Outline of Coverage

Oscar Insurance Company
1-855-672-2755
P.O. Box 52146
Phoenix, AZ 85072-2146
Effective Date: January 1, 2022

Notice of Insured's Right to Examine Plan for Ten Days
If You are not satisfied You have the right to return this Plan within 10 days of delivery to You, for a full refund of any Premium paid.

[XXXXX]

COST SHARING FEATURES

Eligible Expenses

Oscar provides coverage for several categories of eligible expenses, including but not limited to:

- Inpatient Hospital Expenses,
- Medical-Surgical Expenses,
- Extended Care Expenses,
- Preventive Care Expenses, and
- Prescription drug Expenses.

Your benefits are calculated on a Calendar Year Benefit Period basis unless otherwise stated. At the end of a Calendar Year, a new Benefit Period starts for each Member.

Allowed Amount

The Allowed Amount is the maximum amount of benefits We will pay for Eligible Expenses You incur under an Oscar Plan. Oscar has established an Allowed Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with Oscar. You will also be responsible for charges for services, supplies, and procedures limited or not covered under an Oscar Plan, Deductibles, any applicable Coinsurance Amounts and Copayment Amounts.

Review the definition of Allowed Amount in the **DEFINITIONS** section of this Plan to understand the guidelines used by Oscar.

Deductibles

Except where stated otherwise, You must pay the Deductible for Covered Services during each Calendar Year before we'll provide payment.

If You have something other than individual coverage, the individual Deductible applies to each person covered under this Plan. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Plan collectively total the family Deductible amount in Your Schedule of Benefits in a Plan Year, no further Deductible will be required for any person covered under this Plan for that Plan Year.

The Deductible runs from January 1 to December 31 of each Calendar Year.

Copayment Amounts

Some of the care and treatment You receive under an Oscar Plan will require that a Copayment Amount be paid at the time You receive the services. Refer to Your Schedule of Benefits for Your specific Plan information. Your Schedule of Benefits will indicate the basis of which a Copayment Amount is calculated. It may be per visit, per day, per service, or any combination thereof.

Coinsurance Amounts

Some of the care and treatment You receive under an Oscar Plan will require that a Coinsurance Amount be paid at the time You receive the services. Refer to Your Schedule of Benefits for Your specific Coinsurance information.

Except where stated otherwise, after You have satisfied the Deductible described above, You must be required to pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount of Your benefit as shown in Your Schedule of Benefits.

Maximum Out of Pocket

Most of Your Eligible Expense payment obligations, including Deductibles, Copayment Amounts, and Coinsurance Amounts, are applied to the Maximum Out of Pocket.

Your Maximum Out of Pocket amount will **not** include:

- Services, supplies, or charges limited or excluded by Us;
- Expenses not covered because a benefit maximum has been reached;
- Any Eligible Expenses paid by the Primary Plan when Oscar is the Secondary Plan for purposes of coordination of benefits;
- Penalties applied for failure to Prior Authorize.

Individual Maximum Out of Pocket Amount

When the Maximum Out of Pocket amount for a Member in a Calendar Year equals the "Individual" "Maximum Out of Pocket" shown on Your Schedule of Benefits for that level, Oscar will provide coverage for 100% of the Allowed Amount for a Covered Services for the remainder of the Calendar Year.

Family Maximum Out of Pocket Amount

When the Maximum Out of Pocket amount for all Members under Your coverage in a Calendar Year equals the "Family" "Maximum Out of Pocket" shown on Your Schedule of Benefits for that level, Oscar will provide coverage for 100% of the Allowed Amount

for a Covered Services for the remainder of the Calendar Year. No Member will be required to contribute more than the Individual Maximum Out of Pocket amount to the Family Maximum Out of Pocket.

Your Cost Sharing - Incorrect Provider Network Information or Our Failure to Provide Certain Requested Information Timely

If a Covered Service was provided by an Out-of-Network Provider (1) based on incorrect information, as described in this section, regarding a Provider's participation status or (2) if we fail to provide such requested information, as described in this section, regarding a Provider's participation status, then Your Cost Share will not be greater than the Cost Share amount that would have applied if the Out-of-Network Provider were an In-Network Provider and We will apply any applicable Deductible or Maximum Out-of-Pocket amount if the Out-of-Network Provider were an In-Network Provider.

These provisions apply:

- If We provide You with incorrect information, for the service You have inquired about, stating that an Out-of-Network Provider is an In-Network Provider through Our online Provider directory applicable to Your Plan, or through Our telephone or website's inquiry portal regarding network participation status; or
- When You, through Our telephone or website's inquiry portal regarding network participation status, have requested information on whether the Provider was an In-Network Provider regarding a particular service that You have inquired about and We have not provided the information regarding participation status in a timely manner as required by law.

Payment of Premiums

Payment of monthly Premiums for coverage under this Evidence of Coverage shall be made by the Subscriber. Premiums shall be remitted on a monthly basis to Oscar within the specified time frames set forth in this Evidence of Coverage. Only a Member for whom the Premium is actually received by Us, who has met all other applicable provisions of this Evidence of Coverage, and who has been accepted by Us, shall be entitled to coverage under this Evidence of Coverage and only for the month for which such Premium is received except respect to Newborn and adopted dependent coverage. Newborn coverage is automatically provided under this Evidence of Coverage for the first 90 days. Coverage for adopted dependents is automatically provided for the first 60 days after adoption or placement for adoption.

Adjustment of Premiums

The monthly Premiums shall be effective until notification of adjustment to Premiums is provided by Us to the Subscriber. Oscar will notify the Subscriber at the last address known to Us, of any adjustment to Premiums, not less than 30 days prior to the Effective Date of such rate change, or as permitted by law. Premium changes are subject to review and approval by the Arkansas Insurance Department.

Time of Payment

The first monthly Premium must be paid no later than 30 calendar days from the coverage Effective Date of the Evidence of Coverage, and succeeding Premiums must be paid on or before the first day of each succeeding month in order for benefits to be provided, subject to the grace period provisions specified under this Evidence of Coverage.

ACCESS TO CARE

Preferred Provider Organization (PPO) Provisions

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 www.hioscar.com. Printed directories are available upon request, without charge. A Member can obtain Covered Services and supplies from Oscar Network Providers or Out-of-Network Providers within the Service Area under this Plan. However, Covered benefits received from Out-of-Network Providers are paid at a rate less than covered benefits from In-Network Providers under this Plan, except in certain limited circumstances, and may result in greater out-of-pocket cost to You than if the same services had been received from an In-Network Provider.

Primary Care Provider (PCP)

Under this Plan, a Member does not have to select a PCP, but is encouraged to do so. The PCP is available to supervise and coordinate the Member 's health care in Oscar's Network. This is an "open Referral" Plan. You do not need a Referral from a PCP or any other person to obtain treatment for covered benefits before receiving Specialist care from an In-Network Specialist.

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, but You must first obtain Prior Authorization from Oscar. Contact Us at 1-855-672-2755 to request the necessary Prior Authorization for Out-of-Network services in this situation.

Women's Health Care Providers

You do not need Prior Authorization 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 Prior Authorization 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, www.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. Coverage includes transportation to an In-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 www.hioscar.com to make Your selections. An updated directory will be available at least annually and Our online directory will be updated at least every 90 days. You should consult Our online directory on Our website at www.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 at 1-855-672-2755, through our mobile application, or on our Member portal at www.hioscar.com.

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, benefits will be available at a higher cost to You. Your coverage for Medically Necessary Out-of-Network Services will be reduced or limited to the Out-of-Network rate, as shown on your Schedule of Benefits. In some cases, You may be required to meet certain Prior Authorization requirements to obtain coverage for Medically Necessary Out-of-Network Services. 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 Copayment, Coinsurance and Deductible.

Exceptions to this are as follows:

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Emergency Services and careCare 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, benefits will be paid as provided by applicable law. In

- 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 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.
- Covered Services provided by Out-of-Network Providers providing Ancillary Services or Diagnostic Services that are provided at an In-Network hospital, In-Network hospital outpatient department, or In-Network ambulatory surgery center will be paid at the In-Network benefit level and You will only be responsible for Your In-Network Cost Share amount.
    - "Ancillary Services" 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" are radiology, laboratory services, and any other services designated as Diagnostic Services by law.

- If an In-Network Provider is not available to meet Your health care needs and You receive Prior Authorization 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.
- Out-of-Network benefits are available only when You receive Services within the Plan's Service Area. Except for certain limited circumstances such as Emergency Medical Services or Prior Authorized care, You are responsible for paying the cost of all care that is provided by Out-of-Network, Out-of-Area Providers.

For Out-of-Network services described in the exceptions in this provision, 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.

Neither Oscar nor a Network Provider shall act in a manner that restricts Your access to the entire Network.

Utilization Review Decisions and Procedures

For initial determinations, Oscar will make the determination within thirty-six hours of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required:

- In the case of a determination to authorize an admission, procedure or service, Oscar will notify the Provider rendering the service by telephone or electronically within 24 hours of making the initial certification, and provide written or electronic confirmation of a telephone or electronic notification to You and Your Provider within two working days of making the initial certification;
- In the case of an Adverse Determination, Oscar will notify the Provider rendering the service by telephone or electronically within 24 hours of making the Adverse Determination; and will provide written or electronic confirmation of a telephone or electronic notification to the You and the Provider within one working day of making the Adverse Determination.

In any case where NCQA or federal authorization time frames conflict with Arkansas standards, Oscar will adhere to the stricter of all relevant time frames.

For craniofacial anomaly, Oscar will make non-urgent decisions within 2 days, and urgent decisions within 24 hours.

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 Evidence of Coverage. Any substitution of this nature will be subject to any quality assurance standards set by the Arkansas Department of Insurance.

Designation of an Authorized Representative

You have the right to designate an Authorized Representative. If You wish to do so, You must complete and sign an Authorized Representative form. This form can be obtained by calling the Member Services Team at the telephone number indicated on the back of Your Identification Card.

Prior authorization for Inpatient and Outpatient services

Prior Authorization is required for all non-emergency inpatient admissions, and certain other admissions, in order to be eligible for benefits. The list of services subject to pre-authorization can be accessed online at hioscar.com/prior-authorization. If You do not obtain prior authorization before an elective admission to a Hospital or certain other facilities, it may result in a penalty.

Prior Authorization is required for payment of benefits. 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.

Please note that emergency admissions may be reviewed post admission.

To obtain Prior Authorization or verify requirements for inpatient or outpatient services, including which services require Prior Authorization, You or Your Provider can call Oscar at 1-855-672-2755 or online at hioscar.com/prior-authorization.

In order to minimize the potential for care delays, We recommend that Prior Authorization 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 abuse treatment admission

- At least five (5) days prior to the start of home healthcare services

Prior Authorization for Prescription Drugs

Prior Authorization 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 Prior Authorization requirements for prescription drugs and supplies, including which prescription drugs and supplies require Authorization, You can call Member Services at 1-855-672-2755 or search for medications on Our website at www.hioscar.com.

Urgent and 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 prior authorization of such services.

We will notify you within 72 hours of receipt of an urgent prior authorization request.

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. We will make a determination within 30 days of receipt of your request. For emergency admissions, Oscar may use retrospective review to confirm that the services provided qualify as Emergency Services as defined in this Policy.

Adverse Determinations

A written notification of an Adverse Determination will include the principal reason or reasons for the determination, the instructions for initiating a Grievance 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 an Oscar 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.

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 1-855-672-2755.

Continuity of Care

You are allowed to continue treatment with a Provider whose contract has been terminated by Us for reasons other than for cause, or a Provider who has terminated his/her contract with Us, for a transitional period of up to 90 days from the date or Provider termination when the continuation of care is Medically Necessary and in accordance with the dictates of medical prudence, including circumstances such as disability, pregnancy, or life-threatening illness. Any Member who is pregnant and receiving treatment in connection with that pregnancy at the time of the termination of that Member's Provider's contract shall have the right to continue receiving health care services from that Provider throughout the remainder of that pregnancy, including six weeks postdelivery care. You will not be liable to the Provider for any amounts owed for medical care other than Deductibles or co-payment amounts specified in this Evidence of Coverage.

COVERED SERVICES

This Evidence of Coverage 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 Provider, 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

If You elect to see an Out-of-Network Provider when the services could have been provided by a Network Provider, benefits will be available at a higher cost to You. Your coverage for Medically Necessary Out-of-Network Services will be reduced or limited to the Out-of-Network rate, as shown on your Schedule of Benefits. In some cases, You may be required to meet certain Prior Authorization requirements to obtain coverage for Medically Necessary Out-of-Network Services. 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 Copayment, Coinsurance and Deductible.

Exceptions to this are as follows:

- 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, You will not be responsible for the difference between the Out-of-Network Provider's charges and the amount allowed by Oscar. You will be responsible for any applicable In-Network Copayment, Coinsurance and Deductible.
- Covered Services provided by Out-of-Network Providers providing Ancillary Services or Diagnostic Services that are provided at an In-Network hospital, In-Network hospital outpatient department, or In-Network ambulatory surgery center will be paid at the In-Network benefit level, unless You sign a consent form from the 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, benefits will not be paid at the In-Network benefit level.
- If an In-Network Provider is not available to meet Your health care needs and You receive Prior Authorization 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.
- Out-of-Network benefits are available only when You receive Services within the Plan's Service Area. Except for certain limited circumstances such as Emergency Medical Services or Prior Authorized care, You are responsible for paying the cost of all care that is provided by Out-of-Network, Out-of-Area Providers.

Our Coverage of Covered Services

Just because Your Physician or any other 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 Evidence of Coverage, 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 Evidence of Coverage in accordance with the "Continuity of Care" provision.

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

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.

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 Your to obtain a second opinion from an out of network Provider.

Identification of Covered Services

Subject to all terms, conditions, definitions, exclusions and limitations in this Evidence of Coverage, 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 Evidence of Coverage.

Abortion

We cover services, devices, drugs or other substances provided by any Provider in any location intended to terminate a woman's pregnancy in order to prevent the death of the female upon whom the abortion is performed, or in cases of rape or incest.

Advanced Imaging Services

We cover Advanced imaging services including, but not limited to:

- CT (computerized tomography) scan
- CTA (computerized tomography angiography) scan
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiography (MRA)

- Magnetic Resonance spectroscopy (MRS)
- Nuclear Cardiology
- PET (positron emission tomography) scans
    - This includes positron emission tomography to screen for or to diagnose cancer upon the recommendation of Your physician when You have a prior history of cancer.
- PET/CT Fusion scans
- QCT (quantitative computerized tomography) Bone Densitometry
- Diagnostic CT Colonography
- Single photon emission computed tomography (SPECT) scans

The list of advanced imaging services may change as medical technologies change. The diagnostic testing must be related to services within the Network Provider's scope of care.

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. 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 Precertification. 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 Precertification.

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 an appropriately licensed psychologist, psychiatrist, or certified behavior analyst.

ABA services, and all other Experimental or Investigational services, are subject to Prior Authorization and must be provided pursuant to a treatment plan. Such authorization overrides other limitations and exclusions in this Plan. Behavioral Health Treatment must be performed by a licensed, appropriately experienced Provider. ABA therapy is only a Covered Service until a member turns 18. Education programs covered through school-based programs are not Covered Services. All such services are subject to Cost-Sharing.

Coverage limits apply:

- Applied Behavioral Analysis Treatment Plan: Three hours every three months;
- Applied Behavioral Analysis Testing: Three hours every three months;
- Applied Behavioral Analysis Supervision: Six hours per week for 50 weeks;
- Applied Behavioral Analysis Direct Line Service 24 hours per week for 50 weeks.

Chemotherapy Medications

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

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.

Clinical Trials

With regards to Clinical Trials as defined in the **DEFINITIONS** section, We cover drugs and devices that are approved for sale by the Food and Drug Administration (FDA), regardless of whether or not the FDA approval specifically applies to the Member's particular condition. We also cover reasonable and Medically Necessary services needed to administer Covered Drugs or use the device under evaluation in the Clinical Trial.

In order to have their services covered, a Member must be actually enrolled in the Clinical Trial and not just applying the Clinical Trial protocol for phase II.

If You're being treated as part of a Clinical Trial, the facility and Physicians You're receiving coverage from must have the expertise and training to provide the treatment necessitated by the trial, and furthermore they must treat a sufficient volume of patients. There must be equal to or superior, non-investigational treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the treatment will be superior to the non-investigational alternatives.

Covered routine patient services do not include the following:

- the investigational service or supply itself;
- services or supplies listed herein as exclusions;
- services or supplies related to data collection for the Clinical Trial (i.e., protocol-induced costs);
- services or supplies which, in the absence of private health care coverage, are provided by a Clinical Trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

Diabetic Medical Equipment, Supplies, Prescription drugs and Services

Benefits are available 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 Member, 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 appurtenances, which include
        - Insulin Infusion devices and 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
    - Podiatric appliances, including up to two pairs of therapeutic footwear per Calendar Year, for the prevention of complications associated with diabetes
- Diabetes Supplies. All Diabetes Supplies listed will be covered in accordance with the specification in the **PHARMACY BENEFITS** section.
- 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
- 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).
- Foot care in conjunction with Diabetes
- 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 Member. Such Diabetic Management Services/Diabetes Self-Management Training for which a Physician or other professional Provider has written an order to the Member or caretaker of the Member 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
    - 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 Member will include the development of an individualized management Plan that is created for and in collaboration with the Member(and/or his or her family) to understand the care and management of diabetes, including nutritional counseling and proper use of Diabetes Equipment and Diabetes Supplies.

We will cover Medically Necessary Diabetic Medical Equipment, Supplies, Prescription drugs and Services for those Members who (a) have insulin Dependent or non-insulin Dependent diabetes, (b) have elevated blood glucose levels induced by pregnancy, or (c) have another medical condition associated with elevated blood glucose levels.

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.

We also cover the following areas of testing and evaluation:

- Psychological testing, including but not limited to assessment of personality, emotionality, and intellectual abilities
- Childhood development testing for children under 6, including but not limited to assessment of motor, language, social, adaptive or cognitive function by standardized developmental instruments
- Neurobehavioral status testing including but not limited to assessment of thinking, reasoning, and judgment
- Neuropsychological testing including but not limited to Halstead-Reitan, Luria and WAIS-R

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 services including:

- Diagnostic radiology and imaging
- Mammograms
- Diagnostic pathology services
- Ultrasound
- Diagnostic Laboratory tests
- Electrocardiograms (EKG)
- Electroencephalography (EEG)
- Echocardiograms.

We also cover:

- Diagnostic hearing and vision tests for a medical condition or injury
- Professional services for test interpretation of these diagnostic services
- X-ray reading

Your Cost Share for laboratory services from a Preferred Laboratory Provider will be less than services obtained from other In-Network Laboratory Providers. See Your Schedule of Benefits for the applicable Cost Share.

Please refer to hioscar.com/search or call Our Member Services team at 1-855-672-2755 for more information.

Durable Medical Equipment (DME) and Related Supplies

Upon Prior Authorization, 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 three 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.
- High frequency chest wall oscillators

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.

Emergency Services

Dial 911 immediately if you believe you are experiencing a medical emergency. 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 and recommend that care. If not reasonably possible, go to the nearest emergency facility, whether or not the facility is in the Network. You do not need to contact us before you obtain Medically Necessary emergency care.

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 he or she can recommend the continuation of any necessary medical services.

In-Network Benefits for Eligible Expenses for or Emergency Care 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 Medical Condition immediately following the visit, the Copayment Amount for the Emergency Room visit will be waived. If You are admitted to the hospital following stabilization of Your Emergency Medical Condition, Prior Authorization of the Inpatient Hospital admission will be required, and Inpatient Hospital coverage will apply.

Coverage of Emergency Services for treatment of Your Emergency Medical Condition will be provided regardless of whether the Provider is a Network Provider. We will also Cover Emergency Services to treat Your Emergency Medical Condition worldwide. However, We will Cover at an In-Network level of benefits only those Emergency Services and supplies that are Medically Necessary and are performed to observe, treat or Stabilize Your Emergency Medical Condition until you can be transported to the Service Area for treatment. Coverage includes transportation to an In-Network Provider.

Prosthetic Appliances and Devices

We cover the initial purchase, fitting, and replacement of External Prosthetic Appliances and Devices when they are Medically Necessary and made or ordered by a Provider. External Prosthetic Appliances and Devices are covered for the alleviation or correction of Injury, Illness or congenital defect and include:

- Prostheses/Prosthetic Appliances and Devices
- Orthoses and Orthotic Devices
- Braces; and
- Splints
- 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.

Coverage is limited to whichever appliance or device We find to be the most appropriate and cost effective. We provide coverage for repair, maintenance or replacement of a covered Prosthetic Appliance or Device, except in the case that replacement is required because You have misused or lost Your Prosthetic.

Coverage is provided for custom foot Orthoses and other Orthoses as follows:

- Only the following non-foot Orthoses are covered, when Medically Necessary:
    - Rigid and semi-rigid custom fabricated Orthoses;

    - Semi-rigid pre-fabricated and flexible Orthoses; and
    - Rigid pre-fabricated Orthoses, including preparation, fitting and basic additions, such as bars and joints.
- Custom foot Orthotics are covered when Medically Necessary, as follows:
    - For Members with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
    - When the foot Orthosis is an integral part of a leg Brace, and it is necessary for the proper functioning of the Brace;
    - When the foot Orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputation) and is necessary for the alleviation or correction of illness, Injury, or congenital defect; and
    - For Members with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot, and there is reasonable expectation of improvement.

We will cover replacement appliances, devices, and orthoses due to the following:

- Replacement due to regular wear; and
- Replacement will be provided when anatomic change has rendered the external Prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.

Frequency of replacement is limited as follows:

- Once or fewer every 24 months for Members 19 years of age and older;
- Once or fewer every 12 months for Members 18 years of age and under; and

Replacement will also be covered due to a surgical alteration or revision of the site.

Some External Prosthetic Appliances and Devices are specifically excluded from coverage under this Plan, such as the following:

- external and internal power enhancements or power controls for Prosthetic limbs and terminal devices; and
- myoelectric prostheses peripheral nerve stimulators.
- Electronic Prosthetic limbs or appliances are not covered unless Medically Necessary when a less-costly alternative is not sufficient.

Some Orthoses & Orthotic Devices are specifically excluded from coverage under this Plan, unless provided for the treatment of diabetes:

- Prefabricated foot Orthoses;
- Cranial banding/cranial orthoses/other similar devices, except when used postoperatively for synostotic plagiocephaly.

- Orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- Orthoses primarily used for Cosmetic rather than functional reasons; and
- Non-foot Orthoses, except only the following non-foot orthoses are covered when Medically Necessary:
    - Rigid and semi-rigid custom fabricated Orthoses;
    - Semi-rigid pre-fabricated and flexible Orthoses; and
    - Rigid pre-fabricated Orthoses, including preparation, fitting and basic additions, such as bars and joints. Copes scoliosis Braces are specifically excluded from coverage under this Plan

We also cover cochlear implants, auditory brain stem implants, implantable ossenointegrated hearing aids, and prosthetic eyes.

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 Reassignment (Confirmation) Services

Treatment for gender dysphoria is subject to review for medical necessity and may include, but is not limited to, hormone therapy, psychotherapy, and/or sex reassignment (gender affirmation) surgery.

General Dental 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 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
- has a significant behavioral problem as determined by the Your Physician as licensed under the Arkansas Medical Practices Act

We may require Prior Authorization for Dental Anesthesia. Please see the "Pediatric Dental" section for more information on Pediatric Dental Coverage.

Hearing Services
We cover the following Hearing services:

- Routine hearing screenings (see "Preventive Care" later section)
- Hearing screenings to determine the presence of hearing loss and/or to diagnose and treat a suspected disease or Injury to the ear.
- Coverage is provided for a Hearing Aid sold by a professional licensed by the State of Arkansas to dispense a Hearing Aid or hearing instrument. Coverage shall not be subject to member Copayment or Deductible but shall be limited to $1,400 per ear, for each three-year period.
- Cochlear implants when Medically Necessary. (see "Durable Medical Equipment" Section)

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 prior Authorization.

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.

Habilitative Development Services

Coverage is provided for Habilitative Developmental Services, limited to a maximum of 180 Developmental Services visits per Benefit Period.

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 his or her 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 his or her 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.

Hospital and Ambulatory Surgical Center Services

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

Subject to Prior Authorization, We cover the following services – above and beyond any services that may be provided in a Hospital and are listed elsewhere in this document – when provided in an In-Network Hospital or (except for Inpatient room, board, and inhalation therapy) an approved Outpatient facility:

- Medical care provided by Hospital staff during a Member's Inpatient stay
- Nursing services
- Special care unit services (e.g., intensive care)
- Semi-private room
- Meals (may include special diets)
- ECT (electroconvulsive therapy)
- Pulmonary function evaluation
- Renal dialysis
- Supply and administration of whole blood, blood plasma, packed red blood cells, or blood derivatives
- Inhalation therapy
- Oxygen (or another therapeutic gas) and its administration
- Hyperbaric oxygenation
- Isolation unit (when ordered by a Physician
- Social work, included as a part of room and board

Members must seek Prior Authorization from Oscar before obtaining services from Out-of-Network Hospitals (except for Emergency Services and Care or emergency ambulance services). If You do not get Prior Authorization, You may have to pay for services completely out of pocket.

Infertility

We cover diagnostic and exploratory procedures to determine infertility, including surgical procedures to correct diagnosed diseases or conditions. Infertility medications, artificial insemination and in vitro fertilization (IVF) are covered.

Limitations: Procedures such as GIFT and ZIFT are not covered. Coverage does not include services for procurement and storage of donor semen/eggs.

Infusion Therapy

We cover Infusion therapy services.

Mammograms

We cover mammograms, including:

- One baseline screening mammogram for women age thirty-five to thirty-nine, inclusive
- One screening mammogram annually for women over forty years of age.
- Upon the recommendation of the patient's Physician, without regard for age, for a woman who has had a prior history of breast cancer, when the woman's mother, or sister, or any first or second degree female relative of the woman has had a history of breast cancer, positive genetic testing, or other risk factors.
- A screening mammogram for any woman, upon the recommendation of a Physician, without regard for age, where the woman's mother, or sister, or any first or second degree female relative of the woman has had a history of breast cancer, positive genetic testing, or other risk factors.
- Screening mammograms, including digital breast tomosynthesis and breast ultrasounds in certain circumstances.

We cover a complete breast ultrasound if a mammogram screening demonstrates heterogeneously dense or extremely dense breast tissue and the woman's primary healthcare Provider or radiologist determines a comprehensive ultrasound screening is medically necessary.

Coverage for screening mammograms, including digital breast tomosynthesis and breast ultrasounds, shall not prejudice coverage for diagnostic mammograms or breast ultrasounds, as recommended by the woman's physician.

"Diagnostic mammogram" means an examination used to evaluate an abnormality in a breast using diagnostic mammography, breast magnetic resonance, or breast ultrasound and is designed to evaluate an abnormality in a breast.

"Screening mammogram" means radiologic procedure provided to a woman, who has no signs or symptoms of breast cancer, for the purpose of early detection of breast cancer. It includes digital breast tomosynthesis.

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;
- Reduction mammoplasty; 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."

Maternity 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 Expense, 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 Prior Authorization and that any Copayment

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

Benefits for Treatment of 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.

Benefits for Maternity Care

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. Planned deliveries at home are covered with Prior Authorization.

We also cover routine nursery care and pediatric charges for a well newborn child for up to five full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

All comprehensive benefits described in this Plan are available for maternity services. Services include testing for pregnant women for lead poisoning and hepatitis C screening. Coverage for hepatitis C screening during pregnancy is not subject to Deductibles or Copayments/Coinsurance.

Post-delivery care will consist of a minimum of 2 visits, at least one of which shall be in the home, and will be performed at a location and schedule as determined by the attending Physician. All care will be provided in accordance with accepted maternal and neonatal physical assessments, and performed by a registered professional Nurse with experience in maternal and child health nursing, or by a Physician. Services provided by the registered professional Nurse or Physician shall include, but not be limited to:

- Physical assessment of the Newborn and mother
- Parent education,
- Assistance and training in breast or bottle feeding,

- Education and services for complete childhood immunizations,
- The performance of any necessary and appropriate clinical tests and
- Submission of a metabolic specimen satisfactory to the state laboratory

These services will be rendered in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization. Any abnormality, in the condition of the mother or the child, observed by the Nurse shall be reported to the attending Physician as medically appropriate.

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. Benefits will also be subject to any Deductible amounts shown on Your Schedule of Benefits.

Medical and Surgical Supplies

We cover medical and surgical supplies that meet the following criteria:

- They are Medically Necessary;
- Serve only a medical purpose;
- Are used once; and
- Are purchased, not rented.

Covered supplies include, but are not limited to, items such as syringes, needles, surgical dressings, Splints, and other similar items that serve only a medical purpose. We do not cover items stocked in the home for general use like Band-Aids, thermometers, and petroleum jelly, creams or lotions.

Medical Foods and Low Protein Modified Food Products

We cover formulas and low protein modified food products prescribed by a Physician for a child with phenylketonuria (PKU) or any other inherited disease of amino and organic acids. Low protein modified food products are foods that are specifically formulated to have less than one gram of protein per serving. They are intended to be used as prescribed by a Physician for the dietary treatment of any inherited metabolic disease. Low protein modified food products do not include foods that are naturally low in protein.

We cover enteral feeding/food supplements, including the cost of Outpatient enteral tube feedings when it:

- Is necessary to sustain life or health
- Is used in the treatment of, or in association with, a demonstrable disease, condition or disorder
- Requires ongoing evaluation and management by a Physician
- Is the sole source of nutrition or a significant percentage of daily caloric intake.

This includes administration, supplies and formula used as food supplements for nutritional supplements for the therapeutic treatment of aminoacidopathic hereditary metabolic disorders and is covered when administered under the direction of a Network Provider. Once You have received Prior Authorization, coverage consideration may also be given when enteral or parenteral feeding is the sole source of nutrition.

We also will cover amino acid-based elemental medical formula. Once You have received Prior Authorization, the usual and customary cost of amino acid-based elemental medical formula for infants and children is covered, provided such formula is ordered by a Network Provider and administered orally or enterally for food protein allergies, food protein-induced enterocolitis syndrome, eosinophilic disorders and short-bowel syndrome. An amino acid-base elemental formula covered under this section is a formula made of 100% free amino acids as the protein source.

We also cover nutritional counseling prescribed by a Physician. Nutritional counseling is covered for cleft palate management.

Miscellaneous Health Interventions

We cover the following Miscellaneous Health Interventions:

- Electrotherapy Stimulators (TENS)
- Neuromuscular Electrical Stimulation (NMES)
- Gastric Pacemaker
- Trans-telephonic Home Spirometry

Other Health Care Facilities – Inpatient Services

Subject to Prior Authorization, We cover the following Covered Services for Inpatient services and supplies provided by another Health Care Facility, except private room charges above the prevailing two-bed room rate of the facility. Payment of benefits for Other Health Care Facility services is subject to all of the following conditions:

- You must be referred to the Other Health Care Facility by a Physician.
- Services must be those which are regularly provided and billed by another Health Care Facility.

- The services must be consistent with the Illness, Injury, degree of disability and medical needs. Benefits are provided only for the number of days required to treat the Illness or Injury, subject to any maximum number of covered days per year shown in the Plan Schedule of Benefits.
- Services covered under this benefit cannot be provided in a less intense setting, such as Outpatient services provided at home.
- You must remain under the active medical supervision of a Physician treating the Illness or Injury for which he or she is confined in the Other Health Care Facility.

Oral Surgery

Covered Oral Surgery includes non-dental treatment of the mouth relating to medically diagnosed congenital defects, birth abnormalities, accidental injury, exotoses, cellulitis or excision of tumors and services as a result of radiation treatment for cancer of the head or neck. It also includes the surgical and non-surgical treatment for Temporomandibular Joint (TMJ) disorder or craniomandibular disorder. TMJ coverage is limited to:

- the correction of dislocation or complete degeneration of the temporomandibular joint (TMJ);
- consultations to determine the need for surgery and/or
- radiologic determinations of pathology.
- Orthognathic (jawbone) surgery for a medical condition or injury which improves function of the joint or bone that is Medically Necessary to gain functional capacity of the joint or bone.

We will only cover these services if they result from a Sickness, as opposed to chewing or biting.

Hospital and Ambulatory Surgical Center services and related professional services provided in connection with a Medically Necessary dental or oral surgery procedure are covered on an Inpatient or Outpatient basis. This type of coverage requires Prior Authorization by Us.

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.

Pediatric Dental Care

For Members up to age 19, We cover dental services including, but not limited to, diagnostic services, preventive services, restorative services, endodontic services, periodontal services, oral and maxillofacial surgery, etc.; as determined

by the standards of generally accepted dental practice. The dental benefits only apply to Members until the end of the month in which the Member turns nineteen (19) of age. See "Pediatric Dental Care" in the Schedule of Benefits for additional information.

This Agreement Covered the Dental Services Below, when they are performed by a Participating Provider (licensed dentist) and when they are necessary and customary, as determined by the standards of generally accepted dental practice. Covered Services received from a Non-Participating Provider will be covered at a lesser rate, as shown on Your Schedule of Benefits. If there is more than one professionally acceptable treatment for Your dental condition, the Plan will cover the least expensive treatment.

We only cover the procedures and services listed in "Covered Services." Additional requests, beyond the stated frequency limitations shall be considered when documented dental necessity is justified due to a physical limitation and/or an oral condition that prevents daily hygiene. If a Member receives a service listed in the Exclusions section. or if the Member exceeds the Benefit Limit, the Member will be financially responsible for all charges or fees associated with the service.

Covered Services

Oscar covers five categories of pediatric dental services, Diagnostic and Preventative, Routine/Basic Services, Major Services, Orthodontics and emergency treatment all subject to annual limitations as determined by the standards of generally accepted dental practice. Each is subject to a different cost-share as noted in the Schedule of Benefits. Covered Services include but are not limited to the following services.

Diagnostic and Preventive	Limitations
Exams (D0120 through D0180)	Two (2) per six (6) months
Bitewing x-rays (D0270 through D0277)	Two (2) per six (6) months
Full mouth x-rays (D0210) or Panoramic Image (D0330)	One (1) per sixty (60) months
Cleanings (D1110, D1120, D4346)	One (1) per six (6) months
Fluoride (D1206, D1208)	One (1) per six (6) months
Space maintainers (D1510 through D1575)	As a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop

Sealants (D1351, D1352)	One (1) per tooth per lifetime, on permanent first and second molars
Palliative Treatment (D9110)	Subject to evidence of dental necessity.
Teledentistry (D9995, D9996)	Subject to evidence of dental necessity.

Routine/Basic Services	Limitations
Fillings, Amalgams (D2140 through D2161)	Composite fillings on posterior (back) teeth will be payable at the amalgam rate
Fillings, Composite (D2330 through D2394)	
Pre-fabricated crowns (D2929 through D2934), sedative fillings (D2940)	Subject to evidence of dental necessity
Consultation (D9310, D9311)	Two (2) per twelve (12) months, unless medically necessary
Deep Cleaning (D4341, D4342)	Subject to evidence of dental necessity
Periodontal Maintenance (D4910)	Subject to evidence of dental necessity
Simple Oral Extractions (D7111, D7140)	Subject to evidence of dental necessity

Major Services	Limitations
Single Crowns (D2740 through D2792)	Subject to Prior Authorization
Re-Cement or Re-bond Crown (D2910)	Subject to Prior Authorization
Endodontics	
Therapeutic Pulpotomy (D3220)	Subject to Prior Authorization
Pulpal Therapy; anterior, posterior (D3230, D3240)	Subject to Prior Authorization
Root Canal (D3310, D3320, D3330)	Subject to Prior Authorization
Apicoectomy (D3410 through D3426)	Subject to Prior Authorization
Periodontal Services	
Gingivectomy (D4210 through D4212) and Gingival flap procedure (D4240/D4241)	Subject to Prior Authorization
Osseous Surgery (D4260/D4261)	Subject to Prior Authorization
Tissue Grafts (D4270, D4273, D4275 D4277 through D4285)	Subject to Prior Authorization

Prosthodontic Services	
Complete Dentures (D5110, D5120), Partial Dentures (D5211 through D5214)	Subject to Prior Authorization
Complete and Partial Denture Repairs (D5511 through D5660)	Subject to Prior Authorization
Complete and Partial Adjustments (D5410 through D5422)	Subject to Prior Authorization
Fixed Prosthodontic, Bridge (D6210 through D6792)	Subject to Prior Authorization, Denture will be covered in lieu of bridge.
Fixed Bridge Repair (D6930)	Subject to Prior Authorization
Major Oral and Maxillofacial Surgery	
Surgical Extractions (D7210 through D7250)	Subject to Prior Authorization (cannot exclude for relief of pain)
Tooth Reimplantation (D7270), Surgical Exposure of Tooth (D7280)	Subject to Prior Authorization
Biopsy of Tissue (D7285, D7286)	Subject to Prior Authorization
Incision & Drainage of Abscess (D7510 through D7521)	Subject to Prior Authorization
Frenulectomy (D7961, D7962)	Subject to Prior Authorization
General Anesthesia (D9222, D9223) IV Sedation (D9239, D9243) (in conjunction with oral surgery), Nitrous Oxide (D9230), Non IV Sedation (D9248)	Subject to Prior Authorization

Orthodontic (Class D)	Limitations
Comprehensive Orthodontic services (D8070, D8080, D8090), Removable and Fixed Appliance Therapy (D8210, D8220)	Orthodontic services are subject to dental necessity criteria outlined below, prior to banding.

Prosthodontics:

We cover removable completed and partial dentures. A partial denture will be covered in lieu of a fixed bridge.

Denture Criteria:

Dentures, including full/partial maxillary (upper) and full/partial mandibular (lower) with clasps, stress breakers and prosthetics are covered as follows:

1. When it is necessary to replace posterior teeth on both side of an arch and the patient's oral condition allows for supporting (abutment) teeth to hold the denture in place
2. Partial dentures are not covered in the presence of untreated moderate to severe periodontal disease or when a proposed supporting tooth/teeth has a poor outcome.
3. Full and partial dentures are not covered for replacement if an existing appliance can be made satisfactory by a denture relining or repair
4. Immediate dentures are not covered

Orthodontic Coverage

We cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions including:

Orthodontia procedures require approval prior to banding, aligned with the generally accepted dental guidelines including, but not limited to:

- Cleft palate and cleft lip
- Maxillary/mandibular micrognathia
- Ankylosis of the temporomandibular joint
- Other significant skeletal dysplasias

Orthodontic needs must meet dentally necessary requirements as determined by a verified score of 26 or higher (or other qualify conditions) on Handicapping Labio-Lingual Deviation (HLD) Index analysis. All treatment must be prior authorized by the Plan prior to banding.

If for any reason orthodontic services are terminated or coverage under the Plan is terminated before completion of the approved orthodontic treatment, the responsibility of the Plan will cease with payment through the month of termination.

Emergency Dental

We Cover emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency dental care is not subject to Our Preauthorization.

Exclusions

1. Any procedures not covered under this Policy.
2. Dental procedures or services performed solely for Cosmetic purposes or that is not Dentally Necessary and/or medically necessary.
3. Any dental services, or appliances, which are determined to be not reasonable and/or necessary for maintaining or improving You or Your Dependent's dental health, as determined by Us based on generally accepted dental standards of care.
4. For elective procedures, including prophylactic extraction of third molars.
5. Replacement of Dentures, Crowns, appliances or Bridgework that have been lost, stolen or damaged.
6. Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a Covered Service in this Rider. Any services related to pathology laboratory fees.
7. Dental services provided for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare.
8. Treatment required due to an accident from an external force or are intentionally self-inflicted, unless otherwise listed as Covered Service.
9. Services that restore tooth structure due to attrition, erosion or abrasion are not covered.
10. The following are not included as Orthodontic benefits:
    a. Repair or replacement of lost or broken appliances;
    b. Retreatment of Orthodontic cases;
    c. Treatment involving: Maxillo-facial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia; Hormonal imbalances or other factors affecting growth or developmental abnormalities, unless specifically covered as medically necessary orthodontia;
    d. Treatment related to temporomandibular joint disorders, unless specifically covered as medically necessary orthodontia;
    e. Composite or ceramic brackets, lingual adaptation of Orthodontic bands and other specialized or Cosmetic alternatives to standard fixed and removable Orthodontic appliances. Invisalign services are excluded.
11. Broken appointments.

Please submit appeals regarding Your dental coverage for Members under nineteen (19) years of age to the following address:

LIBERTY Dental Plan
Attn: Grievances and Appeals
Quality Management Department
PO BOX 26110
Santa Ana, CA 92799-6110
Online: www.libertydentalplan.com

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 Evidence of Coverage;
- 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

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.

Covered Physician Services in a Hospital or Ambulatory Surgical Center include:

- surgical procedures, anesthesia, and consultation with and treatment by consulting Physicians; and
- Inpatient professional consultation services provided by a licensed psychiatrist, clinical psychologist or other licensed Behavioral Health professional in an acute Hospital.

Preventive Care Services

We cover benefits for routine preventive care services in accordance with the most recent guidelines published by the following organizations:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- United States Preventive Services Task Force;
- Health Resources and Services Administration; and
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

Some of these services include, but are not limited to:

- Routine physical exams, including guidance and counseling regarding Substance Use Disorder, alcohol misuse, tobacco use, obesity, exercise and healthy diet and nutritional counseling.
- Two Smoking Cessation Attempts (maximum of 4 counseling sessions per attempt). We cover Prescription drugs related to smoking cessation treatment under the Prescription drug benefit.
- An Annual mammogram, Pap test, PSA, colonoscopy and colorectal cancer screening.
    - Screening for colorectal cancer begins at age 45, and includes an initial colonoscopy and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal, rather than a colonoscopy performed every 10 years.
- Charges for or in connection with the diagnosis, treatment and appropriate management of osteoporosis for Members with a condition or medical history for which bone mass measurement is Medically Necessary, provided that these services are received by a Physician licensed to practice medicine and surgery in Arkansas.
- Evidence-based items or services that have an A or B rating in current recommendations of the U. S. Preventive Services Task Force (USPSTF);
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
    - Except for Preventive Care Services, this plan does not cover physical examinations, immunizations and vaccinations required for foreign travel or employment purposes.
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Evidence-informed preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- Initial hearing aids provided to a Newborn for initial amplification following a Newborn hearing screening (including any necessary rescreening, audiological assessment and follow-up; see "Preventive care");
- Preventive care and screenings for women, provided for by the guidelines supported by the Health Resources and Services Administration (HRSA). These include (but are not limited to) all Food and Drug Administration (FDA) approved Contraceptive methods for women, sterilization procedures, and patient education and counseling for all women (and Dependent daughters) with reproductive capacity, and Medically Necessary BRCA genetic testing for women who have any symptoms or any significant, proven risk factors of developing breast cancer.
- Prostate specific antigen (PSA) screening and digital rectal examination (DRE) are covered annually if the following criteria is met:

    - If you are under 40 years of age and are at high risk because of any of the following:
        - Family history (i.e., multiple first-degree relatives diagnosed at an early age)
        - African-American race
        - Previous borderline PSA levels
    - If you are age 40 and older.
- Colorectal Cancer Screening: Screening colonoscopy and sigmoidoscopy procedures, including medically necessary anesthesia services (for the purposes of colorectal cancer screening) will be covered under the preventive care services. Diagnostic endoscopic procedures (except screening colonoscopy and sigmoidoscopy), performed in an outpatient facility require the copayment or coinsurance applicable for outpatient facility services.

Primary Care Office Visits

Office visits for Primary Care Services are covered.

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.

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 prior Authorization.

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.

Restorative or Reconstructive Surgery

Covered Services are limited to the following, which are subject to Prior Authorization:

- 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
- Surgery performed on a child age 12 years and under to correct a medically diagnosed congenital defect or birth abnormality, correction of a cleft palate or cleft lip, or removal of a port-wine stain or hemangioma on the face.
- Reduction mammoplasty, including following mastectomy
- Surgery to correct craniofacial anomaly; must be performed by a nationally approved cleft-craniofacial team approved by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina. Coverage includes reconstructive surgery, dental care, vision care, and the use of at least one hearing aid. As a part of this coverage, We will also provide the following, when Medically Necessary:
    - On an annual basis, We will cover:
        - Sclera contact lenses, including coatings
        - Office visits;

        - An ocular impression of each eye; and
        - Any additional tests or procedures that are medically necessary for a craniofacial patient;
    - Two hearing aids every two years
    - A dehumidifier every 4 years

Mental Health and Substance Abuse (Chemical Dependency) Services

Precertification is required for certain Mental Health and Substance Abuse services. Emergency Services never require precertification. Covered Services include services for Mental Health and Substance Abuse. 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 Abuse Conditions, Severe Mental Illness (SMI) of a person of any age, and Serious Emotional Disturbances (SED) of a child as defined by the most recent edition of the DSM.

Mental Health Covered Services include the following:

- Inpatient Services in a licensed, network Hospital, Residential Treatment Center, or any Facility that We must cover per State law. Inpatient benefits include:
    - Inpatient Facility services for acute Mental Health Conditions, including Physician Services;
    - Inpatient psychiatric observation for acute psychiatric crisis, including Physician Services, medications and testing;
    - Residential Treatment
- Outpatient Office Visits
    - Individual and group Mental Health evaluation and treatment;
    - Outpatient services for monitoring Drug therapy;
    - Behavioral Health Treatment Office Visit for Autism Spectrum Disorders (See also "Behavioral Health Treatment Autism" earlier in this section for a description of additional Covered Services.)
- Outpatient Items and Services
    - Short-term Partial Hospitalization;
    - Short-term intensive outpatient psychiatric treatment;
    - Outpatient psychiatric observation for an acute psychiatric crisis;
    - Psychological testing and neuropsychological testing to evaluate a mental condition;
    - Behavioral Health Therapy Home Visit for Autism Spectrum Disorder
- Substance Abuse (Chemical Dependency) Services include the following:
    - Inpatient Services in a licensed, network Hospital, Residential Treatment Center or any Facility that we must cover per State law. Inpatient benefits include:
        - Services for detoxification, including Physician services

        - Transitional residential recovery services for assistance with post-detoxification treatments
    - Outpatient Office Visits including Office Visits and treatment in an outpatient department of a Hospital or outpatient Facility, such as:
        - Individual and group chemical dependency counseling; and Medical treatment for withdrawal symptoms.
    - Outpatient Items and Services
        - Day treatment program for substance use disorder
        - Intensive outpatient treatment for substance use disorder
        - Ambulatory detoxification
        - Non-emergency psychiatric transportation
- Covered services for mental health include certain medications and testing or diagnosis covered under the medical benefit

Outpatient coverage includes diagnosis and treatment of psychiatric conditions, individual and group psychotherapy, psychological testing, Office Visits, outpatient facility and Physician charges, and medication management checks.

Inpatient Services include individual psychotherapy, group psychotherapy, psychological testing, and counseling with family members to assist with the patient's diagnosis and treatment, and convulsive therapy, detoxification, and rehabilitation treatment; Hospital and inpatient professional charges in any Hospital or facility required by state law.

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)
- Other recognized Substance Use Professionals

Exclusions for Mental Health include:

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;

- Services for psychological testing associated with the evaluation and diagnosis of learning disabilities or for intellectual disabilities;
- Services for educational purposes;
- Services for marital counseling;

- Services for court-ordered care or testing, or required as a condition of parole or probation, unless otherwise covered by this Policy;
- Services to test aptitude, ability, intelligence or interest;
- Services required to maintain employment, unless otherwise covered by this Policy;
- Services for cognitive remediation; and inpatient stays that are primarily intended as a change of environment

To obtain a list of Mental Health and Substance Use Disorder Providers within Our network please contact Us at 1-855-672-2755 or access Our website at www.hioscar.com.

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.

Surgical Procedures

Anesthesiology

We cover anesthesia provided as part of a covered surgical, Infusion (local anesthesia only), certain covered dental services (as applicable), electroconvulsive or other procedure in a doctor's office, Hospital, or other appropriate setting. Anesthesia may be provided by an anesthesiologist, a certified registered Nurse anesthetist (if supervised by a Physician) or the Physician performing the procedure.

Surgery

We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a Sickness or Injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an Inpatient and Outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a Nurse practitioner), standby physician, and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant. We cover surgeries for Hospital, facility and professional services performed in:

- An In-Network Hospital (whether Inpatient or Outpatient)
- An In-Network freestanding ambulatory surgery facility
- An In-Network professional Provider's or Physician's office

We also cover presurgical consultations, however, the consulting Physician must be a licensed MD, DO, podiatrist or an oral surgeon. The Physician must also be an In-Network Provider.

- If the surgery is Medically Necessary and is one in which We cover, Oscar will also cover the associated presurgical consultation.
- Members are limited to three presurgical consultations per surgical diagnosis. The three consultations consist of
    - A second opinion,
    - A third opinion (if second opinion differs from the original presurgical opinion or proposal for surgery), and
    - A non-surgical opinion to assess appropriate medication for the proposed surgery.

Telemedicine

We cover Medically Necessary Covered Services offered through Telemedicine by an In- Network Provider subject to the terms and conditions of Our contracts with In-Network Providers. We will provide coverage for Covered Services appropriately delivered by In-Network Providers through Telemedicine on the same basis and to the same extent that We are responsible for the same Covered Service through in-person diagnosis, consultation, or treatment. Members 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 through an in-person consultation. We will not require Prior Authorization for Health Care Services provided through Telemedicine that exceeds the Prior Authorization requirements that would be applicable if the same Health Care Service were provided through an in-person consultation.

Visits, goods, or services offered or referred through Telemedicine from certain Oscar-designated In-Network Providers may be subject to lower cost share (e.g. are discounted or covered in full). Additional services ordered by these Oscar-designated In-Network Providers may also be discounted or covered in full. These Visits can be requested through Oscar's website, mobile application, and our member services line. Call member services at 1-855-672-2755 or contact them via Our website at www.hioscar.com for additional information.

Transplant Services - Organ & Tissue

Oscar provides covered services for organ and stem cell transplants performed in a Designated Facility after approval by Us (see section Pre Authorization). Transplant services can be performed in in-network Hospitals (inpatient or outpatient) or in-network 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:

- Heart, Simultaneous Heart/ Lung, Kidney, Stem cell / Bone Marrow (Autologous/ Allogeneic), Simultaneous Kidney/ Pancreas, Pancreas, Liver, Lung (s), Small bowel (intestine), Corneal, Small bowel/liver, Kidney/liver
- FDA approved ventricular assist devices (VADs) are covered as a bridge to transplant when used according to FDA labeling instructions. VADs are not covered when used as artificial hearts.

Benefits will be available for:
A recipient who is a Member; and a Donor who is a Member donating to another Member:

- 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; and,
- Procurement of organs or tissues from a living or deceased Donor

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. 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.
- Donor Searches
- 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 designated Facility will not be considered covered expense.

Prior Authorization

Precertification 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.

Precertification can be obtained by calling Us toll free at 1-855-672-2755.

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:

- All travel expenses are authorized by Us in advance.
- 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.
- Benefits for transportation, lodging and food 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 Designated 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)
    - Coach airfare to and from the Facility when the designated 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 limited to one (1) room, double occupancy.

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, rental cars, buses, taxis or shuttle services, except as specifically approved by Us; 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 1-855-672-2755 for further information and to obtain a reimbursement form.

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. Coverage is provided for Urgent Care services received from In-Network and Out-of-Network Providers; however, Your Cost Share will generally be less when You receive care from In-Network Providers. If You need Urgent Care services and are in the Service Area, We encourage You to contact your Primary Care Physician before seeking services at an Urgent Care Center.

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 a 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.

Pediatric Vision Services

Children under age 19 are covered for one routine eye examination per Plan Year to determine the refractive error of the eye. Services must be performed by a Network Provider who is either a Doctor of Optometry or a Medical Doctor who specializes in Ophthalmology and are subject to the cost-shares outlined in the Schedule of Benefits.

We cover one pair of eyeglasses (lenses and frames) and contact lenses for children under age 19. Such eyeglasses and contact lenses are covered when prescribed for vision correction by a licensed ophthalmologist or optometrist. We also consider lens coatings and/or treatments that will be made a permanent part of the eyewear to be prescription eyewear. Repair and replacement for Eye Glasses are covered under warranty if originally covered by this Evidence of Coverage.

We cover eye prosthesis, including polishing. These services are subject to Prior Authorization. Please refer to the "Prosthetic Appliances and Devices" section for more information.

You must obtain your prescription eyewear from a professional or commercial vendor licensed to dispense prescription eyewear. A Dependent child will no longer be eligible for this benefit on the last day of the month in which the child turns 19.

Eyeglasses for children diagnosed as having the following diagnoses must have a surgical evaluation in conjunction with supplying eyeglasses:

- Ptosis (droopy lid)
- Congenital Cataracts
- Extropia or Vertical Tropia

Therapy and testing are also covered, specifically with regards to orthoptic and pleoptic training and sensorimotor exams.

Wellness Program

The purpose of the wellness program is to encourage You to take a more active role in managing Your health and well-being. Throughout the course of the year, We may provide incentives in connection with the use of or participation in wellness and health promotion actions and activities, including but not limited to: a health risk assessment tool, health risk assessment visits, a designated smoking cessation program, a designated weight management program, self-management of chronic diseases, self-management of follow-up care, use of Oscar-designated high-value Providers, obtaining preventive care, one annual wellness exam per adult Member, per Calendar year through an In-Network Oscar-designated Telemedicine Provider or through an in-home health assessment facilitated by Oscar, and a designated health or fitness program (such as step tracking).

Rewards for participation in the wellness program may include but are not limited to the waiver or reduction of Copayments, Coinsurance, or Deductibles; full or partial reimbursement of the cost of participating in smoking cessation or weight management programs; payment for care-adjacent services that directly address social determinants of health, such as transportation to medical visits, or food costs; and monetary rewards and financial incentives in the form of gift cards. We encourage You to use Your gift card for a product or service that promotes good health, such as healthy cookbooks, over-the-counter vitamins or exercise equipment. Based on the terms of the program being offered, You (the Subscriber), and in some cases, Your Dependent(s) 18 years of age or older can receive rewards. 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 www.hioscar.com or call Us at 1-855-672-2755. Oscar is committed to helping you achieve your best health. If you think you might be unable to participate in this program, you might qualify for an opportunity to earn the same reward in a different way. Contact Your Member Service team at 1-855-672-2755 and We will work with you (and, if you'd like, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status. Our wellness program and any products and services available under this program are not Covered Services under the Plan.

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 amounts above the maximums stated in this Plan.
2. Services obtained from an Out-of-Network Provider outside of the Service Area, unless for Emergency Services or Prior Authorized care.
3. Services not listed as Covered Services in this Plan.
4. Services for treatment of complications of non-covered procedures or services; except for Emergency Medical Conditions services or those resulting from complications related to an approved Clinical Trial.
5. Services or supplies that are not Medically Necessary.
6. Services or supplies that are considered to be for Experimental, Investigative, or Unproven Procedures.
7. Services received before the Effective Date of coverage under this Plan.
8. Services received after coverage under this Plan ends.
9. Services for which You have no legal obligation to pay, or for which no charge would be made if You didn't have coverage under a Plan.
10. Any condition for which benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, after the Member has been fully compensated, even if the Member does not Claim those benefits. Nothing in this section shall prohibit coordination of benefits with such plans.
11. Health Care Services provided or charges billed as a result of injuries, conditions, or disabilities suffered while or as a result of committing or attempting to commit a criminal act;
12. Health Care Services provided or charges billed as a result of injuries, conditions, or disabilities suffer while or as a result of engaging in an illegal occupation;
13. Health Care Services provided or charges billed as a result of injuries, conditions, or disabilities suffered while or as a result of participating in a riot, rebellion or insurrection;
14. 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.
15. Any services provided by a local, state or federal government agency, unless

payment under this Plan is required by federal or state law.

16. Any services required by state or federal law to be supplied by a public school system or school district.
17. Any services for which payment may be obtained from any local, state or federal government agency (except Medicaid). Veterans Administration Hospitals and Military Treatment Facilities will be considered for payment according to current legislation.
18. If You are eligible for Medicare Part A, B or D, We will provide Claim payment according to this Plan, less any amount paid by Medicare. This will not exceed the amount Oscar would have paid if it were the only insurance carrier.
19. Unless required by a Provider, and a Covered Service under this Plan, Court-ordered treatment or Hospitalization is not covered
20. Professional services or supplies received or purchased directly or on Your behalf by anyone, including a Physician, from You, Your employer, someone who lives in the Your home, or that person's employer, a person who is related to You by blood, marriage or adoption, or that person's employer, or a facility or health care professional that provides remuneration to You, directly or indirectly, or to an organization from which You receive, directly or indirectly, remuneration.
21. Services that are not for an Emergency Medical Condition provided in a Hospital emergency room
22. Custodial Care.
23. Private duty nursing
24. Charges for Inpatient room and board that are in connection with a Hospital stay primarily for environmental change or Physical Therapy, Custodial Care or rest cures, services provided by a rest home, a home for the aged, a nursing home or any similar facility service.
25. Services that are received during an Inpatient Hospital stay, if the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of mental health
26. Complementary and alternative medicine services
27. Services and supplies provided by a nursing home or any facility a significant portion of the activities of which include rest, recreation, leisure, or any other services that are not Covered Services.
28. Assistance in Activities of Daily Living
29. Services performed by unlicensed practitioners or services which do not require licensure to perform. Some of these services may include breathing exercises, mediation, and guided visualization.
30. If they could have been performed safely as Outpatient services, We do not cover Inpatient room and board charges in connection with a Hospital stay primarily for diagnostic tests
31. Services and supplies that are prescribed, ordered, referred or provided by a member of Your immediate family, including Your Spouse, Domestic Partner, child, sibling, parent, legal guardian, or in-law are excluded from coverage. As used in this

exclusion, "provided by" does not include the dispensing of medications or supplies at a pharmacy. Self-directed or self-prescribed services, supplies and medications are also excluded from coverage.

32. Services ordered by a Physician or other Provider who is an employee or representative of a free-standing or Hospital-based diagnostic facility, when that Physician or other Provider has not been actively involved in your medical care prior to ordering the service. We also don't cover these services if the Physician or other Provider is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography.
33. Dental services, dentures, bridges, crowns, caps, implants or other Dental Prostheses, extraction of teeth or treatment to the teeth or gums, unless states otherwise in the COVERED SERVICES section of the Plan
34. Orthodontic Services, Braces and other orthodontic appliances including orthodontic services for Temporomandibular Joint Dysfunction.
35. Routine hearing tests except as provided under Preventive Care which include necessary rescreening, audiological assessment and follow-up, and initial amplification.
36. Genetic screening or pre-implantation genetic screening
37. Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, unless otherwise stated in this Plan under Pediatric Vision.
38. An eye surgery solely for the purpose of correcting refractive defects of the eye
39. Cosmetic surgery or other services for beautification, to improve or alter appearance or self-esteem or to treat Psychological or psychosocial Complaints regarding one's appearance. This does not apply to Reconstructive Surgery needed to restore a bodily function or correct a deformity caused by Injury. Additionally, this does not apply to surgery performed on a child age 12 years and under to correct a medically diagnosed congenital defect or birth abnormality, correction of a cleft palate or cleft lip, or removal of a port-wine stain or hemangioma on the face.
40. 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 memory books.
41. Non-medical counseling or ancillary services
42. Services and procedures for redundant skin surgery, including abdominoplasty/panniculectomy, removal of skin tags, craniosacral/cranial therapy, applied kinesiology, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, macromastia or gynecomastia, varicose veins, rhinoplasty, blepharoplasty, and orthognathic surgeries regardless of clinical Indications.
43. Any treatment, prescription drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire.

44. Except for services related to infertility in the **COVERED SERVICES** section, the treatment of fertility and/or infertility. Coverage does not include gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and services for procurement and storage of donor semen/eggs.
45. Cryopreservation of sperm or eggs, or storage of sperm for artificial insemination. This includes donor fees.
46. Collection or donation of blood or blood products
47. Blood administration for the purpose of general improvement in physical condition
48. Orthopedic shoes unless for diabetic treatment or when joined to Braces
49. Services primarily for weight reduction or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method for treatment. This includes any morbid obesity surgery, even if You have other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
50. Routine physical exams or tests that do not directly treat an Illness, Injury or condition, including any required by employment or government authority, physical exams required for or by an employer or for school, or sports physicals
51. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing career, school, athletic or recreational performance. This can include, but is not limited to routine, long term, or maintenance care, provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
52. Items which are furnished primarily for personal comfort or convenience
53. Massage therapy.
54. Educational services except for Diabetes Self-Management Training Program, treatment for Autism, or as otherwise provided or arranged by Us
55. Food supplements
56. Exercise equipment, comfort items and other medical supplies and equipment not specifically listed in the **COVERED SERVICES** section of this Plan. Some examples of excluded medical equipment include, but is not limited to: orthopedic shoes or shoe inserts; air purifiers, air conditioners, humidifiers; exercise equipment, treadmills; spas; elevators; supplies for comfort, hygiene or beautification; disposable sheaths and supplies; correction appliances or support appliances and supplies such as stockings, and consumable medical supplies other than ostomy supplies and urinary catheters, including, but not limited to, bandages and other disposable medical supplies, skin preparations and test strips except as otherwise stated in this Plan.
57. Physical, and/or Occupational Therapy/Medicine unless provided during an Inpatient Hospital, or under the "Rehabilitation Services" section.
58. Routine foot care including cutting or removal of corns or calluses, nail trimming, routine hygienic care, or any service rendered in the absence of localized Illness, Injury or symptoms involving the feet

59. Charges for which We cannot determine Our liability because the Member failed to authorize Us to receive all the medical records and information We requested or provide Us with information We requested regarding the circumstances of the Claim or other insurance coverage, within 60 days, or as soon as reasonably possible.
60. Services of a standby Physician, except in the even that such Physician is required to assist with high-risk services.
61. Animal to human organ transplants.
62. Claims We receive 15 months after the date service was rendered, except in the event of a legal incapacity.
63. Charges for surrogate mother
64. Home delivery of childbirth unless Prior Authorized by Us
65. Customization of vehicles, vehicle lifts for wheelchairs and/or scooters, modifications of the Member's home (e.g. ramp installation)
66. Coma stimulation,
67. Compulsive gambling treatment, unless defined as a Gambling disorder by the American Psychiatry Association in the DSM-V.
68. Any federal, state or local taxes due on benefits, goods or services, shipping and handling charges, services required while incarcerated
69. Fees for no shows and late cancellation. We do not cover fees Your Provider charges for no shows or late cancellations of appointments.
70. Bariatric surgery
71. Acupuncture
72. Abortions that do not meet the coverage criteria described in the **COVERED SERVICES** section of this Certificate.
73. Reversal of any sterilization procedures
74. 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.
75. 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.
76. Except as indicated in **COVERED SERVICES** section above, wigs or hairpieces are not covered
77. 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. 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.

PHARMACY BENEFITS

What do We Cover?

Formulary Drugs

The Oscar Formulary is a list of drugs we typically cover.

Oscar maintains a list of medications, typically a portion of those approved by FDA, that Oscar will cover. This list, referred to as the Oscar Formulary, is reviewed and updated by Oscar on a regular cycle. Oscar's Pharmaceutical and Therapeutics Committee oversees the review process to ensure clinical, quality and cost considerations are appropriately considered. The Oscar Formulary includes medications in almost all classes of medications, but does not necessarily include all forms of a given Prescription Drug (e.g. oral tablets, liquids, topical etc.).

We regularly update the Oscar Formulary.

Oscar updates the Oscar Formulary on an ongoing basis, but when modifying always ensures it is effective uniformly among all individuals in a given plan type. When changes are made, Oscar will notify both you and the Insurance Commissioner in accordance with federal and state specific law. To receive coverage for an Oscar Formulary medication, you must have a Health Care Provider prescribe you the medication and the medication must be determined by Oscar to be medically necessary, (see Section: How Your Coverage Works).

To request coverage for a medication not listed on the Oscar Formulary, you or your Health Care Provider can submit a request (see section 'What if You Disagree?') section. If You have a question regarding whether a Drug is on the Formulary, please visit Our website at www.hioscar.com or call Us at 1-855-672-2755.

Diabetes Supplies

We cover appropriate diabetic supplies.

Your Oscar plan covers medically necessary diabetic supplies, but as with all covered medications, you are responsible for cost-sharing amount as applicable.
Common supplies your plan covers include (but are not limited to):

- Test strips specified for use with a corresponding covered 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

Vaccinations and Administration

We cover vaccines. Most pharmacists can also administer them.

Your Oscar plan covers medically necessary vaccinations and annual flu shots. These can be administered by any Health Care Provider, including in most states, pharmacists.

However, not all pharmacists provide vaccinations, and so we encourage you to contact them in advance. All vaccinations and flu shots, when administered per ACIP (Advisory Committee on Immunization Practices) guidelines, will not be subject to copayments, coinsurances, or deductible. Some pharmacists may charge an administration fee, which is not always reimbursable under Your plan. Annual Flu shots will be covered in full.

Complications from Smallpox vaccinations are also a covered benefit.

Drugs Used in Treatment of Cancer

We cover appropriate cancer medications.

Your Oscar plan covers medically necessary medications for the treatment of cancer. Oscar requires the drug to either be approved by the FDA or to have been studied in scientific literature as safe and effective for your specific type of cancer such as the National Comprehensive Cancer Network Guidelines or other Nationally recognized clinical guidelines.

If You have a question regarding whether a Drug is covered call Us at 1-855-672-2755.

Benefits will also not be denied for any drug prescribed to treat a covered Indication so long as the drug has been approved by the United States Food and Drug Administration for at least one Indication and the drug is recognized for treatment of

the covered Indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

We cover medications for pain related to cancer

Oscar covers medications used for treating cancer-related pain even if the dosage administered exceeds the standard FDA approved amount, if deemed Medically Necessary by your Healthcare Provider.

Off-Label Use
Except as otherwise noted in this Plan, drugs must be approved by the Food and Drug Administration ("FDA") for treatment of the condition for which it is prescribed in order to be covered. We cover off-label uses when the drug is recognized for treatment of the condition for which it is prescribed by:

- the American Hospital Formulary Service Drug Information,
- the United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional" or
- two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective for treatment of the condition unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal

We also provide coverage for off-label use of intravenous immunoglobulin, also known as "IVIG", to treat individuals diagnosed with pediatric acute-onset neuropsychiatric syndrome and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection.

Orally Administered Cancer Medication

We cover appropriate oral cancer medications.
Your Oscar plan covers Medically Necessary orally administered anticancer medication. This Coverage will be equal to or better than intravenously administered or injected cancer medications that are covered under the medical benefit portion of Your Oscar Plan.

Self-Administered Injectable Drugs

We cover appropriate injectable drugs

Your Oscar plan covers medically necessary Self-Administered injectable drugs. These injectable drugs are pharmaceuticals administered by You with a needle or syringe via

the skin (typically intravenously or intramuscularly). As part of this benefit, the necessary disposable needles or syringes are also covered.

Physician Administered Medications

Prescription Drugs Administered in Physician Offices and Outpatient Facilities

These medications are commonly referred to as 'Physician-Administered Drugs' and are applied towards the Medical Benefit portion of your Oscar plan.

When prescription drugs are Covered under Your Medical benefit, they cannot be billed under the Prescription Drug Coverage section of this Policy.

Oscar designates a subset of these Physician-administered Drugs as preferred.
The list of preferred drugs are available on www.hioscar.com/forms and is periodically reviewed, and updated by Oscar as the status of existing medications changes and new drugs enter the market. Medications designated as preferred by Oscar may still require prior authorization. (see 'How Your Coverage Works' for additional Information).

Infertility Treatment

Your Oscar Plan covers medically necessary medications for the treatment of Infertility only when used as part of a medical treatment listed under the infertility treatment benefit in the "Covered Services" section of this Policy.

Medications when used for the purpose of In vitro Fertilization (IVF), gamete intrafallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT), are covered if medically necessary.

Smoking Cessation

We cover multiple types of treatment for smoking cessation.

Your Oscar plan covers medically necessary pharmaceuticals to aid Smoking Cessation, in accordance with "A" or "B" recommendations of the U.S. Preventive Services Task Force. This includes nicotine replacement therapy such as nicotine patches, gum, and lozenges.

We also cover screenings, intervention, and behavioral services for Smoking Cessation, as in accordance with "A" and "B" recommendations of the U.S. Preventive Task

Force. You may also call the National Quitline at 1-800-QUIT-NOW at any time to assist with Smoking Cessation Attempts.

Medical Foods

We cover appropriate medical foods.

Your Oscar Plan covers Medical Foods and any Medically Necessary services associated administration. Coverage may be subject to utilization review, including periodic review, of the continued medical necessity of the product. Medical foods includes but is not limited therapeutic food, formulas, amino acid-based elemental formula, or low-protein modified food products that are indicated for the therapeutic treatment of inborn errors of metabolism or genetic conditions and are administered under the direction of a physician.

How Your Coverage Works

Cost-Sharing Amounts

The Formulary tier determines how much you pay.

The cost-sharing amount for your medications is determined by the Formulary tier of the drug being dispensed. Please see your Schedule of Benefits for more details about your plan's specific cost-sharing amounts.

In the event the negotiated amount for your medication is less than your applicable cost-sharing amount, you will pay only the negotiated amount.

Prescription drugs required to be covered as "Preventive Drugs" that have a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force ("USPSTF") are not subject to the Deductible, Copayment, or Coinsurance.

Day Supply and Early Refills

Some drugs have limits on the day supply dispensed.

Covered Drugs are provided up to the maximum day supply limit as indicated on Your Schedule of Benefits and/or Formulary. Oscar has the right to determine the day supply and refill thresholds.

Payment for medications covered under this Plan may be denied if they are dispensed or delivered in a manner intended to change, or having the effect of changing or circumventing the stated maximum day supply limitation.

You may be able to fill your medication early if traveling.

This Plan allows Members to receive an early refill of certain medications in anticipation of extended travel (a "vacation override"). A vacation override is subject to Your coverage under this Plan and the maximum day supply limit as indicated by Your Schedule of Benefits and/or Formulary.

Your Oscar plan does not cover the replacement of previously dispensed drugs or supplies that have been lost, misused, stolen, broken, or destroyed.

Quantity and Time Limits

Some drugs have limits on the quantity dispensed.

Some medications have limits, placed by Oscar, on the quantity that your pharmacist can supply to you at a given time. These limits are based on clinical data from the FDA and from nationally recognized clinical guidelines. The limits apply regardless of the quantity prescribed by your Healthcare Provider.

You or your doctor can request an exception.

If you or your Health Care Provider believes you require a higher quantity of medication than the limit, your Health Care Provider can submit a request to Oscar for an exception. An Oscar clinician will review the request based on the submitted information. Any drugs dispensed by your pharmacist in a manner intended to change or circumvent the maximum limits set by Oscar will be denied.

Refill of Eye Drops

Eye drops have special rules for refills.

We allow refill for covered eye drops to treat a chronic eye disease or condition if, at the point of sale, You pay the maximum amount allowed under the “Your Cost” section of this Plan and:

- the original prescription states that additional quantities of the eye drops are needed;
- the refill does not exceed the total quantity of dosage units authorized by the prescribing Provider on the original prescription, including refills; and

- the refill is dispensed on or before the last day of the prescribed dosage period and:
- not earlier than the 22nd day after the date a prescription for a 30-day supply of eye drops is dispensed;
- not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed; or
- not earlier than the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed

Brand Name vs. Generic Drug Pricing Difference

Requiring a brand name drug may cost additional

If you or your healthcare Provider requests a pharmacy to fill the branded version of a medication when a generic version is available, you will pay a higher cost-sharing amount. The higher cost-sharing amount will be the applicable cost-sharing of the branded medication plus the difference in the allowed amount between the branded and generic versions.

Drug Coupons, Rebates or Other Drug Discounts

You must pay Oscar the difference if third party assistance exceeds the cost of a medication

Third parties, such as Drug Manufacturers may offer coupons, rebates, other drug discounts, or payment assistance such as Copayment or Coinsurance assistance to Members, which may impact the benefits provided under this Plan. The total benefits payable will not exceed the balance of the Allowed Amount remaining after all drug coupons, rebates, other drug discounts, or payment assistance have been applied. The Member agrees to reimburse Oscar any excess amounts for benefits that We have paid You and for which You are not eligible due to the application of drug coupons, rebates or other drug discounts.

For any medication where third party payment assistance is used, You shall receive credit toward your Maximum Out-of-Pocket and Deductible, if applicable, for any out-of-pocket amounts that are due that are covered by a manufacturer coupon or rebate.

Medication Synchronization Plan

You can pick up all your drugs at the same time

If you are filling more than one prescribed medication on an ongoing basis, you have the option to coordinate the refilling of your medications to a single pharmacy visit.

To utilize this option, notify your pharmacist at your next visit that Oscar supports medication synchronization and you'd like to coordinate your refills. Your pharmacist may refer to this option as a 'medication synchronization program'.

A Schedule II controlled substance, a prescription drug dispensed in an unbreakable package, or a multidose unit of a prescription drug may not be partially filled for the purpose of aligning refill dates.

Your Pharmacist can utilize overrides codes if needed to 'sync' your medication, or Contact us for assistance.

We will prorate on a per day basis, any Cost-Sharing amounts for a quantity that is less than a 30 days' supply when dispensed as part of a Medication Synchronization.

Selecting a Participating Pharmacy

Our website has a list of pharmacies You can go to.

As an Oscar member, you have two methods to fill a prescription: (1) Visiting your local Retail Pharmacy, (2) Using a Mail-Order Pharmacy (see section on Mail-Order).

If using a Retail Pharmacy, first check on our website (www.hioscar.com) or contact Member Services at 1-855-672-2755 to confirm the pharmacy is in the Oscar Network, as some large chains and smaller independents are excluded depending on your plan type. Additionally, certain drugs are not available at standard retail pharmacies (see section: Specialty Pharmacy).

At the pharmacy you will be required to present your Oscar Insurance Card and your prescription (if not already sent electronically by your Healthcare Provider). The pharmacy may also require additional information to fill your prescription and process the claim. At the time of pickup, you will be required to pay any cost-sharing amounts (deductibles, coinsurance, or copayments) and pricing differences (if applicable).

Mail Order Program

Your drugs can be delivered by mail

Mail Order Pharmacies are an alternative way you can get your medications. Certain eligible covered drugs, such as maintenance medications can be delivered to your home. You are not required to use Our Mail Order program. Not all Medications listed on our formulary can be filled at Mail Order. You can find more information and our

Drug Formulary by going to www.hioscar.com or if You have any questions or need assistance in determining the amount of Your payment, or need to obtain the mail-order prescription form, You may contact Member Services at 1-855-672-2755.

If your In-Network Retail Pharmacy offers you a delivery option, this is not the same as Our Mail Order Program. Oscar will not prohibit your Pharmacy from offering this as an extra service. Your pharmacy will let You know of any fees associated with the delivery, including any fees not reimbursable by Us.

Benefits for Specialty Drugs

Some drugs have unique clinical requirements and must be filled at a Specialty Pharmacy

Drugs that require specialized patient education prior to use and ongoing patient assistance while under treatment are called 'Specialty Drugs'.

These 'Specialty Drugs' must be dispensed through an Oscar contracted Specialty Pharmacy. Please visit our website at www.hioscar.com or call Member Services at 1-855-672-2755 to find out if your medication is considered a Specialty Drug and/or identify the best Specialty Pharmacy option for you.

Selecting a non-Participating Pharmacy

Pharmacies not listed in our directory will cost You more.

If you choose to visit a pharmacy not in the Oscar Network (a non-participating pharmacy), you will pay the full amount for the medication.

If the non-participating pharmacy is willing to accept reimbursement at the same rates as a participating pharmacy, they can submit a request for reimbursement to Oscar. Contact us at 1-855-672-2755 if you and your pharmacy wish to pursue this option.

Prior Authorization

Our clinicians review some prescriptions to confirm they are appropriate

Some medications, despite being prescribed by your Healthcare Provider, require an additional review by a Clinician before you can fill the prescription. This process is called Prior Authorization. A Clinician performs a Prior Authorization review to ensure the prescribed drug is safe, effective, and appropriate for your specific treatment

plan. A list of the medications which require a Prior Authorization and the required forms are available on our website at www.hioscar.com or by contacting member services at 1-855-672-2755.

We will review all Prior Authorization requests and make a decision to approve or deny coverage for the requested medication based on established clinical criteria. A decision will be made within the time limits specified by State or NCQA (National Committee for Quality Assurance) regulations. If You or Your Health Care Provider do not agree with the decision made by Oscar, you have the ability to contest the decision (see "What if You Disagree'). You can request either an expedited or standard review timeframe.

We may request Medical Records from Your Provider as part of our Clinical Review. A Provider's failure to supply these when asked may result in a denial. Should Your review be denied our "Rights of Appeal' section provides more detail.

If your Health Care Provider does not obtain a Prior Authorization, the pharmacy will be alerted when they are attempting to submit a claim to Oscar and you will not be able to receive your medication.

In certain cases at Oscar's discretion, Oscar may review medicines for medical necessity even though they are not subject to our Prior Authorization requirements. If so, your prescribing doctor will be asked for clinical information to support the medical necessity of your use of the drug. If the determination is unfavorable, future claims for this medication will be denied; in such an event that determination will be eligible for an appeal or exception processes.

Step Therapy

We sometimes require you to try an alternate drug before taking the one you were prescribed

Some medications, despite being prescribed by your Healthcare Provider, are covered by Oscar only after you have first tried a clinically appropriate alternative. Your pharmacist or Health Care Provider may refer to this as a 'Step Therapy Requirement'. Oscar uses our history of your previous prescriptions (via submitted pharmaceutical claims) to automatically confirm if you have already tried the necessary alternative.

You or your doctor can request an exception

If you or your Health Care Provider believe the alternative medication is not safe or appropriate to try, your Healthcare Provider can submit a request for an exception by contacting Us at 855-672-2755. A request for an exception should also be submitted if you have previously tried the necessary alternative but while at another Health Plan.

If your Health Care Provider does not obtain an exception or if we cannot confirm you have already tried the necessary alternative, the pharmacy will be alerted when attempting to submit a claim to Oscar and you will not receive coverage for your medication.

Drug Switching Incentive Programs

We may offer an incentive if you switch medications

As an Oscar member you may be eligible for incentives for switching from a higher-cost to a lower-cost, clinically similar prescribed medication. Oscar will notify you of these recommendations via mail, phone, or messaging. If you are not notified of a specific switching recommendation, you will not be eligible for the applicable incentives

Medical vs. Pharmacy Benefit Coverage

Some drugs are available only through the pharmacy medical benefit.

Certain medications are designated to be received only as a Pharmacy or Medical Benefit drug. Medications received under the Medical Benefit are administered by a physician and a list of these medications are available on our website www.hioscar.com. When medications are billed under Your Oscar plan's medical benefit, they will not be provided as a Pharmacy Benefit Drug.

What if You Disagree?

Right of Appeal

You can request Oscar to reconsider a clinical decision.

Certain medications have requirements or restrictions placed by Oscar (see 'How Your Coverage Works'). In the event your Health Care Provider requests us to review these requirements or restrictions placed on Your Medication and the request is denied by Oscar, you have the right to appeal the decision.

The **COMPLAINTS AND GRIEVANCES** section of this plan outlines this in more detail.

Prescription Drug Formulary Exception Request

You can request that Oscar cover a drug that isn't listed on our Formulary

If you or your Health Care Provider believe your treatment needs require a medication not on the Oscar Formulary, your Health Care Provider can submit an exception request.

The necessary form can be found on our website at www.hioscar.com. Once submitted, the exception request will be reviewed by a Clinician in accordance with state specific timeframes. You can request either an expedited or standard review timeframe.

External Exception Request for Denial of Standard or Expedited Formulary Exceptions

You can request Oscar to have an independent clinical organization to review our clinical decision.

If Oscar denies the Formulary exception, reviewed in either a Standard or Expedited manner, a request for a review by the Independent Review Organization can be initiated by You, Your designee, or Your Healthcare Provider. These requests, also called an external exception, will be reviewed in the timeframes set forth by the Independent Review Organization and State regulations.

A Request for external exception review does not eliminate Your right to request an Appeal.

The **COMPLAINTS AND GRIEVANCES** section of this plan outlines this in more detail.

If the review is approved by the Independent Review Organization, Oscar will cover the medication for the duration determined by the Independent Review Organization. Any drug covered through the exception process will count towards Your satisfaction of the annual limitation on Cost Sharing, also known as Your Maximum Out Of Pocket amount.

What do We Not Cover?

Limitations and Exclusions

- Your Oscar plan does not cover vitamins or dietary supplements for which there is a clinically equivalent non-prescription over-the-counter alternative. This does not apply to

USPSTF endorsed preventive treatments such as prenatal vitamins, fluoride tablets, or multivitamins with fluoride preparations.

- Allergy Serums as a Pharmacy benefit are not covered
- Your Oscar plan does not cover prescription drugs prescribed for the treatment of obesity or for use in any weight reduction, weight loss, or dietary control. Non-pharmacological healthy diet counseling and obesity screening, as endorsed by the USPSTF remain covered.
- Your Oscar plan does not cover prescription drugs used to enhance cosmetic appearance or performance. This includes, but is not limited to anti-aging, athletic performance (anabolic steroids, androgens or related), hair loss (rogaine, minoxidil or related), sweating (botox or related) and treatments for scarring.
- Your Oscar plan does not cover prescription drugs used to treat male and female sexual dysfunction, including, but not limited to: Addyi, Vyleesi, sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form, or other generic formulations. These drugs are covered if prescribed to treat a Medically Necessary indication other than sexual dysfunction.
- Your Oscar plan does not cover experimental or investigational prescription drugs prescribed or administered by a Dentist or Dental Specialist used to support the non-medical, dental procedures such as extractions, root canals, or periodontal treatments. This includes locally applied dental antibiotics such as Arestin+ or similar.
- Your Oscar plan does not cover rinses, gels, pastes, or creams containing only stannous fluoride or sodium fluoride under Your Pharmacy benefit unless listed as required in the dental section.
- Your Oscar plan does not cover growth hormone therapy used to treat familial short stature. This exclusion does not apply to growth hormone therapy when determined Medically necessary to treat a medical condition other than familial short stature
- Your Oscar plan does not cover vaccinations necessary solely for the purpose of travel to a region outside of the United States.
- Vitamin B-12 injections are not covered except for the treatment of pernicious anemia when oral vitamin B cannot be absorbed.
- Your Oscar plan does not cover prescription drugs, devices or supplies available in an over-the-counter form or comprised of components that are available in a clinically equivalent over-the-counter form. This does not apply to over-the-counter products that Oscar is required to cover under federal or state laws or as a USPSTF endorsed preventive service.
- Your Oscar plan does not cover drugs, vaccines, devices, and. or and supplements which are not approved by the FDA or are labeled as "Investigational / Experimental" use only
- Your Oscar plan does not cover drugs obtained in an unauthorized manner (e.g. fraudulent identification) or drugs for which the intended use would be illegal, unethical, or otherwise improper. This includes drugs that have been repackaged by anyone other than the original manufacturer.

- Your Oscar plan does not cover the replacement of previously dispensed drugs or supplies that have been lost, misused, stolen, broken, or destroyed.
- Your Oscar plan does not cover prescriptions filled at a Pharmacy owned by You or a member of Your Family.
- Your Oscar plan does not cover prescriptions written by an Immediate Family Member or as a result of 'self-prescribing'.
- Your Oscar plan does not cover compounded drugs unless it contains at least one ingredient that has been approved by the United States Food and Drug Administration (FDA). We will also not cover compounded drugs that are available as a similar commercially available Prescription Drug. All compounds are subject to a Medical Necessity review.
- Your Oscar plan does not cover prescription drug compounding kits sent to You to be mixed at home (ex. foot-baths) or services provided to You related to the kits. This does not include drug compounds made and dispensed at a Pharmacy.
- Your Oscar plan does not cover drugs dispensed in a Medical Office, Hospital, Acute Care, or Long Term Facility for which the Office or Facility is also seeking reimbursement from Your Medical Benefit or for which they receive a Standard Daily Rate for inclusive services.
- Your Oscar plan does not cover prescription drugs, supplies or devices provided in connection with an occupational sickness or an injury sustained in the scope of employment

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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 aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - 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

If you need these services, contact Member Services at 1-855-OSCAR-55 (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: 1-855-OSCAR-55 (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 1-855-Oscar-55 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။