Oscar Health Plan of North Carolina, Inc.

Individual HMO Plan

1-855-672-2755
P.O. Box 52146
Phoenix, AZ 85072-2146
Effective Date: January 1, 2021
Evidence of Coverage

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.

Oscar Health Plan of North Carolina, Inc. is a Qualified Health Plan issuer in the Federal Health Insurance Marketplace

This is a legal contract. Please read Your Policy carefully!

Important Cancellation Information – Please Read The Provision Entitled "Termination," Found On Page "53."

[XXXXX]

POLICY

Oscar Health Plan of North Carolina, Inc. (herein called "Oscar")

Guaranteed Renewable/Premium Subject to Change: This Plan may be subject to non-renewal for Dependents who surpass the maximum Dependent age limit. Otherwise, Your Oscar Plan is guaranteed renewable to at least age 65 upon monthly payment of the required Premium. This Plan will remain in effect continually until terminated by You or by Us per the terms of the **TERMINATION** section and, subject to Our right to terminate coverage and any amendments permitted under applicable law. We'll never base non-renewal on the deterioration of Your mental or physical health. Please refer to the **WHO GETS BENEFITS** section of this contract for more information. Your Premium might be increased upon the Renewal Date of this Plan. In the event of a rate increase, We will provide written notice of the increase at least 60 days before the increase takes effect. Rate increases will only take affect after the North Carolina Department of Insurance has approved the change, and will apply only at the beginning of a new Plan Year.

Oscar hereby certifies that it has issued an Health Maintenance Organization Health and Pharmacy Benefit Contract (herein called the "Plan"). Subject to the provisions of this Plan, You, together with Your eligible Dependents for whom application is initially made and accepted, shall have coverage under this Plan, beginning on the Effective Date, if You make timely payment of total Premium due to Oscar. Issuance of this Plan by Oscar does not waive the eligibility and Effective Date provisions stated in this Plan.

In-Network Benefits: This Plan only covers In-Network Benefits. To receive In-Network Benefits, You must make sure Your care is received exclusively from Network Providers in Our Network. You're responsible for paying the cost of all care that is provided by Out-of-Network Providers, unless the care is for an Emergency Medical Condition or if the services You need aren't available from Network Providers.

NOTICE

THIS HMO MAY HAVE RESTRICTIONS REGARDING WHICH PHYSICIANS OR OTHER HEALTH CARE PROVIDERS AN HMO MEMBER MAY USE. PLEASE CONSULT YOUR MEMBER HANDBOOK OR PROVIDER DIRECTORY FOR MORE DETAILS. IF YOU HAVE ANY ADDITIONAL QUESTIONS, PLEASE WRITE OR CALL US AT: OSCAR, P.O. BOX 52146 PHOENIX, AZ 85072-2146 OR 1-855-672-2755

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INTRODUCTION

Thank You so much for choosing Oscar! We're so excited to meet You, and look forward to partnering with You towards living Your healthiest life.

In this Plan, "We", "Us" and "Our" means Oscar. "You" are the eligible Subscriber whose individual enrollment application has been accepted by Us. "You" and "Your" may also refer to any eligible Dependents who are covered under this Plan. The word "Member" means You and any eligible Dependents who are covered under this Plan.

We know that health insurance can be confusing. At Oscar, we're committed to making Our plans as simple as possible, because it's really important to Us that You understand:

- How Your Plan works and
- How much You will pay for care.

In this Plan, We will talk to You about a few things:

- The rights and responsibilities that You have, and that We have
- How You can get health care
- What services are covered
- What part of which costs You will need to pay

The benefits provided are intended to assist You with many of Your health care expenses for Medically Necessary services and supplies.

The defined terms in this Plan are capitalized and shown in the appropriate provision in the Plan, or in the **DEFINITIONS** section of the Plan. Whenever these terms are used, the meaning is consistent with the definition given.

Please read this Plan completely and carefully, as many parts are related. Reading just one or two sections may not give You a full understanding of Your coverage. Individuals with special health care needs should read those sections that apply to them carefully.

Our Notice of Privacy Practices describes how We use and disclose protected health information. You can access Oscar's Notice of Privacy Practices on Our website at www.hioscar.com. You can also request a paper copy, at no cost to you, by calling Member Services at the number listed on the back of Your Oscar ID card.

IMPORTANT CONTACT INFORMATION

Resource	Contact Information	Accessible Hours
Member Services Helpline	1-855-672-2755	Monday – Friday 8:00 AM – 8:00 PM
Website	www.hioscar.com	24 hours a day 7 days a week
Mailing Address	P.O. Box 52146 Phoenix, AZ 85072-2146	24 hours a day 7 days a week
Chat with Your Member Services team	Oscar smartphone app Oscar's Member portal at www.hioscar.com	Monday – Friday 8:00 AM – 8:00 PM

Member Services Helpline
Member Services Representatives can:

- Identify Your Service Area
- Give You information about Network and Other Providers contracting with Oscar
- Distribute Claim forms
- Answer Your questions on Claims
- Assist You in identifying a Network Provider
- Provide information on Oscar's Plan features
- Record comments about Providers
- Assist You with questions regarding the **PHARMACY BENEFITS.**

Oscar Website
Visit the Oscar website at www.hioscar.com for information about Us, access to forms referenced in this Plan, and much more.

How to Get Language Assistance
Oscar offers a Language Assistance Program to assist Members with limited English proficiency understand the health coverage provided under this Agreement at no additional cost. We provide oral interpretation services, as well as written translation for written materials vital to understanding Your health coverage.

This service also allows You and Your Physician to talk about Your medical or behavioral health concerns in a way You both can understand. We have representatives that speak Spanish and have medical interpreters to assist with other languages.

Requesting language assistance is easy. Just contact Member Services by calling 1-855-672-2755 to update Your language preference, to receive future translated documents, or to request interpretation assistance. Oscar also sends/receives TDD/TTY messages by using the National Relay Service through calling 711 or a number listed below. A special operator will get in touch with Us to help with Your needs.

How to Find a Provider in the Network
There are two (2) ways You can find out if a Provider or Facility is in the network for this Agreement. You can also find out where they are located and details about their license or training.

- See Our directory of In-Network Providers at www.hioscar.com, which lists the Physicians, Providers and Facilities that participate in Our network.
- Call Member Services at 1-855-672-2755 or access Our website at www.hioscar.com for a list of Physicians, Providers and Facilities that participate in Our network, based on specialty and geographic area.

DEFINITIONS

The definitions used in this Plan apply to all coverage unless otherwise indicated.

Abortion refers to services, devices, drugs or other substances provided by any Provider in any location intended to terminate a woman's pregnancy for the following purposes:

- In order to prevent the death of the female upon whom the abortion is performed

Acceptable Third Party Payer means one or more of the following:

- A Ryan White HIV/AIDS Program established under Title XXXVI of the Public Health Service Act;
- an Indian tribe, tribal organization, or urban Indian organization;
- a local, State or Federal government program, including a grantee directed by a government program to make payments on its behalf; or

Oscar will review all other third-party payments, including payments made by private, not-for-profit foundations, on a case-by-case basis. Oscar may decline to accept third-party payments, including payments by third-party individuals, that raise concerns for potential conflicts of interest, adverse selection, or fraud.

Acute Care means active, short-term medical care, usually for a short-term illness or condition (requiring a Hospital stay of 30 days or less), requiring a wide range of medical, obstetrical and pediatric, and surgical and related services.

Acute Care Facility means a facility that primarily provides Acute Care and that is not used primarily for:

- Custodial, convalescent, tuberculosis or rest care
- Care of the aged or those with Substance Use Disorder
- Non-acute treatment of Chronic Conditions
- Skilled or other nursing care

Advance Health Care Directive means a written statement made in accordance with legal requirements that expresses a person's wishes and instructions for health care and health care directions when the person is determined to be incompetent and has an end-stage medical condition or is permanently unconscious. It could also mean a written statement made by a person designating another individual to make health care decisions for them should they be incapacitated or incompetent.

Adverse Determination means a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other Health Care Service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for the requested service is therefore denied, reduced or terminated

Alcoholism Treatment Facility means a residential or nonresidential facility certified for the treatment of alcoholism by the State of North Carolina.

Allowed Amount means the maximum amount Oscar considers eligible for payment to a Provider or Facility for a particular service, supply, or procedure.

For Hospitals and other facility Providers, Physicians, and other professional Providers contracting with Us, the Allowed Amount is based on the terms of the Provider contract and the payment methodology in effect on the date of service. The payment methodology used may include diagnosis-related groups (DRG), fee schedule, package pricing, global pricing, per diems, case-rates, discounts, or other payment methodologies.

- For multiple surgeries – The Allowed Amount for all surgical procedures performed on the same patient on the same day will be the amount for the single procedure with the highest Allowed Amount plus a determined percentage of the Allowed Amount for each of the other covered procedures performed.
- For Covered Drugs as applied to Participating Pharmacies – The Allowed Amount for Participating Pharmacies and the Mail-Order Program will be based on the provisions of the contract between Oscar and the Participating Pharmacy or Pharmacy for the Mail-Order Program in effect on the date of service.

As applied to Participating Pharmacies, the Allowed Amount is based on the provisions of the contract between Oscar and the Participating Pharmacy in effect on the date of service.

Allogeneic Transplant means a non-Experimental procedure or set of procedures to transplant any part or portion of another individual’s bone marrow, peripheral blood Stem Cells or umbilical cord blood into a patient, including syngeneic transplants.

Ambulatory Surgical Center means a facility not located on the premises of a Hospital which provides specialty Outpatient surgical treatment. It doesn’t include individual or

group practice offices of private Physicians or dentists, unless the offices have a distinct part used solely for Outpatient surgical treatment on a regular and organized basis.

Appeal means a formal request, in writing, to Oscar to reconsider a determination not to certify an admission, extension of stay, or other health care service or procedure, and will include both formal standard appeals and Expedited Appeals.

Applied Behavior Analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of:

- direct observation;
- Measurement; and
- functional analysis of the relations between environment and behavior.

Approved Amount means the lower of the billed charge or Our maximum payment level for the Covered Service. Any Copayments and/or Deductibles that may be required of You are subtracted from the Approved Amount before We make Our payment. For prescription drugs: The lower of the billed charge or the sum of the drug cost plus the dispensing fee and incentive fee, if applicable (in each case set according to Our contracts with In-Network pharmacies or mail-order Providers) for a Covered Drug. The Approved Amount is not reduced by rebates or other credits received directly or indirectly from the drug manufacturer. Any Copayments and/or Deductibles that may be required of You are subtracted from the Approved Amount before We make Our payment.

Audiologist means a professional licensed or legally qualified in the state in which the individual receives care to perform audiometric and other procedures to assist in the diagnosis, treatment and management of individuals with hearing loss or balance problems.

Authorized Representative means a parent, guardian, or other person authorized to act on behalf of an Member with respect to health care decisions.

Autism Spectrum Disorder means a neurobiological disorder that includes autism or pervasive developmental disorder—not otherwise specified, or Asperger's Syndrome, as defined in the current American Psychiatric Association Diagnostic and Statistical Manual. The diagnosis of Autism Spectrum Disorders refers to assessments, evaluations, or tests in order to diagnose whether a Member has an Autism Spectrum Disorder. Treatment for Autism Spectrum Disorders refers to care prescribed or

ordered by a Provider, including Medically Necessary equipment for such care, including, but not limited to:

- Psychiatric Care;
- Psychological Care;
- habilitative or Rehabilitative care, including Applied Behavior Analysis therapy;
- therapeutic care; and Pharmacy care.

Balance Billing is when an Out-of-Network Provider bills You for an amount greater than Your applicable Copayment, Coinsurance, and Deductible. A Network Provider may not Balance Bill You for Covered Services.

Behavioral Health means the diagnosis and treatment of a mental or behavioral disease, disorder, or condition listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association ("DSM)", as revised, or any other diagnostic coding system as used by Oscar, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin. For the purposes of this Plan, Behavioral Health and Mental Health mean the same thing.

Benefit Limit refers to the specific limitation on a benefit. Limits will be explained in the Schedule of Benefits, and/or in the Evidence of Coverage as an age requirement, dollar amount or number of services covered per Benefit Period.

Benefit Period refers to one Calendar Year or one Plan Year, as applicable per the terms of the Member's plan. However, when a Member is initially enrolled, the Benefit Period will be the date of enrollment through the end of the then current Calendar Year.

Brace is an orthopedic appliance that supports or holds a movable part of the body in the correct position while still allowing for that part to move.

Brand Name Drug means a drug or product manufactured by a single manufacturer as defined by a nationally recognized Provider of drug product database information. There may be some cases where two manufacturers will produce the same product under one license, known as a co-licensed product, which would also be considered as a Brand Name Drug. There may also be situations where a drug's classification changes from generic to Preferred Brand Name due to a change in the market resulting in the generic being a single source, or the drug product database

information changing, which would also result in a corresponding change in cost-sharing obligations from generic to Preferred Brand Name.

Calendar Year means the period commencing on January 1 and ending on the next succeeding December 31.

Evidence of Coverage Effective Date means 12:01 a.m. on the date on which coverage and enrollment under this Evidence of Coverage begins.

Chemical Dependency means the Psychological or Physiological dependence upon or abuse of drugs, including alcohol. It is characterized by any combination of drug tolerance, withdrawal and impairment of social or occupational role functioning.

Chronic Condition means a persistent, frequently recurring or long-lasting condition, such as arthritis, asthma and heart disease, that may or may not be helped by therapy and that may eventually result in significant disability and/or death.

Claim means a request for payment that You or Your Health Care Provider submits to Us when You get items or services You think are covered. Claims typically include proof of loss, or evidence of a Claim, which includes the form on which the Claim is made, bills and statements reflecting services and items (and their respective charges) provided to a Member, and correct diagnosis codes and procedure codes for the services and items.

Clinical Peer means a Health Care Provider in the same, or in a similar, specialty that typically manages the medical condition, procedure, or treatment under review.

Clinical Criteria means a written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by Oscar to determine the Medical Necessity and appropriateness of healthcare services. Clinical Criteria may be modified from time to time at Oscar's discretion based on new or updated medical or scientific evidence, subject to the procedures for Clinical Criteria review and approval adopted by the Our Board of Directors.

Clinical Trial means phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that:

- involve the treatment of life-threatening medical conditions,
- are medically indicated and preferable for that patient compared to available noninvestigational treatment alternatives, and

- have clinical and preclinical data that shows the trial will likely be more effective for that patient than available noninvestigational alternatives.

Covered Clinical Trials must also meet the following requirements:

- Must involve determinations by treating physicians, relevant scientific data, and opinions of experts in relevant medical specialties.
- Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The Health Benefit Plan may also cover clinical trials sponsored by other entities.
- Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

Coinsurance means Your share of the cost of Covered Services, which are represented as percentages. The Coinsurance will be calculated based on contracted rates, if any, between Oscar and Our In-Network Providers.

Compound Medications mean those drugs that have been measured and mixed with FDA- approved pharmaceutical ingredients by a pharmacist to produce a unique formulation that is Medically Necessary because commercial products either do not exist or do not exist in the correct dosage, size, or form. The drugs used must meet the following requirements:

- The drugs in the compounded product are FDA approved;
- The approved product has an assigned National Drug Code (NDC); and
- The primary active ingredient is a Covered Drug under an Oscar Plan.

Congenital Condition means a medical condition present at or before birth.

Contraceptive Medication, Devices, and Methods refer to any drug, device, or service used or performed for the express purpose of preventing pregnancy at the time of its administration, such as oral Contraceptive drugs, injectable Contraceptive drugs or patches. Services refer to Outpatient services only.

Copayment means the fee, which You are required to pay in order to receive a particular benefit. This is Your share of the cost of Covered Services. The dollar amount of the Copayment may be $0 (no charge).

Cost Sharing means the Copayment, Coinsurance, Deductible and any amounts exceeding Benefit Limits that a Member will incur as an expense for Covered Services and Pharmacy Benefits. Specific Cost Sharing amounts for Covered Services can be found on the Schedule of Benefits

Cosmetic refers to services that:

- Can be expected or is intended to improve the physical appearance of a Member; or
- Is performed for Psychological purposes; or
- Restores form but does not correct or materially restore a bodily function.

Covered Drugs refer to injectable insulin, Legend Drugs, or such drugs that Oscar designates as covered, so long as the following conditions are met:

- It is Medically Necessary and is ordered by an authorized Health Care Provider naming a Member as the recipient
- A prescription for the drug must be issued by a prescriber who is legally authorized to prescribe drugs for human use
- The cost of the drug must not be included in the charge for other services or supplies and for which a separate charge is customarily made;
- The drug is not entirely consumed at the time and place where the prescription is written
- Which is dispensed by a Pharmacy and is received by the Member while covered under an Oscar Plan, **except when** received from a Provider's office, or during confinement while a patient in a Hospital or other Acute Care or Facility (refer to **Limitations and Exclusions**).
- The drug must be approved by the Food and Drug Administration ("FDA") for treatment of the condition for which it is prescribed or 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

Any compounded drugs are covered if they meet all the above requirements, subject to the provisions and exclusions of this Evidence of Coverage

Covered Oral Surgery means maxillofacial surgical procedures limited to:

- Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;

- Incision and drainage of facial abscess;
- Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
- Reduction of a dislocation of, excision of, and injection of the temporomandibular joint, except as excluded under the Plan.

Covered Service means a Health Care Service that is identified as payable in this Evidence of Coverage that is Medically Necessary, and ordered or performed by a Provider that is legally authorized or licensed and appropriately credentialed or privileged, as determined by Oscar, to order or perform the service. With regards to Prescription drugs, Covered Services mean drugs or supplies used to treat medical conditions, such as disposable needles and syringes when dispensed with insulin, or chemotherapeutic drugs.

Custodial, Domiciliary or Convalescent Care means care comprised of services and supplies, including room and board and other Institutional services, provided to a Member primarily to assist in activities of daily living and to maintain life and/or comfort with no reasonable expectation of cure or improvement of Sickness or Injury. Custodial Care is care which is not a necessary part of medical treatment for recovery, and includes, but is not limited to, helping a Member walk, bathe, dress, eat, prepare special diets, and take medication.

Member Services Team refers to Oscar representatives who are available to answer Member's questions and provide information regarding Oscar.

Date of Occurrence means the Date of Occurrence is the date on which the event that prompted the complainant to initiate the Grievance occurred. In the context of Claims-related Grievances, this typically would be the date that the EOB or EOP was sent to the Member or provider.

Deductible means the amount that You must pay for Covered Services, under this Evidence of Coverage, before benefits are payable. Payments made toward Your Deductible are based on the Approved Amount at the time of the Claims are processed. Your Deductible is not altered by an audit, adjustment, or recovery and in the case of prescription drugs, Your Deductible is not reduced by any rebate or other credit received directly or indirectly from the drug manufacturer.

Dental Prostheses mean dentures, crowns, caps, bridges, clasps, habit appliances, and partials.

Designated Behavioral Health Benefit Program means a program in which Oscar manages Behavioral Health services (including Inpatient and Outpatient Behavioral Health and Substance Abuse care).

Designated Transplant Facility refers to a facility that has entered into an agreement with Oscar, Our transplant subcontractor or national organ transplant network to provide Transplant Services when a transplant service is Medically Necessary for a Member. The Designated Transplant Facility is determined by Us or Our transplant subcontractor and may or may not be located in the Service Area.

Department means the North Carolina Department of Insurance.

Dependent refers to a person covered under Your plan, in addition to You, the Subscriber. Please refer to the **WHO GETS BENEFITS** section for more details.

Durable Medical Equipment (DME) means equipment that:

- can withstand repeated use;
- generally is not useful to a person in the absence of illness or Injury;
- is appropriate for use in an individual's home or otherwise outside a medical facility or may be necessary for use at other locations or in the community to allow basic activities of daily living; and
- is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience, including, but not limited to, scooters

Durable Medical Equipment Provider means a Provider that provides therapeutic supplies and Rehabilitative equipment.

Effective Date means the date on which coverage begins under this Plan for You, or the date coverage begins under this Plan for Your or Your Dependent , as the context in which the term is used suggests.

Eligible Person means a Resident of the Service Area, who is not covered under Part A or Part B of Title XVIII of the federal Social Security Act (42 U.S.C. § 1395 et. seq.) (Medicare). An Eligible Person must be a U.S. Citizen, National, or lawfully present in the United States.

Emergency Medical Condition means a medical or behavioral condition manifesting itself by acute symptoms of sufficient severity or severe pain such a prudent layperson

who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the Member, or with respect to a pregnant woman, the health of a woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part

Emergency Services and Care (also referred to as Emergency Services) means any health care items and service provided or required to screen and Stabilize a Member experiencing an Emergency Medical Condition. These may include, but are not limited to, Health Care Services provided in a licensed Hospital's emergency facility by an appropriate provider. to a Member after the sudden onset of an Emergency Medical Condition.

Transportation and related Emergency Services provided by a licensed ambulance service shall constitute an Emergency Service if the condition is as described in this definition.

Enrollment Letter. The Enrollment Letter is a letter to You by Us as notification that You are an enrolled Member under this Plan. The Enrollment Letter sets forth Your Effective Date of coverage under an Oscar Plan.

Episode means a distinct course of Chemical Dependency treatment separated by at least thirty days without treatment.

Essential Health Benefits refer to a set of Health Care Service categories that must be covered by health plans under the PPACA.

Evidence of Coverage means this Evidence of Coverage provided by Oscar to all Members awarded individual coverage, which sets forth Covered Services and the terms and conditions of coverage.

Exchange means the federally-facilitated Marketplace.

Expedited Appeal refers to an Expedited Appeal of a noncertification, which may be requested by a covered person or his or her provider acting on the covered

Experimental / Investigational means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the

diagnosis, evaluation, or treatment of a disease, Injury, illness, or other health condition for which one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought:

- The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply cannot be legally marketed in the United States without the final approval of the FDA or other licensing or regulatory agency, and such final approval has not been granted;
- The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply has been determined by the FDA to be contraindicated for the specific use;
- The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is provided as part of a clinical research protocol or Clinical Trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply;
- The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is subject to review and approval of an Institutional Review Board ("IRB") or other body serving a similar function;
- The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigational, or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigational based on the criteria above may still be deemed Experimental/Investigational by Oscar based on assessment as to whether;

- The scientific evidence is conclusory concerning the effect of the service on health outcomes;
- The evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
- The evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- The evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by Oscar to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or

supply is Experimental/Investigational under the above criteria may include one or more items from the following list, which is not all inclusive:

- Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- Documents issued by and/or filed with the FDA or other federal, Commonwealth, or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Documents of an IRB or other similar body performing substantially the same function; or
- Consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- Medical records; or
- The opinions of consulting providers and other experts in the field.

Extended Care Expense refers to the Allowed Amount of charges incurred for those Medically Necessary services and supplies provided by a Skilled Nursing Facility, a Home Health Agency, or a Hospice as described in this Plan.

Formulary means the list that identifies those Prescription Drugs for which coverage may be available under this Plan. You may determine to which tier a particular Prescription Drug has been assigned by visiting www.hioscar.com or by calling Oscar at 1-855-672-2755.

Gender Reassignment (Confirmation) Services means a collection of Medically Necessary drugs and services that are used to treat gender dysphoria, including hormone treatment, counseling and psychiatric services, excluding drugs or services Oscar considers to be Cosmetic or Experimental or Investigational.

Generic Drug or Generic Equivalent means a drug that has the same active ingredient as a Brand Name Drug and is allowed to be produced after the Brand Name Drug's patent has expired. In determining the brand or generic classification for Covered Drugs and corresponding Member Cost-Sharing Amount responsibility, Oscar utilizes the generic/brand status assigned by a nationally recognized Provider of drug product database information.

Grievance means a written complaint submitted by or on behalf of an enrollee regarding:

- An insurer's decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a covered person about a decision rendered solely on the basis that the Health Benefit Plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the certificate of coverage.
- Claims payment or handling; or reimbursement for services.
- The contractual relationship between a covered person and an insurer.
- The outcome of an appeal of a noncertification under this section

A benefit clearly excluded by us is not a valid Grievance.

Habilitative Services mean services that are:

- designed to assist a child to develop a physical, speech or mental function which has not developed normally or has been delayed significantly from the normal developmental time frame,
- are expected to result in significant and measurable therapeutic or developmental improvement over a clearly defined period of time, and
- are individualized, with documentation outlining quantifiable, measurable and attainable treatment goals
- professional, counseling, and guidance services and treatment programs, including Applied Behavior Analysis, that are necessary to develop the functioning of a Member

Health Care Provider means a licensed Hospital or health care facility, medical equipment supplier or person who is licensed, certified or otherwise regulated to provide Health Care Services under any applicable law, including a Physician, podiatrist, optometrist, psychologist, licensed clinical social worker, certified substance abuse counselor, certified fee-based practicing pastoral counselor, licensed marriage counselor, Physical Therapist, advance practice Nurse, certified Nurse practitioner, registered Nurse, Nurse midwife, Physician's assistant, chiropractor, dentist, pharmacist or an individual accredited or certified to provide Behavioral Health services. This includes Health Care Providers authorized by other states .

Health Care Service means services provided for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

Health Benefit Plan refers to all health insurance policies or contracts that are individually underwritten or provide such coverage for specific individuals and Members of their families, which provide for Hospital treatment. A Health Benefit

Plan shall also include any individually underwritten coverage issued by a health maintenance organization.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 and implementing regulations, as may be amended from time to time.

Home Health Agency means a business that provides Home Health Care and is licensed, approved, or certified by the appropriate agency of the state in which it is located or be certified by Medicare as a supplier of Home Health Care.

Home Health Care means the Health Care Services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients confined at home due to a Sickness or Injury requiring skilled health services on an intermittent, part-time basis.

Home Infusion Therapy means the Health Care Services for which benefits are provided under the Plan when such services are provided during a visit by a Home Health Agency to patients confined at home due to a Sickness or Injury requiring skilled health services on an intermittent, part-time basis.

Hospice Care Program refers to any of the following:

- a coordinated, interdisciplinary program used to meet the physical, Psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or Inpatient care during the Illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services refer to services provided by the following:

- a Hospital,
- a Skilled Nursing Facility or a similar Institution,
- a Home Health Agency and Visiting Nurse Associations
- a hospice facility, or
- any other licensed facility or agency under a Hospice Care Program.

Hospital means a facility that: is primarily engaged in providing medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; provides 24-hour nursing service by or under the supervision of a registered professional Nurse (R.N.); is duly licensed by the agency responsible for licensing such Hospitals; and is accredited by the Joint Commission, the American Osteopathic

Association, or similar nationally recognized Hospital facility accrediting body. Hospital does not mean health resorts, spas or infirmaries at schools or camps.

Identification Card means the card issued to You by Oscar indicating pertinent information applicable to Your coverage.

Independent laboratory means a Medicare certified laboratory that provides technical and professional anatomical and/or clinical laboratory services.

Indication means a medical reason to use a certain test, medication, procedure, or surgery (the opposite of Indication is contra-Indication). For a drug to be covered, it must be approved by the FDA for at least one Indication.

Infertility means the condition that an otherwise presumably healthy individual has, meaning he or she is unable to conceive or produce conception during a period of one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy

Infusion and Injectable Specialty Prescription Medications are medications ordered or prescribed by a Physician and administered under the supervision of a healthcare professional for rare and/or Chronic Conditions. For example, this type of medication includes but is not limited to hemophilia factor and supplies, enzyme replacements and Intravenous immunoglobulin. These specialty medications may require Prior Authorization.

Injury means an accidental bodily Injury.

Institution refers to an establishment that furnishes food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

In-Network means the benefits available under the Plan for services and supplies that are provided by a Network Provider, or an Out-of-Network Provider when acknowledged by Oscar.

Inpatient Services means care, including professional services, at a licensed Hospital, Skilled Nursing, or Rehabilitation facility, including preadmission testing, diagnostic testing related to an Inpatient stay, professional and nursing care, room and board, Durable Medical Equipment, ancillary services, drugs administered during an Inpatient

stay, meals and special diets, use of operating room, and use of intensive care and cardiac units.

Inquiry means a request for information from Members (or their Authorized Representatives). Where We are unable to distinguish between a Grievance and an Inquiry, it shall be considered a Grievance.

Intensive Care Unit means the part of a Hospital service specifically designed as an intensive care unit. It is permanently equipped and staffed to provide more extensive care for critically ill or injured patients than available in other Hospital rooms or wards, and includes close observation by trained and qualified personnel, whose duties are primarily confined to the aforementioned part of the Hospital.

Legal Custody means the legal right to make major decisions affecting the best interest of a minor including, but not limited to, medical, religious and educational decisions pursuant to applicable state law.

Legal Guardian or Legal Guardianship means the appointment of a guardian by a court of an incapacitated person pursuant to applicable state law.

Legend Drugs mean drugs, biologicals, or compounded prescriptions which are required by law to have a label stating "Caution - Federal Law Prohibits Dispensing Without a Prescription," and which are approved by the FDA for a particular use or purpose.

Licensed Professional means a licensed Physician specializing in the treatment of mental illness, a licensed psychologist, a licensed clinical social worker or a Licensed Professional counselor. Only prescription rights under this act shall apply to medical Physicians and doctors of osteopathy;

Limited Distribution Drugs (LDDs) are drugs with special requirements used to treat conditions which affect only a small percentage of the population. Because of this, the manufacturer may choose to limit the distribution of the drug to only a few pharmacies, or as recommended by the Food and Drug Administration (FDA) for the drug as a condition of its approval of the drug. This type of restricted distribution allows the manufacturer to:

- monitor the inventory of the drug;
- educate the dispensing pharmacists about the required necessary monitoring; and
- ensure that any associated risks are minimized.

Managed Care means the determination of availability of coverage under a Health Benefit Plan through the use of clinical standards to determine the Medical Necessity of an admission or treatment, and the level and type of treatment, and appropriate setting for treatment, with required authorization on a prospective, concurrent or retrospective basis, sometimes involving case management;

Maximum Age means the point in time which a Dependent is no longer eligible for coverage, as described in the **WHO GETS BENEFITS** section of this Evidence of Coverage.

Maximum Out-of-Pocket means the annual maximum dollar amount that You must pay as Copayment, Deductible and Coinsurance for all Covered Services and supplies in a Calendar Year. Except as stated, all amounts paid as Copayment, Deductible and Coinsurance shall count toward the Maximum Out of Pocket.

Once the Maximum Out of Pocket has been reached, the Member has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Covered Services and supplies for the remainder of the Calendar Year. Once any combination of Member s in a family meet an amount equal to two times the individual Maximum Out of Pocket, no Member in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for Covered Services and supplies for the remainder of the Calendar Year.

Medical Director means the licensed Physician designated by Us to direct the medical and scientific aspects of Oscar and to monitor and oversee the quality and appropriateness of the managed health services.

Medical Necessity or **Medically Necessary** means those covered services or supplies that are:

- Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.
- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
- Within generally accepted standards of medical care in the community.
- Not solely for the convenience of the insured, the insured's family, or the provider.

For medically necessary services, nothing in this subsection precludes an insurer from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

Medical Surgical Expenses means the Allowed Amount for those charges incurred for the Medically Necessary items of service or supply listed below for the care of a Member, provided such items are: 1. Furnished by or at the direction or prescription of a Physician, Behavioral Health Practitioner or other professional Provider; and 2. Not included as an item of Inpatient Hospital expense or Extended Care Expense in the Plan.

Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medicare means the programs of health care for the aged and disabled established by Title XVIII of the United States Social Security Act of 1965, as may be amended from time to time.

Member (also referred to as "Enrollee") means an Eligible Person who is insured under this Plan. Throughout this Plan, Member is often referred to using "You" and "Your." It may mean different things, depending on who is covered under the plan. Please refer to the **WHO GETS BENEFITS** section. For purposes of the **HOW YOUR PLAN WORKS** section of this Evidence of Coverage, the term Member shall also include a person who is duly authorized to pursue a Grievance on the Member's behalf (the Member's Authorized Representative). The Member is the "patient" when receiving Covered Drugs or services

National Drug Code (NDC) means a national classification system for the identification of drugs.

Network Providers refer to providers who, under a contract with Us or with Our contractor or subcontractor, have agreed to provide health care services to covered persons in return for direct or indirect payment from Us, other than coinsurance, copayments, or deductibles

Newborn refers to an infant within 31 days of birth.

Non-Preferred Brand Name Drug means a Brand Name Drug which does not appear on the *Preferred Drug List* and is subject to the Non-Preferred Brand Name Drug Cost-

Sharing Amount. This *Preferred Drug List* is available by accessing Our website at www.hioscar.com or calling Member Services at 1-855-672-2755.

Nurse means a registered graduate professional Nurse (R.N.), a licensed practical Nurse (L.P.N.), or a licensed vocational Nurse (L.V.N.).

Office Visit means a visit by the Member to the office of a Provider during which one or more of only the following 3 specific services are provided:

- History (gathering of information on an Illness or Injury);
- Examination; or
- Medical Decision Making (the Physician's diagnosis and plan of treatment).

This does not include other services (e.g. x-rays or lab services) even if performed on the same day.

Out-of-Network Provider means a Hospital, Physician, Behavioral Health practitioner or other Provider who has not entered into an agreement with Oscar. Benefits are generally not available for services provided by Out-of-Network Providers.

Open Enrollment Period means those periods of time established by applicable regulators during which Eligible Persons may enroll.

Orthotic Device means custom-made rigid or semi-rigid supportive device used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body, or which limits or stops motion of a weak or diseased body part.

Oscar refers to Oscar Health Plan of North Carolina, Inc., a North Carolina corporation.

Out-of-Area Services are services available to Members living or traveling outside Our Service Area.

Out-of-Network means a services provided by an Out-of-Network Provider or goods received from an entity that has not entered into an agreement with Oscar.

Outpatient Services means Outpatient medical and surgical, emergency room and ancillary services including ambulatory surgery and all ancillary services pursuant to ambulatory surgery, Outpatient laboratory, radiology and diagnostic procedures, emergency room care that does not result in an admission within 24 hours of the

delivery of emergency room care, and other Outpatient services covered by Oscar, including professional services.

Outpatient Setting means a Physician's office, Outpatient facility, Member's home, Ambulatory Surgical Center, or a Hospital when a patient is not admitted for Inpatient services.

Participating Pharmacy means an independent retail Pharmacy, chain of retail Pharmacies, mail-order Pharmacy or Specialty Drug Pharmacy which has entered into a written agreement with Oscar to provide pharmaceutical services to Members under an Oscar Plan.

Patient Protection and Affordable Care Act of 2010 (PPACA) refers to the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Pharmacy means a state and federally licensed establishment where the practice of Pharmacy occurs, that is physically separate and apart from any Provider's office, and where Legend Drugs and devices are dispensed under Prescription Orders to the general public by a pharmacist licensed to dispense such drugs and devices under the laws of the state in which the pharmacist practices.

Physical and/or Occupational Therapy/Medicine means using therapeutic physical agents other than drugs. It uses physical, chemical and other properties of heat, light, water, electricity, massage, exercise, spinal manipulation and radiation.

Physician A doctor of medicine, osteopathy, podiatry, chiropractic or an oral surgeon, who is duly licensed in the state s/he is practicing in. This term may also include other types of professional Providers when they perform Covered Services within their scope of practice.

Plan refers to Your policy which provides coverage for specific Health Care Services or benefits. You are the Planholder. It refers to the document which describes the agreements between us and the Planholder, and is constituted of Your:

- Evidence of Coverage (this document)
- Schedule of Benefits
- Riders or Amendments (if applicable)

Planholder, also referred to as Covered Person, means a policyholder, subscriber, enrollee, or other individual covered by Us.

Plan Year refers to the Benefit Period for which Your plan is active. This may be the same as a Calendar Year. It can also refer to a different period of coverage.

Premium means the dollar amount You pay each month for Your health insurance or plan.

Primary Care Physician means a person licensed in the State of North Carolina, or another State, as applicable, as a doctor of medicine or osteopathy (or his designee) who has an agreement with Oscar to coordinate and provide initial and basic care to Members and who may initiate standing Referrals for Specialist care. The Provider List indicates the current Primary Care Physicians and is updated from time to time.

Preferred Brand Name Drug means a brand name prescription drug product that is identified on the *Preferred Drug List* and is subject to the Preferred Brand Name Drug Cost-Sharing Amount. This list is available by accessing Our website at www.hioscar.com or calling Member Services at 1-855-672-2755.

Prescription Order means a written or verbal order from an authorized Health Care Provider to a pharmacist for a drug or device to be dispensed. Orders written by an authorized Health Care Provider located outside the United States to be dispensed in the United States are not covered under an Oscar Plan.

Prior Authorization means the process by which Oscar determines the Medical Necessity of otherwise covered healthcare services prior to the rendering of such healthcare services including, but not limited to, preadmission review, pretreatment review, utilization management. For the purposes of this document, the term "Prior Authorization" is considered to be synonymous with "Prior Authorization" or "Prior Authorization."

Primary Payer means the health care coverage Plan that pays first when You are provided benefits by more than one carrier (for example Oscar and another commercial carrier).

Prosthetic Device means artificial devices including limbs or eyes, Braces or similar Prosthetic or orthopedic devices, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently

inoperative or malfunctioning body organ (excluding dental appliances and the replacement of cataract lenses). For purposes of this definition, a wig or hairpiece is not considered a Prosthetic Device.

Provider means a Health Care Provider.

Provider Directory means a published listing (as amended from time to time) provided to You by Us which sets forth the names, addresses and telephone numbers of current Network Providers who have contracted with Oscar to provide Covered Services. The current Provider List can be found on Our website at www.hioscar.com/search. You may also request a copy of the most current Provider Directory by calling the Member Services Team at the number on the back of Your Identification Card or by writing to the Member Services Team. We will provide You a paper copy of the Provider Directory, upon request, at no charge to You.

Provider Outside of the USA means any Institutional or professional Provider of medical or psychiatric treatment or care who practices in a country outside the United States of America.

Psychiatric Care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological Care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Qualified Health Plan means a health Plan that:

- has in effect a certification that such Plan meets the criteria as described in the Patient Protection and Affordable Care Act (PPACA) section 1311(c) issued or recognized by the Federally Facilitated Marketplace (FFM); and
- provides the Essential Health Benefits package described in PPACA section 1302(a); and
- is offered by Us which;
    - is licensed and in good standing to offer health insurance coverage in the state of North Carolina;
    - agrees to offer at least one plan in the silver level and at least one plan in the gold level in the FFM;
    - agrees to charge the same Premium rate for each QHP without regard to whether Oscar is offered through the FFM, directly by Us or through an agent of Oscar; and

- complies with the regulations developed by the Secretary of Health and Human Services under PPACA section 1311 (d) and such other requirements as the FFM or the Oscar Marketplace may establish.

Reconstructive Surgery for Craniofacial Abnormalities means surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Rehabilitation Services are Health Care Services that help a patient retain, get back, or improve skills and functioning for daily living that have been lost or impaired because of illness, Injury or disability

Referral refers to a process in which a Member's PCP sends the Member to another Provider for a specified service or treatment plan.

Resolved means that the Grievance has reached a final conclusion with respect to the Member's submitted Grievance, and there are no pending internal review levels within the plan's Grievance system, including entities with delegated authority.

Rider (also referred to as an Amendment) means an amendment to the Evidence of Coverage that modifies the benefits that are covered.

Schedule of Benefits is a Schedule of coverage for a Member that identifies the Subscriber, applicable Copayments, Coinsurance, Deductibles, Maximum Out-of-Pocket and Benefit Limits for Covered Services. A newly issued Schedule of Benefits replaces all prior Schedule of Benefits as of the Effective Date.

Secondary Plan refers to the health care Plan is the insurance that pays for Your medical Claims after Your primary health Plan has paid its portion of the medical Claim.

Service Area means the geographic area in North Carolina as described by Us pursuant to G.S. 58-67-10(c)(11) where We enroll persons who either work in the service area, reside in the service area, or work and reside in the service area, as approved by the Commissioner pursuant to G.S. 58-67-20.

Sickness means the Sickness or disease of a Member, which is diagnosed or treated after Your Effective Date and while Your Plan is in force.

Skilled Nursing Facility means a facility primarily engaged in providing Skilled Nursing services and other therapeutic services and which is:

- Operated in accordance with state law (where the state law provides for licensing of such facility); or
- Approved for payment of Medicare or Medicaid eligible as a supplier of skilled Inpatient nursing care, or qualified to receive such approval
- Primarily engaged in providing, in addition to room and board accommodations, Skilled Nursing care under the supervision of a duly licensed Physician
- Provides continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional Nurse (R.N.).
- Maintains a daily medical record of each patient.

A Skilled Nursing Facility is not:

- Any home, facility or part thereof used primarily for rest
- A home or facility for the aged or for the care or treatment of drug and alcohol abuse
- A home or facility primarily used for the care and treatment of mental disease or disorders or Custodial or educational care

Smoking Cessation Attempt refers to a Member attending 4 tobacco cessation counseling sessions per attempt of at least 10 minutes each (including telephone counseling, group counseling and individual counseling). It also includes one 90-day regimen per attempt of certain Food and Drug Administration (FDA)-approved tobacco cessation medications

Special Enrollment Period means a period of time that is 60 days following the date of a Triggering Event during which:

- individuals are permitted to enroll in a standard Health Benefit Plan or standard Health Benefits Plans; and
- individuals who already have coverage are allowed to replace current coverage with a different standard Health Benefit Plan or standard Health Benefits Plans.

Specialist means a Network Provider that focuses on a specific area of medicine or a group of patients to diagnose, manage or treat particular symptoms, conditions or diseases.

Specialty Drug means a high cost prescription drug that meets any of the following criteria:

- Is used in limited patient populations or Indications,
- Is typically self-injected,
- Has limited availability, requires special dispensing, or delivery and/or patient support is required and therefore, is difficult to obtain via traditional Pharmacy channels,

- Requires complex reimbursement procedures, and/or
- A considerable portion of the use and costs are frequently generated through office-based medical Claims.

Splint means an appliance which prevents joint movement, or is meant to fix displaced or movable parts.

Stabilize means to provide medical care that is appropriate to prevent a material deterioration of the person's condition, within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies, and regulations pertaining to responsibilities of hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C.S. § 1395dd), including medically necessary services and supplies to maintain stabilization until the person is transferred .

Step Therapy Protocol means an evidence based and updated protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are deemed medically appropriate for a particular patient, including self-administered and physician-administered drugs, and are covered by Us. We require Prior Authorization for certain Prescription drugs and Related Supplies, including Specialty Medications, that are subject to a Step Therapy Protocol. The Prescription drugs and Related Supplies that are subject to a Step Therapy Protocol can be identified on the Prescription drug List at www.hioscar.com.

Stem Cells are undifferentiated cells that are able to differentiate into specialized cell types.

Subscriber refers to You! You're an individual who meets the requirements for eligibility, who has enrolled in an Oscar Plan, and for whom payment has actually been received by Us. A Subscriber is also a Member.

Subscriber Application refers to the written request for enrollment and coverage under this Evidence of Coverage.

Substance Use Disorder means a disorder in which a person takes alcohol or other drugs (this includes tobacco) in amounts that can harm a person's physical, mental, social and economic well-being, cause a loss of self-control as reflected by thought,

mood, cognitive or behavioral alterations or endanger the safety or welfare of self or others because of the substance's habitual influence on the person.

Telemedicine means a health care service delivered by a Physician licensed in the State of North Carolina, or a health professional acting under the delegation and supervision of a Physician licensed in the State of North Carolina, and acting within the scope of the Physician's or health professional's license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology.

Terminal Illness means an illness due to which a person receives a prognosis of six months or less to live, as diagnosed by a Physician.

Therapeutic Care means services provided by licensed therapists.

Triggering Event means an event that results in an individual becoming eligible for a Special Enrollment Period. Please refer to the **WHO GETS BENEFITS** section to learn what Triggering Events result in a Special Enrollment Period.

Urgent Care means care for an illness, Injury or condition serious enough that a reasonable person would seek care right away to prevent long term harm, but not so severe that it requires emergency room care.

Urgent Services Request means a request for Prior Authorization or Appeal of a previous Adverse Determination for medical care or another service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

- Could seriously jeopardize the life, health, or safety of the Member or others due to the Member's Psychological state; or
- In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

Utilization Review ("UR") means a set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers, or facilities. These techniques may include:

- Ambulatory review. - Utilization review of services performed or provided in an outpatient setting.
- Case management. - A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.

- Certification. - A determination by an insurer or its designated URO that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies the insurer's requirements for medically necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness.
- Concurrent review. - Utilization review conducted during a patient's hospital stay or course of treatment.
- Discharge planning. - The formal process for determining, before discharge from a provider facility, the coordination and management of the care that a patient receives after discharge from a provider facility.
- Prospective review. - Utilization review conducted before an admission or a course of treatment including any required preauthorization or precertification.
- Retrospective review. - Utilization review of medically necessary services and supplies that is conducted after services have been provided to a patient, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review includes the review of claims for emergency services to determine whether the prudent layperson standard in G.S. 58-3-190 has been met.
- Second opinion. - An opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

Utilization Review Organization or "URO" means an entity that conducts utilization review under a managed care plan, but does not mean an insurer performing utilization review for its own Health Benefit Plan

We, Us, Our, and Ours refer to Oscar.

You and Your refers to the Planholder and/or any Dependents covered by this Evidence of Coverage.

HOW YOUR PLAN WORKS

Health Maintenance Organization (HMO) 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. Except in the case of Emergency Services and Care, a Member must obtain Covered Services and supplies from Oscar Network Providers to receive benefits under this Plan. Services and supplies obtained from Providers that are not Oscar Network Providers will generally not be covered.

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, and Oscar may assign each Member to a PCP at their discretion. This is an "open Referral" Plan. You do not need a Referral from a PCP to obtain treatment for covered benefits before receiving Specialist care (including OB-GYN care) from an In-Network Specialist.

You may choose a pediatrician for Your child's PCP.

Additionally, if You are diagnosed with a serious or chronic degenerative, disabling, or life-threatening disease or condition, You may select a Specialist with expertise in treating the disease or condition. This Specialist must be responsible for and capable of providing and coordinating Your primary and specialty care.

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. Contact Us at 1-855-672-2755 to request the necessary Prior Authorization for Out-of-Network services in this situation.

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. The list of Network Provider may change occasionally, so make sure the Providers You select are still Network Providers at the time of service. An updated directory will be available at least annually or You may access Our website at 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 – not You – 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 any Deductibles, Copayment Amounts, and Coinsurance Amounts as set forth in Your Schedule of Benefits. You may be required to pay for limited or non-Covered Services. No Claim forms are required. An In-Network Provider is not permitted to bill You for anything other than Copayment, Coinsurance and Deductible for Medically Necessary Covered Services.

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

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

When You visit an Out-of-Network Provider for pre-authorized services not available from Network Providers, or if You cannot reasonably reach a Network Provider for Emergency Care, We will:

- pay the Claim, at the usual, customary and reasonable rate for the service, less any patient Coinsurance, Copayment, or Deductible responsibility under the Oscar Plan;
- pay the Claim at the In-Network benefit cost-sharing level; and
- when issuing payment, provide You with an explanation of benefits

You will not be penalized or subject to the Out-of-Network benefit levels offered under this Policy, including if You have an extended or standing referral, unless In-Network Providers able to meet Your health needs are reasonably available to You without unreasonable delay.

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

Emergency Services and Care
If You are outside of Our Network, and immediately need Medically Necessary services, We will provide coverage, provided the following conditions are met:

- Your service meets the definition of an Emergency Medical Service
- You could not have reasonably forseen the condition for which You need these services;
- Your medical condition does not permit You to return to the Network for treatment; and
- You were outside of the Service Area for some purpose other than the receipt of treatment for a medically-related condition

Should these conditions be met, You may go to 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 the Member's medical condition permits travel or transport to a Network Provider. If You receive care and treatment for an Emergency 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.

Utilization Review Decisions and Procedures
You have a right to Utilization Review. For initial determinations, Oscar will make the determination within 3 business days of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. For purposes of this section, "necessary information" includes pertinent clinical information, 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 North Carolina standards, Oscar will adhere to the stricter of all relevant time frames.

Our Responsibilities

We will:

- Routinely assess the effectiveness and efficiency of Our Utilization Review program.
- Coordinate the Utilization Review program with Our other medical management activity, including quality assurance, credentialing, Provider contracting, data reporting, grievance procedures, processes for assessing satisfaction of Covered Persons, and risk management.
- Provide Covered persons and their Providers with access to Our review staff by a toll-free or collect call telephone number whenever any Provider is required to be available to provide services which may require prior certification to any plan enrollee. Every insurer shall establish standards for telephone accessibility and monitor telephone service as indicated by average speed of answer and call abandonment rate, on at least a month-by-month basis, to ensure that telephone service is adequate, and take corrective action when necessary.
- Limit its requests for information to only that information that is necessary to certify the admission, procedure or treatment, length of stay, and frequency and duration of Health Care Services.
- Have written procedures for making Utilization Review decisions and for notifying Covered Persons of those decisions.
- Have written procedures to address the failure or inability of a Provider or Covered Person to provide all necessary information for review. If a Provider or Covered Person fails to release necessary information in a timely manner, We may deny certification.

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. If You do not obtain prior authorization before an elective admission to a Hospital or certain other facilities, it

may result in a penalty.

Inpatient Prior Authorization reviews both the necessity for the admission and the need for continued stay in the Hospital. Outpatient Certification should only be requested for non-emergency procedures or services, and should be requested by You or Your Dependent at least three working days (Monday through Friday) prior to having the procedure performed or the service rendered.

Prior Authorization does not guarantee 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 will be reviewed post admission.

To obtain Prior Authorization or verify requirements for inpatient or outpatient services, including which other types of facility admissions require Prior Authorization, You or Your Provider can call Oscar at 1-855-672-2755.

We will limit information requests to that which is necessary to authorize the service in question.

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

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

We will render Our decision within 3 days of receipt of all necessary information as required by state law. Certifications will be communicated to providers, and noncertifications will be communicated to You and Your Provider.

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 1-855-672-2755.

The appeal process described in this section does not apply to noncertifications rendered solely basis that We do not provide benefits for the health care services performed or being requested, as outlined in this Evidence of Coverage. Please see procedures in this policy for filing a Grievance relating to the determination that the requested benefits are not covered.

Information Requests
When making Medically Necessary determinations for Inpatient and Outpatient Services (whether Prospective, Concurrent or Retrospective), Oscar obtains the relevant information from the member and/or the member's Provider that is necessary to determine whether or not the clinical needs of the member meet the established criteria for the requested service. Relevant information may include diagnoses, medical records, and other data obtained from the member's medical history and/or communications with the requesting Provider. Oscar collects only the information necessary to certify the admission, procedure or treatment, length of stay, frequency, and duration of services. Oscar takes into account an individual's unique circumstances, including age, comorbidities, complications, progress of treatment, psychosocial situation, home environment, and, when applicable, the local Provider Network and delivery system available to members with specific needs, e.g. for services rendered by skilled nursing facilities, subacute facilities, and home health agencies. Oscar reviews an individual member's request and supporting information taking into consideration his or her unique situation and provides specific guidance tailored to the member and any special circumstances. Authorizations are provided when the requested service is Medically Necessary and provided in the most efficient and cost effective manner without compromising quality of care.

Expedited Appeals
An Expedited Appeal of a noncertification may be requested You or Your provider acting on Your behalf only when an Expedited Appeal would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. Oscar may require documentation of the medical justification for the Expedited Appeal. Oscar shall, in consultation with a

medical doctor licensed to practice medicine in North Carolina, provide expedited review, and communicate the decision in writing to the Member and his or her provider as soon as possible, but not later than four days after receiving the information justifying expedited review. If the expedited review is a concurrent review determination, We will remain liable for the coverage of health care services until the covered person has been notified of the determination. Oscar is not required to provide an expedited review for retrospective noncertifications.

Non Expedited Appeals

Within three business days after receiving a request for a standard, non Expedited Appeal, We will provide You with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, non Expedited Appeals, We will give written notification of the decision, in clear terms, to You and Your provider within 30 days after We receive the request for an Appeal. If the decision is not in Your favor, the written decision shall contain:

- The professional qualifications and licensure of the person or persons reviewing the appeal.
- A statement of the reviewers' understanding of the reason for the covered person's appeal.
- The reviewers' decision in clear terms and the medical rationale in sufficient detail for the covered person to respond further to the insurer's position.
- A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria.
- A statement advising the covered person of the covered person's right to request an External Review and a description of the procedure for submitting an External Review.
- Notice of the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.

Each appeal shall be evaluated by a medical doctor licensed to practice medicine in this State who was not involved in the noncertification.

Concurrent Review

For concurrent review determinations, Oscar will make the determination within one working day of obtaining all necessary information:

- In the case of a determination to certify an extended stay or additional services, Oscar will notify by telephone or electronically the provider rendering the service within one working day of making the certification, and provide written or electronic confirmation to the You and the provider within one working day after telephone or electronic notification. The written notification will include the number of extended days or next

review date, the new total number of days or services approved, and the date of admission or initiation of services;
- In the case of an Adverse Determination, Oscar will notify by telephone or electronically the provider rendering the service within twenty-four hours of making the Adverse Determination, and provide written or electronic notification to You and the provider within one working day of a telephone or electronic notification. The service will be continued without liability to You until You have been notified of the determination.

We remain responsible for Health Care Services undtil You have been notified of the noncertification. We will notify You orally or in writing.

Emergency Situations
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.

Retrospective Review
If Prior Authorization was not performed, Oscar will use retrospective review to determine if a scheduled or outpatient service was Medically Necessary. In the event the services are determined to be Medically Necessary, benefits will be provided as described in this Plan. If it is determined that a service was not Medically Necessary, You may be responsible for payment of the charges for those services. For retrospective review determinations, Oscar will make the determination within thirty working days of receiving all necessary information. Oscar will provide notice in writing of Oscar's determination to a You within five working days of making the determination. Retrospective review includes Emergency claims and the prudent layperson standard. With respect to emergency admissions, Oscar will use retrospective review of emergency admissions to confirm that the services provided constitute emergency services as defined in this Policy.

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 the clinical review criteria used to make the determination. Oscar will provide the clinical rationale in writing for an Adverse Determination, including the clinical review criteria used to make that determination, to any party who received notice of the Adverse Determination and who requests such information. We do not provide Expedited Appeals for Retrospective Reviews.

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.

You may contact Us at any time with questions. You may also contact the Managed Care Patient Assistance Program (MCPAP) for additional assistance. The contact information for MCPAP is:

Managed Care Patient Assistance Program (MCPAP)
Consumer Protection Division, Office of Attorney General
PO Box 629
Raleigh, NC 27602
Phone: (919) 733-6272, (866) 867-6272 (toll free)
Fax: (919) 733-6272

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.

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 Colorado Division of Insurance.

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 will not be eligible for benefit consideration and 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.

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

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 60 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.

WHO GETS BENEFITS

You, the Subscriber to whom this Plan is issued, are covered under this Plan, subject to the applicable Premium payments. You must live or reside in Our Service Area to be covered under this Plan. If You are eligible for Medicare, You are not eligible to purchase this Plan. Members of Your family may also be covered depending on the type of coverage You selected.

Types of Coverage

We offer the following types of coverage:

- Individual. If You selected individual coverage, then You are covered.
- Individual and Spouse. If You selected individual and Spouse coverage, then You and Your Spouse are covered.
- Individual and Child(ren). If You selected individual and child(ren) coverage, then:
    - You and Your Dependent Child(ren), as described below, are covered;
    - Multiple children residing within the same residence who share a common Legal Guardian are covered; and
    - Child(ren) subject to a valid support order requiring health benefit coverage will be covered, whether or not there is an adult who will be provided coverage.
- Family. If You selected Family Coverage, then You, Your Spouse and Your Dependent Child(ren) are covered.
- Child-Only. If a child under 18 years of age needs coverage, then the child may enroll in his or her own Plan with a responsible party. A responsible party must be 18 years old or older and is not covered under the child's Plan. The responsible party is responsible for payment of Premium.
- Catastrophic. If You are under age 30 at the start of Plan Year or qualify based on a hardship exemption, and selected Catastrophic coverage, then You are covered.

Who Can Be Covered

- The Planholder – You, if You are an Eligible Person
- Your spouse, under an existing marriage legally recognized under the laws of the state of North Carolina
- Your Domestic Partner under the terms and conditions of this Certificate is eligible for enrollment
- If You selected individual and child(ren) or Family Coverage, Your child (married or unmarried) who has not yet attained the age of 26 is eligible for enrollment. Children covered under this Plan include:
    - Your natural Children
    - Legally adopted Children
    - Step Children

- Children awarded coverage pursuant to an administrative or court order. We will not require that such children reside with You, or that You claim them as dependent on federal income tax returns. Additionally, the enrollment period will be waived for such children.
- Foster Children who are placed by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction, and
- An adopted child, including a child who is placed with You for adoption, is automatically covered for 31 days from the date of the adopted child's placement for adoption or initiation of a suit of adoption. To continue coverage past that time You must enroll the child as an Insured Family Member by applying for his or her enrollment as a Dependent within 60 days of the date of adoption, and pay any additional Premium. Coverage for an adopted Dependent child enrolled within 60 days of adoption will be retroactive to the date of the child's placement for adoption or initiation of a suit of adoption.
- Your own, or Your spouse's Newborn children are automatically covered for the first 31 days of life. To continue coverage past that time You must enroll the child as an Insured Family Member by applying for his or her enrollment as a Dependent within 60 days of the date of birth, and pay any additional Premium. Oscar will allow You an additional 10 days from the date the forms and instructions are provided in which to enroll the newly born child. Coverage for a Newborn Dependent child enrolled within 60 days of birth will be retroactive to the date of the child's birth.

- Coverage lasts until the end of the Calendar Year in which the Child turns 26 years of age.
- Handicapped or Disabled Children - You may have a child with a mental or physical handicap, or developmental disability, who is incapable of earning a living. Subject to all of the terms of this section and the Plan, such a child may stay eligible for Dependent health benefits past this the age of 26, as long as the following are true:
  - The child will stay eligible as long as the child is and remains incapable of earning a living, and if:
    - the condition started before the child reached age 26;
    - the child became covered under this or any other Plan before the child reached age 26 and stayed continuously covered after reaching age 26; and
    - the child depends on You for most of his or her support and maintenance.
  - However, for the child to stay eligible, You must send Oscar and the Exchange written proof that the child is incapacitated or developmentally disabled and depends on You for most of his or her support and maintenance. You have 31 days from the date the child reaches the age of 26 to do this. We may ask for periodic proof that the child's condition continues, but after two years, We will not ask for proof more than once a year.

- Such child must be a full-time resident of the Service Area unless s/he is covered by a court order or qualified medical support order pursuant to the laws of the state of North Carolina.
- The child's coverage ends when Your coverage ends or, in the case of a child-only plan, when the responsible party directs Us to terminate coverage.
- We will extend coverage for a child enrolled in a post-secondary educational institution during a Medically Necessary leave of absence

Application to Enroll or Change Coverage

The Patient Protection and Affordable Care Act of 2010 (PPACA) specifies that an Eligible Person must enroll for coverage or change plans during the Annual Open Enrollment Period. If You fail to enroll or change plans during the Annual Open Enrollment Period, You must wait until the next Annual Open Enrollment Period to do so. However, if You experience a Triggering Event, which We describe below, You may receive a 60-day Special Enrollment Period during which You can enroll, add Dependents and change coverage.

The Annual Open Enrollment Period and Special Enrollment Period are explained below.

Annual Open Enrollment Period

The Annual Open Enrollment Period is a specified period of time each Calendar Year during which Eligible Persons can apply to enroll for coverage or change coverage from one plan to another.

You must submit a completed and signed application for coverage under this Plan for Yourself and any eligible Dependent(s), and We must receive that application during the Annual Open Enrollment Period in order for You to be enrolled in a Plan.

Your coverage under this Plan becomes effective upon the earliest day allowable under federal rules for that Calendar Year's Open Enrollment Period. If You don't apply to obtain or change coverage during the Annual Open Enrollment Period, You won't be able to apply again until the following Calendar Year's Annual Open Enrollment Period unless You qualify for a Special Enrollment Period.

Special Enrollment Periods

If You experience a Triggering Event, You may qualify for a Special Enrollment Period, during which You can enroll for coverage and enroll Your eligible Dependent(s), instead of waiting for the next Annual Open Enrollment Period.

Triggering Events for a Special Enrollment Period can be categorized into the following groups:

- Loss of qualifying health coverage;
- Change in household size;
- Change in primary place of living;
- Change in eligibility for Exchange coverage or help paying for coverage;
- Enrollment or plan error;
- Other qualifying changes.

Note that failure to pay premiums, or coverage that is lost on the basis of fraud or an intentional misrepresentation of material fact is never a triggering event.

"Loss of qualifying health coverage" includes:

- You or Your dependent has lost minimum essential coverage during or at the end of the coverage year, including but not limited to Medicaid, CHIP, qualifying employer sponsored coverage
- It is the end of the plan year for Your non-calendar Year employer-sponsored coverage;
- Your COBRA coverage has been exhausted;
- You are no longer eligible to be covered as a dependent due to reaching the limiting age;
- You or Your dependent loses employer-sponsored health plan coverage because of voluntary or involuntary termination of employment or a reduction in work hours, for reasons other than misconduct; or
- You, Your spouse or child loses coverage under an employer-sponsored health plan due to the employee's becoming entitled to Medicare, divorce or legal separation of the covered employee, or death of the covered employee.

"Change in household size" includes:

- You gain a dependent or become a dependent through marriage;
    - Note that one spouse must have had minimum essential coverage for one or more days in the 60 days prior to the marriage, unless that spouse was living in a foreign country or US territory, or is a member of a federally recognized tribe or a shareholder in an Alaska Native Corporation.
- You gain a dependent or become a dependent through birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order

"Change in primary place of living" includes:

- You or Your dependent gain access to new plans as a result of a permanent move.
    - Note that You or Your dependent must have had minimum essential coverage for one or more days in the 60 days prior to the marriage, unless You or Your

dependent were living in a foreign country or US territory, or is a member of a federally recognized tribe or a shareholder in an Alaska Native Corporation.
    - Moving solely for medical treatment or vacation are not valid Triggering Events.

"Change in eligibility for Exchange coverage or help paying for coverage" includes:

- You or Your dependent become newly eligible for Exchange coverage due to gaining status as a citizen, national, or lawfully present individual;
    - Note that changing from one legally present status to another is not a valid Triggering Event.
- You gain or maintain status as a member of a federally-recognized tribe or a shareholder in an Alaska Native Corporation;
    - This Triggering Event can only be used one time per month.
- You or Your dependent is released from incarceration;
- You or Your dependent are determined newly eligible or newly ineligible for advance payments of the premium tax credit (APTC) or has a change in eligibility for cost-sharing reductions (CSR);
- You were previously both (1) ineligible for APTC solely because of household income below 100 percent of the federal poverty level and (2) ineligible for Medicaid because You were living in a non-Medicaid expansion state, also known as being in the coverage gap, and then experience a change in household income or move to a new state, which results in You becoming newly eligible for APTC.

"Enrollment or plan error" includes:

- You or Your dependent's enrollment or non-enrollment in a Plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee or agent of the Exchange, or of the Department of Health and Human Services (HHS), its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities;
- You or Your dependent's enrollment or non-enrollment in a Plan or inaccurate eligibility determination is a result of a technical error;
- You or Your dependent adequately demonstrate to the Exchange or State Regulatory Agency, that the plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrolle;
- You or Your dependent applied for coverage through the Exchange either during the annual open enrollment period or due to a qualifying event or at the State Medicaid or CHIP agency during the annual open enrollment period, and are determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after Open Enrollment has ended or more than 60 days after the qualifying event.
- You or Your dependent adequately demonstrate to the Exchange that a material error related to plan benefits, service area, or premium influenced the enrollee's decision to purchase the plan through the Exchange.

"Other qualifying changes" includes:

- You or Your dependent are survivors of domestic abuse or spousal abandonment;
- At the option of the Exchanges, where a consumer resolves a data matching issue following the expiration of an inconsistency period or has an annual household income under 100 percent of the Federal poverty level and did not enroll in coverage while waiting for HHS to verify that he or she meets the citizenship, national, or immigration status.
- You or Your dependent's enrollment or non-enrollment in a plan is the result of an exceptional circumstance, as determined by the Secretary of HHS, including being incapacitated or experiencing a natural disaster.
- You or Your dependent's enrollment or non-enrollment in a plan is the result of an unforeseen event or a first-time requirement for Exchange enrollees.
- You or Your dependent's, enrollment or non-enrollment in a plan is the result of a significant life event resulting in lack of access to his or her application or account and the individual, enrollee, or dependent has experienced a change in situation or status that now requires that he or she obtain minimum essential coverage. This includes AmeriCorps servicemen and women who are starting or ending their service.

Triggering Events do not include loss of coverage due to failure to make Premium payments on a timely basis. This includes COBRA Premiums prior to the expiration of Your COBRA coverage and situations allowing for a rescission as specified under federal and state law.

Special Enrollment Periods begin on the date the Triggering Event occurs, and end on the 61st day afterwards. Note that for "Loss of qualifying health coverage" and "Change in primary place of living" categories of Triggering Event, You may also submit an application in the 60 days leading up to the event. Persons who enroll during a Special Enrollment Period will have their coverage Effective Dates determined as follows:

- In the case of birth, adoption, placement for adoption, placement in foster care, or a child support order or other court order, Your coverage is effective on the date the event;
- In the case of marriage, or in the case where You lose minimum essential coverage, coverage is effective on the first day of the following month.
- In the case where the application is submitted before the event, coverage is effective the first day of the month following the event.

In all other cases, the Effective Dates are as follows:

- For an application made between the first and the 15th day of any month, the Effective Date of coverage will be the first day of the following month;or

- For an application made between the 16th and the last day of the month, the Effective Date of coverage will be the first day of the second following month.

Specific Causes for Ineligibility
Unless described differently in the "Continuation" section, a Member **will become ineligible for coverage** under the Plan for the following reasons:

- If Premiums are not paid according to the due dates and grace periods as described in the **HOW THE PLAN WORKS** section.
- If a spouse is no longer married to the Member.
- For You and Your Dependents - when You no longer meet the requirements listed in the **WHO GETS BENEFITS** section.
- The date the Plan terminates.
- When a Member no longer lives in the Enrollment Area.

It is Your responsibility to notify Us immediately if any changes occur which may affect You or any of Your Dependents eligibility for benefits under this Plan.

Active Duty Military Service
We do not cover conditions which occur while a Member is participating in the military service. If You become an active duty Member of any branch of military service, You must notify Us. After receiving this notification, We will issue a pro-rata refund of unearned Premium.

Continuation
You have the right to continuation of Your insurance if Your eligibility under this Plan would terminate due to the Your death, divorce or if other Dependents would become ineligible due to age or no longer qualify as Dependents under this Plan, unless You have failed to pay the Premium. Your Coverage will continue provided that the Member exercising the continuation right notifies Oscar and pays the appropriate monthly Premium within 60 days following the date this Plan would otherwise terminate. If this is the case, coverage will continue without evidence of insurability.

TERMINATION

The initial term of this Evidence of Coverage commences on the Evidence of Coverage Effective Date and continues through the Benefit Period. This Evidence of Coverage shall automatically be renewed thereafter from year-to-year, unless sooner terminated by the Subscriber or Oscar as set forth below.

Termination by the Subscriber
The Subscriber may terminate this Evidence of Coverage by giving notice to the Exchange. Termination of the Evidence of Coverage by the Subscriber shall result in the individual rights to benefits and services awarded under this Evidence of Coverage to cease as of the Effective Date of termination, except as set forth in the "Continuation" provision.

Termination by Oscar
Oscar may terminate this Evidence of Coverage for the following reasons:

- Failure to Pay By the Subscriber
    - In the event You don't pay the full Premium amount due to Oscar, or fail to make any required Copayment, Deductible or Coinsurance amount on behalf of Yourself or any Dependent, coverage shall terminate for the Subscriber and all Dependents. Any Premiums that are owed to Oscar for previous coverage at the time of re-application to Oscar, or re-application to another Oscar insurance entity, may be required to be paid as a condition of acceptance in addition to payment of the binder payment for new coverage. Please refer to the "Grace Period" provision in the **GENERAL PROVISIONS** section to understand Your rights to a grace period.
- Fraud or Intentional Misrepresentation of a Material Fact
    - Fraud or an intentional misrepresentation of a material fact by any Member in an attempt to secure benefits or coverage shall be deemed to be fraud in the inducement of Your contractual relationship with Oscar and shall result in the termination of coverage for You subject to 31 days written notice by Us to the Subscriber. For termination of coverage with a retroactive effect, 31 days advance written notice will be provided to You. This decision may be Appealed through Our established Complaint procedure as set forth herein.
- Any Member who knowingly files an Application or other form containing any false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act. Such act shall constitute an intentional misrepresentation of a material fact, and is grounds for the termination of coverage subject to 31 days written notice by Us to the Subscriber. This decision may be Appealed through Our established Complaint procedure as set forth herein.
- Misuse of Member Identification Card

    - If any Member permits the use of his/her/their own or any other Member's Identification Card by any other person, or uses another Member's card, the card may be retained by any Network Provider or by Us. Misuse of Your Identification Card may constitute an intentional misrepresentation of a material fact, and is grounds for the termination of coverage subject to 31 days written notice by Us to the Subscriber. This decision may be Appealed through Our established Complaint procedure as set forth herein.
- Discontinuation by Us
    - In the event We stop offering the class of policies to which this Plan belongs, this Evidence of Coverage may be terminated by Us by giving written notice to the Subscriber at least 90 days before the coverage will be discontinued. If We stop offering all health insurance coverage in the individual market in the State of North Carolina, this Evidence of Coverage may be terminated by Us by giving written notice to the Subscriber at least 180 days before the coverage will be discontinued.
- Failure to Continue to Meet Eligibility Requirements
    - If a Member ceases to meet the eligibility requirements under this Evidence of Coverage, coverage shall terminate, however you may be eligible to re-enroll with a Qualifying Life Event..
- Residence Out of the Service Area
    - To be eligible to enroll and to continue enrollment in an Oscar Plan, Members must be full-time, permanent Residents of the Service Area. If Members spend fewer than 6 months at the address provided to Us, or provide an address that is an AirBnB, hotel, or similar, they will generally no longer be considered a permanent Resident of the Service Area and coverage shall be terminated upon 31 days written notice by Us to the Subscriber. We reserve the right to audit Your enrollment based on the address You provide.
- Failure of Adoption, Legal Guardianship or Legal Custodianship Proceedings
    - Any adoption, Legal Guardianship or Legal Custodianship that fails or is terminated will result in termination of coverage with respect to the child subject to 31 days written notice by Us to the Subscriber. This decision may be Appealed through Our established Complaint procedure as set forth herein.
- Divorce
    - Coverage under this Plan will end as of the date of the divorce.
- Abusive Conduct Towards Oscar
    - If You engage in extreme and abusive or threatening conduct towards a staff Member of Oscar, Your coverage may be terminated. We will provide you with one warning and, if the conduct occurs after the warning, We will provide You with 31 days advance written notice of the termination.

Reinstatement

If the Plan is terminated because You didn't pay Your Premium in the time allowed, We may agree to reinstate coverage under this Plan upon Your request and Our discretion. If We do reinstate the Plan, We will only provide benefits for an accidental Injury that occurs after the date of reinstatement, or an Illness which begins more than 10 days after the date of reinstatement. Aside from this, You and Oscar will have the same rights as existed right before the due date of the missed Premium. Additionally, this is subject to any amendments or endorsements attached to the reinstated Plan. All Premiums that We accept in connection with Your reinstatement will be applied to the period for which You haven't already paid premium. If You or Your Dependent(s) are deployed or called to Active Duty in the U.S. Military, and want to be reinstated upon Your return, We will provide You with the same benefits in effect before the Plan lapsed. We won't increase Your Premium unless rate increases are applicable to all Planholders.

Refunds after Termination
When a Member's coverage is terminated any periodic payments received on account of the terminated Member applicable to periods after the Effective Date of termination, less any amounts due to Oscar or Network Providers for coverage and/or Covered Services provided prior to the date of termination, shall be refunded or credited to the Subscriber. Neither Oscar nor Network Providers shall have any further liability under this Plan.

Health Status.
Members enrolled under this Evidence of Coverage will not have coverage terminated because of health status, or the need for Medically Necessary Covered Services.

Unpaid Premium.
Any unpaid Premium may be sent to collections for recovery.

Continuation
You have the right to continuation of Your insurance if Your eligibility under this Plan would terminate due to the Your divorce or if other Dependents would become ineligible due to age or no longer qualify as Dependents under this Plan, unless You have failed to pay the Premium. Your Coverage will continue provided that the Member exercising the continuation right notifies Oscar and pays the appropriate monthly Premium within 60 days following the date this Plan would otherwise terminate. If this is the case, coverage will continue without evidence of insurability. Please see the Special Enrollment Periods section under Who Gets Benefits for further detail.

ELIGIBLE EXPENSES, PAYMENT OBLIGATIONS AND BENEFITS

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.

NOTICE: Your actual expenses for covered services may exceed the stated Coinsurance percentage or Copayment amount because actual Provider charges may not be used to determine Our and Your payment obligations.

If We enter into a contract with a Health Care Provider for the rendering of Covered Services at a discounted rate of payment, and Your Deductibles and Copayments are based on a percentage of the fees for services rendered, the amount You pay will be computed based on the discounted rate of payment.

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:

- Cost-sharing for Out-of-Network services, except for Emergency Services;
- 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.

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 with respect to Newborn coverage, which is automatically provided under this Evidence of Coverage for the first 31 days.

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 North Carolina Department of Insurance.

Misrepresentation Regarding Tobacco Use
If a Member makes an intentional misrepresentation of a material fact regarding the use of tobacco on the Subscriber Application and is later found to be using tobacco, the misrepresentation may result in You being charged the rate applicable if the tobacco use had been disclosed at the beginning of the Evidence of Coverage Enrollment Date. We reserve the right to retroactively bill you for the difference in Premium. We will not terminate Your Plan for misrepresentation of tobacco use.

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.

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 are not subject to the Deductible, Copayment, or Coinsurance.

How a Covered Service may be obtained, Coverage Limits and Member's Cost Sharing obligations:
The following Sections sets forth how You may obtain a Covered Service from a Network Provider, when services from an Out-of-Network Provider are Covered Services, what Covered Services You're able to receive, where You can get Covered Services, and second opinion coverage.

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

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

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

- Emergency Services as set forth in this Evidence of Coverage;
- when You obtain Prior Authorization because Covered Services are not available from a Network Provider or cannot be provided within the Service Area; and/or
- for Covered Services under this Evidence of Coverage in accordance with the continuity of care provisions

Our Coverage of Covered Services

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

Out-of-Network Maternity care

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

Covered Service Location Cost Sharing

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

Second Opinion Coverage

Second Cancer Opinion. We cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.

Second Surgical Opinion. We cover a second surgical opinion by a qualified Physician on the need for surgery.

Required Second Surgical Opinion. We may require a second opinion before We preauthorize a surgical procedure. There is no cost to 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.

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
- 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.

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. Vary per state law.

Allergy Testing and Treatment
We cover allergy testing and treatment, including allergy shots and serum only when administered in an In-Network office visit setting.

Ambulance Services
We cover Ambulance services for emergency situations, to the nearest facility capable of handling the emergency. 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.

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.

Behavioral Health Treatment for Autism
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.

Chemotherapy and Chemotherapy Medications
We Cover chemotherapy for the treatment of a disease by chemical or biological antineoplastic agents. Refer to the Pharmacy Benefits section.

Clinical Trials
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, III or IV.

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
- Diabetic eye examinations. This does not include a refraction of the eye(s).
- 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 Memberwill 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.

- Routine foot care relating to Diabetes

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.

Dialysis

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

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 INN providers or facilities.

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 five years when obtained from a Network Provider or when approved in advance by Us.

Mastectomy prosthesis may be made more frequently. Replacements may be more frequent if You are under age 19 and replacements may be warranted by growth.

Orthotic devices for correction of positional plagiocephaly are limited to 1 device per lifetime.

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 admitted for the Emergency Medical Condition immediately following the visit, Prior Authorization of the Inpatient Hospital admission will be required, and Inpatient Hospital coverage will apply.

Notwithstanding anything in this Plan to the contrary, for Out-of-Network Emergency Care or Services rendered by Out-of-Network Providers, the Allowed
Amount shall be at least equal to the greatest of the following—not to exceed billed charges:

- the amount We have negotiated with Network Providers for the Emergency Service furnished (and if more than one amount is negotiated, the median of these amounts);
- the amount for the Emergency Service calculated using the same method the Plan generally uses to determine payments for out-of-network services; or
- the amount that would be paid under Medicare for the Emergency Service.

Each of these amounts is calculated excluding any applicable Copayment, Deductible or Coinsurance. 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 only those Emergency Services and supplies that are Medically Necessary and are performed to treat or Stabilize Your Emergency Medical Condition until You can be transported to the Service Area for treatment.

External 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

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

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 Anesthesia for Dental

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

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

Hearing Aids
We cover one hearing aid per hearing impaired ear, and replacement hearing aids for members under the age of 22, once every 36 months.

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.
- Cochlear implants when Medically Necessary. (see "Durable Medical Equipment" Section)

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 also cover services provided by a private-duty registered nurse rendered on an outpatient basis. 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.

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
- 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

Members must seek Prior Authorization from Oscar before obtaining services from (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.

Infertility
We cover the diagnosis, treatment, and correction of any underlying causes of Infertility. Benefits are limited to three medical ovulation induction cycles per lifetime per member. Certain prescription drugs related to treatment of infertility are covered as well. Infertility drugs are limited to benefit lifetime maximums per member.

The following procedures are not covered: artificial insemination, IVF, GIFT, ZIFT, services for procurement and storage of donor semen/eggs, and drugs for infertility treatment.

Infusion Therapy
We cover Infusion therapy services.

Mammograms, Cervical Cancer, and Ovarian Cancer Testing
We cover mammograms, including:

- One baseline mammogram for women age thirty-five to thirty-nine, inclusive;

- One mammogram for women age forty to forty-nine, inclusive, every two years or more frequently based on the recommendation of the patient's Physician
- One mammogram every year for women age fifty and over
- A mammogram for any woman, upon the recommendation of a Physician, where such woman, her mother or her sister has a prior history of breast cancer

Mammograms are also sometimes covered in accordance with Your preventive care services benefits.

We also cover screenings for cervical cancer, and surveillance tests for women age 25 and older at risk for ovarian cancer.

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, call Us at the number on the back of Your Oscar ID card.

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

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

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
Members are eligible for coverage of Maternity Care based on biological sex. Benefits for Eligible Expenses incurred for Maternity Care will be determined on the same basis as for any other Illness. Dependent children will be eligible for Maternity Care benefits.

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

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

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

Preauthorization is not required for the aforementioned minimum Inpatient stay after delivery. Routine care for Your newborn is also covered. All comprehensive benefits described in this Plan are available for maternity services. Should You, after consulting with Your Physician and mutually agreeing on a shorter Inpatient stay, terminate Your Inpatient stay earlier than 48 or 96 hours, Post-delivery care will be provided no later than 72 hours following discharge.. All care will be provided in accordance with accepted maternal and neonatal physical assessments, and performed by a registered nurse, physician, nurse practitioner, nurse midwife, or physician assistant experienced in maternal and child health in:

- The home, a provider's office, a hospital, a birthing center, an intermediate care facility, a federally qualified health center, a federally qualified rural health clinic, or a State health department maternity clinic; or
- Another setting determined appropriate under federal regulations promulgated under Title VI of Public Law 104-204.

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.

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 covered with Prior Authorization.

Medical or Accident Related Dental
We cover medical-related dental services received from a Provider or dentist. We also cover orthodontia related to cleft lip and palate. This section does not describe coverage for comprehensive dental procedures.

Comprehensive dental procedures are services rendered by a dentist, orthodontist, or similar professional to treat teeth, their supporting soft tissue and bony structure, or the alignment or occlusion of the teeth. These services are not covered under any section of this Plan.

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 Enteral Nutrition

We cover formulas and low protein modified food products prescribed by a Physician for a child until 6 years of age 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 nutitrional counseling.

Other Health Care Facilities – Inpatient Services

Subject to Prior Authorization, We cover the following Covered Services for Inpatient services and supplies provided by an Other 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 an Other Health Care Facility.
- The services must be consistent with the Illness, Injury, degree of disability and medical needs. Benefits areprovided 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, or excision of tumors. It also includes treatment for Temporomandibular Joint (TMJ) surgery. 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 covered or non-covered dental or oral surgery procedure are covered on an Inpatient or Outpatient basis, only if the Hospital or Ambulatory Surgical Center services are required for an existing medical condition unrelated to the dental or oral surgical procedure. 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 medically necessary dental services including diagnostic services, preventive services, restorative services, adjunctive services, implants, and orthodontics, 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 "Dental - Child Dental Services" 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 are not covered, unless otherwise described in this Certificate. 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 the "Covered Services" section. 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, Medically Necessary Orthodontics and emergency treatment all subject to annual limitations. Each is subject to a different cost-share as noted in the Schedule of Benefits.

Diagnostic and Preventive	**Limitations**
Exams	One (1) per six (6) months
Bitewing x-rays	Two (2) per calendar year

Full mouth x-rays	1 every 36 mo
Cleanings	One (1) per six (6) months
Fluoride	One (1) per six (6) months
Space maintainers	As a result of prematurely lost deciduous first and second molars, or permanent first molars that have not, or will never develop, one (1) every thirty-six (36) months
Sealants	One (1) every 36 month on permanent first and second molars
Palliative	No limit

Routine/Basic Services	Limitations
Amalgams (resin and composites)	One (1) per surface per tooth every thirty-six (36) months
Pre-fab crowns, sedative fillings	One (1) per surface per tooth every thirty-six (36) months
Non-Surgical Periodontia (Deep cleanings, Perio maintenance, Full mouth debridement)	One (1) per site/quadrant in every thirty-six (36) month period
Simple Oral Extractions	

Major Services	**Limitations**
Inlays, Onlays, Crowns, Pin retention	One (1) per surface per tooth every forty (40) months
Endodontics	See below
Surgical Periodontics	One (1) every twenty-four (24) mo per area of the mouth
Major Oral Surgery	Subject to Prior Authorization
General Anethesia/ IV Sedation (in conjunction with oral surgery)	Subject to Prior Authorization
Removable Prosthodontia (Complete, Immediate, Removable and Partial Dentures)	One (1) every sixty (60) months

Implants (includes both primary and permanent teeth)	One (1) per tooth every sixty (60) months

Medically Necessary Ortho	**Limitations**
Comprehensive Orthodontic services	One (1) per lifetime

Endodontics

We Cover root canals, apexification/recalcification, apicoectomy, and hemisection, including procedures for treatment of diseased pulp chambers, pulp canals, and therapeutic pulpotomy, where Hospitalization is not required. Pulpotomy included with cost of root canal if root canal was complete within forty-five (45) days of pulpotomy

Service	**Limitation**
Therapeutic pulpotomy (excluding final restoration)	One (1) per primary tooth
Pulpal debridement, partial pulpotomy and pulpal therapy	One (1) per tooth
Root canal and internal root repair	
Root canal therapy	Initial treatment is covered once (1) per tooth per lifetime Retreatment is limited to once (1) after twelve (12) months of initial treatment

Prosthodontics

Benefits include the following:

1. Fixed bridges – Bridges made of cast, porcelain baked with metal, or plastic processed to gold are covered as follows:
    a. A fixed bridge is covered when it is necessary to replace a missing permanent anterior (front) tooth and the patient's oral health and general dental condition permits
    b. Fixed bridges are covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered an Optional Treatment
    c. Fixed bridges used to replace missing posterior teeth are considered Optional Treatment when the abutment teeth are sound and would be crowned only for the purpose of supporting a pontic
    d. Fixed bridges are considered Optional Treatment when provided in connection with a partial denture on the same arch

e. Replacement of a fixed bridge is covered only if the existing bridge cannot be made satisfactory by repair

2. Fixed partial denture repair
3. Recementation of bridges
4. Unspecified fixed prosthodontic procedure, by report
5. Dentures (Including full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers and prosthetics.) Dentures are covered as follows:

Service	**Limitation**
Complete and partial dentures	One (1) per arch every five (5) Year period
Immediate dentures	One (1) per arch per patient.
Adjustments	Two (2) per arch every twelve (12) months, one (1) per arch per date of service per provider
Replacement of missing or broken teeth	four (4) per arch per provider, limited to twice (2) every twelve (12) months per provider
Repairs for resin denture base, and cast framework limited	Two (2) per arch per provider every twelve (12) months, limited to one (1) per arch per date of service per provider
Repair or replace broken clasp	Three (3) per arch per provider every twelve (12) months, limited to one (1) per arch per date of service per provider
Replace broken teeth	Four (4) per arch per provider every twelve (12) months, limited to one (1) per arch per date of service per provider
Add tooth	Three (3) per arch per date of service per provider, one (1) per tooth
Add clasp to existing partial denture	Three (3) per date of service per provider, twice (2) per arch per provider every twelve (12) months
Complete or Partial denture Relines	One (1) every twelve (12) months, covered six (6) months after initial placement of appliance if extractions were required, twelve (12) months after initial placement of appliance if extractions were not required
Tissue conditioning	Two (2) per arch every thirty-six (36) months
Complete overdenture	One (1) per arch every five (5) Year period

Medically Necessary Orthodontia Coverage
The determination of Medical Necessity will be made by the Provider in accordance with guidelines established by the Plan. When there is a conflict of opinion on whether or not a service or procedure is Medically Necessary between the Provider and the Plan, the opinion of the Plan will be final.

Orthodontia procedures will only be approved for:

- Dentofacial abnormalities that severely compromise the Member's physical health; or
- A serious handicapping malocclusion.
    - Presence of a serious handicapping malocclusion is determined by the magnitude of the following variables:
        - Degree of malalignment;
        - Missing teeth;
        - Angle classification;
        - Overjet and overbite;
        - Open bite and crossbite.

Orthodontic needs must meet medically 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

- Any procedures not covered under this Policy or Rider.
- Provided to Members by a Non-Participating Provider except when immediate dental treatment is required as a result of a Dental Emergency occurring more than 50 miles from the Member's home.

- Dental procedures or services performed solely for Cosmetic purposes or that is not Dentally Necessary and/or medically necessary.
- 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.
- For elective procedures, including prophylactic extraction of third molars.
- Replacement of Dentures, Crowns, appliances or Bridgework that have been lost, stolen or damaged.
- Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a Covered Service in this Rider. Any services related to pathology laboratory fees.
- 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.
- Treatment required due to an accident from an external force or are intentionally self-inflicted, unless otherwise listed as Covered Service.
- Services that restore tooth structure due to attrition, erosion or abrasion are not covered.
- The following are not included as Orthodontic benefits:
    - Repair or replacement of lost or broken appliances;
    - Retreatment of Orthodontic cases;
    - 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;
    - Treatment related to temporomandibular joint disorders, unless specifically covered as medically necessary orthodontia;
    - 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.
- Broken appointments.
- For Prescription or nonprescription drugs, home care items, vitamins or dietary supplements.

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

LIBERTY Dental Plan
PO BOX 26110
Santa Ana, CA 92799

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

Physician Services

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

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

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. This does not apply if You are an Inpatient in a psychiatric unit or in a mental Hospital, because Inpatient psychiatric unit and Behavioral Health services by licensed psychiatrist, clinical psychologist or other licensed Behavioral Health professional are not covered under this Plan.

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, Prostate-specific antigen (PSA) test, colonoscopy and colorectal cancer screening.
- 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 North Carolina.
- 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.

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.

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 to correct a medically diagnosed congenital defect or birth abnormality

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 includes certain medications and testing or diagnosis covered under the medical benefit

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 beyond the period necessary for evaluation and diagnosis of learning disabilities or for intellectual disabilities;
- Services for educational purposes;
- Services for marriage counseling unless related to a Mental and Nervous Disorder as defined in this Contract, regardless of the underlying cause, or effect, of the disorder;
- Services for pre-marital counseling;
- Services for court-ordered care or testing, or required as a condition of parole or probation;
- Services to test aptitude, ability, intelligence or interest;
- Services required to maintain employment;
- 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.

Services for Rehabilitative and Habilitative Therapy (Physical/Manipulation Therapy, Occupational Therapy, Speech Therapy, and Cardiac/Pulmonary Therapy)
We cover the following Rehabilitative services:

- Therapeutic use of heat, cold, exercise, electricity or ultraviolet light; or
- Manipulation of the spine; or
- Massage to improve circulation, strengthen muscles, encourage return on range of motion, as part of treatment for an Illness or Injury; and
- Services for the necessary care and treatment of loss or impairment of speech;
- Cardiac and pulmonary therapy

These benefits are covered up to the maximum visit limit as shown on the Schedule of Benefits. "Visit" means any Outpatient visit to a Physician during which one or more of the therapies listed above are provided.

We cover supplies and additional fees charged in conjunction with Rehabilitative and Habilitative Services as a part of payment for the visit. Maximums for Short-term Rehabilitative Services shown in the Schedule of Benefits do not apply to services for treatment of Autism Spectrum Disorders.

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

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), 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 cover bariatric surgery when Medically Necessary and for the surgical treatment of morbid obesity.

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.

Visits 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 pre authorizing 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 US
This Plan provides benefits for services and supplies received from Providers Outside of the US for Medical Emergencies and other urgent situations where treatment could not have been reasonably delayed until the Member was able to return to the United States.

Oscar does not accept assignment of benefits from Providers Outside of the US. You and Your Family Member can file a Claim with Oscar for services and supplies from a Provider Outside of the USA but any payment will be sent to the Member. The Member is responsible for paying the Provider Outside of the USA. The Member at their expense is responsible for obtaining an English language translation of Provider Outside of the USA Claims and any medical records that may be required. Benefits are subject to all terms, conditions, limitations, penalties, 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
Benefits for Eligible Expenses for Urgent Care will be determined as shown on Your Schedule of Benefits. A Copayment Amount, in the amount indicated on Your Schedule of Benefits, will be required for each Urgent Care visit. Urgent Care means the delivery of medical care in a facility dedicated to the delivery of scheduled or unscheduled, walk-in care outside of a Hospital emergency room/treatment room department or Physician's office.

If You need Urgent Care Services while you are out of the Service Area, You will be responsible for the difference between the Out-of-Network Provider's charge and the Allowed Amount. You will also be responsible for the In-Network Coinsurance, Copayment or Deductible for these Urgent Care Services. If the Provider is within Our Network, but outside of Your Plan's Service Area, We will cover Urgent Care Services as In-Network. When You're in Your Plan's Service Area, you need to use In-Network Providers to obtain Covered Services at the lowest cost to You.

Vision Services
Vision services are covered, subject to the **EXCLUSIONS** section, as follows:

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.

Prescription Eyewear
We cover one pair of eye glasses (lenses and frames) and contact lenses for children under age 19. Such eye glasses 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.

Prescription Eyewear Vendor
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.

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 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. Services obtained from an Out-of-Network Provider, unless for Emergency Services
2. Any amounts above the maximums stated in this Plan.
3. Services not listed as Covered Services in this Plan.
4. Acupuncture
5. 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.
6. Services or supplies that are not Medically Necessary.
7. 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.
8. Services received before the Effective Date of coverage under this Plan.
9. Services received after coverage under this Plan ends.
10. 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.
11. 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, even if the Member does not Claim those benefits.
12. 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;
13. 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;
14. 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;
15. Expenses related to repatriation and medical evacuation from outside the United States
16. Any services provided by a local, state or federal government agency, unless payment under this Plan is required by federal or state law.
17. Any services required by state or federal law to be supplied by a public school system or school district.
18. 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.

19. 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.
20. Unless required by a Provider, and a Covered Service under this Plan, Court-ordered treatment or Hospitalization is not covered
21. 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.
22. Services that are not for an Emergency Medical Condition provided in a Hospital emergency room
23. Custodial Care.
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. Self-directed Services to a free-standing or Hospital based diagnostic facility.
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-implantations 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 Grievances regarding one's appearance. This does not apply to Reconstructive Surgery needed to restore a bodily function or correct a deformity caused by Injury or congenital defect
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. All services related to the evaluation or treatment of fertility and/or Infertility, except those listed in the **COVERED SERVICES** section.. This includes but is not limited to, tests, consultations, examinations, medications, invasive, medical, laboratory or surgical procedures including elective sterilization reversals and In vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT).
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 "Services for Rehabilitative Therapy (Physical/Manipulation Therapy, Occupational Therapy and Speech Therapy" section.
58. All charges for Providers Outside of the US are excluded under this Plan except as specifically stated in the "Treatment Received from Providers Outside of the US" section.
59. Routine foot care including cutting or removal of corns or calluses, nail trimming, routine hygienic care, or any service rendered for cosmetic or palliative reasons
60. 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.
61. Services of a standby Physician.
62. Animal to human organ transplants.
63. Claims We receive 15 months after the date service was rendered, except in the

event of a legal incapacity.

64. Charges for surrogate mother
65. Home delivery of childbirth
66. Customization of vehicles, vehicle lifts for wheelchairs and/or scooters, modifications of the Member's home (e.g. ramp installation)
67. Coma stimulation,
68. Compulsive gambling treatment,
69. Any federal, state or local taxes due on benefits, goods or services, shipping and handling charges, services required while incarcerated
70. 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.
71. Fees for no shows and late cancellation. We do not cover fees Your Provider charges for no shows or late cancellations of appointments.
72. Abortions that do not meet the coverage critier described in the **COVERED SERVICES** section of this Certificate.
73. Reversal of any sterilation procedures.

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 do you get it).

To request coverage for a medication not listed on the Oscar Formulary, you or your health care provider can submit a request (see 'What if I 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 will 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.

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.

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.

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.

Injectable Drugs
We cover appropriate injectable drugs.

Your Oscar plan covers medically necessary injectable drugs. Injectable drugs are pharmaceuticals administered by 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 – Preferred Drug List
If your doctor is directly administering a medication, we prefer she uses certain ones first.

Your Oscar plan covers medically necessary medications supplied and administered directly by a physician. These medications are commonly referred to as 'Physician Administered Medications' and are applied towards the medical benefit portion of your Oscar plan.

Oscar designates a subset of these Physician Administered Medications as preferred medications. The designation is developed using guidelines from the American Medical Association, Academy of Managed Care Pharmacies, and other clinical organizations, describing clinical outcomes, efficacy, and side-effects. The list of preferred medications is 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 you Get it' for additional Information).

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.

Contraceptives
We cover Oral Contraceptives.

Your Oscar plan covers contraceptives as part of Family Planning services, see our formulary for a list of covered oral contraceptives. If you do not see your medication listed see our 'What if I Disagree' section.

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.

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 - also known as a vacation override. A vacation override may not exceed members' eligibility expiration with Oscar.

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

Early refills of medications are allowed when a state of disaster and emergency is declared.

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.

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 a coupon exceeds the cost of a medication.

Drug Manufacturers may offer coupons, rebates or other drug discounts 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, or other drug discounts 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.

Some coupons will not count towards Your Out-of-Pocket Maximum or Deductible
Some specialty medications may qualify for third party Copayment assistance programs which could lower Your out of pocket costs for those products, subject to Our prior approval. For any such specialty medication where third party Copayment assistance is used, You shall not receive credit toward their Maximum Out-of-Pocket or Deductible for any Copayment or Coinsurance amounts that are applied to 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 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. 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 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 "When you disagree').

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.

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. An 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. Typically, medications received under the Medical Benefit are administered by a physician and a list of these medications and the benefit they are designated to are available on our website. 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 do I get it). 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 APPEALS** 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.

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 through Our Member Appeal procedures.

The **COMPLAINTS AND APPEALS** 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 and fluoride preparations.
- 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 sexual dysfunction, including, but not limited to: sildenafil citrate (Viagra), phentolamine (Regitine), alprostadil (Prostin, Edex, Caverject), and apomorphine in oral and topical form. These drugs are covered if prescribed to treat a medically necessary indication other than sexual dysfunction.
- Your Oscar plan does not cover 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 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.
- 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, 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 drugs or supplies that have been lost, stolen, or destroyed.
- Your Oscar plan does not cover prescriptions written as a result of 'self-prescribing' or prescriptions filled at a pharmacy owned by you or an immediate family member.
- 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 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.

GRIEVANCES

Grievances
If You have a concern regarding a person, a service, the quality of care, contractual benefits, an initial eligibility denial, or a rescission of coverage, You can call 1-855-672-2755 and explain Your concern to one of our Member Services representatives. We will do our best to resolve the matter on Your initial contact. If We need more time to review or investigate Your concern, We will get back to Your as soon as possible, but in any case within 30 days.

If You are not satisfied with the review and our response, You, Your health care provider or Your authorized representative acting upon Your behalf, may file a Grievance. You also may file a Grievance without first requesting a review. Filing a Grievance is voluntary. A Grievance is a written Grievance about: the availability, delivery or quality of Health Care Services, including a Grievance regarding an Adverse Determination made pursuant to utilization review; claims payment, handling or reimbursement for health care services; or matters pertaining to the contractual relationship between You and Oscar. We will not charge You anything to file a Grievance. You may file a Grievance within 180 days of receipt of the initial Adverse Determination.

The North Carolina Department of Insurance is available to assist insurance consumers with insurance related problems and questions. You may inquire in writing to the Department at 1201 Mail Service Center, Raleigh, NC, 27699 or by telephone at 1-800-546-5664.

Grievance Procedure - Expedited Review
If Your Grievance concerns a decision or action by us that could significantly increase the risk to Your life, health, or ability to regain maximum function, please call 1-855-672-2755 to file an expedited grievance. We will notify You orally of the determination within 72 hours after receipt of the expedited review request. We will then send written confirmation to You within three working days.

You may request an expedited review of the first level or second level of Grievance review. You may request an expedited review of the second level of Grievance review whether or not Your initial review was expedited. Expedited reviews will meet all requirements of non-expedited reviews.

When You are eligible for an expedited second-level review, We will conduct the review proceeding and communicate its decision within four days after receiving all necessary information. The review meeting may take place by way of a telephone conference call or through the exchange of written information.

Grievance Procedure - First Level
A standard Grievance should be submitted to us by You or Your authorized representative either by phone at 1-855-672-2755 or in writing at:

Oscar Health Plan of North Carolina, Inc.
P.O. Box 52146
Phoenix, AZ 85072-2146

Upon filing Your Grievance, please include any records or other information You believe supports Your Grievance. We will carefully consider Your issue. We will not charge You anything to file a Grievance, and filing a Grievance will not affect Your benefits. You may submit written material for this first level of review. We will provide You with the name, address, and telephone number of the Grievance coordinator, and instructions for submitting written material, within three business days of receipt of Your Grievance. You may not attend the first level of review.

Then, We will conduct a complete investigation of the Grievance. We will issue a written decision to You and Your Provider within 30 days of the receipt of the Grievance. The persons reviewing the Grievance will not be the same as those who initially handled the matter, and at least one medical doctor with appropriate expertise will be involved, should the matter be one of a clinical nature.

For a first level Grievance review concerning quality of clinical care, We will acknowledge Your Grievance within 10 business days. Our acknowledgment will inform You that we will refer Your Grievance to Our quality assurance committee for review and consideration. We will also inform You that North Carolina State Law does not allow second level Grievance review for grievances concerning quality of clinical care.

Grievance Procedure - Second Level
If You remain dissatisfied with the response to the first level Grievance, You or Your Provider acting on Your behalf may submit any additional information, including written comments, records or documents that You want us to consider along with Your

letter requesting Second Level Review of Your Grievance, addressed to us at the address below.

Oscar Health Plan of North Carolina, Inc.
P.O. Box 52146
Phoenix, AZ 85072-2146

You may also submit these documents via fax at 844-965-9053.

Within 10 days of Our receipt of Your request for a second level review, We will provide You with information on the Grievance process and Your rights. We will also send You the name, address, and telephone number of the Grievance review coordinator, once determined. You have the right to present Your case to the review panel, and You may submit supporting material prior to and at the meeting. You also have the right to ask questions of any member of the panel, and the right to be assisted or represented by a person of Your choosing, such as a family member, employer representative, or attorney.

The Grievance will be reviewed by the review panel. The review panel will schedule a review meeting within 45 days after receiving Your request for a second level review. We will notify You of the date of the review meeting in writing at least 15 days before the review meeting date. Your right to a full review will not be conditioned on Your attendance of the review meeting.

Our decision will be issued in writing to You and Your Provider within 7 business days after the review meeting. Our decision will include the professional qualifications and licensure of the review panel members, a statement of the review panel's understanding of Your Grievance, the review panel's recommendation to Us and rationale behind such decision, and a description of the evidence that was considered. We'll also include any clinical rational in a review of a clinical matter.

If Our decision differes from the review panel's, We will tell You why. However, this decision is Our final determination in this matter. You may contact the Commissioner's office or Health Insurance Smart NC for additional assistance. Please see below for contact information:

BY MAIL:
North Carolina Department of Insurance
Health Insurance Smart NC

1201 Mail Service Center
Raleigh, NC 27699-1201
Toll Free Telephone: (855) 408-1212
www.ncdoi.com/smart

IN PERSON:
For the physical address for Health Insurance Smart NC, please visit the web-page:
http://www.ncdoi.com/smart
Toll Free Telephone: (855) 408-1212

At any time, You can request free copies of all records and other information We have relevant to Your written Grievance, including the name of any healthcare professional We consulted. To obtain copies, send a written request to the address given above. When We receive Your Request for Second Level Review of Your Grievance, We will carefully consider any new information We receive, as well as all other information We have about Your claim.

External Review
North Carolina law provides for review of noncertification decisions by an external, Independent Review Organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review Your case once the NCDOI establishes that Your request is complete and eligible for review. You or someone You have authorized to represent You may request an external review. Oscar will notify You in writing of Your right to request an external review each time You:

- receive a noncertification decision, or
- receive an appeal decision upholding a noncertification decision

In order for Your request to be eligible for external review, the NCDOI must determine the following:

- that Your request is about a medical necessity determination that resulted in a noncertification decision;
- that You had coverage with Oscar in effect when the noncertification decision was issued;
- that the service for which the noncertification was issued appears to be a covered service under Your policy; and
- that You have exhausted Our internal review process as described below.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

For a standard external review, You will be considered to have exhausted the internal review process if You have:

- completed Oscar's appeal process and received a written determination on the appeal from Oscar, or
- filed an appeal and except to the extent that You have requested or agreed to a delay, have not received Oscar's written decision on appeal within 60 days of the date You can demonstrate that You submitted the request, or
- received notification that Oscar has agreed to waive the requirement to exhaust the internal appeal process.

If Your request for a standard external review is related to a retrospective noncertification (a noncertification which occurs after You have received the services in question), You will not be eligible to request a standard review until You have completed Our internal review process and received a written final determination from Oscar.

If You wish to request a standard external review, You (or Your representative) must make this request to NCDOI within 120 days of receiving Our written notice of final determination that the services in question are not approved. When processing Your request for external review, the NCDOI will require You to provide the NCDOI with a written, signed authorization for the release of any of Your medical records that may need to be reviewed for the purpose of reaching a decision on the external review. Within 10 business days of receipt of Your request for a standard external review, the NCDOI will notify You and Your provider of whether Your request is complete and whether it is accepted. If the NCDOI notifies You that Your request is incomplete, You must provide all requested additional information to the NCDOI within 150 days of the date of Our written notice of final determination. If the NCDOI accepts Your request, the acceptance notice will include:

- the name and contact information for the Independent Review Organization (IRO) assigned to Your case;
- a copy of the information about Your case that Oscar has provided to the NCDOI;
- notice that Oscar will provide You or Your authorized representative with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO); and

- notification that You may submit additional written information and supporting documentation relevant to the initial noncertification to the assigned IRO within 7 after receipt of the notice of acceptance.

If You choose to provide any additional information to the IRO, You must also provide that same information to Oscar at the same time using the same means of communication (e.g., You must fax the information to Oscar if You faxed it to the IRO). When faxing information to Oscar, send it to 1-855-672-2755. If You choose to mail Your information, send it to:

Oscar Health Plan of North Carolina, Inc.
P.O. Box 52146
Phoenix, AZ 85072-2146

Please note that You may also provide this additional information to the NCDOI within the 7-day deadline rather than sending it directly to the IRO and Oscar. The NCDOI will forward this information to the IRO and Oscar within two business days of receiving Your additional information.

The IRO will send You written notice of its determination within 45 days of the date the NCDOI received Your standard external review request. If the IRO's decision is to reverse the noncertification, Oscar will, reverse the noncertification decision within 3 business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the noncertification decision. If You are no longer covered by Oscar at the time Oscar receives notice of the IRO's decision to reverse the noncertification, Oscar will only provide coverage for those services or supplies You actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

An expedited external review of a noncertification decision may be available if You have a medical condition where the time required to complete either an expedited internal appeal or second level grievance review or a standard external review would reasonably be expected to seriously jeopardize Your life or health or would jeopardize Your ability to regain maximum function. If You meet this requirement, You may make a written request to the NCDOI for an expedited review after You:

- receive a noncertification decision from Us AND file a request with Oscar for an Expedited Appeal, or
- receive an appeal decision upholding a noncertification decision.

You may also make a request for an expedited external review if You receive an adverse first level appeal decision concerning a noncertification of an admission, availability of care, continued stay or emergency care, but have not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOI will review Your request and determine whether it qualifies for expedited review. You and Your provider will be notified within 2 days if Your request is accepted for expedited external review. If Your request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if Oscar's internal review process was already completed, or (2) require the completion of Oscar's internal review process before You may make another request for an external review with the NCDOI. An expedited external review is not available for retrospective noncertifications.

The IRO will communicate its decision to You within 3 days days of the date the NCDOI received Your request for an expedited external review. If the IRO's decision is to reverse the noncertification, Oscar will, within one day of receiving notice of the IRO's decision, reverse the noncertification decision for the requested service or supply that is the subject of the noncertification decision. If You are no longer covered by Oscar at the time Oscar receives notice of the IRO's decision to reverse the noncertification, Oscar will only provide coverage for those services or supplies You actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

The IRO's external review decision is binding on Oscar and you, except to the extent You may have other remedies available under applicable federal or state law. You may not file a subsequent request for an external review involving the same noncertification decision for which You have already received an external review decision.

For further information about External Review or to request an external review, contact the NCDOI at:

By Mail:
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
(fax)919-807-6865

In Person:
NC Department of Insurance
Albemarle Building
325 N. Salisbury St.
Raleigh, NC 27603
855-408-1212 (toll-free)
www.ncdoi.com/Smart for External Review information and Request Form

The Health Insurance Smart NC Program is also available to provide assistance to consumers who wish to file an appeal or grievance with their health plan.

CLAIMS AND REIMBURSEMENT

Claims

Oscar is not liable under this Plan unless proper notice is furnished by You (or someone acting on Your behalf) to Us that Covered Services have been rendered to a Member.

Network Provider Claims

The Network Provider is responsible for filing all Claims in a timely manner. You will not be responsible for any Claim which is not filed on a timely basis by the Network Provider. If you provide your insurance card to an In Network Provider at the time of service, the Provider will bill Oscar directly for claims incurred, and if covered, Oscar will reimburse your Provider directly.

Out-of-Network Provider Claims

You or your Provider are required to give notice of any Claim for any services rendered by an Out-of-Network Provider. No payment will be made for any Claims filed by a Member for services rendered by an Out-of-Network Provider unless You give written notice of such Claim to Oscar within 120 days of the date of service or as soon as reasonably possible.

To give notice of a Claim, please call Us at the phone number listed on Your Identification Card to obtain a Claim form. You must sign the Claim form before Oscar will issue payment to a Provider or reimburse You for services received under this Plan. You must complete a Claim form for services rendered by an Out-of-Network Provider and submit it, together with an itemized bill and proof of payment, to the following address:

Oscar P.O. Box 52146
Phoenix, Arizona 85072-
2146

Reimbursement

Reimbursement will be made only for Covered Services received in accordance with the provisions of this Plan. In the event You are required to make payment other than a required Copayment, Deductible or Coinsurance amount at the time Covered Services are rendered, We will ask that your Provider reimburse you, or We will reimburse You by check.

Claim Forms
When We receive the notice of claim, We will direct you to where you can access a claim form or send You a claim form by mail if you request it..

All claims submitted by to Us by Your Provider shall be submitted on a uniform form or format that shall be developed by the Department and approved by the Commissioner, whether submitted by writing or electronically.

Time of Payment of Claims
After receiving a claim form, Oscar will either make a request for additional information, or make a coverage decision within 30 calendar days.

Payment of Claims
Benefits will be paid to You. We may pay all or a portion of any indemnities provided for health care services to the health care services Provider, unless You direct otherwise in writing by the time claim forms are filed. We cannot require that the services are rendered by a particular health care services Provider, except that the provider must in In-Network where possible.

Unpaid Premium
At the time of payment of a Claim under this Plan, any Premium then due and unpaid may be deducted from the claim payment.

COORDINATION OF BENEFITS

Coordination of this contract's benefits with other benefits
The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans does not exceed 100% of the total allowable expense.

Definitions
A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

- Plan includes: group and nongroup insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
- Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) of Paragraph A is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all plan benefits do not exceed 100% of the total allowable expense.

Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense.
The following are examples of expenses that are not allowable expenses:

- The difference between the cost of a semi-private hospital room and a private hospital room is not an allowable expense, unless one of the plans provides coverage for private hospital room expenses.
- If a person is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
- The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

Closed panel plan is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Order of benefit determination rules

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other plan.

B. (1) Except as provided in Paragraph B (2) a plan that does not contain a coordination of benefits provision that is consistent with K.A.R. 40-4-34 is always primary unless the provisions of both plans state that the complying plan is primary.
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. These types of situations include major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each plan determines its order of benefits using the first of the following rules that apply:

- Non-dependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, Member or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the plan covering the person as an employee, member, policyholder, Member or retiree is the Secondary plan and the other plan is the primary plan.
- Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
    - For a dependent child whose parents are married or are living together, whether or not they have ever been married:
        - The plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
        - If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
    - For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
        - If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is

primary. This rule applies to plan years commencing after the plan is given notice of the court decree;

- If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Paragraph D (2)(a) above shall determine the order of benefits;
- If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (a) above shall determine the order of benefits; or
- If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    - The plan covering the custodial parent;
    - The plan covering the spouse of the custodial parent;
    - The plan covering the non-custodial parent; and then
    - The plan covering the spouse of the non-custodial parent.
- For a dependent child covered under more than one plan of individuals who are the parents of the child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

- Active Employee or Retired or Laid-off Employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) of Appendix A can determine the order of benefits.
- COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, Member or retiree or covering the person as a dependent of an employee, member, Member or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D (1) can determine the order of benefits.
- Longer or Shorter Length of Coverage. The plan that covered the person as an employee, member, policyholder, Member or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.
- If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans meeting the definition of plan.

In addition, this plan will not pay more than it would have paid had it been the primary plan.

Effect on the benefits of this plan
When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the Primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

Facility of payment
A payment made under another plan may include an amount that should have been paid under this plan. If it does Oscar (and any third-party vendors it uses for Coordination of Benefits administration) may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Oscar (and any third-party vendors it uses for Coordination of Benefits administration) will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made'' means the reasonable cash value of the benefits provided in the form of services.

Right of recovery
If the amount of the payments made by Oscar (and any third-party vendors it uses for Coordination of Benefits administration) is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

GENERAL PROVISIONS

Agreements Between Us and Network Providers
Any agreement between Us and Network Providers may only be terminated by Us or the Providers. This Plan does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Network Provider or any health benefits program.

Application
Applicants for coverage under this Plan shall complete and submit to Oscar an Application and other forms or statements as Oscar may reasonably request. Applicants for coverage represent that all information contained in each Application and accompanying forms or statements submitted to Oscar shall be true, correct and complete to the best of their knowledge or belief, and all rights to benefits hereunder are subject to the condition that such information shall be true, correct and complete. Please see the "Timeline of Certain Defenses" section regarding time limits on certain defenses regarding information submitted by Members.

Assignment of Benefits
No assignment of benefits under this Policy to any person, corporation, entity or other organization is valid. To the extent assignment of benefits is specifically authorized under applicable state or federal law, such assignment must (1) meet any requirements under applicable law, (2) be to a licensed Provider who provided Services to You in accordance with the provisions of this Policy, and (3) be received by Oscar in writing.

Change of Beneficiary
Unless You make an irreversible designation of beneficiary, You reserve the right to change Your beneficiary. The consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this Plan or to any change of beneficiary or beneficiaries, or to any other changes in this Plan.

Computation of Time
Unless We state otherwise, all references in this Evidence of Coverage to "day" shall mean calendar day. All references to "Evidence of Coverage Effective Date" shall mean 12:01 a.m. on the date on which coverage and enrollment under this Evidence of Coverage begins.

Conformity with Law
Any term of this Policy which is in conflict with North Carolina law or with any applicable federal law that imposes additional requirements from what is required under North Carolina law will be amended to conform with the minimum requirements of such law.

Continuation of Benefit Limitations
Some of the benefits in this Policy may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

Clerical Error
Clerical error, whether by You or Us, with respect to this Plan, or any other documentation issued by Us in connection with this Plan, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

Effective Date
Your benefits begin on the Effective Date of Your policy.

End Stage Renal Disease
Oscar will coordinate coverage with Medicare for Members with ESRD. Oscar follows Medicare Secondary Payer rules and regulations when coordinating coverage. Please contact Oscar's Member Services Team at 1-855-672-2755 or online at www.hioscar.com, for more information on coordination. You can also contact the Social Security Administration, at 1-800-772-1213, for more information on ESRD benefits.

Entire Contract; Changes
This Plan, including an application for coverage and any enrollment forms; amendments, riders, and endorsements; and a Schedule of Benefits, if any, constitutes the exclusive and entire contract of insurance between You and Oscar, and shall be binding upon all Covered Persons, Oscar, and any of our subsidiaries, affiliates, successors, heirs, and permitted assignees. All prior negotiations, agreements, and understandings are superseded hereby. No oral statements, representations, or understanding by any person can change, alter, delete, add or otherwise modify the express written terms of this contract. There are no warranties, representations, or

other agreements between You and Us in connection with the subject matter of this Plan, except as specifically set forth herein.

This Plan may not be modified, amended, or changed, except in writing and signed by an Oscar officer or the person designated by an Oscar officer. No employee, agent, or other person is authorized to interpret, amend, modify, waive, or otherwise change this Plan or any of its provisions. Notwithstanding the foregoing, Oscar has the right to and may modify or otherwise change the terms and conditions of the Agreement in order to make periodic administrative modifications. For example, Oscar may modify its process for filing a Grievance, or the address to which a complaint must be sent. We will provide written notice to You of any modifications to this Agreement.

Evidence of Coverage
You have been provided with this Plan and an Identification Card as evidence of coverage.

Fraud and Abuse
Reporting Healthcare Fraud
Oscar's mission is to make healthcare smart and simple. Our goal is to empower Members with information to help guide their health care decisions, including how to protect themselves, and Oscar, against healthcare fraud.

What is health care fraud?
Health care fraud occurs when someone intentionally provides false or misleading information to obtain health benefits or money. Health care fraud is a crime.

How does this impact me?
Health care fraud places a burden on both Oscar and Our Members. Providers who engage in fraud may be willing to prioritize their own financial gain over quality of treatment and diagnosis.

Also, health care fraud raises the cost of health insurance for everyone.
How do I know if someone has committed health care fraud? Health care fraud can be committed by a number of people including doctors, Hospitals, labs, medical equipment suppliers, and even Members.

Some examples are:
- Provider fraud:
    - Billing for services that were not performed

    - Using a falsified diagnosis to bill tests or procedures that are not Medically Necessary
    - "Upcoding" or billing for more expensive services than the ones that were performed
    - Accepting money from another Provider for Member Referrals or "kickback"
    - Waiving a Member's cost share in order to bill Your insurer more
    - Reselling Medical Items
- Examples of Member fraud:
    - Using someone else's Oscar coverage or card
    - Falsely alleging the theft of medical equipment

Help avoid health care fraud

Oscar keeps Your personal health data safe, and it's important that You take steps to protect Your information as well.

Be careful about sharing Your personal health information with others.

Make sure You keep Your Oscar card safe and use a password if You access the Oscar app. When You go to the doctor, ask questions about the care You receive.
Once You receive medical bills from Your Provider compare them to Your Oscar explanation of benefits.

If You're confused by what You were charged, contact Oscar's Member services department at 1-855-672-2755 or help@hioscar.com.

Oscar has a Special Investigations Unit (SIU) to investigate allegations of fraud.
If You suspect fraud, report Your concern to Oscar's Special Investigations Unit at fraud@hioscar.com or call Our 24/7 toll-free fraud hotline at 1-844-392-7589.
You can also mail Oscar a report:

Attn: Special Investigations Unit
Oscar 75 Varick Street
5th Floor
New York, NY, 10013

When leaving Oscar's SIU a message, please provide as much information as You can (names of those involved, locations, and any other details), so that We can investigate and take appropriate action. Oscar does not trace calls and will not make an attempt to identify the caller.

Reports can be made without worry of retaliation or intimidation. Oscar also partners with the National HealthCare Anti-Fraud Association (NHCAA) to improve the prevention, detection, and investigation of health care fraud. For more information on the NHCAA's initiatives, visit their website here https://www.nhcaa.org/.

Governing Law
This Evidence of Coverage will be governed by the laws of the State of North Carolina and federal law where applicable.

Grace Period
If You do NOT receive federal health insurance subsidies (Advance Premium Tax Credits and/or Cost Sharing reduction subsidies) You shall have a 31-day grace period in which to pay Premium after it becomes due. If payment of the appropriate Premium is not made within the 31-day grace period, the Plan will be terminated by Us on the last day of the grace period. This grace period does not apply to your first month's Premium payment.

If You receive federal health insurance subsidies (Advance Premium Tax Credits and/or Cost Sharing reduction subsidies), You shall have a 3- month grace period in which to pay Premium after it becomes due. If payment of the appropriate Premium is not made within the 3-month grace period, the Evidence of Coverage will be terminated by Us retroactive to the last day of the first month of the 3-month grace period. This grace period does not apply to your first month's Premium payment.

Modifications
This Evidence of Coverage is subject to amendment, modification or termination in accordance with any provision thereof or hereof without the consent or concurrence of or notice to You, except as provided for herein. When You elect coverage pursuant to this Evidence of Coverage or accepting benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions, amendments and provisions thereof and hereof. We will send You a disclosure notice of any change to benefits within 30 days of the Effective Date of the change.

Non-Discrimination
Oscar does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, genetic information, or health status in the administration of the Plan, including enrollment functions and benefit determinations.

Notices
Any notice that We give You under this Policy will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery. You agree to provide Us with notice of any change of Your mailing or electronic address.

If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to:

Oscar
P.O. Box 52146
Phoenix, Arizona 85072-2146

However, claims and requests for reimbursement should be sent to Oscar as outlined in the **CLAIMS AND REIMBURSEMENT** section.

Operations
Covered Services may be delayed or made impractical by circumstances not reasonably within Oscar's control, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of Hospital or medical group personnel or similar causes. If services are delayed or made impractical, Oscar and its In-Network Providers will use their best efforts to provide services and benefits covered under this Plan, but neither Oscar nor any providers shall incur any liability or obligation for failure to provide services or other benefits.

Physical Examinations and Autopsy
We have the right and opportunity to examine any Member, at Our own expense, when and as often as is reasonable during the time in which a Claim is pending, and to make an autopsy in case of death where it is not forbidden by law.

Policy on Third-Party Payment of Cost-Sharing and Premium
Oscar requires each policy holder to pay his or her Premiums as communicated on Your monthly billing statements. Oscar payment policies were developed based on guidance from the Centers for Medicare and Medicaid Services (CMS) recommendations against accepting third party Premiums. Consistent with CMS guidance, the following are the ONLY acceptable third parties who may pay Oscar Premiums on Your behalf:

- Ryan White HIV/AIDS Program under Title XXVI of the Public Health Services Act;
- Indian tribes, tribal organizations or urban Indian organizations;

- State and Federal government programs;
- Dependents and Family Members; or
- Third-party payors to the extent required by state and federal law.

We will review all other third-party payments, including payments made by private, not-for-profit foundations, on a case-by-case basis. We may decline to accept third-party payments, including payments by third-party individuals, that raise concerns for potential conflicts of interest, adverse selection, or fraud.

Upon discovery that Premiums were paid by a person or entity other than those listed above, We may reject the payment and inform the Member that the payment was not accepted and that the subscription charges remain due.

Premium Refunds
We will give a refund for overpayment of Premium to You, if due, upon request. If You do not request a refund, the overpayment will be applied to your next month's Premium bill.

Rates
Your rate will be based upon the rating factors permitted by federal law: age, tobacco use and where You live.

Refund of Benefit Payments
We reserve the right to recover any payments made by Us that were:
- Made in error;
- Made to You or any party on Your behalf, where We determine that such payment made is greater than the amount payable under this Policy;
- Made to You and/or any party on Your behalf, based on fraudulent or misrepresented information; or
- Made to You and/or any party on Your behalf for charges that were discounted, waived or rebated.

We reserve the right to adjust any amount applied in error to the Deductible or Out-of- Pocket Limit.

Our right to recover payments, as specified above, will be limited to 18 months from the date of the payment.

Renewal Guarantee
The renewal date for this Plan is January 1 of each year. This Plan will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Plan or by You upon 30 days' prior written notice to Us.

Reporting Changes
You are required to notify us of any events or changes in Your family, such as adoption, birth, marriage, divorce, death or the start of military service. We must receive Your notice when a dependent or Spouse is removed from coverage or added within 60 days of the change if Your coverage was not purchased on the Marketplace. The Effective Date of the change to Your Plan is the date of the event. You are also required to notify the Marketplace within 60 days of the change in Your family, if applicable. The Marketplace will then notify Oscar of the Effective Date, which is determined by federal law.

Right to Receive and Release Information
Each Member, as part of participating in the delivery or receipt of services,

- Authorizes any insurer, employer, organization, and health care services Provider to release to Us any and all information relating to administration of and coverage under this plan, including but not limited to past, present and future health care examinations, treatments and diagnoses; and,
- Authorizes Oscar to release the information described above to administer Your Plan

You agree to assist us in obtaining this information if needed, including but not limited to executing a release and/or authorization for Us to obtain records if requested by Us during the term of Your coverage. Failure to assist Us in obtaining the necessary information when requested may result in the delay or rejection of Your claims until the necessary information is received by Us. We reserve the right to reject or suspend a Claim based on lack of medical information or records.

Our Notice of Privacy Practices describes our use of Your information. In order to administer coverage and benefits, we may, in accordance with applicable law, release to or obtain from any person, plan, or organization, any information with respect to persons applying for coverage under this Plan, or to You or Your Dependents covered under this Plan which We deem to be necessary. You can access this document on our website, at hioscar.com. A copy of the Notice of Privacy Practices is available to you at no charge upon request. Contact us at 1-855-672-2755 to request a copy.

Severability
If any provision or any word, term, clause, or part of any provision of this Plan shall be determined to be invalid for any reason, the remainder of this Plan and the provisions thereof shall not be affected and shall remain in full force and shall in no way be affected, impaired or invalidated.

Time Limit on Certain Defenses.
in the absence of fraud, all statements made by You are considered representations and not warranties. No statement made by You voids coverage under this Plan or reduces benefits after the coverage has been in force for two (2) years from the Effective Date, unless the statement was material and contained in a written application. There is no time limit on defenses in instances of fraud.

Who Receives Payment Under this Plan
Payments under this Plan for services provided by a Network Provider will be made directly by Us to the Provider. If You receive services from an Out-of-Network Provider, We reserve the right to pay either You or the Provider. See the Assignment of Benefits section of this Policy for more information about assignment of benefits.

Worker's Compensation
The coverage provided under this Policy is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law. Workers' compensation Claims that are not a benefit under this Policy are not payable by Us.