Individual [Metal Level] [Product] Plan

Oscar Insurance Company
1-855-672-2755
P.O. Box 52146
Phoenix, AZ 85072-2146
Effective Date: January 1, 2026
Outline of Coverage

REQUIRED OUTLINE OF COVERAGE AND WRITTEN PLAN DESCRIPTION

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of some of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Oscar Insurance Company, an insurance entity, is responsible for the coverage described in this Plan, which is designed to provide you with coverage for major hospital, medical, and surgical expenses which you incur as the result of a covered injury or sickness. Hospital confinement indemnity coverage is designed to provide you with a fixed daily benefit during periods of hospital confinement resulting from a covered injury or sickness. Coverage is provided for the benefits outlined under Benefits. The benefits described may be limited by the Limitations and Exclusions. This Plan only provides benefits for services received from a preferred provider, except as otherwise noted in the policy, written description or as otherwise required by the law

For any questions regarding this Outline of Coverage or Your Plan, visit the Oscar website at www.hioscar.com or call 1-855-672-2755.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

COVERED SERVICES

This Policy lays out the Covered Services that You are entitled to receive by being a part of an Oscar Plan. It also tells You what exclusions, conditions, and limitations You'll be subject to. The Covered Services You receive need to be Medically Necessary, and a Provider needs to be the one billing Us for them. You can look at Your Schedule of Benefits to see the payments we'll ask You to make for these Covered Services.

The benefits listed as Covered in this section are subject to the Deductible, Copayment or Coinsurance, and Maximum Out-of-Pocket limit that are shown on Your Schedule of Benefits. However, Preventive Services and preventive drugs are not subject to the Deductible, Copayment, or Coinsurance.

How a Covered Service may be obtained, Coverage Limits and Member's Cost Sharing obligations:

The following Sections sets forth how You may obtain a Covered Service from a Network Provider, when services from an Out-of-Network Provider are Covered Services, what Covered Services You're able to receive, where You can get Covered Services, and second opinion coverage.

We encourage You to call the telephone number on the back of Your Identification Card if there are questions relating to the coverage of Covered Services set forth in this Section, Member's Cost Sharing or how the Covered Service may be obtained by You.

Covered Services from a Network Provider

You may access Covered Services without a Referral from a Network Provider.

Covered Services from an Out-of-Network Provider

Covered Services must be obtained from a Network Provider, except as set forth in this Section. The following are exceptions where Covered Services may be obtained from an Out-of-Network Provider within or outside the Service Area:

- Emergency Services as set forth in this Policy in the "Out-of-Network Providers" section in **HOW YOUR PLAN WORKS**;
- Covered Services provided by Out-of-Network Providers providing Covered Services during a visit at an In-Network facility, as described in this Policy in the "Out-of-Network Providers" section in **HOW YOUR PLAN WORKS** (unless You sign a consent form from the Out-of-Network Provider as described in that section);
- Out-of-Network diagnostic imaging Provider or laboratory service Provider that performed Services in connection with In-Network care, as set forth in this Policy;

- When You obtain Preauthorization because Covered Services are not available from a Network Provider or cannot be provided within the Service Area; and/or
- For Covered Services under this Policy in accordance with the continuity of care provisions.

Our Coverage of Covered Services

Just because Your Physician or any other Network Provider may prescribe, order, recommend or approve a medical service or supply does not automatically mean that We will cover that service. We will only cover benefits expressly stated as covered in this Policy, or otherwise approved by Us.

Coverage of Service when a Network Provider's Relationship is Terminated with Oscar
If You are receiving Covered Services from a Network Provider who no longer is a Participating Provider with the Plan, Oscar will provide payment for Covered Services under this Policy in accordance with the "Continuity of Care" provision.

Out-of-Network Maternity Care

Maternity care will not be covered at the Network Provider benefit level if received outside the Service Area, if the delivery is normal term. However, We do cover treatment of unexpected complications of pregnancy and care for unexpected early delivery as Emergency Services, which means that We would cover Out-of-Network Providers at the In-Network benefit level.

Covered Service Location Cost Sharing

As indicated on Your Schedule of Benefits, certain Covered Services will subject You to a Cost Sharing obligation based on the type of facility where the Covered Service is provided. Some examples of this are dental anesthesia and Hospice services. Location Cost Sharing is in addition to any Cost Sharing obligation for the Covered Service being provided to You.

Second Opinions

We cover Second Opinions for cancer diagnoses and treatment and Second Opinions for surgical procedures. 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 You to obtain a Second Opinion from an Out-of-Network Provider.

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

Identification of Covered Services

Subject to all terms, conditions, definitions, exclusions and limitations in this Policy, a Member is entitled to receive the following Covered Services as set forth in this Section. All Covered Services must be Medically Necessary except for Preventive Services as set forth in the "Preventive Services" provision in this Policy.

Abortion

We cover services, devices, drugs or other substances provided by any Provider in any location intended to terminate pregnancy in order to prevent the death of the Member upon whom the abortion is performed as permitted by State law.

Allergy Testing and Treatment

We cover allergy testing and treatment, including allergy shots and serum only when administered in an In-Network Office Visit setting.

Ambulance Services

We cover Ambulance services for emergency situations, to the nearest facility capable of handling the emergency. Emergency Ambulance services will be covered as described in Emergency Services and Care. The following Ambulance services are also covered:

- Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground, air or water service for transportation to and from a Hospital or Skilled Nursing Facility.
- Monitoring, electrocardiograms (EKGs or ECG's), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. A legally licensed person must render the services in order for them to be covered.

Fixed and Rotary Wing Air Ambulance

Air Ambulance Services are subject to Medical Necessity review by Oscar. We retain the right to select the Air Ambulance Provider. This includes fixed wing, rotary wing or

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

Autism Spectrum Disorders and Applied Behavior Analysis

We cover Medically Necessary services provided by In-Network Physicians and other approved Providers for the diagnosis and treatment of Autism Spectrum Disorders (ASD). Covered diagnostic services include the Autism Diagnostic Observation Schedule and other assessments and screenings determined as Medically Necessary. Treatments covered under the medical benefit include, but are not limited to approved speech, physical, nutritional and Occupational Therapies and services. Treatments covered under the behavioral health benefit include Applied Behavioral Analysis (ABA), if provided by a Board Certified Behavior Analyst (BCBA) or other qualified Provider under the appropriate supervision.

ABA services are subject to Preauthorization, and may be focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning. Such authorization overrides other limitations and exclusions in this Plan. Behavioral Health Treatment must be performed by a licensed, appropriately experienced Provider. Education programs covered through school-based programs are not Covered Services. All such services are subject to Cost-Sharing.

Individuals providing treatment prescribed under that plan must be a health care practitioner:

- Who is licensed, certified, or registered by an appropriate agency of the state of Texas;
- Whose professional credential is recognized and accepted by an appropriate agency of the United States; or
- Who is certified as a Provider under the TRICARE military health system.

Treatment may include services such as:

- Evaluation and assessment services;
- Screening at 18 and 24 months;
- Applied behavior analysis;
- Behavior training and behavior management;
- Speech therapy;
- Occupational therapy;
- Physical therapy; or
- Medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

Biomarker Testing

We cover Biomarker Testing for the purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a Member's disease or condition in order to guide treatment decisions when the test is medically necessary and/or as mandated by state law. Oscar will provide these services in a manner that limits disruptions in care, including limiting the number of biopsies and biospecimen samples.

Chemotherapy Medications

We Cover chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents. Refer to the **PHARMACY BENEFITS** section.

Clinical Trials

Benefits for Eligible Expenses for Routine Patient Care Costs, as defined in the **DEFINITIONS** section, are provided in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life- threatening disease or condition and is approved by one of the following institutions:

- The CDC of the United States Department of Health and Human Services;
- The National Institutes of Health (NIH);
- The FDA;
- The United States Department of Defense;
- The United States Department of Veterans Affairs;
- The United States Department of Energy;
- The Agency for Health Care Research and Quality;
- The Centers for Medicare & Medicaid Services (CMS);
- A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants; or
- An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

Benefits are not available under this section for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the Research Institution conducting the clinical trial.

Exclusion
Costs that are generally covered by the clinical trial, including, but not limited to:

- Research costs related to conducting the clinical trial such as research Physician and nurse time, analysis of results, and clinical tests performed only for research purposes.
- The investigational item, device or Service itself. Services inconsistent with widely accepted and established standards of care for a particular diagnosis.
- Services related to an Approved Clinical Trial received outside of the United States.
- Drugs administered or prescribed as part of, or in conjunction with a clinical trial protocol when the drug is the subject of the trial.

Diagnostic Services

If ordered in advance by a Network Provider, We will cover diagnostic tests, services, and materials, including diagnostic radiology and imaging, laboratory tests and electrocardiograms. The diagnostic testing must be related to services within the Network Provider's scope of care" and provided by In-Network Providers or facilities.

Laboratory Procedures and Radiology Services

We cover the following x-ray, laboratory procedures, diagnostic tests, services, and materials, including:

- X-rays
- X-ray therapy
- Fluoroscopy
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Laboratory tests
- Therapeutic radiology services.

We will cover diagnostic tests, materials, and screening services including:

- Diagnostic radiology and imaging
- Mammograms
- Prostate-specific antigen (PSA) blood tests with or without a digital rectal exam (DRE)
- Diagnostic pathology services
- Ultrasound
- Diagnostic Laboratory tests
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms.

We also cover:

- Professional services for test interpretation of these diagnostic services
- X-ray reading
- Biomarker Testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition when the test is medically necessary and/or as mandated by state law.

See Your Schedule of Benefits for the applicable Cost Share.

Please refer to hioscar.com/search or call Our Member Services team at (855) 672-2755 for more information.

Dialysis

We cover benefits for acute renal failure and chronic (end-stage) renal disease, including hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). Covered Services include dialysis treatments in an outpatient dialysis facility or doctor's office. Covered Services also include home dialysis and training for You and the person who will help You with home self-dialysis.

Diabetes

Benefits are available and will be determined on the same basis as any other sickness for those Medically Necessary items for Diabetes Equipment and Diabetes Supplies (for which a Physician or Other Professional Provider has written an order) and Diabetic Management Services/Diabetes Self-Management Training. Such items, when obtained for a Qualified Participant, shall include but not be limited to the following:

- Diabetes Equipment
    - Blood glucose meters (including noninvasive glucose meters and meters for the blind);
    - Insulin pumps (both external and implantable) and associated accessories, which include:
        - Insulin infusion devices,
        - Batteries,
        - Skin preparation items,
        - Adhesive supplies,
        - Infusion sets,
        - Insulin cartridges,
        - Durable and disposable devices to assist in the injection of insulin, and
        - Other required disposable supplies; and
    - Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes.

- Diabetes Supplies
    - Test strips specified for use with a corresponding blood glucose monitor
    - Lancets and lancet devices
    - Visual reading strips and urine testing strips and tablets which test for glucose, ketones, and protein
    - Insulin and insulin analog preparations
    - Injection aids, including devices used to assist with insulin injection and needleless systems
    - Insulin syringes
    - Biohazard disposable containers
    - Prescriptive and non-prescriptive oral agents for controlling blood sugar levels, and
    - Glucagon emergency kits
    - NOTE: All Diabetes Supplies listed in item (2) above will be covered in accordance with the specifications in the **PHARMACY BENEFITS** section.
- When Your practitioner is not available, diabetes equipment and supplies dispensed by a pharmacist for an emergency refill is covered in the same manner as for a non-emergency refill of such diabetes equipment and supplies. For purposes of this provision, diabetes equipment or supplies includes needles, syringes, cartridge systems, prefilled pen systems, glucose meters and test strips, but excludes insulin pumps.
- Repairs and necessary maintenance of insulin pumps not otherwise provided for under the manufacturer's warranty or purchase agreement, rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump.
- As new or improved treatment and monitoring equipment or supplies become available and are approved by the FDA, such equipment or supplies may be covered if determined to be Medically Necessary and appropriate by the treating Physician or Other Professional Provider who issues the written order for the supplies or equipment.
- Medical-Surgical Coverage provided for the nutritional, educational, and psychosocial treatment of the Qualified Participant. Such Diabetic Management Services/Diabetes Self-Management Training for which a Physician or Other Professional Provider has written an order to the Participant or caretaker of the Participant is limited to the following when rendered by or under the direction of a Physician.
- Initial and follow-up instruction/education concerning:
    - The physical cause and process of diabetes;
    - Nutrition, exercise, medications, monitoring of laboratory values and the interaction of these in the effective self-management of diabetes;
    - Prevention and treatment of special health problems for the diabetic patient;
    - Adjustment to lifestyle modifications; and
    - Family involvement in the care and treatment of the diabetic patient. The family will be included in certain sessions of instruction for the patient.

Diabetes Self-Management Training for the Qualified Participant will include the development of an individualized management plan that is created for and in collaboration with the Qualified Participant (and/or their family) to understand the care and management of diabetes, including proper use of Diabetes Equipment and Diabetes Supplies.

A Qualified Participant means an individual eligible for coverage under this Contract who has been diagnosed with (a) insulin dependent or non-insulin dependent diabetes, (b) elevated blood glucose levels induced by pregnancy, or (c) another medical condition associated with elevated blood glucose levels.

Durable Medical Equipment (DME) and Related Supplies

Upon Preauthorization, We will cover the cost of renting, or if We prefer, purchasing Medically Necessary DME and related Supplies when prescribed in advance by a Network Provider for use consistent with the FDA approved use. Delivery and installation, if applicable, are covered as a part of this benefit, and repair and replacement are covered only to the extent required by normal wear and tear. You must obtain DME from a Network Provider. We reserve the right to recover any DME We've purchased when it is no longer Medically Necessary for You. Examples of Covered DME include, but are not limited to:

- Orthotic Devices, when prescribed in advance by a Network Provider or when approved in advance by Us.
- Prosthetic Devices
    - Oscar will pay for the purchase of one Prosthetic Device, or the replacement of component parts or modification of an existing Prosthetic Device every five years when obtained from a Network Provider or when approved in advance by Us. Mastectomy prosthesis may be made more frequently. Replacements may be more frequent if You are under age 19 and replacements may be warranted by growth.
    - Wigs, when necessitated by hair loss due to active treatment for cancer or second or third degree burns. Coverage is limited to the first wig following active cancer treatment or burn injury, not to exceed one per Benefit Period.
    - Limited coverage is provided under this prosthetics benefit for prescription eyeglasses and contact lenses when necessary to treat medical conditions of the eyes or following a covered ocular surgery. See the Vision Services (All Ages) section for more information.

We retain the right to determine if DME items shall be leased or purchased.

Custom equipment is only covered when (a) appropriate conventional or pre-fabricated equipment is not available (e.g. contracture or deformity interferes with fitting) or (b) pre-fabricated equipment is not expected to result in a clinically equivalent outcome.

Family Planning

Family planning Services include:

- Family planning counseling and Services, such as counseling and information on birth control; sex education, including prevention of venereal disease; and fitting of diaphragms;
- Contraceptive medication by injection provided and administered by a Physician;
- Preventative intra-uterine devices. Coverage includes the insertion and removal; and
- Surgical sterilization (tubal ligations and vasectomies).

Note: Some family planning Services are covered under the Preventive Services category and will be paid in accordance with that category. Please refer to that category and Your Schedule of Benefits for more information. Contraceptive medications, devices and appliances, other than as noted above may be covered under Your pharmacy benefit. Refer to the **PHARMACY BENEFITS** section for more information.

Gender-Affirming Services (Transgender and Gender Diverse Services) for gender dysphoria are subject to review for Medical Necessity and may include, but are not limited to, hormone therapy, counseling and psychiatric services, and/or gender-affirming surgical services. Services that Oscar considers to be cosmetic, experimental, or investigational are excluded. This benefit is not available to a child who is younger than 18 years of age.

In addition to the services mentioned above, Oscar will also cover services related to:

- All possible adverse outcomes related to the gender transition procedure or treatment, including any short- or long-term side effects of the procedure or treatment;
- Any baseline and follow-up testing or screening necessary to monitor mental and physical health on at least an annual basis without regard to the sex or gender identity designation in the Member's medical record; and
- Any procedure, treatment, or therapy necessary to manage, reverse, reconstruct from, or recover from the gender transition procedure or treatment.

These services will be covered for a Member who has undergone a gender transition procedure or treatment regardless of whether the Member was enrolled in this Oscar Plan at the time of the procedure or treatment.

General Anesthesia

General anesthesia and associated facility and physician charges for dental procedures rendered in a Hospital or Ambulatory Surgery Center setting is a Covered Service for Members who, as determined by their Provider, meet any of the following conditions:

- Is under nine years of age
- Is under 13 years of age; and
    - Unable to undergo the dental service without general anesthesia due to a documented physical, mental, or medical reason; and,
    - The anesthesia is performed by a qualified provider of anesthesia services.
- Is developmentally or physically disabled, or has a serious mental illness or
- Has compromised health or a medical or behavioral condition for which general anesthesia is Medically Necessary; or
- Has sustained extensive facial or dental trauma, unless otherwise covered by workers' compensation insurance
- Has a medical condition and requires admission to a hospital or outpatient surgery facility and general anesthesia for dental care treatment

We may require Preauthorization for Dental Anesthesia.

Habilitation Services

Habilitation Services are covered on an Outpatient and Inpatient basis to help a person keep, learn, or improve skills and functioning for daily living. An example of a Habilitation Service is therapy for a child who is not walking or talking at the expected age. Covered services include:

- Physical Therapy provided by a Physician or Licensed Physical Therapist;
- Occupational Therapy provided by a Physician or Licensed Occupational Therapist; and
- Speech Therapy provided by a Physician or Licensed Speech Therapist.

All therapy services must be considered Medically Necessary and may require Preauthorization.

When provided in a Facility on an Outpatient basis or in Physician's office, You will be responsible for the Outpatient Habilitation Cost Share listed on Your Schedule of Benefits for each visit. When provided to You as an Inpatient, You will be responsible for the applicable Inpatient Cost Share listed on Your Schedule of Benefits.

The therapies listed in this category are in addition to therapy benefits listed in the Home Health Care Services, Rehabilitation Services, and Skilled Nursing Facility Services categories in this section.

Devices that are Medically Necessary to help a person keep, learn, or improve skills and functioning for daily living are covered under the Durable Medical Equipment, prosthetics, or orthotics benefit, as applicable.

Benefits are limited to the maximum number of visits listed on Your Schedule of Benefits. For the purposes of this benefit, the term "visit" means any outpatient visit to a Physician or Facility during which one or more of the therapies listed above are provided. The outpatient Habilitation Services benefit limits described on Your Schedule of Benefits do not apply to therapy services provided for the treatment of a mental health condition, including Autism Spectrum Disorder, or for the treatment of a Substance Use Disorder. These limits also do not apply to inpatient Habilitation Services or Habilitation Services provided as part of home health or hospice care.

Hearing Services and Devices

We cover the following hearing services and devices:

- Hearing screenings and tests for newborns, children, and adolescents, in accordance with the Bright Futures/American Academy of Pediatrics' recommendations for preventive pediatric health care. (See the "Preventive Care Services'' section of this Plan).
- Hearing exams and diagnostic hearing tests to diagnose a suspected medical condition or Injury to the ear.
- Cochlear implants, related services and external component parts required for the proper functioning of a cochlear implant. An external speech processor and controller with necessary components replacement is covered once every three years. Cochlear implants are prosthetic devices and are covered under the prosthetics benefit of this Plan.
- Hearing aids, including replacement hearing aids when alterations to the existing hearing aid cannot adequately meet the needs of the Member. This benefit is limited to one hearing aid per hearing-impaired ear every three years. Coverage is provided for Medically Necessary hearing aid parts, attachments, supplies, repairs and related services necessary to access, select and adjust or fit a hearing aid (e.g., an audiological exam, fitting, adjustments, earmolds). For purposes of this benefit, "hearing aid" means any wearable or implantable instrument or device designed to aid or compensate for impaired human hearing (not including cochlear implants).
- The following are not covered as part of this hearing aid benefit:
    - Batteries and chargers;
    - Cords;
    - Personal sound amplification products; and
    - Direct audio input, Bluetooth capability, or other additional features.

Home Health Care Services

We cover Home Health Services when You are homebound and:

- Require skilled care;
- Are unable to obtain the required care as an ambulatory Outpatient;
- And do not require confinement in a Hospital or Other Health Care Facility.

You will be considered homebound when Your medical condition prohibits You from leaving Your home without extraordinary effort. It does not apply to Covered Services for medical treatment that cannot be reasonably provided in the home.
Home Health Services are skilled Health Care Services that can be provided during visits by Other Health Care Professionals, including Medically Necessary services of a medical social worker. We cover services provided by a home health aide when they are rendered in direct support of skilled Health Care Services provided by other Health Care Providers.

We also cover Medically Necessary consumable medical supplies and Home Infusion Therapy administered or used by Providers when administering Home Health Care Services. Home Health Services do not include services by a person who is a Member of Your family or Your Dependent's family, or who normally resides in Your house or Your Dependent's house even if that person is a Provider. Skilled Nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and Benefit Limitations.

We cover Home Health Care prescribed by Your Physician when the following criteria is met:

- The care described in the Plan of care must be for intermittent Skilled Nursing, or Physical, Occupational, and other short-term Rehabilitative therapy services.
- The Member must be confined at home, in lieu of Hospitalization, under the active supervision of a Physician.
- The Home Health Agency delivering care must be certified within the state where the care is received.
- The care that is being provided is not Custodial Care.

If the Member is a minor or adult who is Dependent upon others for non-skilled care, Custodial Care and/or activities of daily living, Home Health Care will be covered only during times when there is a Family Member or care giver present in the home to meet the Member's non-skilled care and/or Custodial Care needs.

The Home Health benefit limits described on Your Schedule of Benefits do not apply to therapy services provided for the treatment of a mental health condition, including Autism Spectrum Disorder, or for the treatment of a Substance Use Disorder.

Hospice Care

We cover benefits for Hospice Care Services under a Hospice Care Program for Members who have a Terminal Illness and for their families. Coverage includes palliative and supportive medical, nursing and other health services in the home or in an Inpatient program. We also cover bereavement counseling for families of the Terminally Ill Member for up to 12 months following their death. To be eligible for this benefit, Your Hospice Services Provider must be legally licensed to provide Skilled Nursing and other services to support and care for persons experiencing the final phases of Terminal Illness. Your Provider must also be approved as a Hospice Provider under Medicare and the Joint Commission on Accreditation of Health Care Organizations or by the appropriate agency of the state in which this Plan is sold.

In order to be eligible for benefits for a Hospice Care Program, a Member must be suffering from a Terminal Illness, as certified by their Physician, notice of which must be submitted to Us in writing. Your Physician must agree to the Hospice Care Program and must be consulted in the development of the treatment plan.

Inpatient Hospital Coverage

The Plan provides coverage for Inpatient Hospital Expense for You and eligible Dependents. Each inpatient Hospital admission requires Preauthorization. Refer to the **HOW YOUR PLAN WORKS** section of this Policy for additional information.

We may authorize a lower level setting of services for coverage under this Plan in lieu of a Hospital. Members must seek Preauthorization from Oscar before obtaining services (except emergency care or emergency ambulance services). If You do not get Preauthorization, You may have to pay for services completely out of pocket.

We will provide benefits for covered Inpatient Hospital Expenses up to the Allowed Amount minus any Deductible, Copayment Amounts, or Coinsurance Amounts that You may owe.

Deductible, Copayment Amounts, and Coinsurance Amounts must be paid directly to Your Network Physician or other Network Provider.

Services and supplies provided by an Out-of-Network Provider will receive In-Network Benefits when those services and supplies are not available from a Network Provider provided Oscar acknowledges Your visit to an Out-of-Network Provider prior to the visit. Otherwise, no benefits will be paid and the Claim will have to be resubmitted for review and adjustment, if appropriate. Refer to the **HOW THE PLAN WORKS** section of this Policy for additional information.

Refer to Your Schedule of Benefits for information regarding Deductibles, Coinsurance percentages, and penalties for failure to preauthorize that may apply to Your coverage.

Infertility Treatment

We cover diagnostic and exploratory procedures to determine infertility, including surgical procedures to correct diagnosed diseases or conditions.

We cover fertility preservation services to a covered person who will receive a medically necessary treatment for cancer, including surgery, chemotherapy, or radiation, that the American Society of Clinical Oncology or the American Society for Reproductive Medicine has established may directly or indirectly cause impaired fertility.

We do not cover:

- Artificial insemination
- IVF, GIFT, ZIFT
- Services for procurement and storage of donor semen/eggs
- Drugs/Services to treat infertility

Infusion Therapy

We cover Infusion therapy services.

Mammograms and Other Breast Imaging Services

We cover screening mammograms, including Breast Tomosynthesis (3D or digital mammography), for Members with no signs or symptoms of breast cancer for the purpose of detecting the presence of breast cancer. See the Preventive Care Services section of this Agreement for covered screening intervals.

In addition to screening mammograms, this Plan provides benefits for the following breast imaging services, subject to the Cost Share set forth on Your Schedule of Benefits:

- Diagnostic mammograms (i.e., mammograms performed to evaluate an abnormality in the breast(s)).
- Breast ultrasounds
- Breast magnetic resonance imaging (MRI).

Medical-Surgical Coverage

The Plan provides coverage for Medical-Surgical Expense for You and Your covered Dependents. Some services require Preauthorization. Refer to the **HOW YOUR PLAN WORKS section** of this Policy for more information.

We will provide benefits for covered Medical-Surgical Expenses up to the Allowed Amount minus any Deductible, Copayment Amounts, or Coinsurance Amounts that You may owe. Deductible, Copayment Amounts, and Coinsurance Amounts must be paid directly to Your Network Physician or other Network Provider.

Medical-Surgical Coverage shall include but are not limited to the following:

- Services of Physicians and Other Professional Providers.
- Consultation services of a Physician and Other Professional Provider.
- Services of a certified registered nurse-anesthetist (CRNA).
- Diagnostic x-ray and laboratory procedures.
- Radiation therapy.
- Dietary formulas necessary for the treatment of phenylketonuria (PKU) or other heritable diseases.
- Amino-acid based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:
    - Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
    - Severe food protein-induced enterocolitis syndromes;
    - Eosinophilic disorders, as evidenced by the results of biopsy; and
    - Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.
- A Prescription Order from Your Health Care Practitioner is required.
- Rental of durable medical equipment (DME) required for therapeutic use unless purchase of such equipment is required by Oscar (replacement or repairs of DME is not covered). DME shall not include:
    - Equipment primarily designed for alleviation of pain or provision of patient comfort or convenience; or
    - Home air fluidized bed therapy.
- Examples of non-covered equipment include, but are not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment, and whirlpool bath equipment.

- Professional local ground ambulance service or air ambulance service to the nearest Hospital appropriately equipped and staffed for treatment of the Participant's condition.
- Anesthetics and its administration, when performed by someone other than the operating Physician or Other Professional Provider.
- Oxygen and its administration provided the oxygen is actually used.
- Blood, including cost of blood, blood plasma, and blood plasma expanders, which is not replaced by or for the Participant.
- Prosthetic Appliances and the professional services related to the fitting and use of those devices, including repairs or replacements necessitated by growth to maturity of the Participant.
- Orthopedic braces (i.e., an orthopedic appliance used to support, align, or hold bodily parts in a correct position) and crutches, including rigid back, leg or neck braces, casts for treatment of any part of the legs, arms, shoulders, hips or back; special surgical and back corsets, Physician-prescribed, directed, or applied dressings, bandages, trusses, and splints which are custom designed for the purpose of assisting the function of a joint. We cover repair and replacement of these items unless necessitated by misuse or loss by the Member. We also cover the professional services related to the fitting and use of these devices.
- Home Infusion Therapy.
- Services or supplies used by the Participant during an outpatient visit to a Hospital, a Therapeutic Center, or a Chemical Dependency Treatment Center, or scheduled services in the outpatient treatment room of a Hospital.
- Certain Diagnostic Procedures, meaning a:
    - Bone Scan;
    - Cardiac Stress Test;
    - CT Scan (with or without contrast);
    - MRI (Magnetic Resonance Imaging);
    - Myelogram; and
    - PET (Positron Emission Tomography) Scan.
- Outpatient Contraceptive Services, prescription contraceptive devices, and prescription contraceptive medications. NOTE: Prescription contraceptive medications are covered under the PHARMACY BENEFITS portion of Your Plan.
- Injectable drugs, administered by or under the direction or supervision of a Physician or Other Professional Provider.

Maternity and Newborn Care

The benefits available under this subsection are generally determined on the same basis as other inpatient Hospital coverage, Medical-Surgical Coverage, and Extended Care Coverage, except to the extent described in each item. Benefits for Medically Necessary services will be determined as indicated on Your Schedule of Benefits. Remember that certain services require Preauthorization and that any Copayment

Amounts, Coinsurance Amounts and Deductibles shown on Your Schedule of Benefits will also apply.

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If You would like more information on these benefits, call Us at the number on the back of Your Oscar ID card.

Complications of Pregnancy

Benefits for Eligible Expenses incurred for treatment of Complications of Pregnancy will be determined on the same basis as treatment for any other sickness.

Maternity Care

Female Participants are eligible for coverage of Maternity Care. Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other treatment of sickness. Dependent children will be eligible for Maternity Care benefits.

Maternity care is subject to a one-time office visit copayment. For Oscar plans with a Copayment, this Copayment Amount should be collected at the time of the initial office visit for Maternity Care, but will not be required for subsequent visits.

Services and supplies incurred by a Participant for delivery of a child shall be considered Maternity Care and are subject to all provisions of the Plan.

The Plan covers inpatient care for the mother and newborn child in a health care facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery; and
- 96 hours following an uncomplicated delivery by caesarean section.

Planned deliveries at home are covered with Preauthorization.

If the mother or newborn is discharged before the minimum hours of coverage, the Plan provides coverage for Post-delivery Care for the mother and newborn. The Post-delivery Care may be provided at the mother's home, a Health Care Provider's office, or a health care facility. Post-delivery Care means postpartum Health Care Services provided in accordance with accepted maternal and neonatal physical assessments.

The term includes:

- Parent education,
- Assistance and training in breast-feeding and bottle feeding, and
- The performance of any necessary and appropriate clinical tests.

Charges for well-baby nursery care, including the initial examination of a newborn child during the mother's Hospital Admission for the delivery, will be considered inpatient Hospital coverage of the child and will be subject to the benefit provisions and benefit maximums as described under Inpatient Hospital Coverage. Coverage includes the administration of a newborn screening test, including the cost of the test kit. Benefits will also be subject to any Deductible amounts shown on Your Schedule of Benefits.

Initial newborn coverage is provided for the first 60 days of the child's birth.

Mental Health and Substance Use Disorder Services

Prior Authorization is required for certain Mental Health and Substance Use Disorder services. Emergency Services never require Prior Authorization. Covered Services include services for Mental Health and Substance Use Disorder. This includes services for all Mental Conditions identified as "Mental Disorders" in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including the diagnosis and Medically Necessary treatment of Substance Use Disorder Conditions, as defined by the most recent edition of the DSM.

Such benefits shall be in parity with the medical and surgical benefits contained in the coverage in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and applicable State law. Mental Health Care and Substance Use Disorders Services include those received on an inpatient or outpatient basis in a Hospital, an Alternate Facility or in a Provider's office. All services must be provided by or under the direction of a Behavioral Health Provider who is properly licensed and qualified by law and acting within the scope of their licensure.

Benefits include the following levels of care:

- Inpatient treatment – includes room and board in a Semiprivate Room (a room with two or more beds)

- Residential Treatment – includes room and board in a Semiprivate Room (a room with two or more beds)
- Partial Hospitalization/Day Treatment/High-Intensity Outpatient
- Intensive Outpatient Program
- Outpatient treatment

Services include the following:

- Diagnostic evaluations, assessment and treatment, and/or procedures
- Medication management
- Individual, family, and group therapy
- Crisis intervention

We also Cover Mental Health Care Services for Autism Spectrum Disorder (including Intensive Behavioral Therapies such as Applied Behavior Analysis (ABA)) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a Board Certified Behavior Analyst (BCBA) or other qualified Provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property, and impairment in daily functioning.

This section describes only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a Covered Health Care Service for which Benefits are available under the applicable medical Covered Health Care Services categories in this Evidence of Coverage.
Providers who can provide Covered Services include, but are not limited to:

- Psychiatrist,
- Psychologist,
- Licensed clinical social worker (L.C.S.W.),
- Mental Health clinical nurse Specialist,
- Licensed marriage and family therapist (L.M.F.T.),
- Licensed professional counselor (L.P.C)
- Board Certified Behavior Analyst (BCBA)
- Other recognized Substance Use Professionals

To obtain a list of Mental Health and Substance Use Disorder Providers within Our network please contact Us at (855) 672-2755 or access Our website at hioscar.com.

Inpatient Services include individual psychotherapy, group psychotherapy, psychological testing, and counseling with family members to assist with the patient's

diagnosis and treatment, detoxification, and rehabilitation treatment; Hospital and inpatient professional charges in any Hospital or Facility required by State law.

Outpatient Services include diagnosis and treatment of psychiatric conditions, individual and group psychotherapy, psychological testing, Office Visits, outpatient Facility and Physician charges, and medication management checks.

Nutritional Counseling Services

Nutritional evaluation and counseling from a Network Provider is covered when dietary adjustment has a therapeutic role of a diagnosed chronic disease/condition, including but not limited to:

- Morbid obesity
- Diabetes
- Cardiovascular disease
- Hypertension
- Kidney disease
- Eating disorders
- Gastrointestinal disorders
- Food allergies
- Hyperlipidemia

All other services for the purpose of diet control and weight reduction are not covered unless required by a specifically identified condition of disease etiology. Services not covered include but not limited to:

- Intra oral wiring
- Gastric balloons
- Dietary formulae
- Hypnosis
- Cosmetics
- Health and beauty aids

Preventive Care Services

Preventive care services are health care services that do one or more of the following:

- Prevent illness, disease or other health care problems, such as routine immunization;
- Promote health, such as counseling on tobacco use; and/or
- Detect disease before noticeable symptoms develop, such as screening for colorectal cancer.

This Plan provides benefits for preventive care services for the following:

- Immunizations recommended for routine use by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC);

- Items and services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF);
- Services provided for in the Health Resources and Services Administration (HRSA)-supported women's preventive services guidelines; and
- With respect to infants, children and adolescents, preventive care and screenings preventive care and screenings in accordance with comprehensive guidelines supported by the HRSA (i.e., Bright Futures Guidelines).

The USPSTF, ACIP or HRSA may modify their recommendations and guidelines periodically. When this occurs, any changes in preventive care benefits will be effective no later than the first day of the Benefit Period that begins one year after the recommendation or guideline is issued, or on such other date as required by state or federal law.

If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of a preventive service, then We may impose reasonable coverage limits on such preventive care. Coverage limits will be consistent with applicable federal and state laws.

When performed by In-Network Providers, preventive services are not subject to Cost Share (Copayments, Deductibles or Coinsurance). However, Cost Share may apply to non-preventive services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost Share amount that would otherwise apply to the office visit will still apply.

Items and services covered under the preventive benefit include, but are not limited to, the following:

A. **Abdominal Aortic Aneurysm Screening.** We cover a one-time screening for abdominal aortic aneurysm with an ultrasonography in men aged 65 to 75 years who have ever smoked.

B. **Abnormal Blood Glucose and Diabetes Screening**. Screening for abnormal blood glucose (prediabetes) and diabetes mellitus is covered in asymptomatic members 35 to 70 years of age who are overweight or obese. Additionally, screening for Type 2 diabetes before and after pregnancy is covered for Members with or without a history of gestational diabetes mellitus. Screening for gestational diabetes mellitus after 24 weeks of gestation is covered for pregnant members. Screening pregnant members with risk factors for type 2 diabetes or GDM before 24 weeks of gestation is also covered.

C. **Alcohol Misuse Screening and Counseling.** We cover screening for unhealthy alcohol use in primary care settings and, for members engaged in risky or hazardous drinking, brief behavioral counseling interventions to reduce unhealthy alcohol use. Screening and behavioral counseling interventions may be performed as part of the annual comprehensive preventive exam.

D. **Anxiety and Depression Screening.** We cover screening for anxiety and/or depression in primary care settings in adolescent and adult members, including those who are pregnant or postpartum, under the preventive care benefit. Screening may be performed as part of the annual comprehensive preventive exam. Screening for major depressive disorder is also covered under this benefit for Members 8 to 18 years of age.

E. **BRCA Genetic Counseling and Testing.** For female members with an increased risk for mutations in the BRCA1 or BRCA2 genes, BRCA counseling and testing to determine genetic risk for breast and ovarian cancer is covered as a preventive care benefit when medical necessity criteria are met.

F. **Breast Cancer Screening.** Clinical breast exams and screening mammography for the detection of breast cancer are covered under the preventive care benefit. Screening mammograms, including Breast Tomosynthesis (3D or digital mammography), are covered as described below.
    - One screening mammogram per Benefit Period for Members 35 years of age and older.
    - Screening mammograms at intervals considered to be Medically Necessary for Members of any age who are at increased risk for breast cancer. No more than one screening mammogram per Benefit Period will be covered under the preventive care benefit. More frequent screenings for members at increased risk will be subject to Cost Sharing.

G. **Breastfeeding Services and Supplies.** Comprehensive lactation support services (including education, counseling, and breastfeeding equipment and supplies) are covered under the preventive care benefit during the antenatal, perinatal, and postpartum periods. Covered equipment and supplies include:
    - One personal-use breast pump per pregnancy, and
    - Breast pump parts and supplies, including replacement parts and supplies, necessary for the breast pump to operate.

H. **Cervical Cancer Screening.** Cervical cancer screening is covered under the preventive care benefit as described below for Members with a cervix. Additional cervical cancer screenings are covered as Medically Necessary for Members at increased risk for cervical cancer, subject to Cost Sharing.
    - Once every three years using cervical cytology (Pap smear) for Members 18 years of age or older, or

- Once every five years with high-risk human papillomavirus (hrHPV) testing alone or in combination with cytology testing for Members 18 years of age or older.

Please see the "Certain Tests for Detection of Human Papillomavirus and Cervical Cancer" section under for additional information.

I. **Cholesterol Screening.** Screening for lipid disorders is covered under the preventive care benefit for members aged 40 to 75 years of age.

J. **Colorectal Cancer Screening**. Colorectal cancer screening is covered under the preventive care benefit in accordance with the screening intervals described below for Members 45 years of age and older.
   - A high-sensitivity guaiac fecal occult blood test (gFOBT) or fecal immunochemical test (FIT) once per Benefit Period.
   - A stool DNA (sDNA) test (e.g., Cologuard®) once per Benefit Period.
   - A screening CT colonography (also known as a virtual colonoscopy) once every five years.
   - A screening flexible sigmoidoscopy once every five years.
   - A screening colonoscopy and a follow-up colonoscopy if the results of the initial screening colonoscopy are abnormal, once per Benefit Period.
   - Members at increased risk for colorectal cancer may need to be screened before age 45 or at more frequent intervals. We cover additional screening tests and procedures at intervals considered to be Medically Necessary for Members of any age who are at increased risk for colorectal cancer, subject to Cost Sharing.

   Medically Necessary items and services that are an integral part of a covered preventive colorectal cancer screening procedure are also covered under the preventive care benefit. This may include a pre-procedure consultation, anesthesia services, bowel preparation medications (covered under the pharmacy benefit of this Plan), polyp removal performed during the screening procedure, and associated pathology services.

   When a stool-based screening test (e.g., gFOBT, FIT, or sDNA), a screening flexible sigmoidoscopy, or screening CT colonography result in abnormal findings, a follow-up colonoscopy will be covered without Member Cost Sharing.

K. **Comprehensive Preventive Exam for Adults.** One comprehensive preventive exam (also referred to as a routine physical examination) is covered per Benefit Period. The following screening and counseling services are included as part of the comprehensive preventive exam benefit:
   - High blood pressure screening,
   - Screening for unhealthy drug use,

- Screening for intimate partner violence,
- Obesity screening,
- Vision and hearing screenings,
- Screening for urinary incontinence, and
- Behavioral counseling for skin cancer prevention.

L. **Contraception Care.** Sterilization procedures, reproductive education and counseling for contraception, and all Food and Drug Administration (FDA)--approved contraceptive methods are covered under the preventive care benefit. Covered contraceptive care includes contraceptive counseling, initiation of contraceptive use, and follow-up care (e.g., management and evaluation as well as changes to and removal or discontinuation of the contraceptive method). FDA-approved, over-the-counter contraceptive drugs and devices are included in this benefit when prescribed by a Health Care Provider.

M. **Exercise Interventions.** We Cover exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at an increased risk for falls.

N. **Hearing Screenings and Tests**. Hearing screenings and tests are covered as a preventive service for newborns, children and adolescents in accordance with the Bright Futures/American Academy of Pediatrics' recommendations for preventive pediatric health care.

O. **Hepatitis C Virus (HCV) Screening.** We cover screening for HCV infection under the preventive care benefit for members 18 to 79 years of age without known liver disease.

P. **Latent Tuberculosis Infection Screening**. Screening for latent tuberculosis infection (LTBI) is covered under the preventive care benefit for asymptomatic members 18 years of age and older who are at increased risk of infection. Up to one screening per Benefit Period is covered under the preventive care benefit.

Q. **Lung Cancer Screening.** We cover screening for lung cancer with low-dose computed tomography (LDCT) in members aged 50 to 80 years who currently smoke or have a history of smoking. Up to one screening per Benefit Period is covered.

R. **Nutritional Counseling and Behavioral Counseling Interventions.** We cover the following behavioral counseling interventions and nutritional counseling services under the preventive care benefit:
   - Counseling and interventions to promote healthy diet and physical activity for members 18 years of age and older who are at increased risk of cardiovascular disease (CVD).
   - Counseling and interventions to promote healthy weight and to prevent excess gestational weight gain in pregnancy.
   - Counseling and interventions for overweight or obese members.

- Counseling and interventions for members with prediabetes.

S. **Osteoporosis Screening**. We cover screening for osteoporosis with bone mass measurement testing in members 65 years of age and older and in postmenopausal members under the age of 65 who are at increased risk for osteoporosis.

T. **Preventive Medications.** When prescribed by a Health Care Provider, this Plan covers FDA-approved medications recommended with an "A" or "B" rating by the USPSTF or provided for in the HRSA-supported preventive services guidelines as a preventive care benefit. These medications are covered under the pharmacy benefit of this Plan and include:
    - Low-dose aspirin for members aged 50 to 59 years who have an increased risk for cardiovascular disease (CVD) and for members who have a high risk for preeclampsia.
    - Statin for the prevention of CVD events and mortality in members aged 40 to 75 years who have one or more risk factors and a calculated 10-year CVD event risk of 10% or greater.
    - Preexposure prophylaxis (PrEP) with antiretroviral therapy for members at high-risk of HIV acquisition.
    - Risk-reducing medications for members at increased risk for breast cancer.
    - For Members 5 years of age and younger:
        i. Oral fluoride supplementation starting at the age of 6 months for Members whose water supply is deficient in fluoride.
        ii. Fluoride varnish application to the primary teeth of all Members starting at the age of primary tooth eruption for the prevention of dental caries.
    - Folic acid supplementation for members planning or capable of pregnancy.
    - Tobacco-use cessation medications for adult members who use tobacco products. See the *Tobacco Use Screening, Cessation Attempts and Behavioral and Pharmacotherapy Interventions section* below for more information.

U. **Routine Gynecological Examinations.** Routine gynecological examinations are covered under the preventive care benefit. We cover one (1) routine gynecological examination, including a pelvic examination and clinical breast examination, per Benefit Period.

V. **Routine Immunizations.** All immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the CDC. Covered immunizations include, but are not limited to, the influenza (flu), varicella (chickenpox), human papillomavirus (HPV), measles, mumps, pneumococcal, shingles, respiratory syncytial virus (RSV), and COVID-19 vaccines. Immunizations will be covered in accordance with the intervals, ages and populations recommended by ACIP.

W. **Routine Prenatal and Postpartum Care.** Routine prenatal and postnatal care, including routine office visits and routine pregnancy-related screenings. Prenatal ultrasounds are not part of the preventive care benefit and will be subject to appropriate Cost Sharing. Pregnancy-related screenings covered under this benefit include:
    - Preeclampsia screening,
    - Asymptomatic bacteriuria screening using urine culture,
    - Rh(D) blood typing and antibody testing,
    - Screening for Diabetes in Pregnancy,
    - Screening for Diabetes after Pregnancy, and
    - Screening for hypertensive disorders.

X. **Sexually Transmitted Infections (STIs Screening and Behavioral Counseling)**. We cover STI screening and behavioral counseling to prevent STIs for adolescent and adult members who are at increased risk for STIs. Behavioral counseling interventions may be performed as part of the annual comprehensive preventive exam. STI screenings covered under the preventive care benefit include:
    - Screening for syphilis infection is covered for members at increased risk for infection and for all pregnant members, once per pregnancy with repeat testing for pregnant members at increased risk of infection.
    - Screening for chlamydia and/or gonorrhea infection is covered for pregnant members; asymptomatic, sexually active members 24 years of age or younger; and members 25 years or older who are at increased risk of infection.
    - Screening for HIV infection is covered for pregnant members, members aged 15 to 65 years, and Members of any age who are at increased risk for infection. This includes universal HIV screening for Members between the 15-year visit and 21-year visit as covered under the Well-child Examinations section of this Plan.
    - Screening for hepatitis B virus (HBV) infection is covered for adolescents and adults at increased risk for infection and in all pregnant members, once per pregnancy. Repeat testing is covered for pregnant members with new or continuing risk factors for HBV infection.

Y. **Tobacco Use Screening, Cessation Attempts and Behavioral and Pharmacotherapy Interventions.** We cover tobacco use screening and, for members who use tobacco products, up to two tobacco smoking cessation attempts per Benefit Period under the preventive care benefit. For this benefit, covering a cessation attempt includes coverage for:
    - Up to four tobacco use cessation counseling sessions of at least ten minutes each (including telephone counseling, group counseling and individual counseling); and
    - For nonpregnant Members 18 years of age and older, one 90-day regimen of US Food and Drug Administration (FDA)-approved medications for the treatment of tobacco smoking dependence, including over-the-counter medications when

prescribed by a Health Care Provider. Such medications are covered under the pharmacy benefit of this Plan.

Z. **Well-Child Examinations.** Well-child examinations, including vision and hearing screenings, developmental and behavioral health assessments, and related laboratory services, are covered under the preventive care benefit in accordance with the Bright Futures/American Academy of Pediatrics' recommendations for preventive pediatric health care.

For current information regarding all available preventive care benefits, please refer to https://www.healthcare.gov/coverage/preventive-care-benefits/.

Certain Tests for Detection of Human Papillomavirus and Cervical Cancer

For each woman enrolled in the Plan who is 18 years of age or older, We cover annual medically recognized diagnostic examinations for the early detection of ovarian cancer and cervical cancer. Coverage includes, at a minimum, a CA 125 blood test and a conventional Pap smear screening or a screening using liquid-based cytology methods as approved by the FDA alone or in combination with a test approved by the FDA for the detection of the human papillomavirus. Additionally, We will cover any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer.

Breast Cancer Screening

Benefits are available for diagnostic imaging and screening mammograms by low-dose mammography, including but not limited to digital mammography and breast tomosynthesis (3D mammography), for the presence of breast cancer. Screening mammograms are available to Members 35 years of age and older, as shown on Your Schedule of Benefits. Age requirements do not apply to diagnostic screenings; they are available when Medically Necessary to Members of any age.

For the purposes of this provision, "diagnostic imaging" means imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging used to evaluate an abnormality detected by a patient or to evaluate an individual with dense breast tissue.

Benefits will not be available for more than one routine mammography screening each Calendar Year.

Certain Tests for Detection of Prostate Cancer

Benefits are available for:

- An annual medically recognized diagnostic physical examination for the detection of prostate cancer, and
- A prostate-specific antigen test used for the detection of prostate cancer for each male under the Plan who is at least:
    - 50 years of age and asymptomatic; or
    - 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Early Detection Tests for Cardiovascular Disease

Benefits are available for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years when performed by a laboratory that is certified by a recognized national organization:

- Computed tomography (CT) scanning measuring coronary artery calcifications; or
- Ultrasonography measuring carotid intima-media thickness and plaque.

Tests are available to each Covered Person who is (1) a male older than 45 years of age and younger than 76 years of age, or (2) a female older than 55 years of age and younger than 76 years of age. The individual must be a diabetic or have a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.

Benefits are limited as indicated on Your Schedule of Benefits.

Primary Care Office Visits

Office visits for Primary Care Services are covered.

Mastectomy and Breast Cancer Reconstructive Surgery

If You have had or are going to have a mastectomy, You may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If You

would like more information on WHCRA benefits, call Us at the number on the back of Your Oscar ID card.

You and Your Physician Network Provider will determine the manner in which Covered Services are to be provided. Coverage for Prosthetic devices and Reconstructive Surgery shall be subject to the same Deductible and Coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits with the exception that no time limit shall be imposed on an individual for the receipt of Prosthetic devices or Reconstructive Surgery.

We will cover Inpatient Hospital care for a minimum of 48 hours following a mastectomy and a minimum of 24 hours following a lymph node dissection for the treatment of breast cancer. We won't deny or reduce coverage for reconstructive breast surgery on the grounds that it is Cosmetic in nature, or that it otherwise does not meet the Plan's definition of "Medically Necessary."

Restorative or Reconstructive Surgery

Covered Services are limited to the following, which are subject to Preauthorization:

- Reconstructive Surgery intended to address a significant variation from normal functionality related to accidental injury, disease, trauma, treatment of a medical condition or a congenital defect, including reconstructive breast surgery. This does not include correction of variations from normal that are deemed cosmetic in nature.
- Restorative Surgery performed to reasonably restore a Member to the approximate physical condition they were in prior to the defect resulting from a covered sickness, previous therapeutic process or incidental to surgery.
- Revision Surgery performed as a subsequent procedure to correct the initial medically necessary procedure that failed to perform the intended outcome, or subsequent surgery needed to address medical complications, including, but not limited to the insertion, removal, and/or replacement of a prosthesis or implant.

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

Radiation Therapy

We cover benefits for the treatment of an illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration, treatment planning, or other forms of therapy using radiation. Proton radiation therapy shall not be held to a higher standard of clinical evidence than other types of radiation therapy for cancer treatment.

Acquired Brain Injury

Benefits for Eligible Expenses incurred for Medically Necessary treatment of an Acquired Brain Injury will be determined on the same basis as treatment for any other physical condition.

Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy and Rehabilitation; Neurobehavioral, Neuropsychological, Neurophysiological and Psychophysiological Testing and Treatment; Neurofeedback Therapy, Remediation, Post-Acute Transition Services and Community Reintegration Services, including Outpatient Day Treatment Services; or any other Post-Acute-Care Treatment Services are covered, if such services are necessary as a result of and related to an Acquired Brain Injury.

Treatment for an Acquired Brain Injury may be provided at a Hospital, an acute or post-acute rehabilitation Hospital, an assisted living facility or any other facility at which appropriate services or therapies may be provided.

Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.
Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury. To ensure that appropriate Post-Acute-Care Treatment Service is provided, this Plan includes coverage for reasonable expenses related to periodic reevaluation of the care of a Covered Person who:

- Has incurred an Acquired Brain Injury;
- Has been unresponsive to treatment; and
- Becomes responsive to treatment at a later date.

Treatment goals for services may include the maintenance of functioning or the prevention of or slowing of further deterioration.

Physician's Offices

The following are considered Covered Services in a Physician's office:

- Preventive diagnostic and treatment services when obtained from a Network Provider as set forth in the "Preventive Services" section in this Policy;
- Cancer chemotherapy and cancer hormone treatments and to the extent Medically Necessary, services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer by a Network Provider;
- Injectable drugs when determined by the Physician to be a necessary part of the care given by the Physician during a visit. Coverage is limited to the amount of drug administered during the visit; and

- Medically Necessary Covered Services received from an Out-of-Network Provider upon Preauthorization because Your medical condition requires Covered Services which cannot be provided by a Network Provider.

Physician Services

The services listed in the "Hospital and Ambulatory Surgical Center" section are covered Physician services in a Hospital or Ambulatory Surgical Center under the following conditions.

- Hospital – The services set forth in the "Hospital and Ambulatory Surgical Center" section are Covered Services when provided by Physician Network Providers (or other Physicians in response to an emergency), or otherwise under the orders of a Physician. These services are also provided in a Hospital while You are admitted to the Hospital as a registered bed patient or while You are being treated as a Hospital Outpatient.
- Ambulatory Surgical Center – The services set forth in the "Hospital and Ambulatory Surgical Center" section are Covered Services when provided in an Ambulatory Surgical Center setting by Physician Network Providers (or other Physicians in response to an emergency) or under the orders of a Physician.

Foot Orthotics

Medically Necessary foot orthotics that are consistent with the Medicare Benefit Policy Manual are covered subject to the same Deductibles, Coinsurance Amounts and Copayment Amounts as for services and supplies generally. There is no Calendar Year maximum, though benefits for foot orthotics require Preauthorization if greater than $500 a year. This is in addition to, and does not affect the coverage for, Podiatric appliances as shown in the "Diabetes" section.

Rehabilitation Services

The following Rehabilitation Services are covered on an Outpatient and Inpatient basis to help a person get back or improve skills and functioning for daily living that have been lost or impaired due to illness, injury, or disability:

- Physical Therapy provided by a Physician or Licensed Physical Therapist;
- Occupational Therapy provided by a Physician or Licensed Occupational Therapist;
- Speech Therapy provided by a Physician or Licensed Speech Therapist;
- Cardiac Rehabilitation Services provided under the supervision of a Physician or an appropriate Provider trained for cardiac rehabilitation; and
- Pulmonary Rehabilitation Services provided under the supervision of a Physician or an appropriate Provider trained for pulmonary rehabilitation.

All therapy services must be considered Medically Necessary and may require Preauthorization.

When provided in a Facility on an Outpatient basis or in a Physician's office, You will be responsible for the Outpatient Rehabilitation Cost Share listed on Your Schedule of Benefits for each visit. When provided to You as an Inpatient, You will be responsible for the applicable Inpatient Cost Share listed on Your Schedule of Benefits.

The therapies listed in this category are in addition to therapy benefits listed in the Home Health Care Services, Habilitation Services, and Skilled Nursing Facility Services categories in this section.

Devices that are Medically Necessary to help a person get back or improve skills and functioning for daily living that have been lost or impaired due to illness, Injury, or disability are covered under the Durable Medical Equipment, prosthetics, or orthotics benefit, as applicable.

Benefits are limited to the maximum number of visits listed on Your Schedule of Benefits. For the purposes of this benefit, the term "visit" means any outpatient visit to a Physician or Facility during which one or more of the therapies listed above are provided. The outpatient Rehabilitation Services benefit limits described on Your Schedule of Benefits do not apply to therapy services provided for the treatment of a mental health condition, including Autism Spectrum Disorder, or for the treatment of a Substance Use Disorder. These limits also do not apply to inpatient Rehabilitation Services or Rehabilitation Services provided as part of home health or hospice care.

Skilled Nursing Facility Services

We will pay for the Facility and professional services in a Skilled Nursing Facility when determined to be Medically Necessary. We pay for an admission to a Skilled Nursing Facility when:

- The Skilled Nursing Facility is Network Provider.
- The admission is ordered by the Patient's Attending Physician. We require written confirmation from Your Physician that Skilled Care is needed.
- Approved in advance through Us with expectations of rehabilitation and increased ability to function within a reasonable and generally predictable period of time.
- Covered Services shall be of a temporary nature and must be supported by a treatment plan.
- Covered Services do not include custodial, domiciliary care, or Long-term care admissions.

We pay for:

- A semi-private room, including general nursing service, meals and special diets
- Special treatment rooms

- Physician services
- Laboratory examinations
- Oxygen and other gas therapy '- Drugs, Biologicals and solutions
- Durable Medical Equipment used in the Facility or outside the Facility when rented or purchased from the Skilled Nursing Facility
- Physical Therapy, speech and language pathology services or Occupational Therapy when Medically Necessary
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts

The Skilled Nursing benefit limits described on Your Schedule of Benefits do not apply to therapy services provided for the treatment of a mental health condition, including Autism Spectrum Disorder, or for the treatment of a Substance Use Disorder.

Specialist Office Visits

Office visits for specialty care services are covered.

Speech and Hearing Services

Benefits as shown on Your Schedule of Benefits are available for the services of a Physician or Other Health Care Provider to restore loss of or correct an impaired speech or hearing function. Benefits for speech and hearing services, including but not limited to, speech therapy, cochlear implants and hearing aids may require Preauthorization.

For information on covered hearing aids and cochlear implants, see the Hearing Services and Devices section of this Policy.

Chiropractic and Osteopathic Services

Diagnostic and treatment services provided by a Doctor of Chiropractic (chiropractor) or a Doctor of Osteopathy are covered. Coverage is limited to services performed in a physician's office that are supportive or necessary to help a Member achieve the physical state enjoyed before an injury or illness, which are determined to be Medically Necessary, and are generally furnished for the diagnosis or treatment of a neuromusculoskeletal condition associated with an injury or illness. Coverage includes the following:

- Examinations
- Adjustments and manipulation by manual or mechanical means
- Adjunctive physiotherapy

Benefits are limited to the maximum number of visits listed on Your Schedule of Benefits. For the purposes of this benefit, the term "visit" means any outpatient visit to

a Chiropractor or Doctor of Osteopathy where one or more therapies described above is provided.

Any radiology or laboratory tests will be Covered in accordance with the terms and conditions of this Agreement and may be subject to separate Cost Share.

The Chiropractic and Osteopathic Services benefit limits described on Your Schedule of Benefits do not apply to therapy services provided for the treatment of a mental health condition, including Autism Spectrum Disorder, or for the treatment of a Substance Use Disorder.

Transplant Services – Organ & Tissue

Oscar provides covered services for organ and stem cell transplants performed in an approved Facility after approval by Us (see section Preauthorization), not including any country known to have participated in forced organ harvesting. Transplant services can be performed in Hospitals (inpatient or outpatient) or approved ambulatory surgery facilities subject to Member cost shares.

After preauthorizing service with us, Hospital, Physician, organ procurement, tissue typing and ancillary services related to the following transplants are covered:

- Human organ, tissue, bone marrow and Stem Cell transplants and infusions and related services.
- FDA approved ventricular assist devices (VADs) are covered when Medically Necessary and used according to FDA labeling instructions.

Benefits will be available for:
A recipient who is a Member; and their Donor:

- Covered Services include but are not limited to services and supplies provided for the:
    - Evaluation of organs or tissues including, but not limited to, the determination of tissue matches of the donor; and removal of organs or tissues from living or deceased donors; and,
    - transportation and short-term storage of donated organs and tissues;
    - Procurement of organs or tissues from a living or deceased Donor; and,
    - Donor search and acceptability testing of potential live donors up to a maximum benefit amount of $15,000 per Calendar Year.

If the Donor is not a Member, Covered Services for the Donor are limited to those services and supplies directly related to the Covered Transplant Procedure itself, which are limited to the following:

- Testing for the donor's compatibility;

- Removal of the organ from donor's body;
- Preservation of the organ;
- Transportation of the organ to the site of transplant

A service is a Covered Service only to the extent not covered by other health insurance or other health coverage. Any medical expenses of a Donor are covered to the extent that the benefits remain and are available under this Policy after benefits for Your own expenses have been paid. In the event of such coverage, the otherwise existing coverage of a Donor shall be secondary to benefits under this Policy. Complications of donor organ procurement are not Covered Services unless the donor is a Member. The cost of donor organ procurement is included in the total cost of Your organ transplant.

Unless otherwise described in this Policy, Covered Services for transplants do not include:

- Transplants that are considered experimental, unproved or investigational.
- Living donor travel expenses.
- Non-human organs or tissue (xenograft) obtained from another species or artificial organs, and the related implantation services.
- Collection and/or storage of blood products to include stem cells for any unscheduled medical procedure, or non-covered medical procedures.
- VADs when used as an artificial heart or as a bridge to transplant.
- Expenses related to maintenance of life of a donor for purposes of organ or tissue donation.
- Purchase of the organ or tissue.
- Charges for services provided for or in connection with a specified transplant performed at a Facility other than the Facility will not be considered covered expense.

Preauthorization

Preauthorization is required for all services related to Human Organ and Tissue Transplants. In order to maximize Your benefits, We strongly encourage You to call Us to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. We will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable.

Preauthorization can be obtained by calling Us toll free at (855) 672-2755.

Transplant Benefit Period

Starts one day prior to a covered Transplant Procedure and continues for the applicable time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Anti-rejection drugs and other transplant-related Prescription drugs may be covered outside that benefit period.

Contact Us for specific Network Transplant Provider information for services received at or coordinated by a Network Transplant Provider Facility.

Transplant Travel Services

Qualified Travel Expenditures incurred by the member in connection with an authorized organ/tissue transplant are covered subject to the following conditions and limitations:

- Transplant travel expenses will be covered in accordance with the terms and conditions of this Agreement if the Member is a live donor.
- Qualified Travel Expenditures are limited to $5,000 per transplant.
- Transplant travel benefits are not available for corneal transplants. Transplant travel benefits are not covered if the member is a donor to a non-member.
- Benefits for transportation and lodging are available only for the recipient of a pre-approved organ/tissue transplant from a transplant facility. The term recipient is defined to include a member receiving authorized transplant related services during any of the following:
    - Evaluation;
    - Candidacy,
    - Transplant event, or
    - Post-transplant care.
- Qualified Travel Expenditures for the member receiving the transplant will include charges for:
    - Ground transportation to and from the approved Facility when the designated Facility is seventy-five (75) miles or more from the recipient's or donor's place of residence. This includes charges for a rental car used during a period of care at the transplant facility and per mileage payment in a personal vehicle (cost per mile to be determined by Us at the time of approval). Our coverage with travel costs includes transportation to and or from the Facility, and lodging for the member and one companion. If the Member receiving care is a minor, then reasonable and necessary costs for transportation and lodging may be allowed for two companions.
    - Coach airfare to and from the Facility when the approved Facility is three hundred (300) miles or more from the recipient's place of residence.
    - Lodging while at, or traveling to and from the transplant site.

Travel expenses that are not covered include, but are not limited to: meals, alcohol, tobacco, or any other non- food items; child care; mileage within the city where the Facility is located, frequent flyer miles, coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related, or a direct result, of the transplant; telephone calls; laundry; postage; entertainment; or return visits for the donor for a treatment of a condition found during the evaluation.

When You request reimbursement of covered travel expenses, You must submit a completed direct reimbursement (claim) form and itemized, legible copies of all applicable receipts. Transportation mileage will be calculated by us based on the home address of the member and the transplant site. Credit card slips are not acceptable. Covered travel expenses are not subject to Deductibles or Copayments/Coinsurance. Please call Member Services at (855) 672-2755 for further information and to obtain a reimbursement form.

Technology Assessment

We regularly evaluate new medical tests and procedures, medical devices, and drugs to determine whether they are safe and effective to be included as a covered service. Any new technology that becomes a covered service will be subject to the terms and conditions of the plan. This includes medical necessity requirements and any applicable member cost-sharing, including copayments, coinsurance, and deductibles.

New technology is identified from the following sources: providers, internal clinical staff, members, scientific publications, regulator guidance, or other evidence of successful application of a technology.

Telehealth and Telemedicine

We cover Covered Services offered through Telehealth or Telemedicine by an In-Network Provider subject to the terms and conditions of Our contracts with In-Network Providers. We will not deny coverage for Covered Health Care Services appropriately provided through Telehealth or Telemedicine on the sole basis that the Health Care Service was provided through Telehealth or Telemedicine and not through an in-person consultation. You will not be subject to any greater Deductible, Co-Payment, or Coinsurance amount than would be applicable if the same Health Care Service were provided by the same In-Network Provider through an in-person consultation.

For adult Members, primary care visits offered via Telehealth or Telemedicine and provided by Oscar-designated virtual Primary Care Providers may be covered in full.

Virtual pediatric primary care services are not available; these services may be obtained in-person from In-Network Providers. Certain visits, goods, and services may also be covered in full when first coordinated by Your Oscar-designated virtual Primary Care Provider:

- Tier 1 Prescription Drugs
- Labs

Please refer to Your Schedule of Benefits for more information on cost sharing specific to Your Plan's telehealth coverage.

When Your Oscar-designated virtual Primary Care Provider needs additional information (e.g. vitals), or orders services needed in connection with Your virtual primary care visit, which need to be provided in person (e.g. vaccines, well-woman care), where available, that in-person primary care visit to obtain additional information or to obtain those ordered services when provided by an Oscar-designated in-person provider, may be covered in full.

You can request a virtual primary care visit through Oscar's website, mobile application, and Our customer service line. Call customer service at (855) 672-2755 or contact them via Our website at hioscar.com for additional information.

Virtual Urgent Care visits requested via Oscar's website, mobile application, or customer service line may be covered in full. Virtual urgent care visits can be used for acute care services (e.g. treatment for upper respiratory conditions, rashes, or urinary tract infections). Certain visits, goods, and services may also be covered in full when first coordinated during Your virtual Urgent Care visit:

- Tier 1 Prescription Drugs
- Labs

You can request a virtual Urgent Care visit through Oscar's website, mobile application, and Our customer service line. Call customer service at (855) 672-2755 or contact them via Our website at hioscar.com for additional information.

Oscar will provide coverage for Covered Services offered through Telehealth or Telemedicine by an In-Network Provider with an originating site or distant site located outside this state on the same basis and to the same extent that We provide coverage for the service or procedure delivered as a Telehealth or Telemedicine service with an originating site and distant site located in this state if:

- You primarily reside in this state; and
- The Health Care Provider who provides the service:

- Is licensed or otherwise authorized to provide the service in this state; and
- Has a physical office in this state.

Treatment Received from Providers Outside of the United States

Benefits are provided for services and supplies received from Providers outside of the United States. Coverage is limited to Emergency Services only.

Oscar does not accept assignment of benefits from Providers outside of the United States. This means that the Member is responsible for paying the Provider for services received while outside the United States. The Member may submit a Claim to Oscar for these services. The Member will be reimbursed up to the Allowed Amount, less the applicable Cost Share, for covered Emergency Services. The Allowed Amount may be less than the amount the Member was charged by the Provider. The Member, at their expense, may be held responsible for obtaining an English language translation of Claims and any medical records that may be required. Benefits are subject to all terms, conditions, limitations, and exclusions of this Plan and will not be more than would be paid if the service or supply had been received in the United States.

Urgent Care

Urgent Care benefits are provided for those services necessary to prevent serious deterioration of Your health resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy. In the case of pregnancy, this would include services necessary to prevent serious deterioration of the health of a mother or her unborn child. Urgent medical conditions are not life threatening and do not require the use of an emergency room, but may require prompt medical attention. Examples of medical conditions that generally require Urgent Care include, but are not limited to, animal bites, minor wounds, minor burns, minor eye irritations or infections, high fever (not above 104 degrees), rash, sprains, and minor fractures.

Coverage includes Urgent Care provided in an Urgent Care Center or rendered in a Physician’s office after normal business hours. The Cost Share amount for Urgent Care indicated on Your Schedule of Benefits will be required for each visit to an Urgent Care Center. When Urgent Care services are received in a Physician’s office instead of an Urgent Care Center, You will be responsible for the appropriate physician’s office visit Cost Share listed on Your Schedule of Benefits.

Urgent Care services are covered both inside and outside the Service Area.

- Inside the Service Area: If You need Urgent Care services and are in the Service Area, You must use an In-Network Provider. We encourage You to contact Your Primary Care Physician before seeking services at an Urgent Care Center.
- Outside the Service Area: If You need Urgent Care services and are outside the Service Area, coverage is provided for Urgent Care services received from an Out-of-Network Provider; however, You will be responsible for the difference between the Out-of-Network Provider's charge and the Allowed Amount, in addition to the applicable Cost Share listed on Your Schedule of Benefits.

Whether inside or outside the Service Area, all follow-up care provided after Urgent Care treatment must be received from an In-Network Provider.

Pediatric Vision Services

Benefits for Eligible Expenses incurred by a child Participant under the age of 19 for vision services will be provided for the following:

- Annual vision examination; and
- One pair of eye glasses (lenses and frames) per year if medically necessary;

Coverage is available until the end of the month in which the Member turns 19.

Vision Services (All Ages)

The following vision services and materials are covered for all Members:

- Eye exams to diagnose and treat injuries and diseases of the eye(s) or related structures, subject to the specialist office visit cost share listed on Your Schedule of Benefits.
- Surgical procedures to treat injuries and diseases of the eye(s) or related structures, such as cataract surgery.
- For Members with diabetes, a retinal or dilated eye exam by an optometrist or ophthalmologist once per Benefit Period. This benefit does not include refraction of the eye(s).
- One pair of prescription eyeglasses or contact lenses following cataract surgery with the insertion of an intraocular lens, subject to the prosthetics cost share listed on Your Schedule of Benefits. Intraocular lens(es) inserted at the time of surgery are not considered contact lenses and will not count as the one pair of contact lenses following cataract surgery. If cataracts are removed from only one eye and the Member selects eyeglasses, then both lenses and frames will be covered.
- Special contact lenses for the treatment of injuries and diseases of the eye(s), when prescribed by an In-Network Provider and determined to be Medically Necessary. Coverage includes, but is not limited to:

- Contact lenses for Members with congenital or acquired aphakia, such as after cataract surgery or due to injury. We cover up to six (6) Medically Necessary aphakic contact lenses per eye, per Benefit Period.
- Scleral shell contact lenses for the treatment of diseases and injuries of the eye(s), such as aniridia.
- FDA-approved hydrophilic contact lenses used as a corneal bandage for the treatment of diseases or injury to the eye(s), or when determined to be Medically Necessary following ocular surgery.

When a Member meets the criteria above for coverage of eyeglasses or contact lenses, the associated fitting and dispensing are also covered. Benefits are limited to the amount available for basic (standard) frames and lenses.

Wellness Program

Sometimes we may offer You rewards or incentives for participating in certain activities and programs we may make available to You in connection with Your coverage. These may be one-time rewards, available periodically or related to completing activities under a particular program we offer. Programs we may offer include wellness programs, care management programs, disease management programs, and health awareness and engagement programs.

If You have a health or medical condition that could prevent Your Participation in the programs We offer, but would like to qualify for the reward or incentive, We may require a written statement from your physician that your condition will prevent or make more difficult Your participation in the activity.

You can get more information about which programs are available through our website at hioscar.com or by contacting customer service at (855) 672-2755. Programs are available while Your coverage is active, unless programs have been changed as communicated in the programs' descriptions and terms. Programs are not available after Your coverage has terminated.

Programs may include simple activities designed to: focus on understanding specific conditions or pharmacy medications; encourage You to engage in Your personal health and wellness; and allow You to better understand and use your coverage. These programs require completion of simple engagement activities, such as:

- Completing an annual physical
- Optimizing your health plan
- Filling out a health assessment

Rewards and incentives include:

- Premium credits
- Reduced copayments, coinsurance or deductibles
- Cash equivalents or other incentives such as gift cards and debit cards
- Free or low cost transportation for medical services,
- Contributions to a health savings account
- Memberships to gyms
- Payment for care
- Discounted screening and testing services that directly address social determinants of health

You and any eligible Dependents may each receive, but not exceed, up to $599 in wellness based rewards in all Oscar plans in which You or an eligible Dependent are enrolled during a calendar year. You are responsible for any taxes related to the redemption of rewards. For more information, visit Our website at hioscar.com or call Us at (855) 672-2788.

Incentive Program

We may offer incentives to adult Members who participate in programs that help reduce Our administrative expenses; make retaining coverage more convenient; educate Members; or provide input on Oscar and its products. We may also offer giveaways and discounts to Members. These incentives include but are not limited to:

- Discounts for third-party vendor products
- A gift card for participation in a digital survey
- A gift card for participation in a moderated interview session

Adult Members can obtain a single discount code per third-party vendor offering in a plan year. You can obtain discount codes by logging in to the Oscar portal and navigating to the Health and Wellness page. You can also call customer service at (855) 672-2755 or contact them via Our website at hioscar.com for additional information if You are interested in obtaining discount codes.

We conduct targeted outreach to Members eligible to participate in a digital survey or moderated interview session. Call customer service at (855) 672-2755 or contact them via Our website at hioscar.com for additional information if You are interested in learning more.

The third-party vendor products and services available under this program are not Covered Services under the Plan. These products and services are available as long as We have not discontinued the products or services and Your coverage under the Plan

remains in force. Program features are not guaranteed under the Plan and could be discontinued at any time. We will give You thirty (30) days' advance notice before We discontinue any third-party vendor products or services. We do not endorse any vendor, product or service associated with this program.

Emergency Care and Treatment of Accidental Injury

The Plan provides coverage for medical emergencies wherever they occur. Examples of medical emergencies are unusual or excessive bleeding, broken bones, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

If reasonably possible, contact Your Network Physician or Behavioral Health Practitioner before going to the Hospital emergency room/treatment room, who can help You determine if You need Emergency Care or treatment of an Accidental Injury and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network.

Whether You require hospitalization or not, You should notify Your Network Physician or Behavioral Health Practitioner as soon as reasonably possible, of any emergency medical treatment so they can recommend the continuation of any necessary medical services.

In-Network Benefits for Eligible Expenses for Accidental Injury or Emergency Care, including Accidental Injury or Emergency Care for Behavioral Health Services, will be determined as shown on Your Schedule of Benefits. Copayment Amounts will be required for facility charges for each outpatient Hospital emergency room/treatment room visit as indicated on Your Schedule of Benefits. If admitted for the emergency condition immediately following the visit, the Copayment Amount for the Emergency Room visit will be waived. If admitted for the emergency condition immediately following the visit, Preauthorization of the inpatient Hospital admission will be required, and inpatient Hospital coverage will apply.

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Network Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or Stabilize Your Emergency Condition in a Hospital.

EXCLUSIONS

This section explains what We do not cover. If You receive a service shown below, You will be responsible for paying all charges and fees associated with it.

General Exclusions

The following services are not covered under the Plan:

1. Any services or supplies which are not Medically Necessary and essential to the diagnosis or direct care and treatment of a sickness, injury, condition, disease, or bodily malfunction.
2. Services not included under the **COVERED SERVICES** section.
3. Any portion of a charge for a service or supply that is in excess of the Allowed Amount.
4. Any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are, or could upon proper Claim be, provided under the Workers' Compensation law.
5. Any services or supplies for which benefits are or could be provided under an applicable law, such as Medicare. This exclusion is not applicable to coverage held by You for hospitalization and/or Medical-Surgical Expenses which is part of or in conjunction with an automobile casualty insurance policy.
6. Any Drugs, Services, Supplies or Treatments related to judicial or administrative proceedings or orders. This exclusion does not apply to services that are determined to be Medically Necessary.
7. Any services or supplies for which a Participant is not required to make payment or for which a Participant would have no legal obligation to pay in the absence of this or any similar coverage, except services or supplies for treatment of mental illness or intellectual disability provided by a tax supported institution of the State of Texas.
8. Any services or supplies provided by a person who is in the Participant's immediate family.
9. Services or supplies for Illness or Injury sustained as a result of war, declared or undeclared, or any act of war or while on active or reserve duty in the armed forces of any country or international authority.
10. Any charges:
    a. Resulting from the failure to keep a scheduled visit with a Physician or Other Professional Provider; or
    b. For completion of any insurance forms; or
    c. For acquisition of medical records.
11. Room and board charges incurred during a Hospital Admission for diagnostic or evaluation procedures unless the tests could not have been performed on an outpatient

basis without adversely affecting the Participant's physical condition or the quality of medical care provided.

12. Any services or supplies provided before the patient is covered as a Participant hereunder or any services or supplies provided after the termination of the Participant's coverage.
13. Any services or supplies provided for Dietary and Nutritional Services, except as may be provided under the Plan for:
    a. An inpatient nutritional assessment program provided in and by a Hospital and approved by Oscar;
    b. The "Diabetes" section as described above;
    c. Benefits for Autism Spectrum Disorder as described above; or
    d. The "Nutritional Counseling Services" section as described above.
14. Any services or supplies provided for Custodial Care.
15. Any non-surgical (dental restorations, orthodontics, or physical therapy) or non-diagnostic services or supplies (oral appliances, oral splints, oral orthotics, devices, or prosthetics) provided for the treatment of the temporomandibular joint and all adjacent or related muscles and nerves.
16. Any services, supplies, or expenses incurred for dental care and treatments or dental appliances, except as provided for in the Restorative or Reconstructive Surgery provision of this Policy.
17. Any services or supplies provided for Cosmetic, Reconstructive, or Plastic Surgery, except as provided for in the Benefits for Cosmetic, Reconstructive, or Plastic Surgery provision of this Policy.
18. Routine hearing tests/screening exams, except as described under the Preventive Care Services section or Hearing Services and Devices section of this Policy.
19. Hearing aids (external or implantable), hearing aid accessories and supplies, and services related to the fitting, provision or repair of hearing aids, except as described under the Hearing Services and Devices section of this Policy.
20. Except as specifically included as an Eligible Expense, any Medical Social Services, bereavement counseling, vocational counseling, or Marriage and Family Therapy.
21. Any occupational therapy services which do not consist of traditional physical therapy modalities and which are not part of an active multi-disciplinary physical rehabilitation program designed to restore lost or impaired body function, except as may be provided under the Benefits for Autism Spectrum Disorder provision of this Policy.
22. Travel or ambulance services because it is more convenient for the patient than other modes of transportation whether or not recommended by a Physician or Other Professional Provider.
23. Any services or supplies provided for reduction of obesity or weight, including surgical procedures, even if the Participant has other health conditions which might be helped by a reduction of obesity or weight, except for healthy diet counseling and obesity screening/counseling as may be provided under Preventive Services.

24. Any services or supplies provided primarily for: Clinical Ecology or any similar treatment not recognized as safe and effective by the American Academy of Allergists and Immunologists; or
    a. Inpatient allergy testing or treatment.
25. Any services or supplies provided as, or in conjunction with, chelation therapy, except for treatment of acute metal poisoning.
26. Any services or supplies in connection with foot care for flat feet, fallen arches, or chronic foot strain.
27. Any prescription antiseptic or fluoride mouthwashes, mouth rinses, or topical oral solutions or preparations.
28. Any services or supplies provided for the following treatment modalities:
    a. Intersegmental traction;
    b. Surface EMGs;
    c. Spinal manipulation under anesthesia; and
    d. Muscle testing through computerized kinesiology machines such as Isostation, Digital Myograph and Dynatron.
29. Benefits for any covered services or supplies furnished by a Contracting Facility for which such facility has not been specifically approved to furnish under a written contract or agreement with Oscar, except in the case of Emergency Services.
30. Any items that include, but are not limited to, an orthodontic or other dental appliance; splints or bandages provided by a Physician in a non-Hospital setting or purchased "over the counter" for support of strains and sprains; orthopedic shoes which are a separable part of a covered brace, specially ordered, custom-made or built-up shoes, cast shoes, shoe inserts designed to support the arch or affect changes in the foot or foot alignment, arch supports, elastic stockings and garter belts. Note: This exclusion does not apply to podiatric appliances when provided as Diabetic Equipment.
31. Supplies for smoking cessation programs and the treatment of nicotine addiction, except as provided under Preventive Services.
32. Any benefits in excess of any day, visit or Calendar Year limitations.
33. Services Provided Outside the United States. Any services and supplies provided to a Member outside the United States are not covered under this Plan, except Emergency Services as described in the Treatment Received from Providers Outside of the United States section of the **COVERED SERVICES** section of this Agreement. Expenses related to repatriation and medical evacuation to the United States from outside the United States are not covered.
34. Donor expenses for a Participant in connection with an organ and tissue transplant if the recipient is not covered under this Plan.
35. Replacement or repair Prosthetic Appliances necessitated by misuse or loss.
36. Private duty nursing services.
37. Any Covered Drugs that are provided under the Pharmacy Benefits portion of the Plan.

38. Any services or supplies not specifically defined as Eligible Expenses in this Plan. Criminal Acts: Oscar does not cover any Health Care Services provided or charges billed as a result of injuries, conditions, or disabilities suffered while or as a result of 1) committing or attempting to commit a criminal act; 2) engaging in an illegal occupation; or 3) participating in a riot, rebellion or insurrection.
39. Any services and supplies provided for routine foot care except when Medically Necessary.
40. Travel expenses, including but not limited to mileage and lodging.
41. Massage therapy.
42. Vocational rehabilitation.
43. Charges for surrogate mother.
44. Home delivery of childbirth unless Preauthorized by Us.
45. Optional accessories or devices primarily for the Member's comfort or convenience, including but not limited to elastic support stockings (except as required for Medically Necessary diabetic care), foot pads, bunion covers, home UV therapy units, home monitoring devices.
46. Customization of vehicles, vehicle lifts for wheelchairs and/or scooters, scooters.
47. Modifications of the Member's home (e.g. ramp installation).
48. Hypnotherapy.
49. Coma stimulation.
50. Any federal, state, or local taxes due on benefits, goods, or services.
51. Shipping and handling services and/or fees.
52. Services required while a Member is incarcerated.
53. Services, care, or treatment for medical complications resulting from or associated with non-covered Services.
54. Abortions that do not meet the coverage criteria described in the "Covered Services: section of this Policy.
55. Bariatric Surgery.
56. In vitro fertilization.
57. Fees for no shows and late cancellation. We do not cover fees Your Provider charges for no shows or late cancellations of appointments.
58. Reversal of any sterilization procedures.
59. Weight Loss programs, whether or not under medical supervision, except as stated as covered, including commercial weight loss and fasting programs; bariatric surgery, including Roux-en-Y, Laparoscopic gastric bypass or other gastric bypass surgery, Gastroplasty, or gastric banding procedures; Drugs used mainly for weight loss. Complications unrelated to Emergency Medical Conditions, as determined by Us, are not covered.
60. Services or supplies that are considered to be for Experimental, Investigational, or Unproven Procedures, and their complications, except for Clinical Trial costs required to be covered under law.

61. Acupuncture.
62. Except as indicated in the **COVERED SERVICES** section above, wigs or hairpieces are not covered.
63. Aids or devices that assist with nonverbal communication, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and hard of hearing, and memory books.
64. This Plan does not cover vaccinations or physical examinations required for foreign travel or employment purposes, unless the exam is within the scope of, and coincides with, the annual comprehensive preventive exam, described in the Preventive Care Services section of this Policy. This exclusion does not apply to immunizations covered under the preventive benefit, as described in the Preventive Care Services section of this Policy.
65. The following vision services and items are not covered:
    a. Vision services and eyewear for Members nineteen (19) years of age and older, except as specifically listed as a covered benefit in the "Vision Services (All Ages)" section of this Agreement.
    b. Two (2) pairs of glasses in lieu of bifocals.
    c. Sunglasses and safety glasses and accompanying frames.
    d. Orthoptics or vision training and any associated supplemental testing.
    e. Plano lenses (i.e., lenses that have no refractive power).
    f. Replacement of lost, stolen or damaged frames or lenses and replacement due to refractive changes, unless the Member has reached the Member's normal interval for service when seeking replacements. This exclusion does not apply to the replacement of special contact lenses, described in the "Vision Services (All Ages)" section of this Agreement, when determined to be Medically Necessary due to a change in condition or ongoing need, as documented by the treating physician.
    g. Eyewear accessories, including, but not limited to, eyeglasses cases and cleaning solution.
    h. Any modification to eyeglasses or contact lenses designed for cosmetic purposes or that are otherwise not Medically Necessary for the treatment of the condition for which they are prescribed. This includes, but is not limited to, oversized lenses and frames, tinted or colored contact lenses, designer frames, anti-reflective coating, polarization, mirror coating, scratch-resistant coating, and UV (ultraviolet) protection.
    i. Drugs, eye surgery and implantable devices solely for the purpose of correcting refractive defects of the eye(s), such as nearsightedness (myopia), farsightedness (presbyopia), and/or astigmatism.
    j. Low vision devices, except as covered under the pediatric vision benefit.
66. Sterilization reversal is not covered for infertility treatment needed as a result of prior voluntary sterilization or unsuccessful sterilization reversal procedure. Voluntary male

sterilization (chemical or procedural) ends coverage for ICSI, IVF, TESE, MESA, and donor sperm based on male factor or unexplained infertility. Any abnormal semen analysis post a reversal ends eligibility for coverage of infertility services. Note: Adding history of voluntary sterilization as an exclusion means it can be a non-covered benefit denial rather than a not medically necessary denial.

67. The following genetic testing services are not covered:
    a. Genetic testing when performed in the absence of symptoms or high risk factors for a heritable disease.
    b. Genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease or reproductive choices.
    c. Genetic testing that has been performed in response to direct to consumer marketing and not under the direction of your physician.
    d. Pre-implantation genetic testing.
    e. Any genetic testing, amniocentesis, or other procedure performed solely for purposes of determining the gender of a fetus.
68. Exclusions for Mental Health include:
    a. Services rendered for a Condition that is not a Mental and Nervous Disorder as defined in this Contract, regardless of the underlying cause, or effect, of the disorder.
    b. Services for educational purposes.
    c. Services for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Contract, regardless of the underlying cause, or effect, of the disorder.
    d. Services for pre-marital counseling.
    e. Services to test aptitude, ability, intelligence or interest; including, but not limited to educational testing for learning disabilities or intellectual disabilities.
    f. Services required to maintain employment.
    g. Services for cognitive remediation.
    h. Inpatient stays that are primarily intended as a change of environment.
    i. Transitional living services (i.e., supportive housing, including recovery residences).
69. Vocational counseling, testing, and support services including job training, placement services, and work hardening programs (i.e., programs designed to return a person to work or to prepare a person for specific work).

HOW YOUR PLAN WORKS

Oscar Network

The Network for this Plan is the Oscar Network. The Oscar Network has been specially curated to contain the best Providers that we're confident will serve all of Your needs. You can access up-to date lists of Our Network Providers and other Oscar Network information at hioscar.com. Printed directories are available upon request, without charge. Except in the case of Emergency Services and Care or Urgent Care services received while outside of the Service Area, a Member must obtain Covered Services and supplies from Oscar Network Providers to receive benefits under this Plan. Services and supplies obtained from Providers that are not Oscar Network Providers will generally not be covered, unless Oscar, at its discretion, determines coverage to be warranted due to extenuating circumstances such as significant barriers to a Member's ability to select an In-Network Provider.

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

Under this Plan, We encourage You to select a Primary Care Provider (PCP) to help manage and coordinate Your health care in Oscar's Network. You are not required to see your PCP or get a referral before making appointments or receiving care from other Network Providers. However, a PCP can often be a helpful first step when You need health care services or recommendations.

Our Provider Directory lists In-Network Providers that You can select as a PCP. If You do not select a PCP, we may suggest one for you so that You have a starting point and contact information for a Network Provider who can help you. You can always see any In-Network PCP, regardless of your current selected PCP.

The following list includes a few additional important things for you to know about PCPs and Your Plan. You may contact Us with questions at any time.:

- You can switch Your PCP at any point in time after We suggest one or You change Your mind about a selected PCP.
- You can see Your current PCP on the digital copy of Your ID card. You can access a digital copy of Your card in Your Oscar web profile or mobile application.
- You do not need to choose the same PCP for each Member in Your family. For children, You may designate an In-Network pediatrician as the PCP.
- This is an "open Referral" Plan and does not have a gatekeeper. You do not need a Referral from a PCP to obtain treatment for covered benefits before receiving Specialist care from an In- Network Specialist. It is recommended that You visit Your assigned PCP to help manage and coordinate Your care, but Your PCP network benefits will still apply should You see another PCP in Oscar's network.

Specialists

A wide range of Specialists are included in the Oscar Network. When You need a Specialist's care, In-Network Benefits will be available, but only if You use a Network Provider.

There may be occasions however, when You need the services of an Out-of-Network Provider. This could occur if You have a complex medical problem that cannot be taken care of by a Network Provider. If the services You require are not available from Network Providers, In-Network benefits may be provided when You use Out-of-Network Providers. You, or an In-Network Provider, will need to submit the Out-of-Network Authorization Request Form to receive the necessary Preauthorization for Out-of-Network services in this situation. If You would like information on the process or the policy and procedure for requesting Out-of-Network authorization, please contact Member Services at (855) 672-2755.

Women's Health Care Providers

You do not need Preauthorization from Us or from any other person (including a PCP) in order to obtain access to obstetrical or gynecological care from a health care professional in Our Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Preauthorization for certain services, following a pre-approved treatment plan, or procedures for making Referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, visit Our website, hioscar.com.

Emergency Services and Care

If You immediately need Medically Necessary Emergency Services, We will provide coverage for those services if they are provided by an In-Network or an Out-of-Network Provider. We will provide benefits for this care, if received from an Out-of-Network Provider, to the same extent as would have been provided if care and treatment were provided by an Oscar Network Provider. We will provide benefits for this care until Your medical condition permits travel or transport to a Network Provider. If You receive care and treatment for an Emergency Medical Condition from an Out-of-Network Provider, You should notify Us as soon as reasonably possible. Emergency Services are available at any Out-of-Network Hospital, within or outside of the Service Area.

We do not provide coverage for Out-of-Area Services for anything other than Emergency Services as outlined above and Urgent Care services subject to the conditions specified in the Urgent Care section of this Plan.

Network Providers

To receive In-Network Benefits as indicated on Your Schedule of Benefits, You must choose Providers within the Network for all care (other than for Emergency Services). The Oscar Network consists of Physicians, Specialty Care Providers, Hospitals, and other health care facilities to serve Members throughout the Service Area. Refer to Your Provider Directory or Visit the Oscar website at hioscar.com to make Your selections. The list of Network Providers may change occasionally, so make sure the Providers You select are still Network Providers at the time of service. An updated directory will be available at least annually or You may access Our website at hioscar.com for the most current listing to assist You in locating a Provider. Our Member Services team is available to assist You in finding the Network Provider that will best suit Your needs through our mobile application on our Member portal at hioscar.com or at (855) 672-2755..

If You choose a Network Provider, the Provider will bill Oscar for services provided. The Provider has agreed to accept as payment in full:

- The billed charges, or
- The Allowed Amount as determined by Oscar, or
- Other contractually determined payment amounts.

You are responsible for paying the Provider any Deductibles, Copayment Amounts, and Coinsurance Amounts as set forth in Your Schedule of Benefits. You may be required to pay for limited or non-Covered Services. No Claim forms are required. An In-Network Provider is not permitted to bill You for anything other than Copayment, Coinsurance and Deductible for Medically Necessary Covered Services.

Your Coinsurance does not apply to charges for services which are not covered and will not be reduced by refunds, rebates or any other form of negotiated post-payment adjustments.

Out-of-Network Providers

If You elect to see an Out-of-Network Provider when the services could have been provided by a Network Provider, no benefits will be available.

However, Oscar will pay In-Network Benefits if an insured:

- Reasonably relied upon a statement that a Provider was a Network Provider as specified in a Provider listing or website information;
- The information was obtained from Oscar or on Oscar's website or through a website of a third party Oscar has designated to provide such information;
- The listing or website information was obtained not more than 30 days prior to the provision of services; and
- The listing or website indicated that the Provider was in Oscar's Network.

Benefits will be available when You receive Covered Services from an Out-of-Network Provider under the following situations and under the conditions described in this section:

- Emergency Services and Care will be covered at the In-Network level of benefits, regardless of whether services are rendered to You by an In-Network or Out-of-Network Provider.
    - For Out-of-Network Emergency Services, provided at a hospital emergency department or freestanding emergency department, including the ancillary services by other Out-of-Network Providers routinely available to the emergency department, You will only be responsible for Your In-Network Cost Share amounts and the Out-of-Network Provider is prohibited from billing You for amounts that exceed that Cost Share amount. If the services do not qualify as Emergency Services or in some instances where applicable law does not apply to the type of Out-of-Network Emergency Services You receive, You may also be responsible for the difference between the Out-of-Network Provider's charges and the amount allowed by Oscar, in addition to any applicable In-Network Copayment, Coinsurance and Deductible.
- For Covered Services provided after You are stabilized from the Emergency Services, that are provided as part of outpatient observation or an inpatient or outpatient stay with respect to the Emergency Services, that are provided at the same Out-of-Network facility where You received the Emergency Services and that are provided by an Out-of-Network Provider at that Out-of-Network facility (regardless of the department in which You receive those services), You will only be responsible for Your In-Network Cost Share amounts and the Out-of-Network Provider is generally prohibited from billing You for amounts that exceed that Cost Share amount, unless the Out-of-Network Provider gave You advanced notification and You sign a consent form from the Out-of-Network Provider where You acknowledge that You may be responsible for amounts beyond Your Cost Share amount. Also, if You sign such a consent, the services may not be Covered Services that are paid for under the Plan and will not be paid at the In-Network benefit level.
- Certain Covered Services (listed below) provided by Out-of-Network Providers during a visit at an:
    - In-Network hospital;

    - In-Network hospital outpatient department;
    - In-Network critical access hospital;
    - In-Network ambulatory surgery center; or
    - Any other type of In-Network facility designed by regulation regardless of whether or not the Out-of- Network Provider furnishing such items or services at one of these facilities, will be paid at the In-Network benefit level and You will only be responsible for Your In-Network Cost Share amounts. The Out-of-Network Provider is prohibited from billing You for amounts that exceed that Cost Share amount, unless the Out-of-Network Provider gave You advanced notification and You sign a consent form from the Out-of-Network Provider where You acknowledge that You may be responsible for amounts beyond Your Cost Share amount. Also, if You sign such a consent, the services may not be Covered Services that are paid for under the Plan and will not be paid at the In-Network benefit level.
- The services covered by this provision during a visit are:
    - "Ancillary Services", which are anesthesiology, pathology, radiology, and neonatology services, whether or not provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists, and intensivists;
    - "Diagnostic Services", which are radiology, laboratory services, and any other services designated as Diagnostic Services by law;
    - Equipment and devices;
    - Telemedicine services;
    - Preoperative and postoperative services; and
    - Other items and services specified by law.
- If an In-Network Provider is not available to meet Your health care needs and You receive Preauthorization from Us for Out-of-Network services prior to receiving such Out-of-Network services from an Out-of-Network Provider, the services will be covered at the In-Network level of benefits.

For Out-of-Network services described in the exceptions in this provision, the Allowed Amount will be determined based on state or federal law, depending on the type of Out-of-Network Provider and the type of services the Out-of-Network Provider furnishes You.

If federal law applies to the Out-of-Network Provider's services, the Allowed Amount shall be the median of Our contracted rates with In-Network Providers in the same or similar specialty, located in the same geographic region, for the same or similar services, and that are for plan types similar to this Plan. If such a median of Our contracted rates is not able to be determined, the Allowed Amount will be an amount We negotiate with the Out-of-Network Provider or that is provided for by law.

When Texas law applies to the Out-of-Network Provider's services, the Allowed Amount will be the usual and customary rate or at a rate agreed to by Oscar and the Out-of-Network Provider for the service.

Oscar determines the usual and customary rate using a variety of relevant factors, including:

- Claims history with similar Providers;
- Accepted reimbursement rates; and
- In-Network reimbursement rates for similar or identical services.

And will comply with the following:

- If based on usual, reasonable, or customary charges, the methodology will be based on generally accepted industry standards and practices for determining the customary billed charge for a service and fairly and accurately reflect market rates, including geographic differences in costs;
- When based on Claims data, the methodology will be based on sufficient data to constitute a representative and statistically valid sample;
- Any Claims data underlying the calculation will be updated no less than once per year and not include data that is more than three years old;
- The methodology will be consistent with nationally recognized and generally accepted bundling edits and logic; and
- If based on the median of Oscar's contracted rates for the service, the methodology will be based on rules established by the US Department of Health and Human Services in conjunction with other agencies.

An Out-of-Network diagnostic imaging Provider or laboratory service Provider that performed Services in connection with In-Network care, may not be permitted to bill You for an amount greater than the applicable Copayment, Coinsurance and Deductible under Your Plan. The applicable Copayment, Coinsurance and Deductible for such Services will be based on the amount initially determined payable by Oscar:

- At the usual and customary rate;
- A rate agreed to by Oscar and the Out-of-Network Provider; or
- A modified amount as determined under Oscar's internal appeal process.

However, for these diagnostic imaging and laboratory services, Your Copayment, Coinsurance and Deductible will not be based on any additional amount determined to be owed to the Out-of-Network Provider under Insurance Code Chapter 1467 (relating to Out-of-Network Claim Dispute Resolution).

Utilization Review Decisions and Procedures

For initial determinations, Oscar will make our determinations within the following timeframes:

- For pre-service urgent requests: within 3 calendar days
- For pre-service non-urgent requests: within 15 calendar days
- For concurrent urgent requests (submitted in a timely manner -- for an extension of care approved previously, where the request is received >24 hours before the expiration of the urgent authorization): within 1 calendar day
- For post-service requests: within 30 days

For approvals, Oscar will provide written notification of our decision within 2 business days of our decision. For denials (Adverse Determinations), we will provide written notification within 1 business day of our determination.

For a concurrent review of the provision of prescription drugs or intravenous infusions for which You are receiving health benefits under Your policy, we will make our decision and provide notification in writing not later than the 30th day before the date on which the provision of prescription drugs or intravenous infusions will be discontinued.

In any case where National Committee for Quality Assurance (NCQA) or federal authorization time frames conflict with Texas standards, Oscar will adhere to the stricter of all relevant time frames.

Alternate Cost Containment Provision

We may, in certain situations, approve services under an alternate treatment plan. An alternate treatment plan might include services or supplies otherwise limited or excluded by the Policy. Provided the alternate treatment plan is mutually agreed to by Us, You, and the Physician, Provider, or other healthcare practitioner, We will provide coverage. Our offering an alternate treatment plan in a particular case does not commit Us to do so in another case, nor does it prevent Us from strictly applying the express benefits, limitations, and exclusions of the Plan at any other time.

Substitution of Non-Covered Services

We have the right to provide any service, supply, equipment or benefit which we otherwise don't cover, or which is limited or excluded, when, in Our judgment, the service, supply, equipment or benefit is Medically Necessary and represents a less costly alternative to equal benefits available under this Policy. Any substitution of this nature will be subject to any quality assurance standards set by the Texas Department of Insurance.

Designation of an Authorized Representative

You have the right to designate an Authorized Representative to whom Oscar can speak to, on Your behalf, about Your Plan and care. If You wish to appoint an Authorized Representative, You must complete and sign an Authorized Representative form. This form can be accessed on our website at hioscar.com/forms under "Medical Management Forms" or by contacting the Member Services Team at (855) 672-2755.

Preauthorization for Inpatient and Outpatient Services

Preauthorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. If You do not obtain preauthorization before an elective admission to a Hospital or certain other facilities, it may result in a penalty.

Preauthorization does not guarantee payment of benefits. The list of services subject to pre-authorization can be accessed online at hioscar.com/prior-authorization. Coverage is always subject to other requirements of this Plan limitations and exclusions, payment of premium and eligibility at the time care and services are provided.

Some Health Care Providers are exempted from the requirement to obtain Preauthorization for certain services that are subject to Preauthorization. This exemption is made for individual Health Care Providers for distinct service types if they meet criteria established by state law. If a Health Care Provider has an exemption, the requirement to obtain Preauthorization will not apply to that exempted Health Care Provider and service during the time period the exemption is in effect. Your Health Care Provider will receive notification from Us if Your Health Care Provider qualifies for this exemption. We encourage You to check with Your Health Care Provider whether the exemption applies to a service You will be receiving if it is one of the service types identified online at hioscar.com/prior-authorization.

Please note that emergency admissions may be reviewed post admission.

To obtain Preauthorization or verify requirements for inpatient or outpatient services, including which services require Preauthorization, You or Your Provider can call Oscar at (855) 672-2755 or online at hioscar.com/prior-authorization.

If care is not available from Network Providers and Oscar authorizes Your visit to an Out-of-Network Provider to be covered at the In- Network Benefit level prior to the visit, In-Network Benefits will be paid. Refer to the **HOW THE PLAN WORKS** section of this Policy for additional information.

If the proposed medical care or Health Care Services involve post-stabilization treatment, or a life-threatening condition coverage will apply at an In- Network Benefit level without Preauthorization, unless the Out-of-Network Provider has notified the member and has received consent from the member, following the process set forth in the Federal No Surprises Act.

If the request is received outside of the period requiring the availability of appropriate personnel, the determination will be issued and transmitted within one hour from the beginning of the next time period requiring appropriate personnel. The determination will be provided to the Provider of record. If We issue an adverse determination in response to a request for post- stabilization treatment or a request for treatment involving a life-threatening condition, We will provide to the You or Your designee, and Your Provider of record.

We will accept requests for renewal of an existing preauthorization beginning 60 days from the date that the existing pre-authorization is set to expire. Upon receipt of a request for renewal of an existing preauthorization, we will to the extent practicable, review the request and issue a determination indicating whether the service is preauthorized before the existing authorization expires.

For concurrent urgent cases (including a member who is hospitalized at the time of the adverse determination), we will make a decision and provide notice to You and Your Provider within 24 hours (1 calendar day) or 1 working day, whichever is shorter. We may choose to issue this notification by telephone to You or Your Provider. In such cases, written notification will be issued to You and Your Provider within 3 calendar days or 3 business days (whichever is shorter) of the oral notification.

For concurrent standard cases (for outpatient care), for approvals, we will make our decision and provide notice to You and Your Provider in writing within 2 business days of receipt of all necessary information. For adverse determinations, we will make our decision and provide notice to You and Your Provider in writing within 3 business days.

In the case of an elective inpatient Hospital admission, Oscar recommends that the call for Concurrent review is made at least two (2) business days before You are admitted unless it would delay Emergency Care. In an emergency, Oscar recommends that Preauthorization takes place within two (2) business days after admission, or as soon thereafter as reasonably possible.

When an inpatient Hospital admission is Preauthorized, a length-of-stay is assigned. Your Plan is required to provide a minimum length of stay in a Hospital facility for the following:

Treatment of Breast Cancer

- 48 hours following a mastectomy
- 24 hours following a lymph node dissection

If You require a longer stay than was first Preauthorized, Your Provider may seek an extension for the additional days and must request such an extension before the end of the initial stay. Benefits will not be available for room and board charges for medically unnecessary days.

To obtain Preauthorization or verify requirements for inpatient or outpatient services, including which services require Preauthorization, You or Your Provider can call Oscar at (855) 672-2755.

In order to minimize the potential for care delays, We recommend that Preauthorization requests be received 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 Use Disorder treatment admission
- At least five (5) days prior to the start of home healthcare services

Preauthorization for Prescription Drugs

Preauthorization is required for certain prescription drugs and related supplies. For complete, detailed information about prescription drug authorization procedures, exceptions and Step Therapy, please refer to the **PHARMACY BENEFITS** section of this Plan.

To verify Preauthorization requirements for prescription drugs and supplies, including which prescription drugs and supplies require Authorization, You can call Member Services at (855) 672-2755 or search for medications on Our website at hioscar.com.

Emergency Situations

If You're experiencing a medical emergency during or after normal business hours, dial 911 immediately. When conducting utilization review or making a benefit determination for Emergency Services, Oscar will cover Emergency Services necessary to screen and stabilize You and will not require preauthorization of such services.

Retrospective Review

After a service has been performed, Oscar may use retrospective (post-service) review to determine if an admission or service was Medically Necessary. In the event the services are determined to be Medically Necessary, benefits will be provided as described in this Plan. If it is determined that a service was not Medically Necessary, You may be responsible for payment of the charges for those services. For emergency admissions, Oscar may use retrospective review to confirm that the services provided qualify as Emergency Services as defined in this Policy.

Adverse Determination

A written notification of an Adverse Determination will include the principal reason or reasons for the determination, the instructions for initiating a Complaint or reconsideration of the determination, and the instructions for requesting a written statement of the clinical rationale, including a reference to specific criteria or guideline used in making the decision. Upon request, Oscar will provide a copy of the criteria or guideline used in our decision.

In cases where the Provider or You will not release necessary information, Oscar may deny certification of an admission, procedure or service.

If an authorized representative of Oscar authorizes the provision of Health Care Services, Oscar will not subsequently retract its authorization after the Health Care Services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless such authorization is based on a material misrepresentation or omission about the treated person's health condition or the cause of the health condition, the health benefit plan terminates before the health care services are provided or the Your coverage under the health benefit plan terminates before the Health Care Services are provided.

Case Management

Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate

benefits and educate Members who agree to take part in the case management program to help meet their health-related needs.

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

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

Medical Necessity

All services and supplies for which benefits are available under the Plan must be Medically Necessary as determined by Oscar. Charges for services and supplies which Oscar determines are not Medically Necessary may not be used to satisfy Deductibles or to apply to the Maximum Out of Pocket amount.

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally- recognized in the United States for diagnosis, care or treatment;

- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not Experimental/Investigative nor subject to an Exclusion under this Policy;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, We will not provide coverage for 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 could be provided in a Physician's office or the home setting.

See the **COMPLAINTS AND APPEALS** section of this Policy for Your right to an Appeal and independent review of Our determination that a service is not Medically Necessary.

Identification Card

The Identification Card tells Providers that You are entitled to benefits under Your Oscar Plan. The ID Card offers a convenient way of providing important information specific to Your coverage including, but not limited to, the following:

- Your Member ID. This unique identification number is preceded by an alpha prefix, 'OSC', which identifies Oscar as Your insurance company.
- Important telephone numbers.

Always remember to carry Your Identification Card with You and present it to Providers or Participating Pharmacies when receiving Health Care Services or supplies. You can access a digital copy of Your card in Your Oscar web profile or mobile application.

Please remember that any time a change in Your family takes place, issuance of a new ID Card may be necessary (refer to the **WHO GETS BENEFITS** section for instructions when changes are made). Upon receipt of the change in information, Oscar will provide a new ID Card. If You lose Your card and need to request a replacement, please call Member Services at (855) 672-2755.

Telemedicine

When permitted by applicable state and Federal law, Your coverage will include Telemedicine visit services provided by designated In-Network Providers. See Your Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and Benefit Limitation information.

Continuity of Care

In the event a Participant is under the care of a Network Provider at the time such Provider stops participating in the Network and, at the time of the Network Provider's termination, the Participant has special circumstances, Oscar will continue providing coverage for that Provider's services at the In-Network Benefit level.

Special circumstances mean a condition such that the treating Physician or Health Care Provider reasonably believes that discontinuing care by the treating Physician or Provider could cause harm to the Participant. Special circumstances include, but are not limited to (1) disability, (2) acute condition, (3) life-threatening illness, or (4) being in the 2nd or 3rd trimester of pregnancy. Special circumstances shall be identified by the treating Physician or Health Care Provider, who must request that the Participant be permitted to continue treatment under the Physician's or Provider's care and agree not to seek payment from the Participant of any amounts for which the Participant would not be responsible if the Physician or Provider were still a Network Provider. For a list of Oscar Providers, information on the Oscar Service Area, and Network demographic information, visit Our website at hioscar.com or call Us at (855) 672-2755.

The continuity of coverage under this subsection will not extend for more than ninety (90) days, or more than nine (9) months if the Participant has been diagnosed with a terminal illness, beyond the date the Provider's termination from the Network takes effect. However, for Participants past the 24th week of pregnancy at the time the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery as if the policy had continued in force.

In order to submit a request for Continuity of Care, You must submit the request in writing within 90 days (or end of postpartum care) of a Provider termination by completing the Continuity of Care/Transition of Care Authorization Request Form. In order to submit a request for Transition of Care, You must submit the request in writing within 90 days (or end of postpartum care) of the Effective Date of Your coverage by completing the Continuity of Care/Transition of Care Authorization Request Form. If You would like information on the process or the policy and procedure for requesting a Continuity of Care or Transition of Care, please contact Member Services at (855) 672-2755.

Failure to Preauthorize

If Preauthorization for treatment, Services, and Supplies which require Preauthorization is not obtained by Your Provider:

- Provider payments may be reduced by up to 50%;
- Additionally, Oscar may review the Medical Necessity of Your treatment or service prior to the final benefit determination.

If any treatment or service described above is not Preauthorized and it is determined that the treatment, service, or extension was not Medically Necessary or Experimental/Investigational, benefits may be reduced or denied.

Urgent Preauthorization Review

For urgent pre-service (preauthorization) requests, we will adhere to the following timeframes:

- For approvals, we will make our determination and provide notification in writing within 2 business days of receipt of all necessary information.
- For adverse determinations (denials), we will make our determination and provide notification in writing within 3 business days of receipt of Your request.

For non-urgent pre-service (preauthorization) requests, we will adhere to the above timeframes, except for an adverse determination (denial) where the request was received after business hours, we will make our determination in writing within 3 calendar days from the next business day.

Review Of Requests Regarding An Acquired Brain Injury

For all requests regarding an Acquired Brain Injury, we will make our determination and provide notification via telephone within 3 business days of receipt of Your request.

Utilization Review Internal Appeals

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal. You may also submit a request for an internal Appeal after receiving an adverse determination from us. You must submit Your appeal request within 180 days of the date of our adverse determination.

TEXAS DEPARTMENT OF INSURANCE NOTICE

Your Plan

Your health plan contracts with doctors, facilities, and other health care providers to treat its members at discounted rates. Providers that contract with your health plan are called "preferred providers" (also known as "in-network providers"). Preferred providers make up a plan's network. Your plan will only pay for health care you get from doctors and facilities in its network. However, there are some exceptions, including: emergencies, when you didn't pick the doctor, and for ambulance services.

Your Plan's Network

Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit.

If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800-252-3439.

List of Doctors

You can get a directory of health care providers that are in your plan's network. You can get the directory online at hioscar.com or by calling (855) 672-2755. If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Bills for Health Care

If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn't pick the doctor, you won't have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care. If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at www.tdi.texas.gov.

Notice of Non-Discrimination:

Discrimination is Against the Law

Oscar complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Coverage for medically necessary health services is made available on the same terms for all individuals, regardless of sex assigned at birth, gender identity, or recorded gender. Oscar will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. Oscar will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual.

Oscar:

- Provides free auxiliary aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Video remote interpreting
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
  - Provides reasonable modifications for qualified individuals with disabilities, when necessary to ensure accessibility and equal opportunity to participate in our programs, activities, services, or other benefits

If you need these services, contact Member Services at (855) 672-2755 (TTY: 7-1-1).

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

CA Members: Oscar Health Plan of California, Attention Grievances PO Box 66550, Los Angeles, CA 90066

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

All Members: Phone: (855) 672-2755 (TTY: 7-1-1), Fax: 1-888-977-2062, Email: help@hioscar.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Oscar's Grievances Department is available to help you.

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

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

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

Language Assistance Services for the Deaf or Hard of Hearing
ATTENTION: If you are deaf or hard of hearing, talk to text services, free of charge, are available to you. Call (855) 672-2755 and dial 711 to receive TTY/TDD services.

Cherokee: Hagsesda: iyuhno hyiwoniha [tsalagi gawonihisdi]. Call 1-855-OSCAR-55 (TTY: 711)

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

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

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

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

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

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

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

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

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

العربية (Arabic): ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1–855–RACSO–55.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ภาษาไทย (Thai): ถ้ า คุณพูดภาษาไทยคุณสามารถใช้ บริการช่ วยเหลือทางภาษาได้ ฟรี โทร 1-855-OSCAR-55.

Deitsch (Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1–855–OSCAR–55 (TTY: 711).

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

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

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

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

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

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-OSCAR-55

Burmese: သတိပြုရန် - အကယ်၍ သင်သည် မြန်မာစကား ကို ပြောပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့်အတွက် စီစဉ်ဆောင်ရွက်ပေးပါမည်။ ဖုန်းနံပါတ် 1-855-OSCAR-55 (TTY: 711) သို့ ခေါ်ဆိုပါ။