS PENDING

You are required to pay your premium by the date it is due. If You do not do so, Your coverage could be terminated. If You do NOT receive federal health insurance subsidies (Advance Premium Tax Credits and/or Cost Sharing reduction subsidies) You will have a 31-day grace period to pay Your premium after it becomes due. If You receive federal health insurance subsidies (Advance Premium Tax Credits and/or Cost Sharing reduction subsidies), You will have a 3-month grace period to pay Your premium after it becomes due. These grace periods do not apply to Your first month's premium payment. If you do

not pay Your past due premium by the end of Your grace period, Your coverage will be terminated.

What is a grace period?

A grace period is a time period when Your coverage will not be terminated even though you did not pay Your premium. Any claims submitted for You during that grace period will be pended.

What does it mean when claims are pended during the grace period?

When a claim is pended, that means no payment will be made for the claim until Your past due premium is paid in full.

How will claims be processed for the timeframe of the grace period?

If You do NOT receive federal health insurance subsidies (Advance Premium Tax Credits and/or Cost Sharing reduction subsidies) and You pay Your full outstanding premium before the end of the grace period, We will pay all claims for covered services You received during the 31-day grace period that are submitted properly. If You receive federal health insurance subsidies (Advance Premium Tax Credits and/or Cost Sharing reduction subsidies), We will pay all claims for covered services that are submitted properly during the first month of the 3-month grace period. During the second and third months of that grace period, any claims You incur will be pended. If You pay Your past due premium in full before the end of the 3-month grace period, We will pay all claims for covered services that are submitted properly for the second and third months of the grace period. If You do not pay all of Your past due premium by the end of the 3-month grace period, Your coverage will be terminated, and We will not pay for any pended claims submitted for You during the second and third months of the grace period. Your provider may balance bill You for those services.

Failure to timely pay premium payments does not qualify You for a special open enrollment event for later coverage under the plan.

RECOUPMENT OF OVERPAYMENTS

What can You do if You think We billed You incorrectly?

If You believe that We have overbilled You for Your premium, or made any other error in billing or payment, please contact Us at (855) 672-2755.

DRUG EXCEPTION TIMEFRAMES AND ENROLLEE RESPONSIBILITIES How

do You check which services are covered under Your Oscar health plan?

The list of services covered by Your plan can be found in the applicable Plan Policy and Summary of Benefits and Coverage available at www.hioscar.com/forms. Also available at that site is the “Formulary” – the list of drugs covered under Your Oscar health plan.

What if a drug that You want is not on our Formulary?

You may need access to drugs that aren’t listed as covered on Our formulary (drug list). If Your drug is not covered and You think it should be, You may ask Us to make an exception to the drug coverage rules. We will review Your request through the formulary exception review process. If Your request qualifies as urgent, You may submit an expedited exception request. In support of Your request, Your doctor or other prescriber must give Us a statement explaining the medical reasons for requesting an exception. You or Your Provider may submit the request to Us by calling (855) 672-2755, or by submitting the necessary form to Us. To find this form, please visit Us at www.hioscar.com/forms, select Your state and the current year, and select the "Oscar Drug Prior Authorization Form" in the “Drug & Formulary Information” section.
To request an expedited review for exigent circumstance, select the “Expedited” option in the “Review Timeframes” section of the Request Form.

We will give You a response within 72 hours, or 24 hours for expedited exception requests of receiving all information We need to make a decision.

If We deny Your request, We will send You a denial letter, and You may request an internal appeal. Then, if You feel We have denied the non-formulary request incorrectly, You may submit the case for an external review by an impartial, third-party reviewer known as an independent review organization (IRO). Your denial letter will contain all the necessary information for initiating this external review with the IRO. You may also contact Us by phone, at (855) 672-2755 to initiate the external review with the IRO. We must follow the IRO's decision. Please call Us at (855) 672-2755 (the number on the back of Your ID card), and We'll help You initiate Your IRO.