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2022 Annual Report

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Our mission is to make a healthier life accessible and affordable for all.

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Dear Oscar Shareholders,

Mario Schlosser and Josh Kushner founded Oscar in anticipation that the U.S. healthcare system would become more consumer, digital, and value-driven. As an industry veteran, I have observed the healthcare system's evolution, and I share Mario and Josh's view that we can create value by accelerating these trends. Oscar is at an exciting and powerful moment in the company's journey. I am thrilled to be leading Oscar through this next chapter.

Oscar's history is fundamentally linked to the growth and maturity of the ACA. The ACA has proven to be the fastest-growing health insurance segment in recent years, growing to nearly 16 million Americans for 2023 and projected to hit 20 million in the near-term. The momentum in the ACA is a proofpoint for the power of a consumer-driven market structure. We believe we are positioned to thrive when choice and buying power is placed in the hands of consumers.

Oscar's story is one of resilience, innovation, and execution. Oscar persevered through years when the markets were unstable by focusing on the customer, performance improvement, and execution. Mario and Josh also knew that if they wanted to build a sustainable business model, they would have to invest heavily in differentiated human capital and our tech infrastructure. By prioritizing these foundational elements, we have pressure-tested our platform, and we believe we are positioned to scale and innovate.

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Capping Off A Transformative Year

Last year was transformative for the company. We nearly doubled our revenue and crossed the one-million member milestone. Our growth was impressive, but even more impressive was how we managed this growth.

By organizing the company around three key objectives — medical cost management, sculpting the portfolio, and administrative cost management — we effectively served more than one million members through 2022, while meaningfully improving our margins. Our results in 2022 speak for themselves:

nearly 2x revenue in '22 vs '21

+1 million members through '22

Membership: We ended the year with ~1.2 million members.

Direct and assumed premiums: Full year direct and assumed policy premiums for 2022 increased 99% YoY to $6.8 billion.

Medical Loss Ratio (MLR): We improved MLR by 360 basis points — hitting 85% for the year — which was right in the middle of our target range, despite doubling in size and accepting a large number of new members.

InsuranceCo Administrative Expense Ratio: Throughout the year, we took a disciplined approach to expense management and improved our InsuranceCo Administrative Expense Ratio from 21.8% to 20.6%.

InsuranceCo Combined Ratio: We finished the year with an InsuranceCo Combined Ratio of 105.8%, a 490 bps improvement YoY.

Net Promoter Score (NPS): We delivered an all-time high NPS of 47 versus the industry average of 3.

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We Continue To Deliver The Oscar Magic

Despite our focus on improving our financials, we did not sacrifice the elements of our business that make Oscar, Oscar. In fact, we continued to invest in our member-experience and our technology, which helps drive our business and our industry-leading NPS score.

11% cost savings for members

Mario and Josh knew early on that if there was any chance of *truly* transforming what it meant to be a health insurer, they had to re-architect the technology and legacy systems on which insurers were typically built. Over the years, the team has tested the boundaries of our technology and have shown the power of our people and tech stack. We have the ambition to power as much of the system as possible, which is why we've brought Campaign Builder, our first +Oscar standalone module, to market. As we think about +Oscar longer term, we believe that focusing our technology on increasing efficiency and profitability in our insurance business will translate to better market offerings, resulting in a significant opportunity for value creation over time.

Our technology and industry-leading member engagement also lowered costs for our business as well as our members. For example, members who went to an Oscar-routed physician generated 11% cost savings, on average, last year. We also applied the best of our technology efforts to areas like medical cost management and to reducing our administrative costs, making it more than just a market differentiator. In fact, these levers have become critical components of our efforts to reach our profitability goals.

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We Are Well Positioned For The Future

We believe that everything we accomplished this past year sets us up to achieve profitability for our Insurance business in 2023 and for our overall company in 2024 on an adjusted EBITDA basis. We have a clear roadmap to achieve these goals. We are well-positioned to hit them.

Our view is that Oscar has built the technology platform and the member experience to succeed in a healthcare future that is more consumerized, more value-driven, and more digital. We also expect that our cloud native technology and richly maintained data will enable us to rapidly deploy groundbreaking technology trends, like large language models, to further evolve and thrive in the changing healthcare landscape.

Although we are aware of the challenges and complexities that we are up against, we are confident that we have the right balance of strategic focus and innovation to tackle any issue. We have proven our resilience and remain anchored by the understanding that our work has real-world impact. The opportunity to serve our members motivates us to continue advancing our mission and evolving the company.

Thank you to Mario and Josh for this opportunity and for entrusting me with your vision. To the employees of Oscar who welcomed me to the team, thank you. To our shareholders, both new and old — thank you for supporting us through the ups and downs. To our providers and partners, thank you for being a critical part of our mission-centered work. Finally, to our members: none of this would be possible without you. Thank you for entrusting us with your health and keeping us tethered to our purpose.

Mark T. Bertolini
CEO of Oscar Health

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

FORM 10-K

[X] ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the fiscal year ended December 31, 2022

or

[ ] TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934

For the transition period from _____to_____

Commission File Number: 001-40154

Oscar Health, Inc.

(Exact name of registrant as specified in its charter)

Delaware	**46-1315570**
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification No.)
	Identification No.)
75 Varick Street, 5th Floor New York, NY	**10013**
(Address of principal executive offices)	(Zip Code)

Registrant's telephone number, including area code: **(646) 403-3677**
Former name, former address and former fiscal year, if changed since last report: **N/A**

Securities registered pursuant to Section 12(b) of the Act:

Title of each class	**Trading Symbol(s)**	**Name of each exchange on which registered**
Class A Common Stock, $0.00001 par value per share	**OSCR**	**New York Stock Exchange**

Indicate by check mark if the Registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes ☐ No ☒

Indicate by check mark if the Registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes ☐ No ☒

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes ☒ No ☐

Indicate by check mark whether the registrant has submitted electronically every Interactive Data File required to be submitted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit such files). Yes ☒ No ☐

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, a smaller reporting company, or an emerging growth company. See the definitions of "large accelerated filer," "accelerated filer," "smaller reporting company," and "emerging growth company" in Rule 12b-2 of the Exchange Act.

Large accelerated filer	☒	Accelerated filer	☐
Non-accelerated filer	☐		
Smaller reporting company	☐	Emerging growth company	☐

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.☐

Indicate by check mark whether the registrant has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report. ☒

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes ☐ No ☒

As of June 30, 2022, the last business day of the registrant's most recently completed second quarter, the approximate market value of the registrant's common stock held by non-affiliates was $727.7 million.

Class of Stock	**Shares Outstanding as of January 31, 2023**
Class A Common Stock, par value $0.00001 per share	181,187,578
Class B Common Stock, par value $0.00001 per share	35,115,807

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's definitive Proxy Statement relating to its 2023 Annual Meeting of Stockholders to be filed with the SEC within 120 days after the end of the fiscal year ended December 31, 2022 are incorporated herein by reference in Part III.

Oscar Health, Inc.
ANNUAL REPORT ON FORM 10-K
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FORWARD-LOOKING STATEMENTS

This Annual Report on Form 10-K for the fiscal year ended December 31, 2022 ("Annual Report on Form 10-K") contains forward-looking statements. We intend such forward-looking statements to be covered by the safe harbor provisions for forward-looking statements contained in Section 27A of the Securities Act of 1933, as amended (the "Securities Act"), and Section 21E of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). All statements other than statements of historical facts contained in this Annual Report on Form 10-K may be forward-looking statements. In some cases, you can identify forward-looking statements by terms such as "may," "will," "should," "expects," "plans," "anticipates," "could," "intends," "targets," "projects," "contemplates," "believes," "estimates," "forecasts," "predicts," "potential" or "continue" or the negative of these terms or other similar expressions. Forward-looking statements contained in this Annual Report on Form 10-K include, but are not limited to, statements regarding our future results of operations and financial position, risk adjustment payments, industry and business trends, stock compensation, business strategy, plans and plan mix, membership and market growth and our objectives for future operations.

The forward-looking statements in this Annual Report on Form 10-K are only predictions. We have based these forward-looking statements largely on our current expectations and projections about future events and financial trends that we believe may affect our business, financial condition and results of operations. Forward-looking statements involve known and unknown risks, uncertainties and other important factors that may cause our actual results, performance or achievements to be materially different from any future results, performance or achievements expressed or implied by the forward-looking statements, including, but not limited to, the important factors discussed in Part I, Item 1A, "Risk Factors" in this Annual Report on Form 10-K. The forward-looking statements in this Annual Report on Form 10-K are based upon information available to us as of the date of this Annual Report on Form 10-K, and while we believe such information forms a reasonable basis for such statements, such information may be limited or incomplete, and our statements should not be read to indicate that we have conducted an exhaustive inquiry into, or review of, all potentially available relevant information. These statements are inherently uncertain and investors are cautioned not to unduly rely upon these statements.

You should read this Annual Report on Form 10-K and the documents that we reference in this Annual Report on Form 10-K and have filed as exhibits to this Annual Report on Form 10-K with the understanding that our actual future results, levels of activity, performance and achievements may be materially different from what we expect. We qualify all of our forward-looking statements by these cautionary statements. These forward-looking statements speak only as of the date of this Annual Report on Form 10-K. Except as required by applicable law, we do not plan to publicly update or revise any forward-looking statements contained in this Annual Report on Form 10-K, whether as a result of any new information, future events or otherwise.

BASIS OF PRESENTATION

As used in this Annual Report on Form 10-K, unless the context otherwise requires, references to:

- "we," "us," "our," "our business," the "Company," "Oscar," and similar references refer to Oscar Health, Inc. and its subsidiaries.
- "Holdco" refers to Oscar Health, Inc. and its consolidated subsidiaries excluding its regulated insurance subsidiaries.
- "ACA" refers to the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010, as amended.
- "Adjusted Administrative Expense Ratio" is defined as provided in "Management's Discussion and Analysis of Financial Condition and Results of Operations—Key Operating and Non-GAAP Financial Metrics—Adjusted Administrative Expense Ratio."
- "Annual Election Period" refers to the yearly period when beneficiaries can enroll or disenroll in an Original Medicare or Medicare Advantage health plan. The Annual Election Period starts on October 15 and ends on December 7 of each year.
- "APTC" refers to advanced premium tax credits.
- "Assumed Policy Premiums" are premiums received primarily as part of our reinsurance arrangements under the Cigna+Oscar small group plan offering.
- "Co-Founders" refers to Joshua Kushner and Mario Schlosser.
- "direct policy premium" refers to monthly premiums collected from our members and/or from the federal government during the period indicated, before risk adjustment and reinsurance.
- "full stack technology platform" refers to our cloud-based end-to-end technology solution, which powers our differentiated member experience engine. Our platform connects our member-facing features, including our mobile application, which we refer to as our app, website, and virtual care solutions with our back-office tools that span all critical health care insurance and technology domains, including member and provider data, utilization management, claims management, billing, and benefits.
- "Health Insurance Marketplaces" refers to the health insurance marketplaces established per the ACA and operated by the federal government for most states and other marketplaces operated by individual states, for individuals and small employers to purchase health insurance coverage in the Individual and Small Group markets that include minimum levels of benefits, restrictions on coverage limitations and premium rates, and APTC.
- "health insurance subsidiary" refers to any subsidiary of Oscar Health, Inc. that has applied for or received a license, certification or authorization to sell health plans by any state Department of Insurance, Department of Financial Services, Department of Health, or comparable regulatory authority. As of December 31, 2022, Oscar Health, Inc. had 14 health insurance subsidiaries.
- "health plans" refers to the health insurance plans that Oscar sells in the Individual and Small Group markets and the Medicare Advantage Plans that Oscar sells in the Medicare Advantage market. The term includes co-branded health plans sold directly by our health insurance subsidiaries and, in the case of the Cigna + Oscar plan, sold directly by our partner and partially reinsured by an Oscar health insurance subsidiary.
- "InsuranceCo Administrative Expense Ratio" is defined as provided in "Management's Discussion and Analysis of Financial Condition and Results of Operations—Key Operating and Non-GAAP Financial Metrics—InsuranceCo Administrative Expense Ratio."
- "InsuranceCo Combined Ratio" is defined as the sum of MLR and InsuranceCo Administrative Expense Ratio.
- "Medical Loss Ratio" or "MLR" is defined as provided in "Management's Discussion and Analysis of Financial Condition and Results of Operations—Key Operating and Non-GAAP Financial Metrics—Medical Loss Ratio."

- "member" refers to any individual covered by any health plans that we offer directly or through a co-branded arrangement. A member covered under more than one of our health plans counts as a single member for the purposes of this metric. Our membership is measured as of a particular point in time and may be affected by enrollment changes, including retroactive disenrollments.
- "Open Enrollment Period" refers to the yearly period when individuals and families can enroll in a health plan or make changes to an existing health plan. The 2023 Open Enrollment Period for the Individual market in the majority of states began on November 1, 2022 and lasted through at least January 15, 2023. The Medicare Advantage Open Enrollment Period, which permits switching between Medicare Advantage plans, started on January 1, 2023 and will end on March 31, 2023.
- "Parent" means Oscar Health, Inc. on a stand-alone basis.
- "PMPM" refers to per member per month.
- "Special Enrollment Period" refers to a period outside the Open Enrollment Period or Annual Election Period when an eligible person can enroll in a health plan or make changes to an existing health plan. A person is generally eligible to participate in a Special Enrollment Period if certain qualifying life events occur, such as losing certain health coverage, moving, getting married, having a baby, or adopting a child or resulting from regulatory requirements. For example in 2023 this includes an extension of the Open Enrollment Period in New York for the duration of the ongoing COVID-19 public health emergency ("PHE"), and a Special Enrollment Period in California also tied to the duration of the PHE. CMS has also announced a sixteen month Special Enrollment Period for individuals that lose Medicaid or Children's Health Insurance Program coverage as a result of the Medicaid redetermination process, which will begin April 1, 2023 and end July 31, 2024.
- "Thrive Capital" refers to Thrive Capital Management, LLC, a Delaware limited liability company, and the investment funds affiliated with or advised by Thrive Capital Management, LLC.
- "Thrive General Partners" refers to Thrive Partners II GP, LLC, Thrive Partners III GP, LLC, Thrive Partners V GP, LLC, Thrive Partners VI GP, LLC, Thrive Partners VII GP, LLC, and Thrive Partners VII Growth GP, LLC, each of which is a general partner of a Thrive Capital-affiliated fund.

Certain monetary amounts, percentages, and other figures included in this Annual Report on Form 10-K have been subject to rounding adjustments. Percentage amounts included in this Annual Report on Form 10-K have not in all cases been calculated on the basis of such rounded figures, but on the basis of such amounts prior to rounding. For this reason, percentage amounts in this Annual Report on Form 10-K may vary from those obtained by performing the same calculations using the figures in our consolidated financial statements included elsewhere in this Annual Report on Form 10-K. Certain other amounts that appear in this Annual Report on Form 10-K may not sum due to rounding.

Reclassification and Reverse Stock Split

In connection with its initial public offering (the "IPO"), on March 3, 2021, the Company filed an amended and restated certificate of incorporation (the "Amended and Restated Certificate of Incorporation") with the Secretary of State of the State of Delaware, which effected a reclassification of the Company's issued and outstanding share capital and a one-for-three reverse stock split. Upon conversion of all outstanding shares of convertible preferred stock, and upon filing of the Company's Amended and Restated Certificate of Incorporation, all outstanding shares of each series of the Company's convertible preferred stock and common stock issued and outstanding prior to the IPO converted and/or were reclassified into an aggregate of 132,760,639 shares of Class A common stock, par value $0.00001 per share (the "Class A common stock") and 35,335,579 shares of Class B common stock, par value $0.00001 per share (the "Class B common stock."), and 943,800 shares of common stock held in treasury were reclassified into an aggregate of 314,600 shares of Class A common stock. In accordance with accounting principles generally accepted in the United States ("U.S. GAAP"), all shares of common stock and per share data that are presented in this Annual Report on Form 10-K have been adjusted to reflect the reclassification and reverse stock split on a retroactive basis for all periods presented. Shares of convertible preferred stock presented in this Annual Report on Form 10-K have not been adjusted for the reclassification or reverse stock split. For additional information, see Note 16 - Stockholders' Equity to our consolidated financial statements included elsewhere in this Annual Report on Form 10-K.

SUMMARY RISK FACTORS

Our business is subject to numerous risks and uncertainties, including those described in Part I, Item 1A. "Risk Factors" in this Annual Report on Form 10-K. You should carefully consider these risks and uncertainties when investing in our Class A common stock. The principal risks and uncertainties affecting our business include the following:

- Our ability to execute our strategy and manage our growth effectively;
- Our ability to retain and expand our member base;
- Heightened competition in the markets in which we participate;
- Our ability to accurately estimate our incurred medical expenses or effectively manage our medical costs or related administrative costs, including as a result of uncertainty due to COVID-19;
- Our ability to achieve or maintain profitability in the future;
- Changes in federal or state laws or regulations, including changes with respect to the ACA and any regulations enacted thereunder;
- Our ability to comply with ongoing regulatory requirements, including capital reserve and surplus requirements and applicable performance standards;
- Changes or developments in the health insurance markets in the United States, including passage and implementation of a law to create a single-payer or government-run health insurance program;
- Our ability to comply with applicable privacy, security, and data laws, regulations, and standards, including as a result of our participation in government-sponsored programs, such as Medicare;
- Our ability to arrange for the delivery of quality care and maintain good relations with the physicians, hospitals, and other providers within and outside our provider networks;
- Unanticipated results of risk adjustment programs;
- Our ability to utilize quota share reinsurance to reduce our capital and surplus requirements and protect against downside risk on medical claims;
- Unfavorable or otherwise costly outcomes of lawsuits and claims that arise from the extensive laws and regulations to which we are subject;
- Our ability to attract and retain qualified personnel;
- Incurrence of cyber-security breaches of our and our partners' information and technology systems;
- Our ability to remediate a material weakness in our internal controls over financial reporting and the identification of additional material weaknesses in the future or other failure to maintain an effective system of internal controls; and
- Adverse publicity or other adverse consequences related to our dual class structure or "controlled company" status.

Before you invest in our Class A common stock, you should carefully consider all of the information in this Annual Report on Form 10-K, including matters set forth under the heading "Risk Factors."

PART I

Item 1. Business

OUR BUSINESS

At Oscar, we make a healthier life accessible and affordable for all.

Oscar is the first health insurance company built around a full stack technology platform and a relentless focus on serving our members. We started Oscar in 2012 to create the kind of health insurance company we would want for ourselves – one that behaves like a doctor in the family. We believe every American deserves access to affordable, high-quality health care that fits their life – from families seeking coverage that works for toddlers and their busy parents, to adults with chronic conditions who know their care providers by their first names – and everyone in between.

Powered by our own differentiated full stack technology platform, we have built a scaled insurance business that enables us to earn our members' trust, leverage the power of personalized data, and help our members find quality care they can afford. We are proud to have earned industry-leading levels of trust, engagement, and customer satisfaction from more than one million members who, as of January 31, 2023, have chosen Oscar.

In addition to supporting our insurance business, our full stack technology platform has already enabled arrangements with other payors and providers in which health plans and products are powered by our platform. As we continue to build and scale our technology, we may seek out additional opportunities to monetize our +Oscar platform.

As we continue to bring the Oscar experience to more individuals, our goal will remain the same: to build engagement, earn trust, and help our members live healthier lives.

Our Offerings

Our technology gives us the flexibility to enter into innovative health system collaborations and achieve market and product optimization. Today, we offer health plans in three insurance markets: Individual, Small Group, and Medicare Advantage.

Individual and Small Group
The Individual market primarily consists of policies purchased by individuals and families through Health Insurance Marketplaces. The Small Group market consists of employees of companies with up to 50 full-time workers in most states and up to 100 full-time workers in selected states.

We offer health plans in the Individual market on exchange and off-exchange under the five "metal" plan categories defined by the ACA: Catastrophic, Bronze, Silver, Gold, and Platinum. These differ based on the size of the monthly premium and the level of sharing of medical costs between Oscar and our members.

Individual and Small Group premium rates, along with specific rate changes, are required to be approved by applicable state and federal regulatory agencies in accordance with the ACA. Additionally, various federal and state laws have minimum Medical Loss Ratio ("MLR") requirements. We elect to participate in a given Individual or Small Group market on an annual basis. In substantially all cases, our base premiums are subject to a risk adjustment based on the health status of our members relative to the overall health status of all individuals in a given state or market.

Medicare Advantage
We have a limited Medicare Advantage business where we offer coverage to adults who are age 65 and older and eligible for traditional Medicare, but who instead select coverage through a private market plan. We have a contract with the Centers for Medicare & Medicaid Services ("CMS") under the Medicare Advantage program to provide healthcare benefits to Medicare beneficiaries. In exchange, we receive a fixed PMPM premium that varies based on a variety of factors, including the CMS Star ratings of our health plans, as well as member geographic location, demographics, and health status. CMS also uses a risk adjustment system to adjust the premiums paid to Medicare Advantage plans that reflects the predicted healthcare costs of their members compared to an "average" beneficiary based on health status and other factors. Medicare Advantage premiums paid to us under our CMS contracts are subject to annual review by CMS, as well as federal government reviews and audits. We elect to participate in a given Medicare geographic region on an annual basis.

+Oscar Platform

We believe we have built a differentiated full stack platform to power our health insurance business, and we continue to invest in building, scaling and improving this platform. We have started to monetize this platform through arrangements with providers and payors in which health plans and products are powered by our platform. We are currently deploying Campaign Builder in the market, which is our first +Oscar modularized solution. Campaign Builder is an engagement and automation platform that enables scalable, personalized interventions and automates workflows, designed to drive growth, deliver best in class clinical outcomes, and optimize administrative operations. In the longer term we plan to continue to evaluate other opportunities to monetize our platform.

Our Provider Contracts and Network

Our health plans include access to a network of high-quality physicians and hospitals, as well as a personalized Care Team that supports members from finding a doctor to navigating costs. As portions of the health care system increasingly shift towards offering more selective networks, we believe the insurers that will thrive are those that can consistently deliver a high-quality experience by engaging their members and routing care to in-network facilities and physicians that offer quality care at affordable rates. Oscar has exclusive provider organizations ("EPO") or similar networks in all of our markets for our Individual and Medicare Advantage products. The Cigna + Oscar Small Group products use Cigna's network to offer preferred provider organization ("PPO") and EPO plans. We selectively work with technology-forward, high brand-recognition health systems, including some of the largest health systems in the U.S.

We are required by federal and state laws and regulation to maintain minimum network adequacy. We apply an algorithmic and proprietary model to develop a provider network that is optimized for quality and cost. While we generally have a standard set of terms that we propose for our provider contracting relationships, each health market in which we operate is unique, and therefore our negotiated contract terms are specific to each market and health provider. For instance, the fee structures for these contracts vary, and can include fee-for-service arrangements, value-based incentives and payment structures, or payments on a capitation basis.

Membership

Markets

Oscar's member-first philosophy and innovative approach to care has earned us the trust of over one million members across our Individual, Small Group and Medicare Advantage plans. We offer coverage in 577 counties and 20 states. We regularly evaluate our markets for strategic fit and periodically enter or exit markets.

Concentration

We generate a substantial majority of our total revenue from direct and assumed policy premiums. Direct policy premiums are collected directly from members and from CMS as part of the APTC program. For the year ended December 31, 2022, $977.0 million and $5.7 billion of direct policy premiums were collected directly from our members and from CMS, respectively. We also receive assumed policy premiums as part of our reinsurance arrangements under our Cigna+Oscar small group plan offering. Assumed premiums for the year ended December 31, 2022 were $138.1 million.

Disaggregated membership information as of December 31, 2022 and 2021 is presented in the tables below:

Membership by Offering

	As of December 31,	
	2022	**2021**
Individual and Small Group	1,084,404	577,799
Medicare Advantage	4,452	3,864
Cigna + Oscar [(1)]	62,627	16,506
Total	**1,151,483**	**598,169**

(1) Represents total membership for our co-branded partnership with Cigna.

Membership by State

	As of December 31,	
	2022	**2021**
Florida	685,205	291,894
Texas	148,362	90,369
Georgia	103,970	6,610
California	72,194	98,532
Ohio	24,953	17,980
Connecticut	20,185	6,177
New York	19,557	27,462
Arizona	16,971	23,561
New Jersey	16,620	13,728
Missouri	6,944	1,541
Tennessee	6,939	5,158
Iowa	5,928	1,330
Oklahoma	4,956	1,425
Pennsylvania	3,691	4,376
Colorado	3,453	2,865
Kansas	3,171	2,455
Nebraska	3,145	—
Illinois	2,045	—
North Carolina	1,007	602
Michigan	985	1,522
Virginia	710	582
Arkansas	492	—
Total	1,151,483	598,169

Seasonality

Our business is generally affected by the seasonal patterns of our member enrollment and medical expenses, health plan mix shift and, to a lesser extent, marketing spend in advance of an Open Enrollment Period or Annual Election Period. Direct policy premiums earned are historically highest in the first quarter, primarily due to the annual enrollment cycles and the enrollment of our members, but may be impacted by Special Enrollment Periods or other market dynamics that allow the overall market to grow throughout the year. Medical expenses are sensitive to the mix shift of the five “metal” health plan categories offered on the ACA. Medical expenses have historically been highest towards the second half of the year due to a number of factors discussed below.

Members

Our membership is measured as of a particular point in time and is concentrated in the Individual market. Membership typically declines throughout the year due to individuals disenrolling before they become effectuated members, as a result of Special Enrollment Periods, and the removal of members for non-payment or in accordance with our fraud, waste and abuse, and other operating policies. The majority of our member growth occurs in connection with the annual Open Enrollment Period. Individual plan membership is historically at its highest at the beginning of the year. For Small Group products, a large portion of membership is acquired between December 1 and January 1, with the remaining members acquired throughout the balance of the year. These patterns can be affected by legislative or regulatory actions, Special Enrollment Periods or other market dynamics that allow the overall market to grow throughout the year.

Claims Incurred
Our medical expenses are impacted by seasonal effects of medical costs such as the utilization of deductibles and out-of-pocket maximums over the course of the policy year, which shifts more costs to us in the second half of the year as we pay a higher proportion of claims. Our medical costs can also vary according to the number of days and holidays in a given period, the risk profile of our membership, and the proportion of our membership that is new in the calendar year. In 2022, and to date in 2023, the emergence of medical claims has differed from that in prior years due to the mix shift to members with higher-premium/lower-deductible Silver plans, and further mix shifts may continue to alter medical claim incurred patterns in the remainder of 2023 and future periods.

Reinsurance
We enter into reinsurance agreements to help us mitigate risk, which includes protecting capital and reducing earnings and cash flow volatility. Our reinsurance is contracted under two different types of arrangements: quota share reinsurance contracts and excess of loss ("XOL") reinsurance contracts. In quota share reinsurance, the reinsurer agrees to assume a specified percentage of the ceding company's losses arising out of a defined class of business in exchange for a corresponding percentage of premiums, net of a ceding commission. In XOL reinsurance, the reinsurer agrees to assume all or a portion of the ceding company's losses in excess of a specified amount. Under XOL reinsurance, the premium payable to the reinsurer is negotiated by the parties based on losses on an individual member in a given calendar year and their assessment of the amount of risk being ceded to the reinsurer because the reinsurer does not share proportionately in the ceding company's losses.

OUR DIFFERENTIATED FULL STACK TECHNOLOGY PLATFORM
We have built our own full stack technology platform, which allows for greater scalability and flexibility, and spans all critical health care insurance and technology domains, including member and provider data, utilization management, claims management, billing, and benefits. We continue to invest in building and developing our platform to power our insurance business, and to enable a best in class experience for our members and providers.

Our full stack technology platform provides our members with a simple and intuitive consumer experience that enables them to take control of their health care decisions. That experience begins with trust and engagement, which we earn by providing our members with features that help them navigate the many disconnected elements of the health care ecosystem. When our members adopt these tools, we not only streamline their day-to-day interactions with the health care system and improve member satisfaction, we also obtain valuable data that lets us better understand their unique health care needs. Trust, engagement, and personalized data allow us to help route our members to the providers that can give them timely care they need at an optimized cost, including virtual care. Our full stack technology platform also permits us to offer personalized insights and benefits. It is the combination of all these factors—trust, engagement, care routing, and personalized insights—that allows us to help our members find quality care at rates they can afford. Our ability to deliver a high-value product, in turn, engenders more trust, engagement, and ability on our part to provide personalized, data-driven insights. We refer to this virtuous cycle as our member engagement engine.

As part of our member engagement engine, members receive the support of a Care Team, which enables us to form relationships and build trust with our members that allows us to shift members to better and more affordable care. Our Care Teams offer personalized guidance because of their access to all of our members' longitudinal data on our full stack technology platform. We believe our Care Team approach is one of the core reasons our member satisfaction is so high. During the fourth quarter of 2022, our net promoter score reached 47 and remains meaningfully higher than the industry average of 3. Our Care Teams have a bird's eye view of a member's journey through the health care system, including claims and authorization history, past appointments, and in some cases, appointments scheduled in the future. We also use artificial intelligence to match members to the best doctors for them, driven by sophisticated cost and quality algorithms. This technology saves both Oscar and members money by routing care to "high value" providers, which we define as providers who, based primarily on Oscar's proprietary cost estimate tool, historical claims data, provider location information, and survey data have lower costs and higher rated reviews from our members. Members can search directly on the Oscar app or website, or if they prefer, in consultation with their Care Team, for the right provider. We offer flexible options when our members seek care through a broad platform tailored to solving specific member needs. We have built a proprietary infrastructure integrated with Oscar claims and data management systems designed to share data appropriately among Care Teams, virtual care providers and members.

Product features such as Care Teams, care routing, and virtual care are our way of building the trust, engagement, and relationships that give us the ability to help members bend the cost curve in health care. By leveraging Campaign Builder, our engagement and automation engine, we're able to rapidly create and iterate upon omnichannel member outreach programs to drive adherence to important clinical pathways. Owning the technologies that power our business from end-to-end lets us pioneer new ways of addressing frictions in the health care system and is the foundation for Oscar's vision to make a healthier life accessible and affordable for all. Today, this platform provides the foundation for our personalized data insight and analysis as well as our critical cost structure savings. As a result, engagement with our technology platform and customer satisfaction remains high, relative to industry average. We believe competitors who lack this member engagement engine will face significant challenges in replicating our consumer experience, and our platform thus forms an important structural moat around the innovations we have developed.

OUR STRATEGIC FOCUS

As we continue our work to reimagine healthcare in the U.S., we are tracking towards delivering on a critical company milestone of reaching profitability for our Insurance business in 2023.

We built our strategy around three core trends in healthcare: consumerization, digital/virtualization, and a shift to value-based care. Over time, we've been observing the overall healthcare system move towards these trends, which not only validates our strategy, but provides us with a first mover advantage. We are now a scaled health insurer with over one million members, high member engagement, and our own technology stack that we have built from end to end. With all of these building blocks in place, we believe we have a clear, achievable plan to deliver on our target of achieving profitability for the Insurance business in 2023.

A critical element of this strategy includes taking a disciplined approach to balancing growth and profitability in our pricing. We've already taken steps to drive down administrative costs, manage our medical costs, and sculpt our portfolio through pricing, network and plan design. We had a successful Open Enrollment Period with results that are in line with our goal to have our 2023 membership be stable year over year. We also took actions to drive improved performance in our medical loss ratio and administrative expense ratio including exiting underperforming markets and optimizing our plan design portfolio to create greater balance towards profitable products.

We believe that these collective actions are guiding us toward our goals and that insurance company profitability is within view. Much of the work to achieve this milestone is already in play, and we are confident that we are well-positioned to take advantage of the market trends and reach our goals. As we look ahead to 2024 and beyond, we plan to position ourselves for growth, while continuing to maintain our disciplined focus on managing administrative and medical costs.

HUMAN CAPITAL RESOURCES

As of December 31, 2022, we had 2,714 full-time employees.

As the first health insurance company built around a full stack technology platform and a relentless focus on serving our members, we are powered by people from a diversity of backgrounds, experiences, and industries. We foster a culture in which our employees share a common connection to our mission: they are passionate about making a frustrating healthcare system easier, more human and better for everyone. These principles drive our core values:

1. What we do is a big deal. *We're solving problems that change and save lives*
2. Powered by people. *Members above all. Developing and growing others is what raises the bar.*
3. No genius without grit. *Be relentless. Be scrappy. Trying and failing beats not trying and changing nothing.*
4. Seek the truth. *But never assume you've found it. Be scientific.*
5. Inspire and provoke. *Develop and display leadership at all levels. Fight to be the best.*
6. Be transparent. *Give and ask for direct feedback. Be grateful for and excited by the help of others.*
7. Make it right. *Admit your mistakes. Then learn from them. Never build alone.*

Talent Recruitment and Retention

As a mission-driven company, we prioritize attracting and retaining qualified personnel who share our mission to make a healthier life affordable and accessible to all. This centers around what we believe to be a compelling employee value

proposition, that includes competitive pay and benefits, flexible work styles, opportunity to make real impact towards the Oscar mission, and ongoing performance development.

We compete to hire and retain highly talented and diverse individuals, and we offer our employees compensation packages designed to be competitive, including a base salary and some of the following, depending on the role and business function: performance bonus, long-term incentive equity, performance-based equity, commission, and overtime pay. We see our compensation philosophy as grounded in a transparent, systemic, and equitable approach to employee compensation that is rooted in data and company performance, and benchmarked against technology, healthcare, and insurance peers. To continue to address turnover throughout external economic swings, we have also offered financial, and non-financial, incentives to try to retain our high performing employees.

As a result of our shift to a flexible workforce and expanding our recruiting efforts beyond states where we maintain a physical office location, we have had the opportunity to further expand the geographic diversity of our workforce in 2022.

Health and Wellbeing

At Oscar we believe that making a healthier life affordable and accessible to all begins with our own workforce, and we continually seek opportunities to optimize our employee offerings including events, activities, benefits, perks and community support. We have invested in a benefits package designed to be comprehensive and affordable, providing protection and support to help our employees achieve health, financial, and wellness goals, including mental health, infertility support, and dependent care. We also believe in the importance of investing in education and development opportunities for our employees, and all employees have access to internally created and third party skills and training programs. Lastly, we understand that individuals need to step away from work duties for a variety of reasons, which is why we provide paid time off and leave packages to all full time employees, including wellness days and parental leave.

Diversity, Equity, and Inclusion

We recognize the importance of diversity, equity, and inclusion in the workplace, and we aim to embed these efforts across our full slate of human capital programming and operations. We believe that having an increasingly diverse employee base will empower our community, drive better business outcomes, and ultimately allow us to better serve our members.

Internally, we aim to promote equity through a transparent, systematic approach to our human capital frameworks and operations. Specifically, with respect to compensation, we reward employees based on performance so that there is parity in job profiles, and we support our compensation decisions through benchmarking and data. Our employees are able to view their total compensation package, including their salary band and leveling, which helps employees understand their pay and encourages proactive conversation between managers and employees. Beyond equitable processes, we strive for inclusivity by offering self-identification options in our human resource information systems and inclusive employee-oriented programming. We believe our Employee Resource Groups (“ERGs”) are another important part of maintaining diverse perspectives and fostering connections across our organizations. In 2022 we had nine ERGs which focused on community, awareness and advocacy in spaces that are often overlooked.

In the effort to increasingly disrupt the healthcare industry, we bring our diverse workforce together to help inform the initiatives of our Culturally Competent Care Program, which strives to provide care to patients with diverse values, beliefs, and behaviors, including tailoring care delivery to meet patients’ social, cultural and linguistic needs.

In 2023, Oscar plans to release its inaugural ESG Report, which will be made available through the “Investor Relations” section of Oscar’s website (ir.hioscar.com). Neither the ESG Report nor the contents of our website are incorporated by reference herein.

COMPETITION

We operate in a highly competitive environment in an industry subject to significant and ongoing changes, including business consolidations, new strategic alliances, market pressures, scientific and technological advances in medical care and therapeutics, as well as regulatory and legislative challenges and reform both at the federal and state level. This reform includes, but is not limited to, the federal and state health care reform legislation described under “—Government Regulation.” In addition, changes to the political environment may drive additional shifts in the competitive landscape.

We compete to enroll and retain new members and employer groups, as we currently derive substantially all of our revenue from direct policy premiums, which is primarily driven by the number of members covered by our health plans. Employer groups choosing a health plan for their employees and individuals who wish to enroll in a health plan or to change health

plans typically choose a plan based on price, the quality of care and services offered, ease of access to services, a specific provider being part of the network, the availability of supplemental benefits, and the reputation or name-recognition of the health plan. We believe that the principal competitive features affecting our ability to retain and increase membership include the range and prices of health plans offered, diversity of coverage, benefits and wellness programs, breadth and quality of provider network, quality of service and member experience, responsiveness to member demands, financial stability, comprehensiveness of coverage, market presence, and reputation.

As attracting new members depends in part on our ability to provide access to competitive provider networks, we compete in establishing such provider networks. We believe that the factors providers consider in deciding whether to contract with a health insurer include existing and potential member volume, reimbursement rates, timeliness and accuracy of claims payment and administrative service capabilities. While our health insurance subsidiaries are required to meet various federal and state requirements regarding the size and composition of our participating provider networks, our business model is based on contracting with selected health care systems and other providers, not all systems and providers in a given area. This allows us to work more closely with high quality health care systems that engage with us using our technology and to receive more favorable reimbursement rates from these health care systems.

The relative importance of each of the competitive factors mentioned in the above paragraphs and the identity of our principal competitors for members, employer groups, and providers varies by market and geography. In the Small Group market, for example, our principal competitors include plans offered by national carriers and local Blue Cross plans, while our principal competitors in the Individual market primarily consist of plans offered by national carriers, regional carriers, Medicaid-focused insurers offering Health Insurance Marketplace products, local Blue Cross plans, and start-up carriers. In the Medicare Advantage market, our principal competitors include Original Medicare fee-for-service plans managed by the federal government and Medicare Advantage plans offered by national, regional, and local managed care organizations and insurance companies, and accountable care organizations.

Additionally, we face significant competition for personnel. We rely on technology experts and a small number of highly-specialized insurance experts, and other highly skilled personnel, and competition in our industry for qualified employees is intense.

SALES AND MARKETING

Our marketing and sales initiatives focus on member growth through four primary avenues: acquiring members through Health Insurance Marketplaces, acquiring members through brokers, acquiring members directly through our digital platform and internal sales team, and signing agreements with small businesses that provide employee coverage as part of their benefits packages. The significant majority of our membership is acquired through the broker channel. The proportion of broker-acquired business increased year over year consistent with the macro trend in the Health Insurance Marketplace, where we see fewer members signing up directly on the exchanges.

We use marketing and sales strategies and various channels, including the internet on a selected basis, to promote our advertisements through social and other media platforms, to reach consumers as well as enterprise benefits leaders. Enterprise marketing and sales strategies also include account-based marketing, business development initiatives, and client service teams focused on member acquisition, employee enrollment, and member engagement. We also use the data generated in member support interactions to constantly refine and improve our marketing campaign.

INTELLECTUAL PROPERTY

We believe that our intellectual property rights are important to our business, and our commercial success depends, in part, on our ability to protect our core technologies and other intellectual property assets. We rely on a combination of copyrights, trademarks, service marks, trade secret laws, technical know-how, confidentiality procedures, and other contractual restrictions to establish and protect our intellectual property. As of December 31, 2022, we exclusively owned two registered trademarks in the United States, the Oscar and Oscar Health marks. While trademark registrations in the United States have terms of limited duration, there is no limit on the number of times that the registrations may be renewed if they remain in use in commerce and if all required filings and payments are made with the United States Patent and Trademark Office. Further, even if a federal registration of a trademark in the United States is not renewed, the owner of the trademark may retain its common law trademark rights thereafter, for as long as the mark remains in use in commerce in the applicable state or states. In addition, we have registered domain names for websites that we use or may use in our business. As of December 31, 2022, we had no issued patents and no pending patent applications anywhere in the world, and therefore, we do not have patent protection for any of our proprietary technology, including our full stack technology platform, proprietary software, mobile app, or web portal. However, our software and other proprietary information are protected by copyright on creation. Copyright registrations, which have so far not been necessary, may be sought on an as-needed basis.

We seek to control access to and distribution of our proprietary information, including our algorithms, source and object code, designs, and business processes, through security measures and contractual restrictions. We seek to limit access to our confidential and proprietary information to a "need to know" basis and enter into confidentiality and nondisclosure agreements with our employees, consultants, members, vendors, and partners that may receive or otherwise have access to any confidential or proprietary information. We also obtain written invention assignment agreements from our employees and consultants that assign to us all right, interest, and title to inventions and work product developed during their employment or service engagement, respectively, with us. In the ordinary course of business, we provide our intellectual property to external third parties through licensing or restricted use agreements. For information on risks associated with our intellectual property rights, see "Risk Factors—Risks Related to our Business—Failure to secure, protect, or enforce our intellectual property rights could harm our business, results of operations, and financial condition."

INFORMATION TECHNOLOGY

Our business is dependent on effective, resilient, and secure information systems that assist us in, among other things, monitoring utilization and other cost factors, processing provider claims, providing data to our regulators, and implementing our data security measures. Our members also depend upon our information systems for enrollment, primary care and specialist physician roster access and other information, while our providers depend upon our information systems for eligibility verifications, claims status, and other information.

We partner with third parties, including Amazon, Appian, Atlassian, inContact, and Google, to support our information technology systems. This makes our operations vulnerable to adverse effects if such third parties fail to perform adequately. We have entered into agreements with third-party vendors who manage certain of our information technology infrastructure services including, among other things, our information technology operations, end-user services, and platforms for cloud computing. As a result of such agreements, we have been able to reduce our administrative expenses over time, while improving the reliability of our information technology functions, and maintain targeted levels of service and operating performance. A segment of the infrastructure services is managed within our cloud platform, while other portions of the infrastructure services are managed externally by vendors. Our use of cloud service providers in particular is intentionally and inherently resilient, with platform level redundancy in networking and computer hardware. As an example, we distribute our Amazon Web Services services across multiple availability zones to reduce the likelihood of infrastructure failure.

We have established a program of security measures to help protect our computer systems from security breaches and malicious activity and have implemented controls designed to protect the confidentiality, integrity, and availability of data, including protected health information ("PHI"), and the systems that store and transmit such data. We have employed various technology and process-based methods, such as network isolation, intrusion detection systems, vulnerability assessments, penetration testing, use of threat intelligence, content filtering, endpoint security (including anti-malware and detection response capabilities), email security mechanisms, and access control mechanisms. We also use encryption techniques for data at rest and in transit.

Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our current and expected operational needs and regulatory requirements. We regularly upgrade and expand our information systems' capabilities. For information on risks associated with our information technology systems, see "Risk Factors—Risks Related to our Business—If we are unable to integrate and manage our information systems effectively, our operations could be disrupted" and "Risk Factors—Risks Related to our Business—If we or our partners or other third parties with whom we collaborate sustain a cyber-attack or suffer privacy or data security breaches that disrupt our information systems or operations, or result in the dissemination of sensitive personal or confidential information, we could suffer increased costs, exposure to significant liability, adverse regulatory consequences, reputational harm, loss of business, and other serious negative consequences."

GOVERNMENT REGULATION

General

Our operations are subject to comprehensive and detailed federal, state, and local laws and regulations throughout the jurisdictions in which we do business. These laws and regulations, which can vary significantly from jurisdiction to jurisdiction, restrict how we conduct our businesses and result in additional burdens and costs to us. Further, federal, state, and local laws and regulations are subject to amendments and changing interpretations in each jurisdiction. In addition, there are numerous proposed health care laws and regulations at the federal, state, and local levels. For information on risks associated with our regulatory framework, see "Risk Factors—Risks Related to the Regulatory Framework that Governs Us—Changes or developments in the health insurance markets in the United States, including passage and implementation of a law to create a single-payer or government-run health insurance program, could materially and adversely harm our business and operating results."

Supervisory agencies, including federal and state regulatory and enforcement authorities, have broad authority to:

- grant, suspend, deny, and revoke certificates of authority to transact insurance;
- regulate our products and services;
- regulate, limit, or suspend our ability to market products, including the exclusion of our products from Health Insurance Marketplaces;
- approve premium rates;
- monitor our solvency and reserve adequacy;
- scrutinize our investment activities on the basis of quality, diversification, and other quantitative criteria; and
- impose criminal, civil, or administrative monetary penalties, and other sanctions for non-compliance with regulatory requirements.

To carry out the above tasks, CMS and other agencies periodically examine our current and past business practices, accounts and other books and records, operations and performance of our health plans, compliance with contracts, adherence to governing rules and regulations, and the quality of care we provide to our members. This information and these practices may be subject to routine surveys, mandatory data reporting and disclosure requirements, regular and special investigations and audits, and from time to time, we may receive subpoenas and other requests for information from government entities. The health insurance business also may be adversely impacted by court decisions that expand or invalidate the interpretations of existing statutes and regulations. It is uncertain whether we can recoup, through higher premiums or other measures, the increased costs caused by potential legislation, regulation, or court rulings.

State Regulation of Insurance Companies and HMOs

Our insurance and health maintenance organization ("HMO") subsidiaries must obtain and maintain regulatory approvals to sell specific health plans in the jurisdictions in which they conduct business. The nature and extent of state regulation varies by jurisdiction, and state insurance regulators generally have broad administrative authority with respect to all aspects of the insurance business. The Model Audit Rule, where adopted by states, requires expanded governance practices, risk and solvency assessment reporting and the filing of periodic financial and operating reports. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. Health insurers and HMOs are subject to state examination and periodic regulatory approval renewal proceedings. Some of our business activity is subject to other health care-related regulations and requirements, including utilization review, pharmacy service, or provider-related regulations and regulatory approval requirements. These requirements differ from state to state and may contain network, contracting, product and rate, licensing and financial and reporting requirements. There are laws and regulations that set specific standards for delivery of services, appeals, grievances, and payment of claims, adequacy of health care professional networks, fraud prevention, protection of consumer health information, pricing and underwriting practices, and covered benefits and services.

In addition, we are regulated as an insurance holding company and are subject to the insurance holding company laws of the states in which our health insurance subsidiaries are domiciled. These laws and other laws that govern operations of insurance companies and HMOs contain certain reporting requirements, as well as restrictions on transactions between an insurer or HMO and its affiliates, and may restrict the ability of our health insurance subsidiaries to pay dividends to our holding companies. For example, under the regulations of certain states, our insurance subsidiaries may not declare or distribute a dividend to shareholders except out of earned surplus. Holding company laws and regulations generally require registration with applicable state departments of insurance and the filing of reports describing capital structure, ownership, financial condition, certain intercompany transactions, enterprise risks, corporate governance, and general business operations. In addition, state insurance holding company laws and regulations generally require notice or prior regulatory approval of certain transactions including acquisitions, material intercompany transfers of assets, and guarantees and other transactions between the regulated companies and their affiliates, including parent holding companies. Applicable state insurance holding company acts also restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. These acts generally define "control" as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person. Some state laws have different definitions or applications of this standard. Dispositions of control generally are also regulated under applicable state insurance holding company laws.

The states of domicile of our health insurance subsidiaries have statutory risk-based capital ("RBC") requirements for insurance companies and HMOs. Most of our subsidiaries are subject to requirements based on the Risk-Based Capital For Health Organizations Model Act, with a few subsidiaries subject to state-specific RBC requirements that are not based on, but function similarly to, the Model Act. These RBC requirements are intended to assess the capital adequacy of life and health insurers and HMOs, taking into account the risk characteristics of a company's investments and products. In general, under these laws, an insurance company or HMO must submit a report of its RBC level to the insurance regulator of its state of domicile each calendar year. These laws typically require increasing degrees of regulatory oversight and intervention if a company's RBC declines below certain thresholds. As of December 31, 2022, the RBC levels of our insurance and HMO subsidiaries met or exceeded all applicable mandatory RBC requirements. For more information on RBC capital and additional liquidity and capital requirements, see "Management's Discussion and Analysis of Financial Condition and Results of Operations—Liquidity and Capital Resources—Overview."

Additionally, as a company that directly or indirectly controls insurers, we have an obligation to adopt a formal enterprise risk management ("ERM") function and file enterprise risk reports on an annual basis. The ERM function and reports must address any activity, circumstance, event, or series of events involving the insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer, including anything that would cause the insurer's RBC to fall below certain threshold levels or that would cause further transaction of business to be hazardous to policyholders or creditors, or the public. Similarly, in accordance with The National Association of Insurance Commissioners' ("NAIC") Risk Management and Own Risk Solvency Assessment Model Act, we must complete an annual "own risk and solvency assessment," which is an internal assessment, appropriate to the nature, scale, and complexity of our company, of the material and relevant risks associated with the current business plan, and of the sufficiency of capital resources to support those risks.

Ongoing Requirements and Changes Stemming from the ACA

The ACA significantly changed the United States healthcare system. While we anticipate continued changes with respect to the ACA, either through Congress, court challenges, executive actions, or administrative action, we expect the major portions of the ACA to remain in place and continue to significantly impact our business operations and results of operations, including pricing, minimum MLRs, the implementation of a risk adjustment program, and the geographies in which our products are available.

The ACA prohibits annual and lifetime limits on essential health benefits, member cost-sharing on specified preventive benefits, and pre-existing condition exclusions. Further, the ACA implemented certain requirements for insurers, including changes to Medicare Advantage payments and the minimum MLR provision that requires insurers to pay rebates to members when insurers do not meet or exceed the specified annual MLR thresholds. In addition, the ACA required a number of other changes with significant effects on both federal and state health insurance markets, including strict rules on how health insurance is rated, what benefits must be offered, the assessment of new taxes and fees, the creation of public Health Insurance Marketplaces for Individuals and Small employer group health insurance and the availability of premium subsidies for qualified individuals. The ACA allows individual states to choose to enact additional state-specific requirements that extend ACA mandates and some of the states where we operate have implemented higher MLR percentage requirements, lower tobacco user rating ratios, and different age curve variations. Changes to our business environment are likely to continue as elected officials at the national and state levels continue to enact, and both elected officials and candidates for election continue to propose significant modifications to existing laws and regulations, including changes to taxes and fees. For information on risks associated with ACA and changes to ACA, see "Risk Factors—Most Material Risks to Us—Any potential repeal of, changes to, or judicial challenges to the ACA and its regulations, could materially and adversely affect our business, results of operations, and financial condition."

In general, the individual market risk pool that includes public Health Insurance Marketplaces has changed significantly since its inception in 2014 and continues to exhibit risk volatility. Based on our experience in public Health Insurance Marketplaces to date, we have made adjustments to our premium rates and participation footprint, and we will continue to evaluate the performance of such products going forward.

In addition, insurers have faced uncertainties related to federal government funding for various ACA programs. On March 11, 2021, President Biden signed into law the American Rescue Plan Act of 2021 ("American Rescue Plan"), which built upon many of the measures in the Coronavirus Aid, Relief, and Economic Security Act ("the CARES Act"). Under the American Rescue Plan, starting April 1, 2021, APTC subsidies were available for the 2021 and 2022 plan years for most individuals and families making more than 400% of the federal poverty level ("FPL"), and APTC subsidies were temporarily increased for all income brackets. The enhanced APTC subsidies were intended to lapse at the end of 2022 but were extended through plan year 2025 by the Inflation Reduction Act of 2022. The American Rescue Plan also provides for enhanced flexibility for states to extend Medicaid eligibility to women for 12 months postpartum.

Further, implementation of the ACA brings with it significant oversight responsibilities by health insurers that may result in increased governmental audits, increased assertions of alleged False Claims Act ("FCA") liability, and an increased risk of other litigation.

Federal regulatory agencies continue to modify regulations and guidance related to the ACA and markets more broadly. Some of the more significant ACA rules are described below:

- The minimum MLR thresholds by market, as defined by U.S. Department of Health and Human Services ("HHS"), are as follows:
  - Small Group: 80%
  - Individual: 80%

- Certain states require us to meet more restrictive MLR thresholds. For example, New York state law requires an 82% MLR for both Small Group and Individual products and plans.

- The minimum MLR thresholds disclosed above are based on definitions of an MLR calculation provided by HHS, or specific states, as applicable, and differ from our calculation of MLR based on premium revenue and benefit expense as reported in accordance with U.S. GAAP. Definitions under applicable MLR regulations also impact insurers differently depending upon their organizational structure or tax status, which could result in a competitive advantage to some insurance providers that may not be available to us, resulting in an uneven playing field in the industry. Failure to meet the minimum MLR thresholds triggers an obligation to issue premium rebates to members.

- The ACA also imposed a separate minimum MLR threshold of 85% for Medicare Advantage plans. Medicare Advantage plans that do not meet this threshold will have to pay a member MLR rebate. If a plan's MLR is below 85% for three consecutive years, enrollment will be restricted and the plan will be prohibited from accepting new members. A Medicare Advantage plan contract will be terminated if the plan's MLR is below 85% for five consecutive years.

- All of our membership associated with our direct policy premium revenue was subject to the minimum MLR regulations as of and for the year ended December 31, 2022.

- The ACA created an incentive payment program for Medicare Advantage plans. CMS has developed the Medicare Advantage Star Ratings system, which awards between 1.0 and 5.0 stars to Medicare Advantage plans based on performance in several categories, including quality of care, access to care, member experience, and operational effectiveness. The Star Ratings are used by CMS to award quality-based bonus payments to plans that receive a rating of 4.0 stars or higher. The methodology and measures included in the Star Ratings system can be modified by CMS annually. For plan year 2023, two of our Medicare Advantage plans were eligible to receive a full Star Rating, and both received overall ratings of 3.5 Stars.

- Further, the ACA directed the HHS Secretary to develop a system that rates qualified health plans ("QHPs"), certified by the Health Insurance Marketplace based on relative quality and price. As a QHP issuer, we must submit quality rating information in accordance with CMS guidelines as a condition of certification and participation in the Health Insurance Marketplaces. Our overall ratings, represented on a scale of 1.0 to 5.0 stars, are based on three categories: member experience, medical care, and plan administration. As of 2021, quality rating information for QHPs is publicly displayed and accessible to consumers on all Health Insurance Marketplaces.

- Federal regulations require premium rate increases to be reviewed for Small Group and Individual products above specified thresholds that may be adjusted from time to time and enrollees to be notified of the premium rate increase in advance. The regulations provide for state insurance regulators to conduct the reviews, except in cases where a state lacks the resources or authority to conduct the required rate reviews, in which cases HHS will conduct the reviews.

- Prior to the implementation of the ACA, health insurers were permitted to use differential pricing based on factors such as health status, gender, and age. The ACA prohibits health insurers selling ACA-regulated plans in the Individual and Small Group markets from using health status and gender in the determination of the insurance premium. In addition, age rating under the ACA is limited to a 3:1 ratio for adults age 21 and older, and tobacco use rating is limited to a 1.5:1 ratio. States also may choose to enact more restrictive rules than the federal minimum standards.

- Medicare Advantage reimbursement rates will not increase as much as they would have absent the ACA, due to the payment formula promulgated by the ACA that continues to impact reimbursements. We also expect further and ongoing regulatory guidance on a number of issues related to Medicare Advantage, including evolving methodologies for ratings and quality bonus payments. While the changes to the RADV program are in part intended to provide health insurers with greater stability and predictability, and promote fairness in the RADV program's administration, such changes may ultimately increase the government's ability to retrospectively claw back or recover funds from health insurers.

Regulation of Medicare Advantage Plans

We are also subject to comprehensive oversight from CMS related to our Medicare Advantage plans. CMS regulates the Medicare Advantage payments made to us and the submission of information relating to the health status of members for purposes of determining the amounts of those payments. Additional CMS regulations govern Medicare Advantage benefit design, eligibility, enrollment and disenrollment processes, call center performance, plan marketing, record-keeping and record retention, quality assurance, timeliness of claims payment, network adequacy, and certain aspects of our relationships with and compensation of providers.

Privacy, Confidentiality and Data Standards Regulation

The Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act of 2009 (together, "HIPAA") and the administrative simplification provisions of HIPAA impose a number of requirements on covered entities (including health insurers, HMOs, group health plans, certain providers, and clearinghouses) and their business associates relating to the use, disclosure and safeguarding of PHI. These requirements include uniform standards of common electronic health care transactions and privacy and security regulations, and unique identifier rules for employers, health plans, and providers.

In addition, the Health Information Technology for Economic and Clinical Health Act of 2009 and corresponding implementing regulations have imposed additional requirements on the use and disclosure of PHI such as additional breach notification and reporting requirements, contracting requirements for HIPAA business associate agreements, and strengthened enforcement mechanisms and increased penalties for HIPAA violations. Federal consumer protection laws may also apply in some instances to our privacy and security practices related to personally identifiable information. We maintain an internal HIPAA compliance program, which we believe complies with HIPAA privacy and security regulations, and have dedicated resources to monitor compliance with this program.

In addition, Health Insurance Marketplaces are required to adhere to privacy and security standards with respect to personally identifiable information and to impose privacy and security standards that are at least as protective as those the marketplaces must follow. These standards may differ from, and be more stringent than, HIPAA.

The use and disclosure of certain data that we collect or process about or from individuals are also regulated in some instances by other federal laws, including the Gramm-Leach-Bliley Act ("GLBA"), and state statutes implementing GLBA, in connection with insurance transactions in the states where we operate. Additionally, in response to the growing threat of cyber-attacks in the insurance industry, certain jurisdictions, including New York, have begun to consider new cybersecurity measures, including the adoption of cybersecurity regulations. In March 2017, the New York Department of Financial Services ("NYDFS") promulgated Cybersecurity Requirements for Financial Services Companies, which require covered financial institutions to establish and maintain a cybersecurity program and implement and maintain cybersecurity policies and procedures that meet specific requirements.

There are also numerous state and federal laws and regulations related to the privacy and security of health information. Laws in all 50 states require businesses to provide notices to affected individuals whose personal information has been disclosed as a result of a data breach, and certain states require notifications for data breaches involving individually identifiable health information. Most states require holders of personal information to maintain safeguards and take certain actions in response to a data breach, such as maintaining reasonable security measures and providing prompt notification of the breach to affected individuals and the state's attorney general. For further discussion, see "Risk Factors—Risks Related to the Regulatory Framework that Governs Us."

Furthermore, states have begun enacting more comprehensive privacy laws and regulations addressing consumer rights to data protection or transparency that may affect our privacy and security practices. This includes, for example, the California Consumer Privacy Act of 2018 ("CCPA"), which governs the collection, use, handling, processing, destruction, disclosure, storage, and protection of California residents' data and imposes additional breach notification requirements. The CCPA requires new disclosures, imposes new rules, and affords California residents new abilities to seek access and deletion of their non-PHI personal information in portions of our business not regulated by the GLBA and state law equivalents.

Additionally, a new California ballot initiative, the California Privacy Rights Act of 2023 ("CPRA"), was passed in November 2020. Effective starting on January 1, 2023, the CPRA imposes additional obligations on companies covered by the legislation and will significantly modify the CCPA, including by expanding consumers' rights with respect to certain sensitive personal information. The CPRA also creates a new state agency that will be vested with authority to implement and enforce the CCPA and the CPRA. Laws similar to the CCPA and CPRA have passed in Virginia and Colorado, and have been proposed in other states and at the federal level, reflecting a trend toward more stringent privacy legislation in the United States. State consumer protection laws may also apply to our privacy and security practices related to personal information, including information related to consumers and care providers.

Newer federal regulations requiring additional transparency could also materially impact our operations. These regulations include federal regulation on data interoperability requiring member data to be made available to third parties unaffiliated with Oscar, as well as federal regulations requiring hospitals and insurers to publish negotiated prices for services as well as the most accurate out-of-pocket cost estimate possible based on an individual's health plan for procedures, drugs, durable medical equipment, and other items or services.

In addition, certain of our businesses are also subject to the Payment Card Industry ("PCI") Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by PCI entities. We rely on vendors to assist us with PCI matters and to maintain PCI compliance. Our business and operations are also subject to federal, state, and local consumer protection laws governing the use of email and telephone marketing.

Fraud, Waste and Abuse Laws and the False Claims Act

Because we receive payments from federal governmental agencies, we are subject to various laws commonly referred to as "fraud, waste, and abuse" laws, including the federal Anti-Kickback Statute, the Stark Law, and the FCA. These laws permit the Department of Justice ("DOJ"), the HHS Office of Inspector General ("HHS-OIG"), CMS, and other enforcement authorities to institute a claim, action, investigation, or other proceeding against us for violations and, depending on the facts and circumstances, to seek treble damages, criminal, civil, or administrative fines, penalties, and assessments. Violations of these laws can also result in exclusion, debarment, temporary or permanent suspension from participation in government health care programs, the institution of corporate integrity agreements ("CIAs"), and/or other heightened monitoring of our operations. Liability under such statutes and regulations may arise if, among other things, we knew, or it is determined that we should have known, that information we provided to form the basis for a claim for government payment was false or fraudulent, or that we were out of compliance with program requirements considered material to the government's payment decision. Companies who receive funds from federal and state governmental agencies are required to maintain compliance programs to detect and deter fraud, waste, and abuse. Although our compliance program is designed to meet all statutory and regulatory requirements, our policies and procedures are frequently under review and subject to updates, and our training and education programs continue to evolve.

Fraud, waste, and abuse prohibitions encompass a wide range of activities, including, but not limited to, kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a health care provider, payments made to excluded providers, and improper marketing and beneficiary inducements. In particular, there has recently been increased scrutiny by the DOJ on health plans' diagnosis coding and risk adjustment practices, particularly for Medicare Advantage plans. The regulations, contractual requirements, and policies applicable to participants in government health care programs are complex and subject to change. Health insurers are required to maintain compliance programs to prevent, detect, and remediate fraud, waste, and abuse, and are often the subject of fraud, waste, and abuse investigations and audits.

In addition to the FCA, under the federal Civil Monetary Penalties Law, the HHS-OIG has the authority to impose civil penalties against any person who, among other things, knowingly presents, or causes to be presented, certain false or otherwise improper claims. There also is FCA liability for knowingly or improperly avoiding repayment of an overpayment received from the government and/or failing to promptly report and return such overpayment. Qui tam actions can be brought by private individuals (for example, a "whistleblower," such as a disgruntled current or former competitor, member, or employee) on behalf of the government alleging that a company has defrauded the government, and the FCA permits the private individual to share in any settlement of, or judgment entered in, the lawsuit. Qui tam actions have increased significantly in recent years, causing greater numbers of health care companies to have to defend a false claim action, pay substantial settlement amounts, and/or enter into a CIA and/or other heightened monitoring arrangements to avoid exclusion from government health care programs as a result of an investigation arising out of such action. See "Risk Factors—Risks Related to the Regulatory Framework that Governs Us—We are subject to extensive fraud, waste, and abuse laws that may require us to take remedial measures or give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our business, financial condition, cash flows, or results of operations."

Further, analogous state laws and regulations, such as state anti-kickback and false claims laws, which may apply to sales or marketing arrangements and claims involving healthcare items or services reimbursed by non-governmental third-party payors, including private insurers, may be broader in scope than their federal equivalents; state insurance laws require insurance companies to comply with state regulations.

Guaranty Fund Assessments

Under certain state insolvency or guaranty association laws, insurance companies and HMOs can be assessed for amounts paid by guaranty funds for policyholder losses incurred when an insurance company or HMO becomes insolvent. Most state insolvency or guaranty association laws currently provide for assessments based upon the amount of premiums received on insurance underwritten within such state (with a minimum amount payable even if no premium is received). Under many of these guaranty association laws, assessments are made or adjusted retrospectively. Some states permit insurers or HMOs to recover assessments paid through full or partial premium tax offsets, or through future policyholder surcharges. The amount and timing of any future assessments cannot be predicted with certainty; however, future assessments are likely to occur.

Corporate Practice of Medicine and Fee-Splitting Laws

Oscar Medical Group, which consists of physician-owned professional corporations, functions as a direct medical service provider and, as such, our arrangements with Oscar Medical Group are subject to additional laws and regulations. Some states have corporate practice of medicine laws prohibiting specific types of entities from practicing medicine or employing physicians to practice medicine. Moreover, some states prohibit certain entities from engaging in fee-splitting practices which involve sharing in the fees or revenues of a professional practice. These prohibitions may be statutory or regulatory, or may be imposed through judicial or regulatory interpretation. The laws, regulations and interpretations in certain states have been subject to limited judicial and regulatory interpretation and are subject to change. See "Risk Factors—Risks Related to Our Business—We make virtual health care services available to our members through Oscar Medical Group, in which we do not own any equity or voting interest, and our virtual care availability may be disrupted if our arrangements with providers like the Oscar Medical Group become subject to legal challenges."

AVAILABLE INFORMATION

Our website is www.hioscar.com. Through the "Investor Relations" section of our website (ir.hioscar.com), we make available free of charge a variety of information for investors, including our annual report on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K and any amendments to those reports, as soon as reasonably practicable after we electronically file that material with or furnish it to the Securities and Exchange Commission ("SEC").

We announce material information to the public about us, our products and services, and other matters through a variety of means, including filings with the SEC, press releases, public conference calls, webcasts and the investor relations section of our website in order to achieve broad, non-exclusionary distribution of information to the public and for complying with our disclosure obligation under Regulation FD.

The information disclosed by the foregoing channels could be deemed to be material information. As such, we encourage investors, the media, and others to follow the channels listed above and to review the information disclosed through such channels.

Any updates to the list of disclosure channels through which we will announce information will be posted on the "Investor Relations" section of our website. Except as specifically indicated otherwise, the information found or available by hyperlink on our website or any other outlets we identify from time to time is not and shall not be deemed to be part of this or any other report we file with, or furnish to, the SEC.

Item 1A. Risk Factors

Our business involves a high degree of risk. You should carefully consider the risks and uncertainties described below, together with all of the other information contained in or incorporated by reference in this Annual Report on Form 10-K, including our audited consolidated financial statements and related notes, as well as our other filings with the SEC. The occurrence of any of the events described below could harm our business, operating results, financial condition, liquidity, or prospects, and could cause our actual results to differ materially from historical results and those expressed in forward-looking statements made by us or on our behalf in filings with the SEC, press releases, communications with investors, and oral statements. In any such event, the market price of our Class A common stock could decline, and you may lose all or part of your investment. Additional risks and uncertainties not presently known to us, or that we currently deem immaterial, may also impair our business.

Most Material Risks to Us

Our business, financial condition, and results of operations may be harmed if we fail to execute our strategy and manage our growth effectively.

Our growth strategy includes, without limitation, acquiring new members and retaining existing members, introducing new products and plans, and monetizing our technology through our +Oscar platform.

We may from time to time expand our membership by entering into new markets and introducing new health plans in the markets in which we currently operate. As our business grows, we may incur significant expenses prior to commencement of operations and the receipt of revenue in new markets or from new plans, including significant time and expense in obtaining the regulatory approvals and licenses necessary to grow our operations. For example, in order to obtain a certificate of authority to market and sell insurance in most jurisdictions, we must establish a provider network and demonstrate our ability to perform or delegate utilization management and other administrative functions, and we may be unable to complete these operational steps in a timely manner or at all. In addition, there are requirements and standards that need to be met, including in some cases an annual recertification process, in order to participate on Health Insurance Marketplaces. Even if we are successful in obtaining a certificate of authority, regulators may not approve our proposed benefit designs, provider networks, or premium levels, or may require us to change them or otherwise operate in ways that harm our profitability. If we are unable to obtain the approvals or licenses necessary, or otherwise meet regulatory and Health Insurance Marketplace requirements, our results of operations and financial condition could be materially and adversely affected.

As we expand our member base and enter new markets, we are also required to contribute capital to our insurance subsidiaries to fund capital and surplus requirements, escrows, or contingency guaranties, which may, at times, be significant. If we are successful in establishing a new health plan or entering a new market, increasing membership, revenues and medical costs could trigger further increased capital requirements, including risk-based capital ("RBC"), that could substantially exceed the net income generated by the health plan or in the new market. In certain states, the applicable statutes mandate higher capital requirements for an initial seasoning period, which may be reduced at the regulator's discretion. In addition, our membership may increase as a result of other factors over which we have limited control, including as a result of regulatory actions or other developments that contribute to an increase in participants in the Health Insurance Marketplace, which similarly could trigger further increased capital requirements that could be substantial. We may not be able to fund on a timely basis, or at all, the increased contribution and RBC requirements with our available cash resources, and may need to incur indebtedness or issue additional capital stock. In the event we need access to capital for such purposes, our ability to obtain such capital may be limited and may come at significant cost. Further, in light of market uncertainty, we have taken, and may in the future take, preemptive steps designed to prudently manage our membership and capital position. For example, prior to the 2023 Open Enrollment Period, the Company requested that regulators limit its membership growth in Florida above a certain threshold so that total membership across all markets would be within its previously announced target range of 900,000 to 1,100,000 at the close of Open Enrollment, which the Company believed would enable it to prudently manage its capital position. Due to strong Open Enrollment performance, the threshold was met and the Company temporarily stopped accepting new members in Florida in the fourth quarter of 2022; however, current members were still able to renew. Our ability to accept new members in Florida in the future, and timing of when we can do so, is subject to regulatory approval. If we are unable to obtain such approval our results of operations and financial condition could be materially and adversely affected.

Further, we may experience delays in operational start dates as we enter new markets or decide to exit geographic markets or terminate insurance products, which could not only result in financial harm, but also reputational harm to our brand. For example, the Company has previously determined to exit certain geographic markets and terminate certain insurance products, and there can be no assurance that any future decisions to exit will not materially impact our financial condition. If competitors seek to retain market share by reducing prices, we may be forced to reduce our prices on similar plan offerings in order to remain competitive. There is no assurance that a reduction in our plan pricing would enable us to maintain our competitive position, and any such reduction could impact our financial condition or require a change in our operating strategies. As a result of these factors, entering new markets or introducing new health plans may decrease our profitability.

We also pursue opportunities to monetize our technology platform through +Oscar and we may be in discussions with respect to one or more such opportunities at any given time. To offer our +Oscar platform administrative services, we may be required to obtain and maintain licenses and approvals in new and existing markets, including for third party administrative services, utilization review administrative services, pharmacy benefit administration, or preferred provider network administration services. We may not be able to do so on our expected timetable or at all, or to otherwise expand our

administrative service offerings and perform on our +Oscar or other commitments in an economically sustainable manner. Further, in 2022 we experienced certain operational challenges implementing full service +Oscar arrangements, including meeting certain service level standards, and a +Oscar client has terminated its +Oscar arrangement. In the future, even if we are able to obtain necessary licenses and approvals, our +Oscar arrangements may pose further operational challenges, may not be implemented on our expected timetable or at all, may not perform as well as expected, may not achieve timely profitability or expected synergies, may require us to incur additional costs, may expose us to additional liability, or may result in limitations on our ability to offer products in certain insurance markets and geographic regions. If we are not able to successfully implement and/or perform on our +Oscar arrangements, this may limit our ability to retain current +Oscar clients or obtain +Oscar clients in the future.

We may also pursue opportunistic partnerships and acquisitions to allow us to provide better health care options for our members as well as to augment existing operations, and we may be in discussions with respect to one or more partnerships or acquisitions at any given time. Partnerships or other acquisition opportunities that we enter into may not perform as well as expected, may not achieve timely profitability or expected synergies, may expose us to additional liability, or may limit our ability to offer products in certain insurance markets and geographic regions.

Pursuing our strategy requires significant capital expenditures, the allocation of valuable management and operational resources, and the hiring of additional personnel, and may strain our operations and our financial and management controls and reporting systems and procedures. For example, we have experienced, and may in the future experience, challenges with respect to our operations, including with respect to our claims systems, and these difficulties could increase as our membership increases. We also have experienced and may in the future experience attrition, which may further exacerbate these challenges. If we are unable to effectively execute our strategy and effectively manage our operations, systems and controls, our results of operations and financial condition could be materially and adversely affected.

Our success and ability to grow our business depend in part on retaining and expanding our member base. If we fail to add new members or retain current members, or manage our membership growth appropriately to meet our business objectives, our business, revenue, operating results, and financial condition could be harmed.

We currently derive substantially all of our revenue from direct policy premiums, which are primarily driven by the number of members covered by our health plans. As a result, the size of our member base is critical to our success. We have experienced significant member growth since we commenced operations; however, we may not be able to maintain this growth or manage our membership growth appropriately to meet our business objectives, and our member base could decrease rapidly or shrink over time.

There are many factors that could negatively affect our ability to retain existing members and expand our member base, many of which are beyond our direct control, including if:

- we are unable to remain competitive on member experience, pricing, and insurance coverage options;
- we are unable to gain access to quality providers;
- we are unable to develop or maintain competitive provider networks;
- our competitors or new market entrants successfully mimic our innovative product offerings or our full stack technology platform;
- as a result of changes in law or otherwise, our competitors participate in the Individual and Small Group markets to a greater extent than they have previously;
- our digital platform experiences technical or other problems or disruptions that frustrate the experience of members or providers or other third party partners;
- we or our partners or other third parties with whom we collaborate sustain a cyber-attack or suffer privacy or data security breaches;
- we experience unfavorable shifts in perception of our digital platform or other member service channels;
- we suffer reputational harm to our brand resulting from negative publicity, whether accurate or inaccurate;
- we are unable to maintain licenses and approvals, or there are material modifications or restrictions on our ability to offer insurance in our current markets or to participate on Health Insurance Marketplaces, obtain licenses and approvals to offer insurance in new markets, or to otherwise expand our plan offerings in an economically sustainable manner;
- we fail to continue to offer new and competitive products;
- our strategic partners terminate or fail to renew our current contracts or we fail to enter into contracts with new strategic partners;
- there is an initiation of new Special Enrollment Periods or other unexpected healthcare market developments;

- insurance brokers that we rely on to build our member base are unable to market our insurance products effectively; or
- we fail to attract brokers to sell our insurance products or lose important broker relationships to our competitors or otherwise.

We operate in a highly competitive environment and some of the health insurers with which we compete have greater financial and other resources, offer a broader scope of products, and may be able to price their products more competitively than ours. Many of our competitors also have relationships with more providers and provider groups than we do, and can offer a larger network or obtain better unit cost economics. Our inability to overcome these challenges could impair our ability to attract new members and retain existing members, and could have a material adverse effect on our business, revenue, operating results, and financial condition. Additionally, if we are not able to grow our membership, we may be unable to attract partners to our +Oscar platform, which could materially affect our ability to execute our growth strategy.

Failure to accurately estimate our incurred medical expenses or effectively manage our medical costs or related administrative costs could negatively affect our financial position, results of operations, and cash flows.

We set our premiums in advance of each policy year based on competitive factors in each market in which we participate as well as a projection of future expenses. As a result, the profitability of our insurance business depends, to a significant degree, on our ability to accurately estimate and effectively manage our medical expenses and administrative costs.

Numerous factors impact our ability to accurately estimate and control our medical expenses, many of which are not within our control, including, but not limited to:

- changes in health care regulations and practices, including subregulatory guidance, regulations, or statutes that govern individual, small group, or Medicare Advantage plans, or the Health Insurance Marketplaces;
- changes in medical utilization rates, including as a result of COVID-19;
- increases in the costs of healthcare facilities and services, medical devices and pharmaceuticals, including as a result of macroeconomic inflationary effects;
- changes in our member mix, the geographic concentration of our members, and the distribution of members among our plans;
- general expansion of the individual health insurance market;
- lack of credible data in new markets or with respect to new plan offerings;
- initiation of new Special Enrollment Periods or other unexpected healthcare market developments;
- the end of the temporary suspension of eligibility recertification for Medicaid recipients in response to the COVID-19 pandemic, which will likely result in an increase in healthcare exchange participation;
- the broader competitive landscape, including new membership resulting from other health insurers exiting our markets;
- the occurrence of natural disasters, terrorism, major epidemics, pandemics (including related to COVID-19 and its variants), and the potential effects of climate change;
- continued inequity and racial discrimination in the U.S. health care system, and the resulting physical and mental health costs in broader society;
- the introduction and adoption of new or costly medical technologies and pharmaceuticals; and
- provider fraud.

On January 30, 2023, the Biden Administration announced that the public health emergency (“PHE”) for COVID-19 will end on May 11, 2023. The Commencement of Medicaid redeterminations was previously linked to the end of the PHE, however, the omnibus spending bill passed in December 2022 delinked Medicaid redeterminations from the end of the PHE and they are set to begin April 1, 2023. As a result, we expect there could be an impact on our expected membership and/or underwriting margin.

Due to the time lag between when services are actually rendered by providers and when we receive, process, and pay a claim for those services, our medical expenses include a provision for claims incurred but not paid. Given the uncertainties inherent in making estimates for such provisions, there can be no assurance that our claims liability estimate will be adequate, and any adjustments to the estimate may unfavorably impact, potentially in a material way, our reported results of operations and financial condition. Further, our inability to estimate our claims liability may also affect our ability to take timely corrective actions, further exacerbating the extent of any adverse effect on our results.

We also incur substantial administrative costs, particularly distribution costs, the costs of scaling and improving our operations and the costs of hiring and retaining personnel. External factors, including general economic conditions such as inflation and unemployment levels, are generally beyond our control and could further reduce our ability to accurately estimate and effectively control our administrative expenses, including the cost of our third party vendors. Furthermore, regulatory changes or developments may require us to change our existing practices with respect to broker commissions and could potentially result in a substantial increase in related costs or limit our ability to manage those costs in the future. For instance, on June 7, 2022, the CMS clarified its guidance that paying differential compensation to agents and brokers for coverage in the same benefit year based on whether the enrollment is completed during a Special Enrollment Period or during the Open Enrollment Period is prohibited under federal law. While Oscar had reduced broker commissions as of a certain date in 2022 in certain states for operational and business reasons, as a result of this guidance, Oscar reinstated payment of broker commissions in such states in accordance with the guidance. Any such increase in costs could cause our actual results to differ, potentially materially, from our prior expectations. As a result of our market expansion, expansion of our plan offerings and growth of our membership, our anticipated medical expenses and administrative costs are subject to additional uncertainty.

From time to time in the past, our actual results have varied from those expected, particularly in times of significant changes in the number of our members. If it is determined that our estimates are significantly different from actual results, our results of operations and financial position could be adversely affected.

We have a history of losses, and we may not achieve or maintain profitability in the future.

We have not been profitable since our inception in 2012 and had an accumulated deficit of $2.0 billion and $2.6 billion as of December 31, 2021 and 2022, respectively. We incurred net losses of $571.4 million and $609.6 million in the years ended December 31, 2021 and 2022, respectively.

In support of our profitability goals, we have taken steps to price for margin expansion, drive down administrative costs and manage our medical costs, and plan to take further actions consistent with a disciplined approach to growth and prioritization of margin in our pricing. We have also taken actions to drive improved performance in our MLR and administrative expense ratio including exiting underperforming markets and optimizing our plan design portfolio to create greater balance towards profitable products. While we believe that we are tracking towards delivering on a critical company milestone of reaching profitability for our Insurance business in 2023, a critical step towards our long-term profitability objectives, we may not achieve our profitability goals on a timely basis, or at all.

In addition, we may make additional investments to further market, develop, and expand our business, including by hiring additional personnel, continuing to develop our full stack technology platform, member engagement engine and operations, acquiring more members, maintaining existing members and investing in partnerships, collaborations and acquisitions, including through our +Oscar platform. The commissions we offer to brokers could also increase significantly as we compete to attract new members.

We may not succeed in increasing our revenue or managing our costs on the timeline that we expect or in amounts sufficient to reduce our net loss and ultimately become profitable. Moreover, if our revenue declines, we may not be able to reduce costs in a timely manner because many of our costs are fixed, at least in the short-term. If we are unable to manage our costs effectively, this may limit our ability to optimize our business model, acquire new members, enter into +Oscar platform arrangements and grow our revenues. Accordingly, despite our best efforts to do so, we may not achieve or maintain profitability, and we may incur further significant losses in the future.

Any potential repeal of, changes to, or judicial challenges to the ACA and its regulations, could materially and adversely affect our business, results of operations, and financial condition.

For the years ended December 31, 2022 and 2021, approximately 99%, and 98%, respectively, of our revenue was derived from sales of health plans subject to regulation under the ACA, primarily comprised of policies directly purchased by individuals and families and secondarily comprised of policies purchased by small employers and provided to their employees as a benefit. Consequently, changes to, or repeal of, portions or the entirety of the ACA and its regulations, as well as judicial interpretations in response to legal and other constitutional challenges, could materially and adversely affect our business and financial position, results of operations, or cash flows. Even if the ACA is not amended or repealed, elected and appointed officials could continue to propose changes impacting the ACA, which could materially and adversely affect our business, results of operations, and financial condition.

The ACA also established significant subsidies to support the purchase of health insurance by individuals, in the form of advanced premium tax credits, or APTCs, available through Health Insurance Marketplaces. The American Rescue Plan added additional APTCs for individuals at every household income level for 2021 and 2022; those additional APTCs have been renewed for three years through 2025 under the Inflation Reduction Act of 2022. During the years ended December 31, 2022 and 2021, the direct policy premiums of approximately 85% and 73%, respectively, of our members were subsidized by APTCs. Although subsidies have been extended through 2025, the future elimination or reduction of APTCs or other subsidies could make such coverage unaffordable to some individuals and thereby reduce overall participation in the Health Insurance Marketplaces and our membership. These fluctuations could have a significant adverse effect on our business and future operations, and our results of operations and financial condition. Further, the lack of federal funding of cost sharing subsidies could additionally impact Health Insurance Marketplace enrollment. Such market and political dynamics may increase the risk that our Health Insurance Marketplace products will be selected by individuals who have a higher risk profile or utilization rate or lower subsidization rate than we anticipated when we established the pricing for products on Health Insurance Marketplaces, possibly leading to financial losses.

Historically, there have been significant efforts to repeal, or limit implementation of, certain provisions of the ACA. Such initiatives include repeal of the individual mandate effective in 2019, as well as easing of the regulatory restrictions placed on short-term limited duration insurance and association health plans, some or all of which may provide fewer benefits than the traditional ACA-mandated insurance benefits. The ACA has also been subject to multiple judicial challenges surrounding its constitutionality. Ongoing political volatility could mean possible changes in state and federal legislation governing Health Insurance Marketplaces. Depending on these changes, this could result in fluctuations in participation from individuals seeking insurance coverage and/or possible non-renewal of existing policies. Because we rely on the Health Insurance Marketplaces, any changes to the ACA that result in reduced membership, or other changes in healthcare law and regulation, could materially and adversely impact our business, financial condition, and results of operations.

Risks Related to the Regulatory Framework that Governs Us

Our business activities are subject to ongoing, complex, and evolving regulatory obligations, and to continued regulatory review, which result in significant additional expense and the diversion of our management's time and efforts. If we fail to comply with regulatory requirements, or are unable to meet performance standards applicable to our business, our operations could be disrupted or we may become subject to significant penalties.

We operate in a highly regulated industry and we must comply with numerous and complex state and federal laws and regulations to operate our business, including requirements to maintain or renew our regulatory approvals or obtain new regulatory approvals to sell insurance and to sell specific health plans.

The NAIC has adopted the Annual Financial Reporting Model Regulation, or the Model Audit Rule, which, where adopted by states, requires expanded governance practices, risk and solvency assessment reporting, and filing of periodic financial and operating reports. Most states have adopted these or similar measures to expand the scope of regulations relating to corporate governance and internal control activities of HMOs and insurance companies. We are also required to notify, or obtain approval from, federal and/or state regulatory authorities prior to taking various actions as a business, including making changes to our network, service offerings, and the coverage of our health plans, as well as prior to entering into relationships with certain vendors and health organizations. Delays in obtaining or failure to obtain or maintain these approvals could reduce our revenue or increase our costs. Existing or future laws and rules could also require or lead us to take other actions such as changing our business practices, and could increase our liability.

The ACA implemented certain requirements for insurers, including changes to Medicare Advantage payments, a minimum MLR provision that requires insurers to pay rebates to consumers when insurers do not meet or exceed specified annual MLR thresholds, and anti-discrimination protections on the basis of race, color, national origin, sex, age, and disability, which may impact the manner in which health insurers receiving any form of federal financial assistance design and implement their benefit packages. Further, the ACA imposes significant fees, assessments, and taxes on us and other health insurers, plans and other industry participants. Additionally, there are numerous steps federal and state regulators require for continued implementation of the ACA including the annual federal updates to implementing market regulations via the Notice of Benefit and Payment Parameters. If we fail to effectively implement or appropriately adjust our operational and strategic initiatives with respect to the implementation of health care reform, or do not do so as effectively as our competitors, our results of operations may be materially and adversely affected.

We also offer Medicare Advantage plans, which requires us to comply with a myriad of rules, regulations, and subregulatory guidance, as well as third party and publicly administered performance standards. In urbanized areas, Medicare Advantage plans must be capable of enrolling at least 5,000 beneficiaries. CMS can waive this minimum enrollment requirement for the

first three years of the contract. If we fail to enroll the minimum number of beneficiaries, CMS may elect not to renew our Medicare Advantage contracts. In addition, a portion of each Medicare Advantage plan's reimbursement is tied to the plan's Star Rating, as published by CMS, with those plans receiving a rating of four (4.0) or more stars eligible for quality-based bonus payments. A plan's Star Rating affects its image in the market, and plans that achieve higher Star Ratings are able to offer enhanced benefits and market more effectively and, as a result, may have a competitive advantage over plans with lower Star Ratings. Medicare Advantage plans with Star Ratings of less than three (3.0) stars for three consecutive years are denoted as "low performing" plans on the CMS website and in the CMS "Medicare and You" handbook and CMS has the authority to terminate the Medicare Advantage contracts for such plans. For plan year 2023, our New York and Texas Medicare Advantage plans received a 3.5 Star Rating. New York earned 3 Stars in Part C and 4 Stars in Part D, while Texas earned 3.5 Stars in both Part C and D. The Florida Medicare Advantage plan is too small and new to earn an overall Star Rating, but it did earn a Part D only rating of 2.5 Stars. The Star Rating system is subject to change annually by CMS, which may make it more difficult to achieve and maintain favorable Star Ratings in the future. Our health insurance subsidiaries' operating results, premium revenue, and benefit offerings will likely depend significantly on their Star Ratings, and there can be no assurances that we will be successful in achieving favorable Star Ratings or maintaining or improving our Star Ratings once achieved.

Similarly, health care accreditation entities such as the National Committee for Quality Assurance ("NCQA"), evaluate health plans based on various criteria, including effectiveness of care and member satisfaction. Health insurers seeking accreditation from NCQA must pass a rigorous, comprehensive review, and must annually report their performance. If we fail to achieve and maintain accreditation from agencies, such as NCQA, we could lose the ability to offer our health plans on Health Insurance Marketplaces, or in certain jurisdictions, which would materially and adversely affect our results of operations, financial position, and cash flows.

In addition, in each of the markets in which we operate, we are regulated by the relevant insurance and/or health and/or human services, or other government departments that oversee the activities of insurance and/or healthcare organizations providing or arranging to provide services to Medicare Advantage members, Health Insurance Marketplace enrollees, or other beneficiaries. For example, our health insurance subsidiaries must comply with minimum statutory capital and other financial solvency requirements, such as deposit and surplus requirements, and related reporting requirements, as well as price transparency requirements that mandate publication or disclosure of information related to the pricing or costs of covered items or services. In October 2020, HHS issued a health transparency regulation which went into effect in July 2022 (the "Health Plan Transparency Rule"). The Health Plan Transparency Rule requires monthly disclosures of, among other things, detailed pricing information regarding our negotiated rates for all covered items and services with in-network providers and historical payments to, and billed charges from, out-of-network providers. Additional disclosures under the Health Plan Transparency Rule went into effect in 2023 (personalized out-of-pocket cost information and negotiated rates for specified healthcare items and services) and will be further expanded in 2024 (all items and services). In December 2020, Congress passed the No Surprises Act, which requires health insurers to hold members harmless for out-of-network costs in certain circumstances, and requires that insurers and healthcare providers work to agree on out-of-network reimbursement, including through utilizing the independent dispute resolution process outlined in the No Surprises Act or a similar process established under applicable state law. The No Surprises Act became effective on January 1, 2022. Many states have enacted separate legislation addressing balance billing or surprise medical bills. These laws and regulations vary in their approach, resulting in different impacts on the health care system as a whole. Our health insurance subsidiaries must also comply with numerous statutes and regulations governing the sale, marketing, and administration of insurance. We have in the past, and we may in the future, fail to take actions mandated by federal and/or state laws or regulations with respect to changes in our health benefits, the health insurance policies for which individuals are eligible, proposed or actual premiums, and/or other aspects of individuals' health insurance coverage. Such failures may result in our having to take corrective action, including making remediation payments to our members or paying fines to regulators, may subject us to negative publicity, or may result in the inability to offer our health plans on Health Insurance Marketplaces. Any such failures could also negatively impact our ability to service our existing +Oscar platform arrangements and enter into new arrangements.

Changes or developments in the health insurance markets in the United States, including passage and implementation of a law to create a single-payer or government-run health insurance program, could materially and adversely harm our business and operating results.

Our business is within the public and private sectors of the U.S. health insurance system, which are evolving quickly and subject to a changing regulatory environment, and our future financial performance will depend in part on growth in the market for private health insurance, as well as our ability to adapt to regulatory developments.

The healthcare regulatory landscape can change unpredictably and rapidly due to changes in political party legislative majorities or executive branch administrations at the state or federal level in the United States and could, among other things:

- require us to restructure our relationships with providers within our network;
- require us to contract with additional providers at unfavorable terms;
- require us to cover certain forms of care provided by out-of-network providers at rates or levels indicated by rule or statute;
- require us to implement changes to our healthcare services and types of coverage, including the offering of standardized plans in addition to or in lieu of non-standardized benefit plan offerings, or prevent us from innovating and implementing technology solutions;
- require us to provide healthcare coverage to a higher risk population without the opportunity to adjust our premiums;
- require us to implement costly processes and compliance infrastructure;
- require us to make changes that restrict revenue and enrollment growth;
- increase our sales, marketing, and administrative costs, including costs attributable to broker commissions;
- impose additional capital and surplus requirements, which may require us to incur additional indebtedness, sell capital stock, or access other sources of funding;
- make it more difficult to obtain regulatory approvals to operate our business or maintain existing regulatory approvals;
- prevent or delay us from entering into new service areas or product lines; and
- increase or change our liability to members in the event of malpractice by our contracted providers.

Changes and developments in the health insurance system in the United States and the states in which we operate could also reduce demand for our services and harm our business. For example, certain elected officials have introduced proposals for some form of a single public or quasi-public agency that organizes healthcare financing, but under which healthcare delivery would remain private, and certain states have proposed, and in some cases passed, legislation creating a public option for individual and small group plans.

As the regulatory and legislative environments within which we operate are evolving, we may not be able to ensure timely compliance with such changes due to limited resources. Furthermore, we may face challenges prioritizing the allocation of resources between implementing systems responsive to new legislative or regulatory requirements, focusing on growth-related operations and implementing management systems and controls related to being a public company.

In addition, changes to government policies not specifically targeted to the healthcare industry, such as a change in tax laws and the corporate tax rate or government spending cuts, could have significant impacts on our business, results of operations, financial condition and liquidity.

If we fail to comply with applicable privacy, security, and data laws, regulations and standards, including with respect to third-party service providers that utilize sensitive personal information on our behalf, or applicable consumer protection laws, our business, reputation, results of operations, financial position, and cash flows could be materially and adversely affected.

As part of our normal operations, we collect, receive, use, maintain, handle, transmit, process, and retain, which collectively in this risk factor we refer to as "Process" or "Processing," personal, medical, sensitive and other confidential information about individuals. We are subject to various federal and state laws and rules regarding the Processing of confidential information about individuals. These laws and regulations include, among others, the HIPAA, the CCPA and the CPRA.

HIPAA imposes privacy, security and breach notification obligations on "covered entities," including certain healthcare providers, health plans and healthcare clearinghouses, and their respective "business associates" that Process individually identifiable health information for or on behalf of a covered entity, as well as their covered subcontractors with respect to safeguarding the privacy, security and transmission of individually identifiable health information. HIPAA requires covered entities and business associates to develop and maintain policies and procedures with respect to the protection of, use and disclosure of PHI, and to implement administrative, physical, and technical safeguards to protect PHI, including PHI Processed in electronic form, and to adhere to certain notification requirements in the event of a breach of unsecured PHI.

Additionally, under HIPAA, health insurers and other covered entities are also required to report breaches of PHI to affected individuals without unreasonable delay, not to exceed 60 days following discovery of the breach by a covered entity or its agents. Notification also must be made to the HHS-Office for Civil Rights and prominent media outlets in any states where 500 or more people are impacted by the breach. Ongoing review and oversight of these measures involves significant time, effort, and expense.

Entities that are found to be in violation of HIPAA as the result of a breach of unsecured PHI or following a complaint about privacy practices or an audit by the HHS, may be subject to significant civil, criminal and administrative fines and penalties and/or additional reporting and oversight obligations if required to enter into a resolution agreement and corrective action plan with HHS to settle allegations of HIPAA non-compliance. HIPAA also authorizes state Attorneys General to file suit on behalf of their residents. Courts may award damages, costs and attorneys' fees related to violations of HIPAA in such cases. While HIPAA does not create a private right of action allowing individuals to sue us in civil court for violations of HIPAA, its standards have been used as the basis for duty of care in state civil suits such as those for negligence or recklessness in the misuse or breach of PHI.

In addition, we are subject to the CCPA, which became effective as of January 1, 2020. The CCPA gives California residents expanded rights to access and require deletion of their personal information, opt out of certain personal information sharing, and receive detailed information about how their personal information is used. The CCPA also provides for civil penalties for violations, as well as a private right of action for data breaches that may increase data breach litigation. Additionally the CPRA was passed in November 2020. Effective starting on January 1, 2023, the CPRA imposes additional obligations on companies covered by the legislation and will significantly modify the CCPA, including by expanding consumers' rights with respect to certain sensitive personal information. The CPRA also creates a new state agency that will be vested with authority to implement and enforce the CCPA and the CPRA. The effects of the CCPA and the CPRA are potentially significant and may require us to modify our data collection or processing practices and policies and to incur substantial costs and expenses in an effort to comply and increase our potential exposure to regulatory enforcement and/or litigation. The CCPA and CPRA contain exemptions to which our business is subject, such as for medical information governed by the California Confidentiality of Medical Information Act, and for PHI collected by a covered entity or business associate governed by the privacy, security, and breach notification rule established pursuant to HIPAA; however, information we hold about individual residents of California that is not subject to such exceptions (or another applicable exception) would be subject to the CCPA and CPRA.

Certain other state laws also regulate issues related to consumer privacy, security and use of personal and medical information; we expect states to continue to enact legislation similar to the CCPA and CPRA that provides consumers with new privacy rights and increases the privacy and security obligations of entities handling certain personal information of such consumers. For example, laws similar to the CCPA and CPRA have passed in Virginia and Colorado, and have been proposed in other states and at the federal level, reflecting a trend toward more stringent privacy legislation in the United States. Such legislation may add additional complexity, variation in requirements, restrictions and potential legal risk, require additional investment of resources in compliance programs, impact strategies and the availability of previously useful data and could result in increased compliance costs and/or changes in business practices and policies.

We are also subject to other laws, regulations and industry standards that govern our business practices, including the Telephone Consumer Protection Act ("TCPA"), which restricts the use of automated tools and technologies to communicate with wireless telephone subscribers or communications services consumers generally, the CAN-SPAM Act, which regulates the transmission of marketing emails, and the PCI Data Security Standard, which is a multifaceted security standard that is designed to protect credit card account data as mandated by PCI entities. We may become subject to claims that we have violated these laws and standards, based on our or our vendors' past, present, or future Processing business practices, which could have an adverse impact on our business and reputation, subject us to fines and/or require us to change our business practices.

The regulatory framework governing the Processing of certain information, particularly financial and other personal information, is rapidly evolving and is likely to continue to be subject to uncertainty and varying interpretations. It is possible that these laws, regulations and standards may be interpreted and applied in a manner that is inconsistent with our existing data management practices or the features of our services and platform capabilities. We may face challenges in addressing current and evolving requirements and making necessary changes to our policies and practices, and may incur significant costs and expenses in our effort to do so. Any failure or perceived failure by us, or any third parties with which we do business, to comply with our posted privacy policies, changing consumer expectations, evolving laws, rules and regulations, industry standards, or contractual obligations to which we or such third parties are or may become subject, may result in actions or other claims against us by governmental entities or private actors, the expenditure of substantial costs, time and other resources or the incurrence of significant fines, penalties or other liabilities. In addition, any such action, particularly to the extent we were found to be guilty of violations or otherwise liable for damages, would damage our reputation and adversely affect our business, financial condition and results of operations.

As we expand our customer base and enter into +Oscar platform arrangements, we may become subject to an increasingly complex array of data privacy and security laws and regulations, further increasing our cost of compliance and doing

business. Differing laws in each jurisdiction in which we do business and changes to existing laws and regulations may also impair our ability to offer our existing or planned features, products and services and increase our cost of doing business.

We are subject to extensive fraud, waste, and abuse laws that may require us to take remedial measures or give rise to lawsuits and claims against us, the outcome of which may have a material adverse effect on our business, financial condition, cash flows, or results of operations.

Because we receive payments from federal governmental agencies, we are subject to various laws commonly referred to as "fraud, waste, and abuse" laws, including the federal Anti-Kickback Statute, the federal Physician Self-Referral Law, or Stark Law, and the FCA. These laws permit the DOJ, the HHS-OIG, CMS, and other enforcement authorities to institute a claim, action, investigation, or other proceeding against us for violations and, depending on the facts and circumstances, to seek treble damages, criminal and civil fines, penalties, and assessments. Violations of these laws can also result in exclusion, debarment, temporary or permanent suspension from participation in government healthcare programs, the institution of CIAs, and/or other heightened monitoring of our operations. Liability under such statutes and regulations may arise, among other things, if we knew, or it is determined that we should have known, that information we provided to form the basis for a claim for government payment was false or fraudulent, or that we were out of compliance with program requirements considered material to the government's payment decision.

Fraud, waste and abuse prohibitions encompass a wide range of activities, including, but not limited to, kickbacks or other inducements for referral of members or for the coverage of products (such as prescription drugs) by a plan, billing for unnecessary medical services by a healthcare provider, payments made to excluded providers, and improper marketing and beneficiary inducements. The DOJ and the HHS-OIG have continuously increased their scrutiny of healthcare payors and providers, and Medicare Advantage insurers, under the FCA, in particular, which has led to a number of investigations, prosecutions, convictions, and settlements in the healthcare industry. In particular, there has recently been increased scrutiny by the government on health insurers' diagnosis coding and risk adjustment practices, particularly for Medicare Advantage plans. In some proceedings involving Medicare Advantage plans, there have been allegations that certain financial arrangements with providers violate other laws governing fraud and abuse, such as the federal Anti-Kickback Statute. We expect this trend to continue. In addition, under applicable regulatory requirements and our policies, we must take appropriate measures to determine whether there is credible evidence that any of our members, particularly those who receive federal subsidies, were enrolled by brokers without their authorization. In such cases, we conduct certain outreach procedures under our policies and refer instances of potentially unauthorized enrollment to the appropriate authorities for potential rescission, which may also entail retroactive adjustment of membership numbers. Our failure to take appropriate measures to refer cases of fraud, waste and abuse to the relevant authorities when we are required to do so may subject us to corrective actions, including regulatory enforcement, fines and penalties, adverse publicity and other effects that could materially harm our business.

Health insurers are required to maintain compliance programs to prevent, detect and remediate fraud, waste, and abuse, and are often the subject of fraud, waste, and abuse investigations and audits.

We are periodically subject to government audits, including CMS RADV audits of our ACA and Medicare Advantage Plans to validate diagnostic data, patient claims and financial reporting, and audits of our Medicare Part D plans by the Medicare Part D Recovery Audit Contractor ("RAC") programs authorized by the ACA. These audits could result in significant adjustments in payments made to our health plans, which could adversely affect our financial condition and results of operations. If we fail to report and correct errors discovered through our own auditing procedures or during a RADV or RAC audit, or otherwise fail to comply with applicable laws and regulations, we could be subject to fines, civil penalties or other sanctions which could have a material adverse effect on our ability to participate in these programs, and on our financial condition, cash flows and results of operations. On November 24, 2020, CMS issued a final rule that amends the RADV program by: (i) revising the methodology for error rate calculations beginning with the 2019 benefit year; and (ii) changing the way CMS applies RADV results to risk adjustment transfers beginning with the 2020 benefit year. According to CMS, these changes are designed to give insurers more stability and predictability with respect to the RADV program and promote fairness in how health insurers receive adjustments. CMS has also announced a policy that payment adjustments as a result of RADV audits will not be limited to the specific MA enrollees for which errors are found but may also be extrapolated to the entire MA plan subject to a particular CMS contract. Based on a recent final rule issued by CMS in January 2023, although 2011 to 2017 plan years are still subject to audit, overpayments to MA plans that are identified as a result of RADV audit will only be subject to extrapolation for plan year 2018 and any subsequent plan year. In addition, CMS will not apply an adjustment factor, known as a Fee-For-Service Adjuster, in RADV audits to account for potential differences in diagnostic coding between the Medicare Advantage program and Medicare fee-for-service program. The future impact of these changes remains unclear, and CMS and HHS-OIG policies and procedures for conducting RADV audits remain subject to change.

These changes and any future changes to the RADV program may ultimately impact expected transfers to or from health insurers resulting from these retrospective program adjustments.

The regulations, contractual requirements, and policies applicable to participants in government healthcare programs are complex and subject to change. Moreover, many of the laws, rules, and regulations in this area have not been well-interpreted by applicable regulatory agencies or the courts. Additionally, the significant increase in actions brought under the FCA's "whistleblower" or "qui tam" provisions, which allow private individuals to bring actions on behalf of the government, has caused greater numbers of healthcare companies to have to defend a false claim action, pay fines, or agree to enter into a CIA to avoid being excluded from Medicare and other state and federal health care programs as a result of an investigation arising out of such action. Health plans and providers often seek to resolve these types of allegations through settlement for significant and material amounts, even when they do not acknowledge or admit liability, to avoid the uncertainty of treble damages that may be awarded in litigation proceedings. Such settlements often contain additional compliance and reporting requirements as part of a consent decree or settlement agreement, including, for example, CIAs, deferred prosecution agreements, or non-prosecution agreements. If we are subject to liability under qui tam or other actions or settlements, our business, financial condition, cash flows, or results of operations could be adversely affected.

We anticipate continued scrutiny by the HHS-OIG and the DOJ in the areas of COVID-19-related fraud, waste, and abuse, including the use of telehealth and telemedicine-based treatment, and we may be subject to audits, reviews and investigations of our COVID-19 and telehealth coverage and payment practices and arrangements by government agencies.

Risks Related to our Business

If we are unable to arrange for the delivery of quality care, and maintain good relations with the physicians, hospitals, and other providers within and outside our provider networks, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

Our profitability depends, in large part, upon our ability to contract at competitive prices with hospitals, physicians, and other health care providers, such that we can provide our members with access to competitive provider networks at affordable prices. Our arrangements with health care providers generally may be terminated or not renewed by either party without cause upon prior written notice. If a provider agreement were terminated, such termination could adversely impact the adequacy of our network to service our members, and may put us at risk of non-compliance with applicable federal and state laws. We cannot provide any assurance that we will be able to renew our existing contracts or enter into new contracts on a timely basis or under favorable terms enabling us to service our members profitably in the future. Health care providers within our provider networks may not properly manage the costs of services, maintain financial solvency or avoid disputes with other providers or their federal and state regulators. Any of these events could have a material adverse effect on the provision of services to our members and our operations.

In any particular market or geography, physicians and other health care providers could refuse to contract, demand higher payments, demand favorable contract terms, or take other actions that could result in higher medical costs or difficulty in meeting regulatory or accreditation requirements, among other things. In some markets and geographies, certain health care providers, particularly hospitals, physician/hospital organizations, or multi-specialty physician groups, may have significant positions or near monopolies that could result in diminished bargaining power on our part. In addition, physicians, hospitals and other health care providers may, consolidate or merge, or form or enter into accountable care organizations, clinically integrated networks, independent practice associations, practice management companies (which aggregate physician practices for administrative efficiency and marketing leverage), and other organizational structures, which may adversely impact our relationships with these providers or affect the way that we price our products and estimate our costs. Any such impacts might require us to incur costs to change our operations, place us at a competitive disadvantage, or materially and adversely affect our ability to market products or to be profitable in those areas.

The insolvency of one of our partners or providers, including providers with which we have a fixed PMPM capitation arrangement or those which we have transitioned to a value-based care model, could expose us to material liabilities. Providers may be unable or unwilling to pay claims they have incurred with third party providers in connection with referral services provided to our members. Depending on state law, we may be held liable for such unpaid referral claims even though the delegated provider has contractually assumed such risk, or we may opt to pay such claims even when we have no obligation to do so due to competitive pressures. Such liabilities incurred or losses suffered as a result of provider insolvency or other circumstances could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In addition, from time to time, we are subject to class action or other lawsuits by health care providers with respect to claims payment procedures, reimbursement policies, network participation, or similar matters. Regardless of whether any such lawsuits brought against us are successful or have merit, they will be time-consuming and costly, and could have an adverse impact on our reputation. As a result, under such circumstances, we may be unable to operate our business effectively.

Some providers that render services to our members are not contracted with our health insurance subsidiaries. While our health insurance subsidiaries are required to meet various federal and state requirements regarding the size and composition of our participating provider networks, we generally contract with a select subset of, and not all, systems and providers in a given area. This allows us to work more closely with high quality health care systems that engage with us using our technology. That approach, however, makes it possible that our members will receive emergency services, or other services which we are required to cover by law or by the terms of our health plans, from providers who are not contracted with our health insurance subsidiaries. This situation is more likely for our members than for members who choose a plan from a competitor of ours with a broader network. In those cases, there is no pre-established contractual understanding between the provider and our health insurance subsidiary about the amount of compensation that is due to the provider. In some states, and under federal law for our business subject to the No Surprises Act and our Medicare Advantage business, the amount of compensation is defined by law or regulation. In certain situations, our health insurance subsidiaries are required to hold our members harmless for out-of-network costs, and to work directly with health care providers within the confines of state law or the No Surprises Act's dispute resolution process to agree on reimbursement. Reimbursement for these out-of-network costs can be significant. It is difficult to predict the amount we may have to pay to out-of-network providers. The uncertainty of the amount to pay to such providers and the possibility of subsequent adjustment of the payment could materially and adversely affect our business, financial condition, cash flows, or results of operations.

Our revenue depends on the direct policy premiums we collect from members who obtain health care services from a limited number of in-network providers, and the loss of any of these providers could result in a material reduction of our membership, which would adversely impact our revenue and operating results.

Almost all of our revenue depends on the direct policy premiums we collect from members or from the federal government on behalf of our members who obtain health care services from a limited number of providers with whom we contract. We generally manage our provider contracts on a state-by-state basis, entering into separate contracts in each state with local affiliates of a particular provider, such that no one local provider contract receives a majority of our allowed medical costs for services rendered to our members. When aggregating the payments we make to each provider through its local affiliates, AdventHealth, HCA Healthcare and Atlantic Coast Healthcare Network (ACHN) accounted for a total of approximately 16%, 10% and 6%, respectively, of total allowable medical costs for the year ended December 31, 2022 and approximately 17%, 10% and 5%, respectively, of total allowable medical costs for the year ended December 31, 2021. We believe that a majority of our revenue will continue to be derived from direct policy premiums obtained from members who receive services from a concentrated number of providers. These providers may terminate or seek to terminate their contracts with us in the future. The sudden loss of any of our providers or the renegotiation of any of our provider contracts could adversely impact our reputation or the breadth and perceived quality of our provider networks, which could result in a loss of a membership that adversely affects our revenue and operating results.

The result of risk adjustment programs may impact our revenue, add operational complexity, and introduce additional uncertainties that have a material adverse effect on our results of operations, financial condition, and cash flows.

The Individual, Small Group, and Medicare Advantage markets we serve employ risk adjustment programs that impact the revenue we recognize for our enrolled membership. As a result of the variability in the mechanics of the program itself, or of certain factors that go into the development of the risk transfers we recognize, such as risk scores, and other market-level factors where applicable, the actual amount of revenue could be materially more or less than our estimates. Consequently, our estimate of our health plans' risk scores for any period, and any resulting change in our accrual of revenues related thereto, could have a material adverse effect on our results of operations, financial condition, and cash flows. The data provided to CMS to determine the risk score are subject to audit by CMS even several years after the annual settlements occur. If the risk adjustment data we submit are found to incorrectly overstate the health risk of our members, we may be required to refund funds previously received by us and/or be subject to penalties or sanctions, including potential liability under the FCA, which could be significant and would reduce our revenue in the year that repayment or settlement is required. Further, if the data we provide to CMS incorrectly understates the health risk of our members, we might be underpaid for the care that we must provide to our members, which could have a negative impact on our results of operations and financial condition.

Adverse market conditions may result in our investment portfolio suffering losses or reduce our ability to meet our financing needs, which could materially and adversely affect our results of operations or liquidity.

We need liquidity to pay our operating expenses, make payments on our indebtedness, if any, and pay capital expenditures. The principal sources of our cash receipts are premiums, administrative fees, investment income, proceeds from borrowings and proceeds from the issuance of capital stock.

We maintain a significant investment portfolio of cash equivalents and primarily short-term investments in a variety of securities, which are subject to general credit, liquidity, market, and interest rate risks and will decline in value if interest rates decrease or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of our investments, which could have a materially adverse effect on our results of operations, liquidity, and financial condition.

In addition, during periods of increased volatility, such as the current macroeconomic environment, adverse securities and credit markets, including due to rising interest rates, may exert downward pressure on the availability of liquidity and credit capacity for certain issuers. Further, our Revolving Credit Facility expires in February 2024 and our access to additional financing will depend on a variety of factors such as market conditions, including recessionary factors, the general availability of credit, the volume of trading activities, the availability of credit to our industry, our credit ratings and credit capacity, as well as the possibility that customers or lenders could develop a negative perception of our long- or short-term financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If one or a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient and, in such case, we may not be able to successfully obtain additional financing on favorable terms, or at all.

If state regulators do not approve payments of dividends and distributions by our health insurance subsidiaries to us, or do not approve other capital efficiency structures we may pursue, we may not have sufficient funds to implement our business strategy.

As we operate as one or more holding companies and we principally generate revenue through our health insurance subsidiaries, we are regulated under state insurance holding company laws. Although most of our subsidiaries are not currently profitable, in the future, if they become profitable or if our current levels of reserves and capital become excessive, we may make requests for dividends and distributions from our subsidiaries to fund our operations. In addition to state corporate law limitations, these subsidiaries are subject to more stringent laws and regulations that may restrict the ability to pay or limit the amount of dividends and distributions that can be paid to us without prior approval of, or notification to, state regulators, including mandatory statutory capital and surplus requirements. As and to the extent we become profitable, we may increasingly rely on distributions from our subsidiaries, and if regulators were to deny our subsidiaries' requests to pay dividends, the funds available to us would be limited, which could harm our ability to implement our business strategy.

In addition, we may from time to time pursue structures to enable a more efficient use of the capital in our insurance subsidiaries, including risk pooling, affiliate reinsurance, or entity stacking. Any such structure would require regulatory approval, and if regulators were to deny our requests, our ability to implement our business strategy would be harmed. Furthermore we have, and we may in the future, enter into tax allocation agreements between our Parent and our insurance subsidiaries, which agreements require regulatory approval, and there is no guarantee that Parent will be able to obtain the tax sharing payments from its subsidiaries under such agreements.

Our limited operating history makes it difficult to evaluate our current business performance, implementation of our business model, and our future prospects.

We launched our business in 2012 and have a limited operating history. Due to our limited operating history and the rapid growth we have experienced since we began operations, there is greater uncertainty in estimating our operating results, and our historical results may not be indicative of, or comparable to, our future results. In addition, we have limited data to validate key aspects of our business model, including our growth strategy. For example, as a relatively new entrant in the small group market, we have limited experience and are unable to predict whether we will be able to effectively and consistently provide solutions that are tailored to the budgets of small businesses and to the health needs of their employees. Furthermore, as a relatively new entrant in the third party services market, we have experienced certain operational challenges implementing our +Oscar arrangements, and a +Oscar client has terminated its +Oscar arrangement. We are unable to predict if we will be able to effectively and consistently service our +Oscar arrangements and any future +Oscar arrangements. We cannot provide any assurance that the data we collect will provide useful measures for evaluating our business model. Moreover, we cannot provide any assurance that partnerships or joint ventures we enter into in the future

will perform as well as historical partnerships or expectations. Our inability to adequately assess our performance and growth could have a material adverse effect on our brand, reputation, business, financial condition, and results of operations.

We utilize quota share reinsurance to reduce our capital and surplus requirements and protect against downside risk on medical claims. If regulators do not approve our reinsurance agreements for this purpose, or if we cannot negotiate renewals of our quota share arrangements on acceptable terms, or at all, enter into new agreements with reinsurers, or otherwise obtain capital through debt or equity financings, our capital position would be negatively impacted, and we could fall out of compliance with applicable regulatory requirements.

We enter into quota share reinsurance arrangements to reduce our capital and surplus requirements, which enables us to more efficiently deploy capital to finance our growth, and to obtain protection against downside risk on medical claims. Our reinsurers are entitled to a portion of our premiums, but also share financial responsibility for health care costs incurred by our members. Our decisions on claims payments are binding on the reinsurer with the exception of any payments by us that are not required to be made under the member's policy.

The amount of business ceded under our reinsurance arrangements can vary significantly from year to year. Because reinsurers are entitled to a portion of our premiums under our quota share reinsurance arrangements, changes in the amount of premiums ceded under these arrangements may directly impact our net premium and/or net income estimates. Reductions in the amount of premiums ceded under quota share reinsurance arrangements may result in an increase to our minimum capital and surplus requirements, and an increase in corresponding capital contributions made by Parent to our health insurance subsidiaries.

If our reinsurers consistently and successfully dispute our obligations to make a claim payment under a given policy, if we cannot renegotiate renewals of our quota share reinsurance arrangements on acceptable terms, if reinsurers terminate their arrangements with us, if we are unable to enter into reinsurance arrangements with other reinsurers, or if our reinsurance arrangements are not approved by any of our regulators (or if our regulators take a different view, whether prospectively or retroactively, with respect to the capital treatment of our reinsurance agreements), we may need to raise additional capital to comply with applicable regulatory requirements, which could be costly. For example, we estimate that had we not had any quota share reinsurance arrangements in place, the insurance subsidiaries would have been required to hold approximately $447 million of additional capital as of December 31, 2022, which Parent would have been required to fund to the extent the applicable insurance subsidiary did not have excess capital to cover the requirement. If we are not able to comply with our funding requirements, we would have to enter into a corrective action plan or cease operations in jurisdictions where we could not comply with such requirements. Termination of our reinsurance arrangements would also increase our exposure to volatility in medical claims. As a result, termination of our reinsurance arrangements through one or more of these scenarios could harm our business, results of operations, and financial condition.

While our financial reporting is based on U.S. GAAP, our ability to receive capital reserve credit for a particular state subsidiary for our reinsurance agreements is determined by Statutory Accounting Principles, which are dependent upon state-specific laws and regulations, as interpreted and applied by state insurance regulators. In some states we are required to seek approval in advance of entering into reinsurance agreements; in others we are not, which means that we may learn of regulators' concerns after the effective date of certain reinsurance agreements. From time to time, we include state-specific provisions in, or subsequently make state-specific amendments to, our reinsurance agreements to reflect capital reserve credit requirements imposed by particular state regulators, or may need to book additional reserves or liabilities to our insurance company statutory financial statements to address regulatory requirements or standards. The net economic effect of such provisions, amendments or actions may not be commercially favorable, and in some instances we have chosen, and may in the future choose, not to enter into certain types of reinsurance agreements, not to seek statutory reserve credit under certain agreements, or to terminate existing agreements rather than include provisions or make amendments required by a particular state in order to receive statutory reserve credit. As described above, any such decision or action would result in an increase in required capital in our insurance subsidiaries, which may be material.

Our reinsurance arrangements also subject us to various obligations, representations, and warranties with respect to the reinsurers. Reinsurance does not relieve us of liability as an insurer. If a reinsurer fails to meet its obligations under the reinsurance contract or if the liabilities exceed any applicable loss limit, we remain responsible for covering the claims on the reinsured policies. Additionally, our exposure under reinsurance arrangements may at times be disproportionately concentrated with a single reinsurer. Although we regularly evaluate the financial condition of reinsurers to minimize exposure to significant losses from reinsurer insolvencies, reinsurers may become financially unsound. If a reinsurer fails to meet its obligations or becomes financially unsound, we may have to cover the claims on such reinsured policies, which may be material.

We are subject to risks associated with our geographic concentration.

The states in which we operate that have the largest concentrations of revenues include Florida, Texas, Georgia and California. Due to the geographic concentration of our business, we are exposed to heightened risks of potential losses resulting from unfavorable changes in the regulatory environment for healthcare, increased competition, and other regional factors in these states, including the following:

- unforeseen changes affecting the cost of living, other benefit costs, and reimbursement rates;
- natural disasters, such as a major earthquake, wildfire, or hurricane;
- the outbreak of an epidemic or pandemic, including COVID-19 and its variants or new viruses;
- a virulent influenza season;
- newly emergent mosquito-borne illnesses, such as the Zika virus, the West Nile virus, or the Chikugunya virus; and
- terrorist activity involving biological or other weapons of mass destruction.

The occurrence of any of these events could result in increased utilization or medical costs in these states or any other geographic area where our membership becomes concentrated in the future, and could therefore have a disproportionately adverse effect on our operating results. States experiencing such events may enact laws and regulations that require us to cover health care costs for members for which we would not typically be responsible, such as requiring us to relax prior authorization requirements, remove prescription drug refill limitations, and cover out-of-network care. In addition, as a result of our geographic concentration, we face heightened exposure to the other risk factors described herein to the extent such risk factors disproportionately materialize in or impact the regions in which our operations are concentrated.

We are subject to risks associated with outsourcing services and functions to third parties.

We contract with third-party vendors and service providers who provide services to us and our subsidiaries to help with our internal administrative functions, as well as third-party vendors and service providers who help us administer our products and plans. For example, Oscar delegates pharmacy claims and network management to a pharmacy benefit manager (PBM), CVS/Caremark. We also contract with Optum to provide us with access to its network of behavioral health providers and manage behavioral health benefits for us. The partial or complete loss of a vendor or other third-party relationship could cause a material disruption to our business and make it difficult and costly to provide services and products that our regulators and members expect, which could have a material adverse effect on our financial condition, cash flows, and results of operations.

Some of these third-parties have direct access to our systems in order to provide their services to us and operate the majority of our communications, network, and computer hardware and software. For example, we currently offer our products through our website and online app using platforms for cloud computing provided by Amazon Web Services, Inc. (“AWS”), a provider of cloud infrastructure services, as well as the Google Cloud Platform (“GCP”). Our operations depend on protecting the virtual cloud infrastructure hosted in AWS and GCP by maintaining its configuration, architecture, and interconnection specifications, as well as the information stored in these cloud platforms and which third-party internet service providers transmit. We also engage with other third parties, including Atlassian Corporation Plc, Appian Corporation and inContact, Inc. for our product offerings and internal operations. In the event that a service agreement with a third-party vendor that we rely upon is terminated, or there is a lapse of service, interruption of internet service provider connectivity, or damage to such facilities, we could experience interruptions in our operations and service to our members and business partners, as well as delays and additional expense in arranging new facilities and services, which could harm our business, results of operations, and financial condition.

Our arrangements with third-party vendors and service providers may make our operations vulnerable if those third parties, either directly or through their subcontractors, fail to satisfy their obligations to us, including their obligations to maintain and protect the security and confidentiality of our information and data, or the information and data relating to our members or customers. We are also at risk of a data security incident involving a vendor or third party, which could result in a breakdown of such third party’s data protection processes or cyber-attackers gaining access to our infrastructure through the third party. To the extent that a vendor or third party suffers a data security incident that compromises its operations, we could incur significant costs and possible service interruption. In addition, we may have disagreements with our third-party vendors or service providers regarding relative responsibilities for any such failures or incidents under applicable business associate agreements or other applicable outsourcing agreements. Any contractual remedies and/or indemnification obligations we may have for vendor or service provider failures or incidents may not be adequate to fully compensate us for any losses suffered as a result of any vendor’s failure to satisfy its obligations to us or under applicable law. Our vendor and

service provider arrangements could be adversely impacted by changes in vendors' or service providers' operations or financial condition, or other matters outside of our control. Violations of, or noncompliance with, laws and/or regulations governing our business or noncompliance with contract terms by third-party vendors and service providers could increase our exposure to liability to our members, providers, or other third parties, or could result in sanctions and/or fines from the regulators that oversee our business. In turn, this could increase the costs associated with the operation of our business or have an adverse impact on our business and reputation. Moreover, if these vendor and service provider relationships were terminated for any reason, we may not be able to find alternative partners in a timely manner or on acceptable financial terms, and may incur significant costs and/or experience significant disruption to our operations in connection with any such vendor or service provider transition. As a result, we may not be able to meet the full demands of our members or customers and, in turn, our business, financial condition, and results of operations may be harmed. In addition, we may not fully realize the anticipated economic and other benefits from our outsourcing projects or other relationships we enter into with third-party vendors and service providers, as a result of unanticipated delays in transitioning our operations to the third-party vendor or service provider, such third-party vendor or service provider's noncompliance with contract terms, unanticipated costs or expenses, or violations of laws and/or regulations, or otherwise. This could result in substantial costs or other operational or financial problems that could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

From time to time, we may become involved in costly and time-consuming litigation and regulatory audits and actions, which require significant attention from our management.

From time to time, we are a defendant in lawsuits and the subject of regulatory actions, and are subject to audits, reviews, assessments and investigations relating to our business, including, without limitation, claims by members alleging failure to provide coverage or pay for or authorize payment for health care, claims related to non-payment or insufficient payments for services by providers, including for alleged failure to properly pay in-network and out-out-network claims, claims under U.S. securities laws, claims of trademark and other intellectual property infringement, claims alleging bad faith or unfair business practices, challenges to the manner in which the Company processes claims, claims relating to sales, marketing and other business practices, inquiries regarding our submission of risk adjustment data, enforcement actions by state regulatory bodies alleging non-compliance with state law, financial and market conduct examinations by state regulatory bodies, and claims related to the imposition of new taxes, including, but not limited to, claims that may have retroactive application.

For example, on May 12, 2022, a securities class action lawsuit against the Company, certain of its directors and officers, and the underwriters that participated in the Company's initial public offering was commenced in the United States District Court for the Southern District of New York, captioned Carpenter v. Oscar Health, Inc., et al., Case No. 1:22-CV-03885 (S.D.N.Y.) (the "Securities Action"). The amended complaint filed on December 6, 2022, primarily alleges that the Company failed to disclose in its IPO registration statement purportedly inadequate controls and systems in connection with the risk adjustment data validation audit for 2019, in violation of Sections 11 and 15 of the Securities Act, and that this alleged omission caused losses and damages for members of the putative class. The amended complaint seeks unspecified compensatory damages as well as interest, fees and costs.

In addition, certain of the Company's health insurance subsidiaries have been or are currently undergoing review by state regulators, including for, among other matters, compliance with applicable laws and regulations and reviews of financial condition. We also may receive subpoenas and other requests for information from various federal and state agencies, regulatory authorities, state Attorneys General, committees, subcommittees, and members of the U.S. Congress and other state, federal, and international governmental authorities.

Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations, and/or cash flows, and may affect our reputation and brand. In addition, regardless of the outcome of any litigation or regulatory proceedings, investigations, audits, or reviews, responding to such matters is costly and time consuming, and requires significant attention from our management, and could, therefore, harm our business and financial position, results of operations or cash flows. Insurance may not cover such claims, may not provide sufficient payments to cover all of the costs to resolve one or more such claims, and may result in our having to pay significant fines, judgments, or settlements, which, if uninsured, or if the fines, judgments, and settlements exceed insured levels, could adversely affect our results of operations and cash flows, thereby harming our business.

The regulations and contractual requirements applicable to us and other market participants are complex and subject to change, making it necessary for us to invest significant resources in complying with our regulatory and contractual requirements. Ongoing vigorous legal enforcement and the highly technical regulatory scheme mean that our compliance efforts in this area will continue to require significant resources, and we may not always be successful in ensuring

appropriate compliance by our Company, employees, consultants, or vendors, for whose compliance or lack thereof we may be held responsible and liable. Regulatory audits, investigations, and reviews could result in significant or material changes to our business practices, including increased capital requirements, and also could result in significant or material premium refunds, fines, penalties, civil liabilities, criminal liabilities, or other sanctions, including marketing and enrollment sanctions, suspension or exclusion from participation in government programs, imposition of heightened monitoring by our federal or state regulators, and suspension or loss of licensure if we are determined to be in violation of applicable laws or regulations. Any of these audits, reviews, or investigations could have a material adverse effect on our financial position, results of operations, or business, or could result in significant liabilities and negative publicity for our Company.

We rely on the experience and expertise of our Co-Founders, senior management team, highly-specialized technology and insurance experts, key technical employees, and other highly skilled personnel.

Our success depends upon the continued service of Mario Schlosser, our Co-Founder, Chief Executive Officer and a member of our board of directors, and Joshua Kushner, our Co-Founder, Vice Chairman and a member of our board of directors, the members of our senior management team, highly-specialized technology and insurance experts, and key technical employees, as well as other highly qualified personnel. We also depend upon our continuing ability to identify, hire, develop, motivate, retain, and integrate additional highly skilled personnel to support our growth. If we are unable to attract and retain qualified personnel, our business and prospects may be adversely affected.

Each of our Co-Founders, members of our senior management team, specialized technology and insurance experts, key technical personnel, and other employees could terminate their relationship with us at any time. The loss of key personnel might significantly delay or prevent the achievement of our strategic business objectives and could harm our business. In addition, much of our essential technology and infrastructure are custom-made for our business by our personnel. The loss of key technology personnel, including members of management, as well as our engineering and product development personnel, could disrupt our operations and harm our business. We also rely on a small number of highly-specialized insurance experts, the loss of any one of whom could also have a disproportionate impact on our business. We face significant competition for personnel across all areas of our business, and we may not be able to replace key personnel in a timely manner or at all.

Our compensation arrangements, such as our equity award programs, may not always be successful in attracting new employees and retaining, motivating and incentivizing our existing employees. Job candidates and existing employees often consider the value of the equity awards they receive in connection with their employment. Fluctuations in the price of our Class A common stock may make it more difficult or costly to use equity compensation to hire new employees and to retain, motivate, and incentivize existing employees. For example, from the completion of our IPO through December 31, 2022, our closing stock price ranged from a high of $36.77 to a low of $2.15. As such, the underlying value of the equity awards held by our employees also fluctuates. Additionally, if and when the stock options or other equity awards are substantially vested, employees under such equity arrangements may be more likely to leave, particularly when the underlying shares have appreciated.

To attract and retain top talent, we will need to continue to offer competitive compensation and benefits packages, including equity compensation. We may also need to increase our employee compensation levels in response to competitor actions. If we are unable to retain highly qualified personnel or hire new employees quickly enough to meet our needs, or otherwise fail to effectively manage our hiring needs or successfully integrate new hires, including our recently hired management team members, our efficiency, ability to execute our growth strategy and our employee morale, productivity, and retention could suffer, which in turn could have an adverse effect on our business, results of operations, and financial condition.

If we or our partners or other third parties with whom we collaborate sustain a cyber-attack or suffer privacy or data security breaches that disrupt our information systems or operations, or result in the dissemination of sensitive personal or confidential information, we could suffer increased costs, exposure to significant liability, adverse regulatory consequences, reputational harm, loss of business, and other serious negative consequences.

Information security risks have generally increased in recent years because of the proliferation of new technologies and the increased sophistication and activities of perpetrators of cyber-attacks, as well as a result of an increase in work-from-home and hybrid work arrangements due to the COVID-19 pandemic and geopolitical events involving high cyber-risk countries. Hackers and data thieves are increasingly sophisticated and operating large-scale and complex automated attacks. Our information technology systems and safety control systems are subject to a growing number of threats from computer programmers, hackers, and other adversaries that may be able to penetrate our network security and misappropriate our confidential member and company information or that of third parties, create system disruptions, or cause damage, security issues, or shutdowns. They also may be able to develop and deploy viruses, worms, and other malicious software programs

that attack our systems or otherwise exploit security vulnerabilities. Because the techniques used to circumvent, gain access to, or sabotage security systems, can be highly sophisticated and change frequently, they often are not recognized until launched against a target, and may originate from less regulated and remote areas around the world. We may be unable to anticipate these techniques or implement adequate preventive measures, resulting in potential data loss and damage to our systems. Further, we may experience cyber-attacks and other security incidents that remain undetected for an extended period. As cyber threats continue to evolve, we may be required to expend additional resources to further enhance our information security measures, develop additional protocols and/or investigate and remediate any information security vulnerabilities.

Our systems and facilities are also subject to compromise from internal threats such as accidental or improper action by employees, including malicious insiders, or by vendors, counterparties, and other third parties with otherwise legitimate access to our systems. Our policies, employee training (including security and privacy awareness training), procedures, and technical safeguards may not prevent all improper access to our network or proprietary or confidential information by employees, vendors, counterparties, or other third parties. Our systems and facilities are also vulnerable to security incidents or security attacks, ransomware attacks, malware, or other forms of cyber-attack, acts of vandalism or theft, misplaced or lost data, human errors, or other similar events that could negatively affect our systems, and our and our members' data. In the past, we have experienced, and third-party service providers who process information on our behalf have experienced, and disclosed to applicable regulatory authorities, data breaches resulting in disclosure of confidential information or PHI. Although none of these data breaches have resulted in any material financial loss or penalty to date, future data breaches could require us to expend significant resources to remediate any damage, interrupt our operations and damage our reputation, subject us to state or federal agency review and could also result in regulatory enforcement actions, material fines and penalties, litigation or other actions which could have a material adverse effect on our business, reputation and results of operations, financial position, and cash flows. Additionally, our third-party service providers who process information on our behalf may cause security breaches for which we are potentially liable.

Moreover, we face the ongoing challenge of managing access controls in a complex environment. The process of enhancing our protective measures can itself create a risk of systems disruptions and security issues. Given the breadth of our operations, including through our +Oscar technology platform, and the increasing sophistication of cyber-attacks, a particular incident could occur and persist for an extended period of time before being detected. The extent of a particular cyber-attack and the steps that we may need to take to investigate the attack may take a significant amount of time and resources before such an investigation could be completed and full and reliable information about the incident is known. During such time, the extent of any harm or how best to remediate it might not be known, which could further increase the risks, costs, and consequences of a data security incident.

In addition, our systems must be routinely updated, patched, and upgraded to protect against known vulnerabilities. The volume of new software vulnerabilities has increased substantially, as has the importance of patches and other remedial measures. In addition to remediating newly identified vulnerabilities, previously identified vulnerabilities must also be updated. We are at risk that cyber-attackers exploit these known vulnerabilities before they have been addressed. The complexity of our systems and platforms, the increased frequency at which vendors are issuing security patches to their products, our need to test patches, and, in some instances, coordinate with third-parties before they can be deployed, all could further increase our risks.

As part of our normal operations, we and our partners and other third parties with whom we collaborate routinely collect, process, store, and transmit large amounts of data, including PHI subject to HIPAA and other federal and state laws and regulations, as well as proprietary or confidential information relating to our business or third parties, including our members, providers, and vendors. Any compromise or perceived compromise of the security of our systems or the systems of one or more of our vendors or service providers could damage our reputation and brand, cause the termination of relationships with our members, result in disruption or interruption to our business operations, marketing partners and carriers, reduce demand for our services, and subject us to significant liability and expense, as well as regulatory action and lawsuits, which would harm our business, operating results, and financial condition. The CCPA, in particular, includes a private right of action for California consumers whose CCPA-covered personal information is impacted by a data security incident resulting from a company's failure to maintain reasonable security procedures and, hence, may result in civil litigation in the event of a data breach impacting such information. Although we maintain insurance covering certain security and privacy damages and claim expenses, we may not carry insurance or maintain coverage sufficient to compensate for all liability and, in any event, insurance coverage would not address the reputational damage that could result from a security incident or any regulatory actions or litigation that may result.

If we are unable to integrate and manage our information systems effectively, our operations could be disrupted.

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, generating forecasts used for strategic decisions and pricing, monitoring utilization and other cost factors, processing provider claims, detecting fraud, and providing data to our regulators. Our healthcare providers also depend upon our information systems for membership verifications, claims status, and other information. We partner with third parties, including Amazon, Appian, Atlassian, inContact, and Google, to support our information technology systems. Our information systems and applications require continual maintenance, upgrading, and enhancement to meet our current and expected operational needs and regulatory requirements. If we underestimate the need to expand or experience difficulties with the transition to or from information systems or do not appropriately plan, integrate, maintain, enhance, or expand our information systems, we could suffer, among other things, operational disruptions, loss of existing members and difficulty in attracting new members, regulatory enforcement, and increases in administrative expenses. In addition, if our providers, brokers and members do not utilize the technology we deploy to them, we may not be able to efficiently and cost-effectively operate our business. Our ability to integrate and manage our information systems may also be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorism. Also, we may from time to time obtain significant portions of our systems-related or other services or facilities from independent third parties, which may make our operations vulnerable if such third parties discontinue such services or fail to perform adequately.

Real or perceived errors, failures or bugs in our systems, website, or app could impair our operations, damage our reputation and brand, and harm our business and operating results.

Our continued success is dependent on our systems, applications, and software continuing to operate and to meet the changing needs of our members and users. We rely on our technology and engineering staff and vendors to successfully implement changes to, and maintain, our systems and services in an efficient and secure manner. Like all information systems and technology, our website and online app may contain material errors, failures, vulnerabilities, or bugs, particularly when new features or capabilities are released, any of which could lead to interruptions, delays, or website or online app shutdowns, or could cause loss of critical data, or the unauthorized disclosure, access, acquisition, alteration or use of personal or other confidential information.

A significant impact on the performance, reliability, security, and availability of our systems, software, or services may harm our reputation and brand, impair our ability to operate, retain existing members, or attract new members, and expose us to legal claims and government action, each of which could have a material adverse impact on our financial condition, results of operations, and growth prospects.

The ongoing COVID-19 pandemic could significantly increase our costs of operation due to unanticipated changes in law or regulation, population morbidity, or utilization behaviors, adversely impact our operational effectiveness, and heighten the risks we face in our business.

The COVID-19 pandemic continues to evolve and the impact of COVID-19 and its variants, and the actions taken to contain their spread or address their impact, could have a material adverse effect on our operations and financial results.

We seek to ensure our direct policy premiums appropriately account for anticipated changes in utilization. However, our ability to do so accurately is limited by the changing nature of COVID-19, including the evolving clinical understanding of COVID-19's post-acute, long-term impacts on health. Additionally, as a result of legislative mandates and trends, we may be unable to fully implement clinical initiatives to manage health care costs and chronic conditions of our members and appropriately document their health risks and diagnoses to substantiate payments we may be entitled to under federal and state risk adjustment programs.

There are also uncertainties associated with the costs of COVID-19-related care, including vaccines and booster shots and their administration, for our covered population. The costs associated with our members who receive COVID-19 vaccines may be greater than we expect if, for example, subsidies for COVID-19 vaccinations are reduced.

Additionally, the long-term health impacts of SARS-CoV-2 infection causing COVID-19 are not yet well known or understood. If a significant number of our members who have contracted COVID-19 need unanticipated ongoing post-acute care, such as regular physical, occupational, or respiratory therapy, additional pharmaceutical intervention, or care for increased frequency of other illness resulting from a COVID-19-weakened immune system, our business could be materially adversely impacted due to an unanticipated increase in covered medical expenses.

As a result of the COVID-19 pandemic, the federal and state governments enacted laws and promulgated regulatory changes that have increased our costs and limited our operational flexibility. We may be required to incur additional expenses to comply with such changes and requirements without being able to modify our rates, which could adversely impact our financial results.

We are continuing to monitor the evolution of COVID-19, changes to our covered services, and the ongoing costs and business impacts of dealing with COVID-19, including continued adverse effects on economic activity and related risks. The extent of this impact will depend on future developments, which remain uncertain and cannot be predicted at this time, including, but not limited to, the transmission rate, introduction of new strains of COVID-19, the severity of future outbreaks, the extent and effectiveness of the actions taken to contain the spread of the virus and address its impacts, including vaccine effectiveness, availability, administration and adoption and related risks. The ultimate impact of the COVID-19 pandemic on our business, results of operations, financial position, and cash flows is uncertain as the pandemic continues to evolve globally, but such impacts could be material to our business, results of operations, financial position and cash flows.

We have identified a material weakness in our internal control over financial reporting. If we are unable to remediate the material weakness in a timely manner, identify additional material weaknesses in the future or otherwise fail to maintain effective internal control over financial reporting, our ability to comply with applicable laws and regulations and accurately and timely report our financial results, and our access to the capital markets, could be adversely affected.

We are a public reporting company subject to the rules and regulations established by the SEC and the NYSE. These rules and regulations require, among other things, that we establish and periodically evaluate procedures with respect to our internal control over financial reporting. Reporting obligations as a public company are likely to continue to place a considerable strain on our financial and management systems, processes, and controls, as well as on our personnel.

In addition, as a public company, we are required to document and test our internal control over financial reporting pursuant to Section 404 of the Sarbanes-Oxley Act so that our management can certify as to the effectiveness of our internal control over financial reporting. Section 404(a) of the Sarbanes-Oxley Act, or Section 404(a), requires that, beginning with our second annual report following our IPO, management assess and report annually on the effectiveness of our internal control over financial reporting, and our independent registered public accounting firm issue an annual report that addresses the effectiveness of our internal control over financial reporting.

As disclosed in Part II, Item 9A, “Controls and Procedures,” of our Annual Report on Form 10-K, in connection with our audit of the consolidated financial statements for the year ended December 31, 2021, we identified a material weakness in our internal control over financial reporting related to information technology general controls. As a result, we concluded that our internal control over financial reporting was not effective as of December 31, 2022. A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement in a company’s annual or interim financial statements will not be prevented or detected on a timely basis. The material weakness identified in Item 9A in our Annual Report on Form 10-K did not result in any misstatement of our financial statements. We are in the process of remediating the material weakness.

We can give no assurance that our efforts will remediate the material weakness in our internal control over financial reporting, or that additional material weaknesses will not be identified in the future. We may also conclude that additional measures may be required to remediate the material weakness in our internal control over financial reporting, which may necessitate additional implementation and evaluation time. If the steps we take do not remediate the material weakness in a timely manner, or if we fail to implement and maintain effective internal control over financial reporting, there could be errors in our annual or interim consolidated financial statements that could result in a restatement of our financial statements, and could cause us to fail to meet our reporting obligations and restrict our access to capital markets, any of which could diminish investor confidence in us and cause a decline in the price of our Class A common stock.

Additionally, ineffective internal control over financial reporting could expose us to an increased risk of financial reporting fraud and the misappropriation of assets and subject us to potential delisting from the NYSE or to other regulatory investigations and civil or criminal sanctions. If we are unable to remediate the material weakness in a timely manner, or if additional material weaknesses exist or are discovered in the future, and we are unable to remediate any such material weaknesses, our reputation, results of operations and financial condition could suffer.

We make virtual health care services available to our members through Oscar Medical Group, in which we do not own any equity or voting interest, and our virtual care availability may be disrupted if our arrangements with providers like the Oscar Medical Group become subject to legal challenges.

Pursuant to state corporate practice of medicine laws, many states in which we operate through our subsidiaries limit the practice of medicine to licensed individuals or professional organizations owned by licensed individuals, and business corporations generally may not exercise control over the medical decisions of physicians. Statutes and regulations, including the interpretation and enforcement of such statutes and regulations, relating to the corporate practice of medicine, fee-splitting between physicians and referral sources, and similar issues, vary widely from state to state. We have management services agreements with four physician-owned professional corporations, known collectively as the Oscar Medical Group. Each of the professional corporations comprising the Oscar Medical Group is wholly owned by a single physician licensed in California, Florida, New York and New Jersey, who oversees the operation of the Oscar Medical Group in her capacity as president and sole director of each Oscar Medical Group professional corporation. This physician also serves as a consultant to Oscar Management Corporation. Under the terms of the management services agreements between Oscar Management Corporation and the Oscar Medical Group, the Oscar Medical Group retains sole responsibility for all medical decisions, as well as for hiring and managing physicians and other licensed health care providers, developing operating policies and procedures, and implementing professional standards and controls. Many of the laws, rules, and regulations with respect to corporate practice of medicine are ambiguous and have not been well-interpreted by applicable regulatory agencies or the courts. Moreover, changes can be made to existing laws, regulations, or interpretations, or new laws can be enacted or adopted, which could cause us to be out of compliance with these requirements. Despite the management services agreements and other arrangements we have with Oscar Medical Group, regulatory authorities and other parties may assert that we are engaged in the prohibited corporate practice of medicine, that our arrangements with Oscar Medical Group constitute unlawful fee-splitting, or that other similar issues exist. If that were to occur, we could be subject to civil and/or criminal penalties, our agreements could be found legally invalid and unenforceable (in whole or in part), or we could be required to terminate or restructure our contractual arrangements, any of which could have a material adverse effect on our results of operations, financial position, or cash flows. State corporate practice and fee-splitting prohibitions also often impose penalties on healthcare professionals for aiding in the improper rendering of professional services, which could discourage physicians and other healthcare professionals from providing clinical services that are currently available to our members.

Our health insurance subsidiaries have entered into provider participation agreements with the Oscar Medical Group that enable the Oscar Medical Group to participate in Oscar's provider network. While we expect that our relationship with the Oscar Medical Group will continue, a material change in our relationship with the Oscar Medical Group, whether resulting from a dispute among the entities or the loss of these relationships or contracts with the Oscar Medical Group, may temporarily disrupt our ability to provide virtual health care services to our members or through our +Oscar platform arrangements and could harm our business.

Significant delays in our receipt of direct policy premiums, including as a result of regulatory restrictions on policy cancellations and non-renewals, could have a material adverse effect on our business operations, cash flows, or earnings.

We currently derive substantially all of our revenue from direct policy premiums and recognize premium revenue over the period that coverage is effective. There can be no assurance that we will receive premiums in advance of or by the end of a given coverage period. Moreover, actions taken by state and federal governments could increase the likelihood of delay in our receipt of premiums. For example, in early responses to the COVID-19 pandemic, state insurance departments, including in states in which we operate, issued guidelines, recommendations, and moratoria around policy cancellations and non-renewals due to non-payment. While none of such state or federal required or recommended moratoria carried over into 2023, if such or similar measures were to be reintroduced and to remain in place for an extended period due to a resurgence of COVID-19 or for other reasons, including unanticipated public health or economic crises, our receipt of premiums, if any, could be significantly delayed, which could have a material adverse effect on our business, operations, cash flows, or earnings.

The federal government also periodically considers reducing or reallocating the amount of money it spends for Medicare. Medicare remains subject to the automatic spending reductions imposed by the Budget Control Act of 2011 and the American Taxpayer Relief Act of 2012. This includes aggregate reductions of Medicare payments to providers and reduced payments to several types of Medicare providers, which, after a temporary suspension from May 1, 2020 through March 31, 2022 under the Coronavirus Aid, Relief, and Economic Security Act (the "CARES Act") followed by a phased-in reintroduction of payment reductions through June 30, 2022 will remain in effect through 2032. We anticipate these and any

future similar initiatives will require government agencies to find funding alternatives, which may result in reductions in funding for programs, contraction of covered benefits, and limited or no premium rate increases, or premium rate decreases.

We may not be able to utilize our net operating loss carryforwards ("NOLs"), to offset future taxable income for U.S. federal income tax purposes, which could adversely affect our cash flows.

As of December 31, 2022, we had federal income tax NOLs of $2.2 billion available to offset our future taxable income, if any, prior to consideration of annual limitations that may be imposed under Section 382 of the U.S. Internal Revenue Code of 1986, as amended (the "Code") or otherwise. Of our NOLs, approximately $1.32 billion of losses will expire between 2032 and 2042, and $839 million of losses can be carried forward indefinitely.

We may be unable to use our NOLs, as we do not have a history of positive earnings. In addition, under Section 382 of the Code, if a corporation undergoes an "ownership change" (very generally defined as a greater than 50% change, by value, in the corporation's equity ownership by certain shareholders or groups of shareholders over a rolling three-year period), the corporation's ability to use its pre-ownership change NOLs to offset its post-ownership change income may be limited. We regularly assess potential NOL limitations under Section 382, and determined that an ownership change occurred in 2016; however, the corresponding limitation amount did not impact the ultimate pre-change NOL available for use. We may experience ownership changes in the future as a result of subsequent shifts in our stock ownership, some of which may be outside of our control. If we undergo another ownership change, our ability to utilize our NOLs existing at the time of the ownership change may be limited. Future regulatory changes could also limit our ability to utilize our NOLs. To the extent we are not able to offset future taxable income with our NOLs, our cash flows may be adversely affected.

Failure to secure, protect, or enforce our intellectual property rights could harm our business, results of operations, and financial condition.

Our commercial success is dependent in part on protecting our core technologies, intellectual property assets, and proprietary rights (such as source code, information, data, processes, and other forms of information, know-how, and technology). We rely on a combination of copyrights, trademarks, service marks, trade secret laws, and contractual restrictions to establish and protect our intellectual property. However, there are steps that we have not yet taken to protect our intellectual property on a global basis. For example, we do not have any patents, which limits our ability to deter patent infringement claims by competitors and other third parties who may hold or obtain patents. Additionally, the steps that we have already taken to protect our intellectual property may not be sufficient or effective, and our confidentiality, non-disclosure, or invention assignment agreements with employees, consultants, partners, or other parties may be breached and may otherwise not be effective in establishing our rights in intellectual property and in controlling access to our proprietary information. Even if we do detect violations, we may need to engage in litigation to enforce our rights.

We currently hold various domain names relating to our brand, including HiOscar.com. We also engage a third-party vendor to monitor fictitious sites that may purport to be us. Failure to protect our domain names could adversely affect our reputation and brand, and make it more difficult for users to find our website and our online app. We may be unable, without significant cost or at all, to prevent third parties from diverting traffic from or acquiring domain names that are similar to, infringe upon, or otherwise decrease the value of our trademarks and other proprietary rights.

While we take precautions designed to protect our intellectual property, it may still be possible for competitors and other unauthorized third parties to copy our technology and use our proprietary brand, content, and information to create or enhance competing solutions and products, which could adversely affect our competitive position in our rapidly evolving and highly competitive industry. Some license provisions that protect against unauthorized use, copying, decompiling, transfer, and disclosure of our technology may be unenforceable under the laws of certain jurisdictions and foreign countries, and the remedies for such events may not be sufficient to compensate for such breaches. We enter into confidentiality and invention assignment agreements with our employees and consultants, and enter into confidentiality agreements with our third-party providers and strategic partners. We cannot assure you that these agreements will be effective in controlling access to, and use and distribution of, our platform and proprietary information. Further, these agreements do not prevent our competitors from independently developing technologies that are substantially equivalent or superior to our offerings. Such arrangements may limit our ability to protect, maintain, enforce, or commercialize such intellectual property rights. If we are unable to prevent the unauthorized use or exploitation of our intellectual property, the value of our brand, content, and other intangible assets may be diminished, competitors may be able to more effectively mimic our service and methods of operations, the perception of our business and service to members, and potential members, may become confused, and our ability to attract customers may be adversely affected. Any inability or failure to protect our intellectual property could adversely impact our business, results of operations, and financial condition.

We have filed, and may in the future file, applications to protect certain of our innovations and intellectual property. We do not know whether any of our applications will result in the issuance of a patent, trademark, or copyright, as applicable, or whether the examination process will require us to narrow our claims. In addition, we may not receive competitive advantages from the rights granted under our intellectual property. Our existing intellectual property, and any intellectual property granted to us, or that we otherwise acquire in the future, may be contested, circumvented, or invalidated, and we may not be able to detect or prevent third parties from infringing our rights to our intellectual property. Therefore, the exact effect of the protection of this intellectual property cannot be predicted with certainty. In addition, given the costs, effort, and risks of obtaining patent protection, including the requirement to ultimately disclose the invention to the public, we may choose not to seek patent protection for certain innovations. Any failure to adequately obtain such patent protection, or other intellectual property protection, could later prove to adversely impact our business.

We may be required to spend significant resources in order to monitor, protect, and defend our intellectual property rights, and some violations may be difficult or impossible to detect. Litigation to protect and enforce our intellectual property rights could be costly, time-consuming, and distracting to management, and could result in the impairment or loss of portions of our intellectual property. Our efforts to enforce our intellectual property rights may be met with defenses, counterclaims, and countersuits attacking the validity and enforceability of our intellectual property rights. Our inability to protect our proprietary technology against unauthorized copying or use, as well as any costly litigation or diversion of our management's attention and resources, could impair the functionality of our platform, delay introductions of enhancements to our platform, result in our substituting inferior or more costly technologies into our platform, or harm our reputation or brand. In addition, we may be required to license additional technology from third parties to develop and market new offerings or platform features, which may not be on commercially reasonable terms, or at all, and could adversely affect our ability to compete or require us to rebrand or otherwise modify our offerings, which could further exhaust our resources. Furthermore, we may also be obligated to indemnify our members or business partners in connection with any such litigation and to obtain licenses.

Increasing scrutiny and changing expectations with respect to environmental, social and governance ("ESG") matters may impose additional costs on us, impact our access to capital, or expose us to new or additional risks.

Increased focus, including from regulators, investors, employees and clients, on ESG matters may result in increased costs (including but not limited to increased costs related to compliance and stakeholder engagement), impact our reputation, or otherwise affect our business performance. Negative public perception, adverse publicity or negative comments in social media could damage our reputation or harm our relationships with regulators, employees or our customers, if we do not, or are not perceived to, adequately address these issues, including if we fail to demonstrate progress towards any current or future ESG goals. Any harm to our reputation could negatively impact employee engagement and retention and the willingness of customers to do business with us.

It is possible that stakeholders may not be satisfied with our ESG practices or the speed of their adoption. At the same time, certain stakeholders might not be satisfied if we adopt ESG practices at all. Actual or perceived shortcomings with respect to our ESG practices and reporting could negatively impact our business. We could also incur additional costs and require additional resources to monitor, report, and comply with various ESG practices.

In addition, a variety of organizations have developed ratings to measure the performance of companies on ESG topics, and the results of some of these assessments are widely publicized. Such ratings are used by some investors to inform their investment and voting decisions. In addition, many investors have created their own proprietary ratings that inform their investment and voting decisions. Unfavorable ratings of our company or our industry, as well as omission of inclusion of our stock into ESG-oriented investment funds, may lead to negative investor sentiment and the diversion of investment to other companies or industries, which could have a negative impact on our stock price and our access to and cost of capital.

Risks Related to our Indebtedness

Restrictions imposed by our Revolving Credit Facility may materially limit our ability to operate our business and finance our future operations or capital needs.

The terms of our senior secured credit agreement with Wells Fargo Bank, National Association as administrative agent, and certain other lenders for the Revolving Credit Facility in the aggregate principal amount of $200 million, may restrict us and our subsidiaries from engaging in specified types of transactions. These covenants, subject to certain limitations and exceptions, restrict our ability, and that of our subsidiaries, to, among other things:

- incur indebtedness;
- incur certain liens;
- enter into sale and lease-back transactions;
- make investments, loans, advances, guarantees and acquisitions;
- consolidate, merge or sell or otherwise dispose of assets;
- pay dividends or make other distributions on equity interests, or redeem, repurchase or retire equity interests;
- enter into transactions with affiliates;
- alter the business conducted by us and our subsidiaries; and
- change our or their fiscal year.

A breach of any of these covenants, or any other covenant in the documents governing our Revolving Credit Facility, could result in a default or event of default under our Revolving Credit Facility. In the event of any event of default under our Revolving Credit Facility, the applicable lenders or agents could elect to terminate borrowing commitments and declare all borrowings and loans outstanding thereunder, if any, together with accrued and unpaid interest and any fees and other obligations, to be immediately due and payable. In addition, or in the alternative, the applicable lenders or agents could exercise their rights under the security documents entered into in connection with our Revolving Credit Facility. We pledged substantially all of our assets as collateral securing our Revolving Credit Facility and any such exercise of remedies on any material portion of such collateral would likely materially adversely affect our business, financial condition or results of operations.

If we were unable to repay or otherwise refinance these borrowings and loans when due, and the applicable lenders proceeded against the collateral granted to them to secure that indebtedness, we may be forced into bankruptcy or liquidation. In the event the applicable lenders accelerate the repayment of any future borrowings, we may not have sufficient assets to repay that indebtedness. Any acceleration of future borrowings under our Revolving Credit Facility or other outstanding indebtedness would also likely have a material adverse effect on us.

Pursuant to our Revolving Credit Facility, we are required to comply with certain financial covenants including (i) receiving specified levels of direct policy premiums (as defined in the Revolving Credit Facility) for each fiscal quarter, (ii) maintaining a minimum liquidity (as defined in the Revolving Credit Facility) of $150 million (or $200 million if the liquidity decreased by a specified amount over the prior six month period) as of the last day of each quarter, and (iii) not exceeding a maximum combined ratio. Our ability to borrow under our Revolving Credit Facility depends on our compliance with these financial covenants. Events beyond our control, including changes in general economic and business conditions, may affect our ability to satisfy the financial covenants. We cannot assure you that we will satisfy the financial covenants in the future, or that our lenders will waive any failure to satisfy the financial covenants.

Our debt obligations contain restrictions that impact our business and expose us to risks that could materially adversely affect our liquidity and financial condition.

As of December 31, 2022, we had outstanding indebtedness due to our issuance in February 2022 of $305.0 million in aggregate principal amount of convertible senior notes due 2031 (the "2031 Notes") in a private placement. We may incur additional indebtedness in the future, including borrowings under the Revolving Credit Facility. Such indebtedness, including borrowings, if any, under the Revolving Credit Facility, could have significant effects on our business, such as:

- limiting our ability to borrow additional amounts to fund capital expenditures, acquisitions, debt service requirements, execution of our growth strategy and other purposes;
- limiting our ability to make investments, including acquisitions, loans and advances, and to sell, transfer or otherwise dispose of assets;
- requiring us to dedicate a substantial portion of our cash flow from operations to pay principal and interest on our borrowings, which would reduce availability of our cash flow to fund working capital, capital expenditures, acquisitions, execution of our growth strategy and other general corporate purposes;
- making us more vulnerable to adverse changes in general economic, industry and competitive conditions, in government regulation and in our business by limiting our ability to plan for and react to changing conditions;
- placing us at a competitive disadvantage compared with our competitors that have less debt; and
- exposing us to risks inherent in interest rate fluctuations because our borrowings are at variable rates of interest, which could result in higher interest expense in the event of increases in interest rates.

Our ability to make scheduled payments of the principal of, to pay interest on or to refinance our indebtedness, including the 2031 Notes, depends on our future performance, which is subject to economic, financial, competitive and other factors

beyond our control. If the assumptions underlying our cash flow projections are incorrect we may not be able to generate sufficient cash flow from our operations to repay our existing or future indebtedness when it becomes due and to meet our other cash needs. If we are unable to generate such cash flow, we will be required to pursue one or more alternative strategies, such as selling assets, refinancing or restructuring our indebtedness or selling additional debt or equity securities. In addition to the restrictions imposed by our Revolving Credit Facility, the Investment Agreement that we entered into in connection with our issuance of the 2031 Notes contains covenants, which, subject to certain conditions, limitations and exceptions, restrict our ability to refinance our indebtedness and incur additional indebtedness. If we fail to comply with these covenants or to make payments under our indebtedness when due, then we would be in default under that indebtedness, which could, in turn, result in our other indebtedness becoming immediately payable in full. Due to such restrictions or other factors, we may not be able to refinance our debt or sell additional debt or equity securities or our assets on favorable terms, if at all, and if we must sell our assets, it may negatively affect our business, financial condition and results of operations. In addition, we may be subject to prepayment penalties depending on when we repay our future indebtedness, including any borrowings under the Revolving Credit Facility, which amounts could be material.

Changes in the method pursuant to which LIBOR is determined and the transition to other benchmarks may adversely affect our results of operations.

LIBOR and certain other "benchmarks" have been the subject of continuing national, international, and other regulatory guidance and proposals for reform. These reforms may cause such benchmarks to perform differently than in the past or have other consequences which cannot be predicted. A portion of our indebtedness bears interest at variable interest rates, primarily based on LIBOR, which may be subject to regulatory guidance and/or reform that could cause interest rates under our current or future debt agreements to perform differently than in the past or cause other unanticipated consequences. Some tenors of LIBOR were discontinued on December 31, 2021. Although we expect that the capital and debt markets will cease to use LIBOR as a benchmark in the near future and the administrator of LIBOR has announced its intention to extend the publication of most tenors of LIBOR for U.S. dollars through June 30, 2023, we cannot predict whether or when LIBOR will actually cease to be available, whether the Secured Overnight Funding Rate, or SOFR, will become the market benchmark in its place or what impact such a transition may have on our business, financial condition and results of operations.

The Revolving Credit Facility has interest rate payments determined directly or indirectly based on LIBOR. Uncertainty regarding the continued use and reliability of LIBOR as a benchmark interest rate could adversely affect the performance of LIBOR relative to its historic values. The Revolving Credit Facility contains "hardwired" benchmark replacement provisions with "early opt-in" triggers that permit the replacement of LIBOR prior to the phasing out of published LIBOR rates. The benchmark replacement language contemplates the use of an alternative benchmark rate to be selected by the Administrative Agent. Even if financial instruments are transitioned to alternative benchmarks, such as SOFR, successfully, the new benchmarks are likely to differ from LIBOR, and our interest expense associated with our outstanding indebtedness or any future indebtedness we incur may increase. Further, transitioning to an alternative benchmark rate, such as SOFR, may result in us incurring significant expense and legal risks, as renegotiation and changes to documentation may be required in effecting the transition. Any alternative benchmark rate may be calculated differently than LIBOR and may increase the interest expense associated with our existing or future indebtedness. Any of these occurrences could materially and adversely affect our borrowing costs, financial condition, and results of operations.

We may be unable to raise the funds necessary to repurchase our outstanding 2031 Notes for cash following a fundamental change or on the optional repurchase dates, or to pay any cash amounts due upon conversion, and our other indebtedness may limit our ability to repurchase the 2031 Notes or pay cash upon their conversion.

Noteholders may, subject to certain conditions described in the Indenture governing the 2031 Notes, require us to repurchase their 2031 Notes following a fundamental change at a cash repurchase price generally equal to the principal amount of the 2031 Notes to be repurchased, plus accrued and unpaid interest, if any. Additionally, pursuant to the Investment Agreement, after the fifth anniversary of the Closing Date of the 2031 Notes, the initial holders of the 2031 Notes have the right to require us to repurchase all of their 2031 Notes for cash, on each of June 30, 2027, June 30, 2028, June 30, 2029 and June 30, 2030 (each, a "Repurchase Date"); provided that, among other conditions, a repurchase notice is delivered to the trustee under the Indenture no later than the later of (i) 120 days prior to the applicable Repurchase Date and (ii) 10 business days following the date on which we file our Annual Report on Form 10-K for the prior year. Furthermore, upon conversion, we will satisfy part or all of our conversion obligation in cash unless we elect to settle conversions solely in shares of our common stock. We may not have enough available cash or be able to obtain financing at the time we are required to repurchase the 2031 Notes or pay any cash amounts due upon conversion. In addition, applicable law, regulatory authorities and the agreements governing our other indebtedness may restrict our ability to repurchase the 2031 Notes or pay any cash

amounts due upon conversion. Our failure to repurchase the 2031 Notes or pay any cash amounts due upon conversion when required will constitute a default under the Indenture. A default under the Indenture or the fundamental change itself could also lead to a default under agreements governing our other indebtedness, which may result in that other indebtedness becoming immediately payable in full. We may not have sufficient funds to satisfy all amounts due under the other indebtedness and the 2031 Notes.

Provisions in the Revolving Credit Facility or the Indenture governing the 2031 Notes could delay or prevent an otherwise beneficial takeover of us.

Certain provisions in the Revolving Credit Facility, the 2031 Notes and the Indenture could make a third-party attempt to acquire us more difficult or expensive. For example, if a takeover constitutes a fundamental change (as defined in the Indenture governing the 2031 Notes), then noteholders will have the right to require us to repurchase their 2031 Notes for cash. In addition, if a takeover constitutes a make-whole fundamental change (as defined in the Indenture governing the 2031 Notes), then we may be required to temporarily increase the conversion rate. Further, if a takeover constitutes a change in control (as defined in the Revolving Credit Facility), such takeover would constitute an event of default under the Revolving Credit Facility. In any such case, and in other cases, our obligations under the Revolving Credit Facility, the 2031 Notes and the Indenture could increase the cost of acquiring us or otherwise discourage a third party from acquiring us or removing incumbent management, including in a transaction that noteholders or holders of our common stock may view as favorable.

Risks Related to Ownership of Our Class A Common Stock

The dual class structure of our common stock will have the effect of concentrating voting control with Thrive Capital and our Co-Founders for the foreseeable future, which will limit the ability of our other investors to influence corporate matters, including the election of directors and the approval of any change of control transaction.

Our Class B common stock has 20 votes per share, and our Class A common stock has one vote per share. As of December 31, 2022, the holders of our outstanding Class B common stock, which consist of Thrive Capital and our Co-Founders, beneficially own 22.3% of our outstanding capital stock and hold 82.7% of the voting power of our outstanding capital stock (assuming the exercise of all options to acquire shares of Class B common stock and the conversion of the 2031 Notes, in each case that are beneficially owned as of December 31, 2022). Thrive Capital and Joshua Kushner (as the sole managing member of the Thrive General Partners), in particular, beneficially own 19.2% of our outstanding capital stock and hold 75.0% of the voting power of our outstanding capital stock as of December 31, 2022. Because of the 20-to-one voting ratio between our Class B common stock and Class A common stock, the holders of Class B common stock, in particular Thrive Capital and Joshua Kushner (as the sole managing member of the Thrive General Partners), collectively control over a majority of the combined voting power of all of our Class A common stock and Class B common stock and therefore will continue to be able to control all matters submitted to our stockholders for approval until a significant portion of such shares of outstanding Class B common stock have been converted to shares of Class A common stock. This concentrated control limits or precludes the ability of our other investors to influence corporate matters for the foreseeable future. For example, Thrive Capital and our Co-Founders have sufficient voting power to determine the outcome with respect to elections of directors, amendments to our certificate of incorporation, amendments to our bylaws that are subject to a stockholder vote, increases to the number of shares available for issuance under our equity incentive plans or adoption of new equity incentive plans, and approval of any merger, consolidation, sale of all or substantially all of our assets or other major corporate transaction requiring stockholder approval for the foreseeable future. In addition, this concentrated control may also prevent or discourage unsolicited acquisition proposals or offers for our capital stock that you may feel are in your best interest as one of our stockholders. This control may also adversely affect the market price of our Class A common stock.

Because Thrive Capital's and our Co-Founders' interests may differ from those of our other stockholders, actions that Thrive Capital and our Co-Founders take with respect to us, as significant stockholders, may not be favorable to our other stockholders, including holders of our Class A common stock.

Thrive Capital and its affiliates engage in a broad spectrum of activities. In the ordinary course of its business activities, Thrive Capital and its affiliates may engage in activities where their interests conflict with our interests or those of our other stockholders. Thrive Capital or one of its affiliates may also pursue acquisition opportunities that may be complementary to our business, and, as a result, those acquisition opportunities may not be available to us. In addition, Thrive Capital may have an interest in us pursuing acquisitions, divestitures and other transactions that, in its judgment, could enhance its investment in us, even though such transactions might involve risks to you.

Future transfers by holders of Class B common stock will generally result in those shares converting to Class A common stock, subject to limited exceptions. As among the individual holders of Class B common stock, the conversion of Class B

common stock to Class A common stock will have the effect, over time, of increasing the relative voting power of those holders of Class B common stock who retain their shares in the long term (and decreasing the relative voting power of those holders of Class B common stock who transfer their shares).

We cannot predict the effect our dual class structure may have on the market of our Class A common stock.

We cannot predict whether our dual class structure will result in a lower or more volatile market price of our Class A common stock, in adverse publicity, or in other adverse consequences. For example, certain index providers, such as S&P Dow Jones, have announced restrictions on including companies with multiple-class share structures in certain of their indices, including the S&P 500. Accordingly, our dual class share structure would make us ineligible for inclusion in certain indices and, as a result, mutual funds, exchange-traded funds, and other investment vehicles that attempt to passively track those indices may not invest in our Class A common stock. These policies are relatively new and it is unclear what effect, if any, they will have on the valuations of publicly-traded companies excluded from such indices, but it is possible that they may depress valuations, as compared to similar companies that are included. Given the sustained flow of investment funds into passive strategies that seek to track certain indices, exclusion from certain stock indices would likely preclude investment by many of these funds and could make our Class A common stock less attractive to other investors. As a result, the market price of our Class A common stock could be adversely affected.

We anticipate incurring substantial stock-based compensation expense related to performance-based awards, including particularly the Founders Awards, which may have an adverse effect on our financial condition and results of operations and may result in substantial dilution

We have in the past and may in the future grant performance-based awards, as a result of which we may incur substantial stock-based compensation expenses and may expend substantial funds to satisfy tax withholding and remittance obligations. For example, in connection with our IPO, on March 5, 2021, we granted to Mario Schlosser and Joshua Kushner, our Co-Founders, an aggregate of 6,344,779 long-term performance-based restricted stock units ("PSUs"), which we refer to as the Founders Awards.

Mr. Schlosser's Founders Award consists of PSUs that cover 4,229,853 shares of Class A common stock, and Mr. Kushner's Founders Award consists of PSUs that cover 2,114,926 shares of Class A common stock, in each case, at target levels. Each Founders Award will be eligible to vest based on the achievement of five pre-determined stock price goals ranging from $90.00 to $270.00 per share over a seven-year period following March 5, 2021, the closing of our IPO. Half of each Founders Award will become earned based on the achievement of such stock price goals (measured as a volume-weighted average stock price over 180 days) at any time between the second and seventh anniversaries of the closing of our IPO. The remaining half of each Founders Award also will become earned based on achieving the same stock price goals, but the period for measuring the achievement of those goals will be scaled between the second and seventh anniversaries of the closing of our IPO. Any PSUs that become earned PSUs will vest on, as applicable the third, fourth, fifth, sixth and/or seventh anniversary of the closing of our IPO or, if later, the date on which the applicable stock price goal is achieved, subject to continued service. Any PSUs that do not vest prior to or on the seven-year anniversary of the grant date automatically will be terminated without consideration. The PSUs are also subject to certain vesting acceleration terms. We will continue to record substantial stock-compensation expense for the Founders Awards. As of December 31, 2022, the amount of unrecognized compensation expense for the PSUs subject to the Founders Awards is $51.5 million, which is expected to be recognized over a weighted-average period of 2.97 years.

In addition, any PSUs subject to the Founders Awards that are earned and vest will be settled in shares of Class A common stock as soon as practicable after becoming vested. As a result, a potentially large number of shares of Class A common stock will be issuable if the applicable vesting conditions are satisfied, which would dilute your ownership of us.

We are a "controlled company" within the meaning of the rules of NYSE and, as a result, we rely on exemptions from certain corporate governance requirements. You will not have the same protections afforded to stockholders of companies that are subject to such requirements.

We are a "controlled company" within the meaning of the corporate governance standards of the New York Stock Exchange ("NYSE"). Under these rules, a listed company of which more than 50% of the voting power is held by an individual, group or another company is a "controlled company" and may elect not to comply with certain corporate governance requirements, including:

- the requirement that a majority of the board of directors consist of independent directors;

- the requirement that our nominating and corporate governance committee be composed entirely of independent directors with a written charter addressing the committee's purpose and responsibilities;
- the requirement that our compensation committee be composed entirely of independent directors with a written charter addressing the committee's purpose and responsibilities; and
- the requirement for an annual performance evaluation of our nominating and corporate governance and compensation committees.

We currently are not relying on these exemptions, except for the exemption from the requirement that our nominating and corporate governance committee be composed entirely of independent directors. However, as long as we remain a "controlled company," we may elect in the future to take advantage of any of these other exemptions. As a result of any such election, our board of directors may not have a majority of independent directors, our compensation committee may not consist entirely of independent directors, and our directors may not be nominated or selected by independent directors. Accordingly, you will not have the same protections afforded to stockholders of companies that are subject to all of the corporate governance requirements of the NYSE.

We do not intend to pay dividends on our Class A common stock for the foreseeable future.

We currently intend to retain all available funds and any future earnings to fund the development and growth of our business. As a result, we do not anticipate declaring or paying any cash dividends on our Class A common stock in the foreseeable future. Any decision to declare and pay dividends in the future will be made at the discretion of our board of directors, subject to applicable laws, and will depend on, among other things, our business prospects, results of operations, financial condition, cash requirements and availability, industry trends, and other factors that our board of directors may deem relevant. Any such decision also will be subject to compliance with contractual restrictions and covenants in the agreements governing our current indebtedness. In addition, our ability to pay dividends in the future depends on the earnings and distributions of funds from our health insurance subsidiaries. Applicable state insurance laws restrict the ability of such health insurance subsidiaries to declare stockholder dividends and require our health insurance subsidiaries to maintain specified levels of statutory capital and surplus. The Revolving Credit Facility contains restrictions on our ability to pay dividends. Moreover, we may incur additional indebtedness, the terms of which may further restrict or prevent us from paying dividends on our Class A common stock. As a result, you may have to sell some or all of your Class A common stock after price appreciation in order to generate cash flow from your investment, which you may not be able to do. Our inability or decision not to pay dividends could also adversely affect the market price of our Class A common stock.

We may issue shares of preferred stock in the future, which could make it difficult for another company to acquire us or could otherwise adversely affect holders of our Class A common stock, which could depress the price of our Class A common stock.

Our amended and restated certificate of incorporation filed in connection with our IPO (the "Amended Charter") authorizes us to issue one or more series of preferred stock. Our board of directors will have the authority to determine the powers, designations, preferences, and relative, participating, optional or other special rights, and the qualifications, limitations, or restrictions thereof, of the shares of preferred stock and to fix the number of shares constituting any series, without any further vote or action by our stockholders. Our preferred stock could be issued with voting, liquidation, dividend, and other rights superior to the rights of our Class A common stock. The potential issuance of preferred stock may delay or prevent a change in control of us, discouraging bids for our Class A common stock at a premium to the market price, and may materially and adversely affect the market price and the voting and other rights of the holders of our Class A common stock.

Future sales and issuances of our Class A common stock or rights to purchase our Class A common stock, including pursuant to our equity incentive plans, or other equity securities or securities convertible into our Class A common stock, could result in additional dilution of the percentage ownership of our stockholders and could cause the stock price of our Class A common stock to decline.

We have filed registration statements with the SEC on Form S-8 to register shares of our Class A common stock issued or reserved for issuance under our 2012 Stock Plan, 2021 Incentive Award Plan, 2022 Employment Inducement Incentive Award Plan, and Employee Stock Purchase Plan and expect to file additional registration statements on Form S-8 in the future. Subject to the satisfaction of vesting conditions, shares issued pursuant to or registered under the registration statement on Form S-8 will be available for resale immediately in the public market without restriction. From time to time in the future, we may also issue additional shares of our Class A common stock, Class B common stock or securities convertible into Class A common stock pursuant to a variety of transactions, including acquisitions. The issuance by us of additional shares of our Class A common stock or securities convertible into our Class A common stock would dilute the ownership of our existing stockholders.

In addition, the sale of substantial amounts of shares of our Class A common stock in the public market, or the perception that such sales could occur, could harm the prevailing market price of shares of our Class A common stock. All of the shares of Class A common stock sold in our IPO are freely tradable without restriction or further registration under the Securities Act, except that any shares held by our affiliates, as that term is defined under Rule 144 of the Securities Act, may be sold only in compliance with certain limitations. The market price of our shares of Class A common stock could drop significantly if the holders of such restricted shares sell them or are perceived by the market as intending to sell them. These factors could also make it more difficult for us to raise additional funds through future offerings of our shares of Class A common stock or other securities.

We are no longer an emerging growth company and the reduced compliance requirements applicable to emerging growth companies no longer apply to us.

We no longer qualify as an emerging growth company as defined in the Jumpstart Our Business Startups Act of 2012 (the "JOBS Act") and as such we no longer are entitled to rely on exemptions from certain compliance requirements that are applicable to companies that are emerging growth companies. As a result, subject to certain grace periods, we are now required to:

- engage an independent registered public accounting firm to provide an attestation report on our internal controls over financial reporting pursuant to Section 404(b) of the Sarbanes-Oxley Act of 2002;
- submit certain executive compensation matters to stockholder advisory votes; and
- disclose a compensation discussion and analysis, including disclosure regarding certain executive compensation related items such as the correlation between executive compensation and performance and comparisons of the chief executive officer's compensation to median employee compensation.

We are no longer able to take advantage of cost savings associated with the JOBS Act. Furthermore, if the additional requirements applicable to non-emerging growth companies divert the attention of our management and personnel from other business concerns, they could have a material adverse effect on our business, financial condition and results of operations. The increased costs will decrease our net income or increase our net loss and may require us to reduce costs in other areas of our business. We cannot predict or estimate the amount or timing of additional costs we may incur to respond to these requirements. Furthermore, if we are unable to satisfy our obligations as a non-emerging growth company, we could be subject to delisting of our common stock, fines, sanctions and other regulatory action and potentially civil litigation

Anti-takeover provisions in our governing documents and under Delaware law could make an acquisition of our company more difficult, limit attempts by our stockholders to replace or remove our current management, and depress the market price of our Class A common stock.

Our Amended Charter, amended and restated bylaws filed in connection with our IPO (the "Amended Bylaws"), and Delaware law contain provisions that could have the effect of rendering more difficult, delaying or preventing an acquisition deemed undesirable by our board of directors. Among others, our Amended Charter and Amended Bylaws include the following provisions:

- a dual class structure that provides our holders of Class B common stock with the ability to control the outcome of matters requiring stockholder approval;
- limitations on convening special stockholder meetings, which could make it difficult for our stockholders to adopt desired governance changes;
- advance notice procedures, which apply for stockholders to nominate candidates for election as directors or to bring matters before an annual meeting of stockholders;
- a prohibition on stockholder action by written consent, which means that our stockholders will only be able to take action at a meeting of stockholders;
- a forum selection clause, which means certain litigation can only be brought in Delaware;
- no authorization of cumulative voting, which limits the ability of minority stockholders to elect director candidates;
- certain amendments to our certificate of incorporation will require the approval of two-thirds of the then outstanding voting power of our capital stock, voting as a single class;
- amendments to our bylaws by our stockholders will require the approval of two-thirds of the then outstanding voting power of our capital stock, voting as a single class;
- the authorization of undesignated or "blank check" preferred stock, the terms of which may be established and shares of which may be issued without further action by our stockholders and which may be used to create a "poison pill";

- newly created directorships are filled by a majority of directors then in office; and
- the approval of two-thirds of the then outstanding voting power of our capital stock, voting as a single class, is required to remove a director.

These provisions, alone or together, could delay or prevent hostile takeovers and changes in control or changes in our management. As a Delaware corporation, we are also subject to provisions of Delaware law, including Section 203 of the Delaware General Corporation Law (the "DGCL"), which prevents interested stockholders, such as certain stockholders holding more than 15% of our outstanding common stock from engaging in certain business combinations for a period of 3 years following the time that such stockholder became an interested stockholder, unless (i) prior to the time such stockholder became an interested stockholder, the board approved the transaction that resulted in such stockholder becoming an interested stockholder, (ii) upon consummation of the transaction that resulted in such stockholder becoming an interested stockholder, the interested stockholder owned 85% of the voting stock of the Company outstanding at the time the transaction commenced (excluding certain shares) or (iii) following board approval, the business combination receives the approval of the holders of at least two-thirds of our outstanding common stock not owned by such interested stockholder.

The insurance laws in most states require regulatory review and approval of a change in control of our domestic insurers. "Control" generally means the possession, direct or indirect, of the power to direct, or cause the direction of, the management and policies of an insurer, whether through the ownership of voting securities, by contract, or otherwise. The state statutes usually presume that control exists if a person or company, directly or indirectly, owns, controls, or holds the power to vote ten percent (10%) or more of the voting securities of an insurer or a parent company, but some states may presume control at a lower percentage. This presumption can then be rebutted by showing that control does not exist. Accordingly, a change in control could trigger regulatory review and approval in one or more states in which we operate.

Any provision of our Amended Charter, Amended Bylaws, Delaware law, or applicable state insurance law that has the effect of delaying, preventing, or deterring a change in control could limit the opportunity for our stockholders to receive a premium for their shares of our Class A common stock, and could also affect the price that some investors are willing to pay for our Class A common stock.

Our Amended Charter provides that the Court of Chancery of the State of Delaware is the sole and exclusive forum for substantially all disputes between us and our stockholders, and federal district courts are the sole and exclusive forum for Securities Act claims, which could limit our stockholders' ability to obtain a favorable judicial forum for disputes with us or our directors, officers, or employees.

Our Amended Charter provides that, unless we consent to the selection of an alternative forum, the Court of Chancery of the State of Delaware is the sole and exclusive forum for: (a) any derivative action, suit, or proceeding brought on our behalf; (b) any action, suit, or proceeding asserting a claim of breach of fiduciary duty owed by any of our current or former directors, officers or other employees or stockholders to us or to our stockholders, creditors, or other constituents; (c) any action, suit, or proceeding asserting a claim arising pursuant to the DGCL, our Amended Charter or Amended Bylaws, or as to which the DGCL confers exclusive jurisdiction on the Court of Chancery of the State of Delaware; or (d) any action, suit, or proceeding asserting a claim governed by the internal affairs doctrine; provided that the exclusive forum provisions will not apply to suits brought to enforce any liability or duty created by the Exchange Act, or to any claim for which the federal courts have exclusive jurisdiction.

Our Amended Charter further provides that, unless we consent in writing to the selection of an alternative forum, the federal district courts are the exclusive forum for the resolution of any complaint asserting a cause of action arising under the Securities Act. We note that investors cannot waive compliance with the federal securities laws and the rules and regulations thereunder. Section 22 of the Securities Act creates concurrent jurisdiction for federal and state courts over all suits brought to enforce any duty or liability created by the Securities Act or the rules and regulations thereunder. The choice of forum provisions may limit a stockholder's ability to bring a claim in a judicial forum that it finds favorable for disputes with us or our current or former directors, officers, or other employees or stockholders, which may discourage such lawsuits against us and our current or former directors, officers, and other employees or stockholders. Alternatively, if a court were to find the choice of forum provisions contained in our Amended Charter to be inapplicable or unenforceable in an action, we may incur additional costs associated with resolving such action in other jurisdictions, which could harm our business, financial condition, and results of operations.

General Risk Factors

The obligations associated with being a public company require significant resources and management attention, and we have and will continue to incur increased costs as a result of being a public company.

As a public company, we face increased legal, accounting, administrative, and other costs and expenses that we did not incur as a private company. We have incurred, and expect to continue to incur, significant costs related to operating as a public company. We are subject to the Exchange Act, the rules and regulations implemented by the SEC, the Sarbanes-Oxley Act, the Dodd-Frank Act, the Public Company Accounting Oversight Board (the "PCAOB"), and the rules and standards of the NYSE, each of which imposes additional reporting and other obligations on public companies. As a public company, we are required to, among others:

- prepare, file, and distribute annual, quarterly, and current reports with respect to our business and financial condition;
- prepare, file, and distribute proxy statements and other stockholder communications;
- expand the roles and duties of our Board and committees thereof, and management;
- hire additional financial and accounting personnel and other experienced accounting and finance staff with the expertise to address complex accounting matters applicable to public companies;
- institute more comprehensive financial reporting and disclosure compliance procedures;
- utilize outside counsel and accountants to assist us with the activities listed above;
- enhance our investor relations function;
- establish new internal policies, including those relating to trading in our securities and disclosure controls and procedures;
- comply with NYSE's listing standards; and
- comply with the Sarbanes-Oxley Act.

These rules and regulations and changes in laws, regulations, and standards relating to corporate governance and public disclosure, which have created uncertainty for public companies, will continue to increase our legal and financial compliance costs and make some activities more time consuming and costly. These laws, regulations, and standards are subject to varying interpretations, in many cases due to their lack of specificity and, as a result, their application in practice may evolve over time as new guidance is provided by regulatory and governing bodies. This could result in continuing uncertainty regarding compliance matters and higher costs necessitated by ongoing revisions to disclosure and governance practices. Our investment in compliance with existing and evolving regulatory requirements has and will continue to result in increased administrative expenses and a diversion of management's time and attention from revenue-generating activities to compliance activities, which could have a material adverse effect on our business, financial condition, and results of operations.

In addition, the need to establish the corporate infrastructure demanded of a public company may also divert management's attention from implementing our business strategy, which could prevent us from improving our business, financial condition, and results of operations. If we do not continue to develop and implement the right processes and tools to manage our changing enterprise and maintain our culture, our ability to compete successfully and achieve our business objectives could be impaired, which could negatively impact our business, financial condition, and results of operations. In addition, we cannot predict or estimate the amount of additional costs we may incur to comply with these requirements. We anticipate that these costs will materially increase our general and administrative expenses.

Being a public company and complying with applicable rules and regulations also makes it more difficult and more expensive for us to obtain director and officer liability insurance. As a result, it may be more difficult for us to attract and retain qualified people to serve on our board of directors, our board committees, or as executive officers.

If our operating and financial performance in any given period does not meet the guidance that we provide to the public, the market price of our Class A common stock may decline.

We may, but are not obligated to, provide public guidance on our expected operating and financial results for future periods. Any such guidance will be comprised of forward-looking statements subject to the risks and uncertainties described in this report, and in our other public filings and public statements. Our actual results may not always be in line with or exceed any guidance we have provided, especially in times of economic uncertainty. If, in the future, our operating or financial results for a particular period do not meet any guidance we provide or the expectations of investment analysts, or if we reduce our

guidance for future periods, the market price of our Class A common stock may decline. Even if we do issue public guidance, there can be no assurance that we will continue to do so in the future.

A new 1% U.S. federal excise tax could be imposed on us in connection with any redemptions we undertake.

On August 16, 2022, the Inflation Reduction Act of 2022 (the "IRA") was signed into federal law. The IRA provides for, among other things, a new U.S. federal 1% excise tax on certain repurchases (including redemptions) of stock by publicly traded U.S. corporations and certain other persons (a "covered corporation"). Because we are a Delaware corporation and our securities are trading on the NYSE, we are a "covered corporation" for this purpose. The excise tax is imposed on the repurchasing corporation itself, not its stockholders from which shares are repurchased. The amount of the excise tax is generally 1% of the fair market value of the shares repurchased at the time of the repurchase. However, for purposes of calculating the excise tax, repurchasing corporations are permitted to net the fair market value of certain new stock issuances against the fair market value of stock repurchases during the same taxable year. In addition, certain exceptions apply to the excise tax. The U.S. Department of Treasury has been given authority to provide regulations and other guidance to carry out and prevent the abuse or avoidance of the excise tax. If we were to conduct repurchases of our stock or other transactions covered by the excise tax described above, we could potentially be subject to this excise tax, which could increase our costs and adversely affect our operating results.

Item 1B. Unresolved Staff Comments

None.

Item 2. Properties

Our corporate headquarters are located in New York, New York, where we lease approximately 161,044 square feet of office space. We lease additional office space in Tempe, Arizona and Los Angeles, California.

Item 3. Legal Proceedings

The information required under this Part I, Item 3 is set forth in Note 19 - Commitments and Contingencies to our consolidated financial statements included elsewhere in this Annual Report on Form 10-K.

Given that such proceedings are subject to uncertainty, there can be no assurance that such legal proceedings, either individually or in the aggregate, will not have a material adverse effect on our business, results of operations, financial condition or cash flows.

Item 4. Mine Safety Disclosures

Not applicable.

PART II

Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

Market Information

Our Class A common stock trades on the New York Stock Exchange under the symbol "OSCR." There is no established public trading market for our Class B common stock.

Holders

As of January 31, 2023, there were 38 holders of record of our Class A common stock and 11 holders of record of our Class B common stock.

Dividend Policy

We have never declared or paid any cash dividends on our capital stock. We currently intend to retain any future earnings to fund the growth of our business and do not anticipate paying any dividends in the foreseeable future. We are regulated under state insurance holding company laws and our subsidiaries are subject to stringent regulations, including mandatory statutory capital and surplus requirements, that may restrict our or our subsidiaries' ability to declare dividends or limit the amount of dividends and distributions that can be paid without approval of, or notification to, state regulators. In addition, the terms of our Revolving Credit Facility, and other indebtedness we may enter into from time to time, restricts our ability and that of our subsidiaries' to, among other things, pay dividends or make other distributions on equity interests. Any decision to declare dividends in the future will be made at the discretion of our board of directors and will depend on a number of factors, including our business prospects, financial condition, regulatory and contractual restrictions, capital and surplus requirements, general business conditions, and other factors that our board of directors may deem relevant.

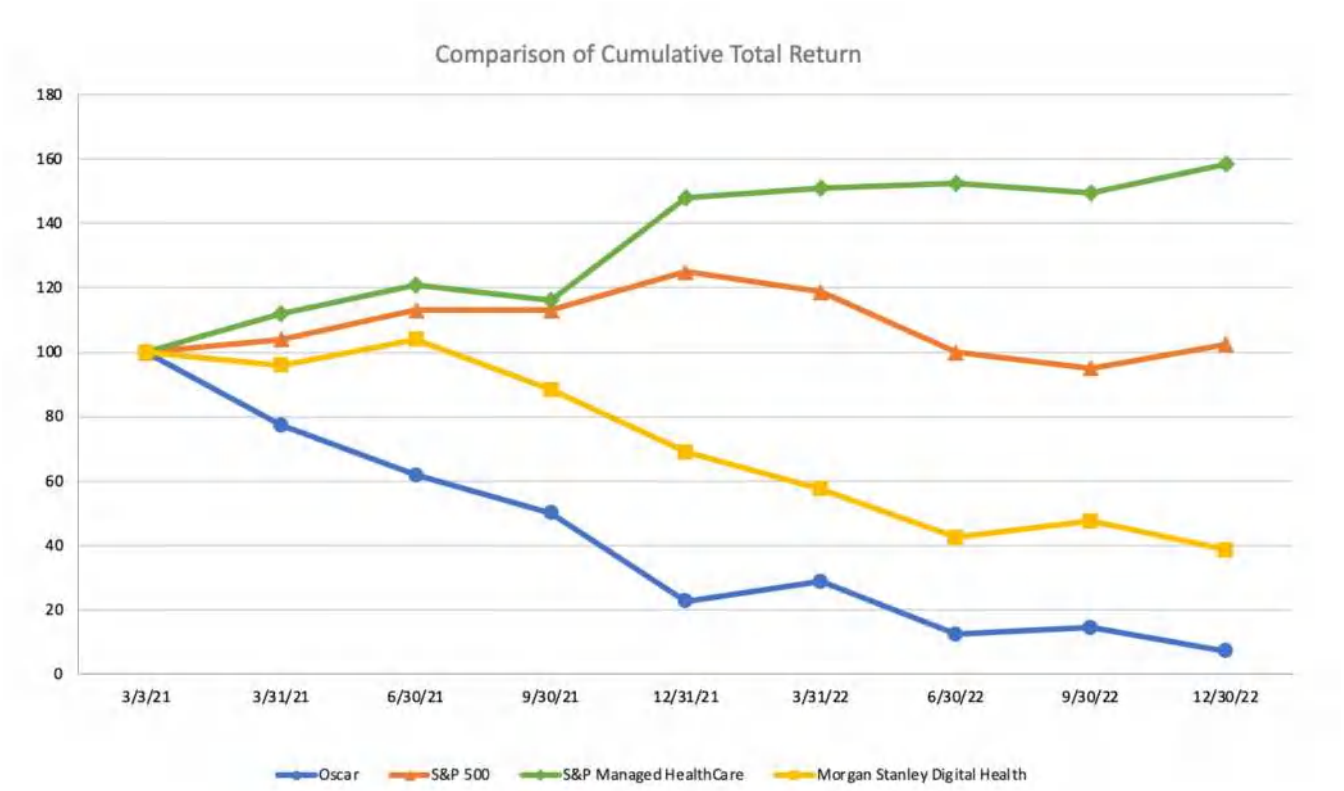
Recent Sales of Unregistered Securities; Purchases of Equity Securities by the Issuer or Affiliated Purchaser

The Company did not sell any equity securities during the year ended December 31, 2022 that were not registered under the Securities Act.

Neither the Company nor any affiliated purchaser purchased any equity securities of the Company during the quarter ended December 31, 2022.

Performance Graph

The following graph illustrates the cumulative total shareholder return on our Class A common stock from March 3, 2021, the first day the Company's stock was publicly traded, through December 31, 2022, relative to the performance of the S&P 500 Index and the Morgan Stanley Digital Health Index. The Morgan Stanley Digital Health Index is composed of Oak Street Health, One Medical, Agilon, Veeva System, Evolent Health, Doximity, Privia Health, R1 RCM, Teladoc, Phreesia, American Well, GoodRx, the Company, Accolade, Health Catalyst, Definitive Healthcare, Alignment Health, Cano Health, LifeStance Health, Bright Health, Sharecare and CareMax. The graph also shows performance of the S&P Managed Healthcare Index, which is the index the Company selected in the Annual Report on Form 10-K filed for the fiscal year ended December 31, 2021. The graph assumes that $100 was invested on March 3, 2021 in each of our Class A common stock, the S&P 500 Index, the Morgan Stanley Digital Health Index and the S&P Managed Healthcare Index, and that any dividends were reinvested. We selected a different index than the index used for the immediately preceding fiscal year because we believe the Morgan Stanley Digital Health Index represents a broader mix of health tech companies to which we are more closely aligned. The comparisons reflected in the graph are not intended to forecast or otherwise be indicative of the future performance of our stock. The performance graph shall not be deemed "soliciting material" or to be "filed" with the SEC for purposes of Section 18 of the Exchange Act or otherwise subject to the liabilities under that Section, and shall not be deemed to be incorporated by reference into any of the Company's filings under the Securities Act.



Company/Index	March 3, 2021	March 31, 2021	June 30, 2021	September 30, 2021	December 31, 2021	March 31, 2022	June 30, 2022	September 30, 2022	December 31, 2022
Oscar Health, Inc.	$ 100.00	$ 77.24	$ 61.78	$ 49.97	$ 22.56	$ 28.65	$ 12.21	$ 14.34	$ 7.07
S&P 500	$ 100.00	$ 104.00	$ 113.00	$ 113.00	$ 125.00	$ 119.00	$ 100.00	$ 95.00	$ 103.00
S&P Managed HealthCare	$ 100.00	$ 112.00	$ 121.00	$ 116.00	$ 148.00	$ 151.00	$ 152.00	$ 149.00	$ 158.00
Morgan Stanley Digital Health	$ 100.00	$ 95.91	$ 103.91	$ 88.31	$ 68.99	$ 57.39	$ 42.40	$ 47.50	$ 38.53

Item 6. [Reserved]

Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations.

The following discussion and analysis of our financial condition and results of operations should be read in conjunction with our audited consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties. Our actual results may differ materially from those anticipated in these forward-looking statements as a result of various factors, including those set forth under Part I, Item 1A."Risk Factors" of this Annual Report on Form 10-K. The following discussion and analysis does not include certain items related to the year ended December 31, 2020, including year-to-year comparisons between the year ended December 31, 2021 and the year ended December 31, 2020. For a comparison of our results of operations for the fiscal years ended December 31, 2021 and December 31, 2020, see Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations of our Annual Report on Form 10-K for the year ended December 31, 2021, filed with the SEC on February 25, 2022.

Overview

Oscar is the first health insurance company built around a full stack technology platform and a relentless focus on serving our members. We offer innovative and consumer-oriented health plans in the Individual, Small Group and Medicare Advantage markets. Our full stack technology platform has enabled arrangements with other payors and providers in which health plans and products are powered by our platform. As we continue to build and scale our technology, we may seek out additional opportunities to monetize our +Oscar platform.

Recent Developments, Trends and Other Factors Impacting Performance

+Oscar Arrangements

On January 19, 2023, we entered into a termination and settlement agreement with Health First Shared Services, Inc ("Health First") under which we agreed (i) to terminate the administrative services agreement with Health First (the "HF Agreement") and transition services from +Oscar to Health First effective December 31, 2022, (ii) to provide run-off services through the end of 2023 and (iii) to forgo an immaterial amount of services revenue in exchange for a settlement and release on mutually agreeable terms.

Reinsurance

We believe our reinsurance agreements help us achieve important goals for our business, including risk management, capital efficiency, and greater predictability in our earnings in the event of unexpected significant fluctuations in MLR. Specifically, reinsurance is a financial arrangement under which the reinsurer agrees to cover a portion of our medical claims (ceded claims) in return for a portion of the premium (premiums ceded). Our reinsurance agreements are contracted under two different types of arrangements: quota share reinsurance contracts and excess of loss ("XOL") reinsurance contracts. Reinsurance agreements do not relieve us of our primary medical claims incurred obligations.

Quota Share Reinsurance

We currently use quota share agreements to limit our risk and capital requirements, which has enabled us to grow while optimizing our use of capital. In quota share reinsurance, the reinsurer agrees to assume a specified percentage of the ceding company's losses arising out of a defined class of business in exchange for a corresponding percentage of premiums. Premiums for quota share reinsurance are based on a percentage of premiums earned before ceded reinsurance. Each quota share reinsurance agreement includes a ceding commission payment from the reinsurer to Oscar to cover administrative costs. To the extent ceded premiums exceed ceded claims and commissions, we typically receive an experience refund.

Because reinsurers are entitled to a portion of our premiums under our quota share reinsurance arrangements, changes in the amount of premiums ceded under these arrangements affect our revenue. Furthermore, reductions in the amount of premiums ceded under quota share reinsurance arrangements may result in an increase to our minimum capital and surplus requirements, and an increase in corresponding capital contributions by Holdco to our health insurance subsidiaries.

The Company currently has quota share reinsurance arrangements with more than one counterparty with multiple state-level treaties. These arrangements are accounted for under both reinsurance accounting and deposit accounting. Our premiums ceded under quota share reinsurance agreements for the year ended December 31, 2022, as compared to the year ended December 31, 2021, are as follows:

	Year Ended December 31,	
Summary of Quota Share Reinsurance Program	**2022**	**2021**
Percentage of premiums ceded under reinsurance programs (reinsurance accounting)	29 %	34 %
Percentage of premiums covered under reinsurance programs (deposit accounting)	18 %	— %

XOL Reinsurance

We use XOL reinsurance to limit our exposure to large catastrophic risk from individual claims. Under XOL reinsurance, the reinsurer agrees to assume all or a portion of the ceding company's losses in excess of a specified amount. The premium payable to the reinsurer is negotiated by the parties based on losses on an individual member in a given calendar year and their assessment of the amount of risk being ceded to the reinsurer. Under our XOL reinsurance contracts in 2022, the reinsurer is paid to cover claims related losses over a $750,000 attachment point, but the amount of the attachment point may change year over year based on a variety of factors.

Risk Adjustment

The risk adjustment programs in the Individual, Small Group, and Medicare Advantage markets we serve are administered federally by Centers for Medicare & Medicaid Services ("CMS") and are designed to mitigate the potential impact of adverse selection and provide stability for health insurers. Under this program, each plan is assigned a risk score based upon demographic information and current year claims information related to its members. The risk score is used to adjust plan revenue to reflect the relative risk of the plan's enrolled population. We reevaluate our risk transfer estimates as new information and market data becomes available until we receive the final reporting from CMS in later periods, up to twelve months in arrears.

Our risk transfer estimates are subject to a high degree of estimation and variability, and are affected by the relative risk of our members, and in the case of ACA, relative to that of other insurers. In the Individual and Small Group lines, there is a higher degree of uncertainty associated with estimates of risk transfers at the beginning of the policy year resulting from composition of the risk score being based on concurrent claim data. Furthermore, there is additional uncertainty for blocks of business that experience high growth compounded by the lack of credible experience data on the newly enrolling population. Actual risk adjustment calculations and transfers could materially differ from our assumptions.

Impact of COVID-19

The COVID-19 pandemic continues to evolve and have an impact on our business.

To date, we have experienced and may continue to experience changes in the utilization patterns of our members, as the pandemic continues to affect the United States, and our members continue to change the way they utilize care. We experienced depressed non-COVID-19 related medical costs as a result of the pandemic and as vaccination rates have increased nationally, members began to resume their utilization of healthcare including care that was deferred, resulting in increased medical claims expenses. However, this trend may reverse if COVID-19 variants continue to proliferate, or COVID-19 vaccines are not effective against new strains or become less effective over time. We also experienced, and may continue to experience, increased COVID-19 testing and treatment costs. We monitor external trends closely as these dynamics result in increased uncertainties around our expectations of both COVID-19 and non-COVID-19 related medical costs. We cannot accurately estimate the future net potential impact, positive or negative, to our medical claims expenses at this time.

Although the Biden Administration announced that the public health emergency ("PHE") for COVID-19 will end on May 11, 2023, the duration, severity and full extent of the impact of this pandemic is unknown and the extent of the business disruption and financial impact depends on factors beyond our knowledge and control.

Regulatory Update

In August 2022, Congress enacted the Inflation Reduction Act, which extended the APTCs under the American Rescue Plan Act for a three year period through the end of 2025. Furthermore, in October 2022, the Treasury Department issued a final rule to address the "family glitch" in the ACA, which relates to determining who is eligible for premium subsidies. In December 2022, Congress passed the omnibus spending bill which delinked the Medicaid continuous coverage from the PHE declaration, and imposed a date of April 1, 2023, for states to begin the Medicaid eligibility redetermination process. It is anticipated that the extension of the APTCs, the "family glitch" fix, and Medicaid redeterminations could lead to significant growth in the ACA marketplace.

As a result of the changing market dynamics following IFP market exits by certain carriers, the Company proactively engaged its regulators regarding options to manage its membership growth. Prior to Open Enrollment for 2023, the Company requested that regulators limit its membership growth in Florida above a certain threshold so that total membership across all markets would be within its previously announced target range of 900,000 to 1,100,000 members at the close of Open Enrollment, which the Company believed would enable it to prudently manage its capital position. Due to strong Open Enrollment performance, the threshold was met and the Company temporarily stopped accepting new members in Florida in the fourth quarter of 2022; however, current members were still able to re-enroll. For further information, see “Risk Factors — Risks Most Material to Us – Our business, financial condition, and results of operations may be harmed if we fail to execute our growth strategy and manage our growth effectively.”

Financial Results Summary and Key Operating and Non-GAAP Financial Metrics

We regularly review a number of metrics, including the following key operating and non-GAAP financial metrics, to evaluate our business, measure our performance, identify trends in our business, prepare financial projections, and make strategic decisions. We believe these operational and financial measures are useful in evaluating our performance, in addition to our financial results prepared in accordance with GAAP.

Financial Results Summary

	Year Ended December 31,	
	2022	2021
	(in thousands)	
Premiums before ceded reinsurance	$ 5,334,520	$ 2,712,988
Reinsurance premiums ceded	(1,463,403)	(881,968)
Premiums earned	$ 3,871,117	$ 1,831,020
Total revenue	$ 3,963,638	$ 1,838,715
Total operating expenses	$ 4,553,505	$ 2,383,196
Net loss	$ (609,552)	$ (571,426)

Key Operating and Non-GAAP Financial Metrics

	Year Ended December 31,	
	2022	2021
Members (as of December 31st)	1,151,483	598,169
Direct and Assumed Policy Premiums (in thousands)	$ 6,842,439	$ 3,436,626
Medical Loss Ratio	85.3 %	88.9 %
InsuranceCo Administrative Expense Ratio	20.6 %	21.8 %
InsuranceCo Combined Ratio	105.8 %	110.7 %
Adjusted Administrative Expense Ratio	24.6 %	28.9 %
Adjusted EBITDA[(1)] (in thousands)	$ (462,255)	$ (429,826)

(1) Adjusted EBITDA is a non-GAAP measure. See "Adjusted EBITDA" below for a reconciliation to net loss, the most directly comparable U.S. GAAP measure, and for information regarding our use of Adjusted EBITDA.

Members

Members are defined as any individual covered by a health plan that we offer directly or through a co-branded arrangement. We view the number of members enrolled in our health plans as an important metric to help evaluate and estimate revenue and market share. Additionally, the more members we enroll, the more data we have, which allows us to improve the functionality of our platform.

Membership increased 93% to 1,151,483 as of December 31, 2022, from 598,169 as of December 31, 2021. The increase is driven largely by strong retention and growth in core Individual markets during open enrollment, including in Florida, Georgia and Texas as well as growth in C+O products.

Direct and Assumed Policy Premiums

Direct Policy Premiums are defined as the premiums collected from our members or from the federal government during the period indicated, before risk adjustment and reinsurance. These premiums include APTC, or premium subsidies, which are available to individuals and families with certain annual incomes. Assumed Policy Premiums are premiums we receive primarily as part of our reinsurance arrangement under our C+O small group plan offering. We believe Direct and Assumed Policy Premiums is an important metric to assess the growth of our individual and small group plan offerings going forward. Management also views Direct and Assumed Policy Premiums as a key operating metric because each of our MLR, InsuranceCo Administrative Expense Ratio, InsuranceCo Combined Ratio and Adjusted Administrative Expense Ratio are calculated on the basis of Direct and Assumed Policy Premiums. Direct and Assumed Policy Premiums increased 99.1% to $6.8 billion as of December 31, 2022 from $3.4 billion as of December 31, 2021, driven primarily by higher membership, rate increases, and mix shift to higher premium Silver plans.

Medical Loss Ratio

Medical loss ratio is calculated as set forth in the table below. Medical claims are total medical expenses incurred by members in order to utilize health care services less any member cost sharing. These services include inpatient, outpatient, pharmacy, and physician costs. Medical claims also include risk sharing arrangements with certain of our providers. The impact of the federal risk adjustment program is included in the denominator of our MLR. We believe MLR is an important metric to demonstrate the ratio of our costs to pay for health care of our members to the premiums before ceded reinsurance. MLRs in our existing products are subject to various federal and state minimum requirements. Below is a calculation of our MLR for the periods indicated.

	Year Ended December 31,	
	2022	**2021**
	(in thousands)	
Direct claims incurred before ceded reinsurance [1]	$ 4,428,000	$ 2,403,108
Assumed reinsurance claims	143,147	21,656
Excess of loss ceded claims [2]	(18,632)	(12,500)
State reinsurance [3]	(30,544)	(14,655)
Net claims before ceded quota share reinsurance [A]	**$ 4,521,971**	**$ 2,397,609**
Premiums before ceded reinsurance [4]	$ 5,334,520	$ 2,712,988
Excess of loss reinsurance premiums [5]	(31,502)	(16,266)
Net premiums before ceded quota share reinsurance [B]	**$ 5,303,018**	**$ 2,696,722**
Medical Loss Ratio [A divided by B]	**85.3 %**	**88.9 %**

(1) See Note 4 - Reinsurance to our consolidated financial statements included elsewhere in this Annual Report on Form 10-K for a reconciliation of direct claims incurred to claims incurred, net appearing on the face of our statement of operations.
(2) Represents claims ceded to reinsurers pursuant to an excess of loss treaty, for which such reinsurers are financially liable. We use excess of loss reinsurance to limit the losses on individual claims of our members.
(3) Represents payments made by certain state-run reinsurance programs established subject to CMS approval under Section 1332 of the ACA.
(4) See Note 3 - Revenue Recognition to our consolidated financial statements included elsewhere in this Annual Report on Form 10-K for an explanation of premiums before ceded reinsurance.
(5) Represents excess of loss insurance premiums paid.

MLR improved for the year ended December 31, 2022 as compared to the year ended December 31, 2021. The improvement was primarily due to lower net COVID-19 related costs, pricing actions, and mix shifts in our member population and medical management actions, partially offset by the impact of prior period development.

InsuranceCo Administrative Expense Ratio

InsuranceCo Administrative Expense Ratio is calculated as set forth in the table below. The ratio reflects the costs associated with running our combined insurance companies. We believe InsuranceCo Administrative Expense Ratio is useful to evaluate our ability to manage our expenses as a percentage of premiums before the impact of quota share reinsurance. Expenses necessary to run the insurance company are included in other insurance costs and federal and state assessments. These expenses include variable expenses paid to vendors and distribution partners, premium taxes and healthcare exchange fees, employee-related compensation, benefits, marketing costs, and other administrative expenses. The numerator and denominator in the calculation below reflect an adjustment to remove the impact of the Company's quota share arrangements. Below is a calculation of our InsuranceCo Administrative Expense Ratio for the periods indicated.

	Year Ended December 31,	
	2022	2021
	(in thousands)	
Other insurance costs	$ 706,439	$ 410,363
Impact of quota share reinsurance[1]	154,741	82,246
Stock-based compensation expense	(51,495)	(42,295)
Federal and state assessment of health insurance subsidiaries	281,049	138,369
Health insurance subsidiary adjusted administrative expenses [A]	**$ 1,090,734**	**$ 588,683**
Premiums before ceded reinsurance [2]	$ 5,334,520	$ 2,712,988
Excess of loss reinsurance premiums	(31,502)	(16,266)
Net premiums before ceded quota share reinsurance [B]	**$ 5,303,018**	**$ 2,696,722**
InsuranceCo Administrative Expense Ratio [A divided by B]	**20.6 %**	**21.8 %**

(1) Includes ceding commissions received from reinsurers, net of the impact of deposit accounting of $(7,205) for the year ended December 31, 2022.

(2) See Note 3 - Revenue Recognition to our consolidated financial statements included elsewhere in this Annual Report on Form 10-K for an explanation of premiums before ceded reinsurance.

The InsuranceCo Administrative Expense Ratio improved for the year ended December 31, 2022 as compared to the year ended December 31, 2021, primarily due to operating expense leverage and scale efficiencies, partially offset by higher distribution expenses.

InsuranceCo Combined Ratio

InsuranceCo Combined Ratio is defined as the sum of MLR and InsuranceCo Administrative Expense Ratio. We believe this ratio best represents the core performance of the consolidated insurance business, prior to the impact of quota share and net investment income.

	Year Ended December 31,	
	2022	2021
Medical Loss Ratio	85.3 %	88.9 %
InsuranceCo Administrative Expense Ratio	20.6 %	21.8 %
InsuranceCo Combined Ratio	**105.8 %**	**110.7 %**

The InsuranceCo Combined Ratio improved for the year ended December 31, 2022 as compared to the year ended December 31, 2021, consistent with the improvement in the MLR and InsuranceCo Administrative Expense Ratio.

Adjusted Administrative Expense Ratio

The Adjusted Administrative Expense Ratio is an operating ratio that reflects the Company's total administrative expenses ("Total Administrative Expenses"), net of non-cash and non-recurring items (as adjusted, "Adjusted Administrative Expenses"), as a percentage of total revenue, including quota share reinsurance premiums ceded and excluding excess of loss reinsurance premiums ceded and non-recurring items ("Adjusted Total Revenue"). Total Administrative Expenses are calculated as Total Operating Expenses, excluding non-administrative insurance-based expenses and the impact of quota share reinsurance. Adjusted Administrative Expenses are Total Administrative Expenses, net of non-cash and non-recurring expense items. Adjusted Administrative Expenses exclude insurance-based expenses, non-cash expenses and non-recurring expenses. We believe Adjusted Administrative Expense Ratio is useful to evaluate our ability to manage our overall administrative expense base. This ratio also provides further clarity into our overall path to profitability. Below is a calculation of our Adjusted Administrative Expense Ratio for the periods indicated.

	Year Ended December 31,	
	2022	2021
	(in thousands)	
Total Operating Expenses	**$ 4,553,505**	**$ 2,383,196**
Claims incurred, net	(3,280,798)	(1,623,995)
Premium deficiency reserve release	25,033	55,325
Impact of quota share reinsurance [1]	154,741	82,246
Total Administrative Expenses	**$ 1,452,481**	**$ 896,772**
Stock-based compensation expense/warrant expense	(112,329)	(99,152)
Depreciation and amortization	(15,283)	(14,605)
Other non-recurring items [2]	—	(898)
Adjusted Administrative Expenses [A]	**$ 1,324,869**	**$ 782,117**
Total Revenue	**$ 3,963,638**	**$ 1,838,715**
Reinsurance premiums ceded	1,463,403	881,968
Excess of loss reinsurance premiums	(31,502)	(16,266)
Adjusted Total Revenue [B]	**$ 5,395,539**	**$ 2,704,417**
Adjusted Administrative Expense Ratio [A divided by B]	24.6 %	28.9 %

(1) Includes ceding commissions received from reinsurers, net of the impact of deposit accounting of $(7,205) for the year ended December 31, 2022. The Company did not apply deposit accounting to its reinsurance contracts during the year ended December 31, 2021.

(2) Represents approximately $0.9 million of non-recurring expenses incurred in connection with the Company's initial public offering ("IPO") during the year ended December 31, 2021.

The Adjusted Administrative Expense Ratio improved for the year ended December 31, 2022, as compared to the year ended December 31, 2021. The improvement was due to operating expense leverage and scale efficiencies, partially offset by distribution expenses.

Adjusted EBITDA

Adjusted EBITDA is defined as net loss for the Company and its consolidated subsidiaries before interest expense, income tax expense (benefit), depreciation and amortization as further adjusted for stock-based compensation, warrant contract expense, changes in the fair value of warrant liabilities, and other non-recurring items as described below. We present Adjusted EBITDA because we consider it to be an important supplemental measure of our performance and believe it is frequently used by securities analysts, investors, and other interested parties in the evaluation of companies in our industry. Adjusted EBITDA is a non-GAAP measure. Management believes that investors' understanding of our performance is enhanced by including this non-GAAP financial measure as a reasonable basis for comparing our ongoing results of operations.

We caution investors that amounts presented in accordance with our definition of Adjusted EBITDA may not be comparable to similar measures disclosed by our competitors, because not all companies and analysts calculate Adjusted EBITDA in the same manner.

Management uses Adjusted EBITDA:

- as a measurement of operating performance because it assists us in comparing the operating performance of our business on a consistent basis, as it removes the impact of items not directly resulting from our core operations;
- for planning purposes, including the preparation of our internal annual operating budget and financial projections;
- to evaluate the performance and effectiveness of our operational strategies; and
- to evaluate our capacity to expand our business.

By providing this non-GAAP financial measure, together with a reconciliation to the most comparable U.S. GAAP measure, we believe we are enhancing investors' understanding of our business and our results of operations, as well as assisting investors in evaluating how well we are executing our strategic initiatives. Adjusted EBITDA has limitations as an analytical tool, and should not be considered in isolation, or as an alternative to, or a substitute for net loss or other financial statement data presented in our consolidated financial statements as indicators of financial performance.

	Year Ended December 31,	
	2022	2021
	(in thousands)	
Net loss	**$ (609,552)**	**$ (571,426)**
Interest expense	22,623	4,720
Other expense (income)	(2,415)	1,201
Income tax expense (benefit)	(523)	846
Depreciation and amortization	15,283	14,605
Stock-based compensation/warrant expense[1]	112,329	99,152
Other non-recurring items[2]	—	21,076
Adjusted EBITDA	**$ (462,255)**	**$ (429,826)**

(1) Represents (i) non-cash expenses related to equity-based compensation programs, which vary from period to period depending on various factors including the timing, number, and the valuation of awards, (ii) warrant contract expense, and (iii) changes in the fair value of warrant liabilities.

(2) Represents debt extinguishment costs of $20.2 million incurred on the prepayment of our Term Loan (refer to Note 15 - Long-Term Debt to our consolidated financial statements included elsewhere in this Annual Report on Form 10-K) and approximately $0.9 million of non-recurring expenses incurred in connection with the IPO during the year ended December 31, 2021.

Components of our Results of Operations

Premiums Before Ceded Reinsurance

Premiums before ceded reinsurance primarily consist of premiums received, or to be received, directly from our members or from CMS as part of the APTC program, net of the impact of our risk adjustment payable. Premiums before ceded reinsurance are generally impacted by the amount of risk sharing adjustments, our ability to acquire new members and retain existing members, and average size and premium rate of policies.

Reinsurance Premiums Ceded

Reinsurance premiums ceded represent the amount of premiums written that are ceded to reinsurers either through quota share agreements that pass risk transfer or XOL reinsurance. We enter into reinsurance agreements, in part, to limit our exposure to potential losses as well as to provide additional capacity for growth. Reinsurance premiums ceded are recognized over the reinsurance contract period in proportion to the period of risk covered. The volume of our reinsurance premiums ceded is impacted by the level of our premiums earned and any decision we make to increase or decrease limits, retention levels, and co-participations.

Administrative Services Revenue

Administrative services revenue includes income earned from administrative services performed as part of the +Oscar platform.

Investment Income and Other Revenue

Investment income (loss) and other revenue primarily includes interest earned and gains on our investment portfolio, along with sublease income.

Claims Incurred, Net

Claims incurred, net primarily consists of both paid and unpaid medical expenses incurred to provide medical services and products to our members. Medical claims include fee-for-service claims, pharmacy benefits, capitation payments to providers, provider disputed claims and various other medical-related costs. Under fee-for-service claims arrangements with providers, we retain the financial responsibility for medical care provided and incur costs based on actual utilization of hospital and physician services. Medical claims are recognized in the period health care services are provided. Unpaid medical expenses include claims reported and in the process of being settled, but that have not yet been paid, as well as health care costs incurred but not yet reported to us, which are collectively referred to as benefits payable or claim reserves. The development of the claim reserve estimate is based on actuarial methodologies that consider underlying claim payment patterns, medical cost inflation, historical developments, such as claim inventory levels and claim receipt patterns, and other relevant factors. The methods for making such estimates and for establishing the resulting liability are continuously reviewed and any adjustments are reflected in the period determined. Claims incurred, net also reflects the net impact of our ceded reinsurance claims.

Other Insurance Costs

Other insurance costs primarily include distribution costs, including broker commissions, wages, benefits, marketing, rent, costs of software and hardware, unallocated claims adjustment expenses, and administrative costs associated with functions that are necessary to support our health insurance business. Such functions include, but are not limited to, member concierge services, claims processing, utilization management, and related health plan operations, actuarial, compliance and portions of information systems, legal and finance. This line item also includes ceding commissions we receive from our reinsurance partners, net of the impact of deposit accounting.

General and Administrative Expenses

General and administrative expenses primarily include wages, benefits, costs of software and hardware, and administrative costs for our corporate and technology functions. Such functions include, but are not limited to executive management, and portions of legal, finance and information systems, including product management and development.

Federal and State Assessments

Federal and state assessments represent non-income tax charges from federal and state governments, including but not limited to healthcare exchange user fees, premium taxes, franchise taxes, and other state and local non-premium related taxes.

Premium Deficiency Reserve Release

Premium deficiency reserve release is the year over year change in the premium deficiency reserve liability. Premium deficiency reserve liabilities are established when it is probable that expected future claims and maintenance expenses will exceed future premium and reinsurance recoveries on existing medical insurance contracts.

Interest Expense

Interest expense consists primarily of interest expense associated with our debt arrangements, including amortization of debt issuance costs and discounts and revolving credit facility fees.

Other Expenses (Income)

Other expenses (income) consists primarily of miscellaneous expenses or income that are not core to our operations, including profit sharing arrangements with our co-branded health plans and changes in the fair value of financial instruments.

Income Tax Expense (Benefit)

Income tax expense (benefit) consists primarily of changes to our current and deferred federal and state tax assets and liabilities. Income taxes are recorded as deferred tax assets and deferred tax liabilities based on differences between the book and tax bases of assets and liabilities. Our deferred tax assets and liabilities are calculated by applying the current tax rates and laws to taxable years in which such differences are expected to reverse.

Results of Operations

Year Ended December 31, 2022 compared to Year Ended December 31, 2021

The following table sets forth our results of operations for the periods indicated:

	Year Ended December 31,			
	2022	2021	$ Change	% Change
	(in thousands)			
Revenue				
Premiums before ceded reinsurance	$ 5,334,520	$ 2,712,988	$ 2,621,532	97 %
Reinsurance premiums ceded	(1,463,403)	(881,968)	(581,435)	66 %
Premiums earned	3,871,117	1,831,020	2,040,097	111 %
Administrative services revenue	61,047	5,394	55,653	1,032 %
Investment income and other revenue	31,474	2,301	29,173	1,268 %
Total revenue	**3,963,638**	**1,838,715**	2,124,923	116 %
Operating Expenses:				
Claims incurred, net	3,280,798	1,623,995	1,656,803	102 %
Other insurance costs	706,439	410,363	296,076	72 %
General and administrative expenses	309,783	265,078	44,705	17 %
Federal and state assessments	281,518	139,085	142,433	102 %
Premium deficiency reserve release	(25,033)	(55,325)	30,292	(55) %
Total operating expenses	**4,553,505**	**2,383,196**	2,170,309	91 %
Loss from operations	(589,867)	(544,481)	(45,386)	8 %
Interest expense	22,623	4,720	17,903	379 %
Other expenses (income)	(2,415)	1,201	(3,616)	*NM
Loss on extinguishment of debt	—	20,178	(20,178)	*NM
Loss before income taxes	(610,075)	(570,580)	(39,495)	7 %
Income tax expense (benefit)	(523)	846	(1,369)	(162) %
Net loss	**$ (609,552)**	**$ (571,426)**	**$ (38,126)**	**7 %**

**NM - not meaningful*

Premiums Before Ceded Reinsurance

Premiums before ceded reinsurance increased by $2.6 billion, or 97%, to $5.3 billion for the year ended December 31, 2022, from $2.7 billion for the year ended December 31, 2021. The increase was primarily due to higher membership driven largely by growth in the Individual line of business, as well as increases due to serving new C+O members and a mix shift towards higher premium plans. Oscar's growth also reflects strong retention and growth in core markets during open enrollment, including in Florida, Georgia and Texas, despite having the lowest cost plan in only 8% of its markets.

Reinsurance Premiums Ceded

Reinsurance premiums ceded increased $581.4 million, or 66%, to $1.5 billion for the year ended December 31, 2022, from $882.0 million for the year ended December 31, 2021. The increase is driven by growth in premiums before ceded reinsurance discussed above.

Administrative Services Revenue

Administrative services revenue increased $55.7 million, or 1,032%, to $61.0 million for the year ended December 31, 2022, from $5.4 million for the year ended December 31, 2021. This increase was driven by the January 2022 launch of our arrangement with Health First, which has since been terminated.

Investment Income and Other Revenue

Investment income and other revenue increased to $31.5 million, or 1,268%, for the year ended December 31, 2022, from $2.3 million for the year ended December 31, 2021, primarily due to changes in interest rates.

Claims Incurred, Net

Claims incurred, net, increased $1.7 billion, or 102%, to $3.3 billion for the year ended December 31, 2022, from $1.6 billion for the year ended December 31, 2021, which was primarily volume-driven due to growth in membership.

Other Insurance Costs

Other insurance costs increased $296.1 million, or 72%, to $706.4 million for the year ended December 31, 2022, from $410.4 million for the year ended December 31, 2021. The increase was primarily attributable to higher broker commissions and higher headcount, which were driven by the increase in membership.

General and Administrative Expenses

General and administrative expenses increased $44.7 million, or 17%, to $309.8 million for the year ended December 31, 2022, from $265.1 million for the year ended December 31, 2021. The increase was primarily attributable to higher headcount and other employee-related costs related to servicing the +Oscar business.

Federal and State Assessments

Federal and state assessments increased $142.4 million, or 102%, to $281.5 million for the year ended December 31, 2022, from $139.1 million for the year ended December 31, 2021, which was primarily due to membership growth.

Premium Deficiency Reserve Release

Premium deficiency reserve release decreased $30.3 million, for the year ended December 31, 2022, from $55.3 million for the year ended December 31, 2021. The change was due to the lower premium deficiency reserve established at the end of 2021 as compared to the reserve established at the end of 2020 as well as the lower premium deficiency reserve established at the end of 2022 as compared to the reserve established at the end of 2021.

Income Tax (Benefit) Provision

Our effective tax rate for the year ended December 31, 2022 and December 31, 2021 was approximately 0.09% and (0.15)%, respectively.

Liquidity and Capital Resources

Overview

We maintain liquidity at two levels of our corporate structure, through our health insurance subsidiaries and through Holdco, our consolidated subsidiaries excluding our regulated insurance subsidiaries.

The majority of the assets held by our health insurance subsidiaries is in the form of cash and cash equivalents and investments. As of December 31, 2022 and December 31, 2021, total cash and cash equivalents and investments held by our health insurance subsidiaries was $2.9 billion and $1.8 billion, respectively, of which $17.7 million and $17.0 million, respectively, was on deposit with regulators as required for statutory licensing purposes and are classified as restricted deposits on the balance sheet.

Our health insurance subsidiaries' states of domicile have statutory minimum capital requirements that are intended to measure capital adequacy, taking into account the risk characteristics of an insurer's investments and products. The combined statutory capital and surplus of our health insurance subsidiaries was $701.5 million and $474.8 million at December 31, 2022 and December 31, 2021, respectively, which was in compliance with and in excess of the minimum capital requirements for each period. The health insurance subsidiaries historically have required capital contributions from Parent to maintain minimum levels. The health insurance subsidiaries may be subject to additional capital and surplus requirements in the future, as a result of factors such as increasing membership and medical costs, which may require us to incur additional indebtedness, sell capital stock, or access other sources of funding in order to fund such requirements. During periods of increased volatility, such as the current macroeconomic environment, adverse securities and credit markets, including due to rising interest rates, may exert downward pressure on the availability of liquidity and credit capacity for certain issuers, and any such funding may not be available on favorable terms, or at all. For additional information on the steps we've taken to balance growth and our capital position, see "Management's Discussion and Analysis of Financial Condition and Results of Operations—Recent Developments, Trends and Other Factors Impacting Performance—Regulatory Update."

In the future, when our health insurance subsidiaries become profitable or if their levels of reserves and capital become excessive, we may make requests for dividends and distributions from our subsidiaries to fund our operations, which may or may not be approved by our regulators. For additional information see Risk Factors - Risk Related to our Business - If state regulators do not approve payments of dividends and distributions by our health insurance subsidiaries to us, we may not have sufficient funds to implement our business strategy.

Our health insurance subsidiaries also utilize quota share reinsurance arrangements to reduce our minimum capital and surplus requirements, which are designed to enable us to efficiently deploy capital to fund our growth. During the year ended December 31, 2022 and 2021, Parent made $423.5 million and $540.9 million of capital contributions, respectively, to the health insurance subsidiaries. We estimate that had we not had any quota share reinsurance arrangements in place, the insurance subsidiaries would have been required to hold approximately $446.8 million of additional capital as of December 31, 2022, which Parent would have been required to fund. The actual amount of any required capital contributions to our insurance subsidiaries may differ at any given time depending on each insurance subsidiary's capital adequacy. For additional information on our capital contributions and reinsurance arrangements, see "Risk Factors – Risks Related to our Business – We utilize quota share reinsurance to reduce our capital and surplus requirements and protect against downside risk on medical claims. If regulators do not approve our reinsurance agreements for this purpose, or if we cannot negotiate renewals of our quota share arrangements on acceptable terms, or at all, enter into new agreements with reinsurers, or otherwise obtain capital through debt or equity financings, our capital position would be negatively impacted, and we could fall out of compliance with applicable regulatory requirements" and "Risk Factors – Risks Most Material to Us – Our business, financial condition, and results of operations may be harmed if we fail to execute our growth strategy and manage our growth effectively."

Short-Term Cash Requirements

The majority of the assets held by Holdco are in the form of cash and cash equivalents and investments. As of December 31, 2022 and December 31, 2021, total cash and cash equivalents and investments held by Holdco was $342.0 million and $738.6 million, respectively, of which $9.8 million and $11.0 million was restricted for 2022 and 2021, respectively. Based on our current forecast, we believe the cash, and cash equivalents and investments held by Holdco, not including restricted cash, will be sufficient to fund our operating requirements for at least the next twelve months.

Our cash flows used in operations may differ substantially from our net loss due to non-cash charges or due to changes in balance sheet accounts. The timing of our cash flows from operating activities can also vary among periods due to the timing of payments made or received. Some of our payments and receipts, including risk adjustment and subsequent reinsurance receipts, can be significant. For example, during the third quarter of 2022, we made a payment through our health insurance subsidiaries of $783.8 million into the risk adjustment program for the 2021 policy year. Therefore, the timing of these payments can influence cash flows from operating activities in any given period which would have a negative impact on our operating cash flows.

The Company's cash requirements within the next twelve months include subsidiary capital infusions, Holdco expenses, and interest expenses. Payments into the risk adjustment program are made annually in the third quarter. We expect the cash required to meet these obligations to be primarily funded by cash available for general corporate use, funds primarily generated through equity or debt financing transactions, cash flows from current operations, and/or the realization of current assets, such as accounts receivable.

Long-Term Cash Requirements
Our long-term cash requirements under our various contractual obligations and commitments include:

- *Operating leases.* See Note 13 – Leases to our consolidated financial statements included elsewhere in this Annual Report on Form 10-K for further detail of our obligations and the timing of expected future payments.
- *Interest payable.* See Note 15 – Long-Term Debt to our consolidated financial statements included elsewhere in this Annual Report on Form 10-K for further detail of our obligations and the timing of future payments.
- *Noncontrolling interests.* See Note 2 – Summary of Significant Accounting Policies to our consolidated financial statements included elsewhere in this Annual Report on Form 10-K for further detail. We do not have any material required redemptions in the next twelve months.

We expect the cash required to meet our long-term obligations to be primarily generated through future cash flows from operations.

Convertible Senior Notes

On January 27, 2022, we entered into an investment agreement (the "Investment Agreement") pursuant to which we agreed to issue and sell $305.0 million in aggregate principal amount of 7.25% convertible senior notes due 2031 (the "2031 Notes") in a private placement to funds affiliated with or advised by Dragoneer Investment Group, LLC, Thrive Capital, LionTree Investment Management, LLC and Tenere Capital LLC . The transaction contemplated by the Investment Agreement closed on February 3, 2022 (the "Closing Date"). In connection with the issuance of the 2031 Notes, on February 3, 2022, we entered into an Indenture between us and U.S. Bank National Association, as trustee. The 2031 Notes bear interest at a rate of 7.25% per annum, payable in cash, semi-annually in arrears on June 30 and December 31 of each year, commencing on June 30, 2022. The Company may determine in the future to repurchase portions of the outstanding 2031 Notes from time to time in accordance with applicable SEC and other legal requirements and in consideration of market and other conditions. See Note 15 - Long-Term Debt to our consolidated financial statements included elsewhere in this Annual Report on Form 10-K for additional information.

Revolving Credit Facility

On February 21, 2021, we entered into a senior secured credit agreement with Wells Fargo Bank, National Association as administrative agent, and certain other lenders for a revolving loan credit facility (the "Revolving Credit Facility"), in the aggregate principal amount of $200 million. The Revolving Credit Facility is guaranteed by Oscar Management Corporation (formerly Mulberry Management Corporation) and Oscar Management Corporation of Florida, each wholly owned subsidiaries of Oscar, and all of our future direct and indirect subsidiaries (subject to certain permitted exceptions, including exceptions for guarantees that would require material governmental consents or in respect of joint venture) (the "Guarantors"). Our Revolving Credit Facility is secured by a lien on substantially all of our and the Guarantors' assets (subject to certain exceptions). Proceeds are to be used solely for general corporate purposes of the Company. The Revolving Credit Facility is available until February 2024, provided we are in compliance with all covenants.

The Revolving Credit Facility permits us to increase commitments under the Revolving Credit Facility by an aggregate amount not to exceed $50 million. The incurrence of any such incremental Revolving Credit Facility will be subject to the following conditions measured at the time of incurrence of such commitments: (i) no default or event of default, (ii) all representations and warranties must be true and correct in all material respects immediately prior to, and after giving effect to, the incurrence of such incremental Revolving Credit Facility and (iii) and any such conditions as agreed between the Borrower and the lender providing such incremental commitment.

As of December 31, 2022, there were no outstanding borrowings under the Revolving Credit Facility.

Interest Rate, Commitment Fees

The interest rate applicable to borrowings under our Revolving Credit Facility is determined as follows, at our option: (a) a rate per annum equal to an adjusted London Inter-bank Offered Rate ("LIBOR"), plus an applicable margin of 4.50% (LIBOR is calculated based on one-, three- or six-month LIBOR, or such other period as agreed by all relevant Lenders, which is determined by reference to ICE Benchmark Administration Limited, but not less than 1.00%), or (b) a rate per annum equal to the Alternate Base Rate plus the applicable margin of 3.50% (the "Alternate Base Rate" is equal to the highest of (i) the prime rate, (ii) the federal funds effective rate plus 0.50%, and (iii) LIBOR based on a one-month interest period, plus 1.00%). A commitment fee of 0.50% per annum is payable under our Revolving Credit Facility on the actual daily unused portions of the Revolving Credit Facility. The Revolving Credit Facility also contains LIBOR replacement provisions in the event LIBOR becomes unavailable during the term of this facility.

The Revolving Credit Facility requires us to comply with certain restrictive covenants, including but not limited to covenants relating to limitations on indebtedness, liens, investments, loans and advances, restricted payments and restrictive agreements, mergers, consolidations, sale of assets and acquisitions, sale and leaseback transactions and affiliate transactions.

In addition, the Revolving Credit Facility contains financial covenants that require us to (i) maintain specified levels of direct policy premiums (as defined in the Revolving Credit Facility) for each fiscal quarter, (ii) maintain a minimum liquidity (as defined in the Revolving Credit Facility) of $150 million (or $200 million if the liquidity decreased by a specified amount over the prior six month period) as of the last day of each quarter, and (iii) not exceed a maximum combined ratio (as defined in the Revolving Credit Facility) of 108% for fiscal year 2022 and 102% for fiscal year 2023, in each case, as of the last day of each quarter. As of December 31, 2022, we were in compliance with all financial covenants under the Revolving Credit Facility.

Investments

We generally invest cash of our health insurance subsidiaries in U.S. treasury and agency securities. We primarily invest cash of the Company in investment-grade, marketable debt securities to improve our overall investment return. These investments are purchased pursuant to board-approved investment policies that reflect our obligations under our credit agreement and conform to applicable state laws and regulations.

Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements that prescribe the types of instruments in which our subsidiaries may invest. These investment policies require that our investments have final maturities of a maximum of three years from the settlement date. Professional portfolio managers operating under documented guidelines manage our investments and a portion of our cash equivalents. Our portfolio managers must obtain our prior approval before selling investments in a loss position.

Our restricted investments are invested principally in cash and cash equivalents and U.S. treasury securities; we have the ability to hold such restricted investments until maturity. The Company maintains cash and cash equivalents and investments on deposit or pledged to various state agencies as a condition for licensure. We classify our restricted deposits as long-term given the requirement to maintain such assets on deposit with regulators.

Summary of Cash Flows

Our cash flows used in operations may differ substantially from our net loss due to non-cash charges or due to changes in balance sheet accounts.

The timing of our cash flows from operating activities can also vary among periods due to the timing of payments made or received. Some of our payments and receipts, including loss settlements and subsequent reinsurance receipts, can be significant. Therefore, their timing can influence cash flows from operating activities in any given period. The potential for a large claim under an insurance or reinsurance contract means that our health insurance subsidiaries may need to make substantial payments within relatively short periods of time, which would have a negative impact on our operating cash flows.

The following table shows summary cash flows information for the periods indicated:

	Year Ended December 31,		
	2022	2021	Change
	(in thousands)		
Net cash provided by (used in) operating activities	$ 380,349	$ (181,745)	$ 562,094
Net cash used in investing activities	(226,519)	(774,515)	547,996
Net cash provided by financing activities	301,110	1,238,712	(937,602)
Net increase in cash and cash equivalents and restricted cash equivalents	**$ 454,940**	**$ 282,452**	**$ 172,488**

Operating Activities

Net cash provided by (used in) operating activities increased $562.1 million to $380.3 million for the year ended December 31, 2022, compared to $181.7 million used in operating activities for the year ended December 31, 2021, primarily due to membership growth, which resulted in increased premiums and accounts receivable and reinsurance recoverable under our quota share reinsurance program. Our risk adjustment transfer payable also increased as a result of membership growth and the health status of our members, who continue to have lower than average risk scores compared to the health status of other participants in ACA plans.

Investing Activities

Net cash used in investing activities decreased $548.0 million to $226.5 million for the year ended December 31, 2022, compared to $774.5 million for the year ended December 31, 2021. The decrease was primarily due to lower purchases of investments in 2022 compared to 2021.

Financing Activities

Net cash provided by financing activities decreased $937.6 million to $301.1 million for the year ended December 31, 2022, compared to $1.2 billion for the year ended December 31, 2021. The decrease was primarily due to net proceeds received from the sale of common stock during our IPO in March 2021, slightly offset by net proceeds received from the issuance of convertible notes in February 2022.

Critical Accounting Policies and Estimates

The preparation of consolidated financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of revenues, expenses, assets, and liabilities and disclosure of contingent assets and liabilities in our financial statements. We regularly assess these estimates; however, actual amounts could differ from those estimates. The most significant items involving management's estimates include estimates of benefits payable, reinsurance, premium deficiency reserve, risk adjustment, stock-based compensation, and income taxes. The impact of changes in estimates is recorded in the period in which they become known.

An accounting policy is considered to be critical if the nature of the estimates or assumptions is material due to the levels of subjectivity and judgment necessary to account for highly uncertain matters or the susceptibility of such matters to change, and the effect of the estimates and assumptions on financial condition, or operating performance. The accounting policies that reflect a significant level of estimation and that are most likely to have a material impact on our reported financial results are described below. Other significant accounting policies such as reinsurance, premium deficiency reserve, risk adjustment, stock-based compensation, and income taxes do not involve significant levels of uncertainty and are disclosed in Item 8, Financial Statements and Supplementary Data in this Annual Report on Form 10-K.

Benefits Payable

Benefits payable includes estimates of our obligations for health care services that have been rendered on behalf of members, but for which claims have either not yet been received or processed. Depending on the health care professional and type of service, the typical billing lag for services can be up to 90 days from the date of service. Approximately 90% of claims related to health care services are known and settled within 90 days from the date of service and substantially all within 12 months from the accepted claims submission.

In each reporting period, our operating results include the effects of more completely developed benefits payable estimates associated with previously reported periods. If the revised estimate of prior period health care claims is less than the previous estimate, we will decrease reported health care claims in the current period (favorable development). If the revised estimate of prior period health care claims is more than the previous estimate, we will increase reported health care costs in the current period (unfavorable development). Health care costs in the years ended December 31, 2022 and December 31, 2021 included unfavorable health care claim development related to prior years of $1.3 million (net of reinsurance) and favorable development of $16.3 million (net of reinsurance), respectively.

In developing our benefits payable estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For example, in recent months, we estimate claim costs incurred by applying assumed medical cost trends to the PMPM medical costs incurred in prior months for which more complete claim data is available, supplemented by a review of near-term completion factors. Additional consideration is also given to settled claims that may reopen as a result of provider disputes.

Completion Factors
A completion factor is an actuarial estimate, based upon historical experience and analysis of current trends, of the percentage of incurred claims during a given period that have been adjudicated by us at the date of estimation. Completion factors are the most significant factors we use in developing our benefits payable estimates. For periods prior to the two most recent months, completion factors include judgments related to claim submissions such as the time from date of service to claim receipt, claim levels, and processing cycles, as well as other factors. If actual claims submission rates from providers (which can be influenced by a number of factors, including provider mix and electronic versus manual submissions) or our claim processing patterns are different than estimated, our reserve estimates may be significantly impacted. For the most recent two months, the completion factors are informed primarily from forecasted per member per month claims projections developed from our historical experience and adjusted by emerging experience data in the preceding months which may include adjustments for known changes in estimates of recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix, and workday seasonality.

The following table illustrates the sensitivity of the estimated potential impact on our benefits payable estimates gross of reinsurance, for those periods as of December 31, 2022 to an increase (decrease) in the underlying completion factors:

Changes in Estimates	Increase (Decrease) in Benefits Payable (in thousands)
(1.00)%	$ 83,319
(0.75)%	62,332
(0.50)%	41,450
(0.25)%	20,673
0.25%	(20,570)
0.50%	(40,918)
0.75%	(60,487)
1.00%	(78,832)

Management believes the amount of benefits payable is reasonable and adequate to cover our liability for unpaid claims as of December 31, 2022; however, actual claim payments may differ from established estimates as discussed above. Assuming a hypothetical 1% difference between our December 31, 2022 estimates of benefits payable and actual benefits payable, excluding any potential offsetting impact from premium rebates, net earnings for the year ended December 31, 2022 would have increased by approximately $83.3 million or decreased by approximately $78.8 million.

For more detail related to our medical claims expenses, see Note 2 - Summary of Significant Accounting Policies to our consolidated financial statements included elsewhere in this Annual Report on Form 10-K.

Risk Adjustment
The risk adjustment programs in the Individual, Small Group, and Medicare Advantage markets we serve are designed to mitigate the potential impact of adverse selection and provide stability for health insurers.

The Company estimates the receivable or payable under the risk adjustment programs based on its estimated risk score compared to the state average risk score. The Company may record a receivable or payable as an adjustment to premium revenues to reflect the year-to-date impact of the risk adjustment based on its best estimate. The Company refines its estimate as new information becomes available.

Under the Individual and Small Group risk adjustment program, each plan is assigned a risk score based upon demographic information and current year claims information related to its members. Plans with lower than average risk scores will generally pay into the pool, while plans with higher than average risk scores will generally receive distributions.

In the Medicare Advantage risk adjustment program, each member is assigned a risk score that reflects the member's predicted health costs compared to an average member. Plans receive higher payments for members with higher risk scores than members with lower risk scores.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Market risk represents the risk of loss that may impact our financial position due to adverse changes in financial market prices and rates. Our market risk exposure is primarily a result of exposure due to potential changes in interest rates and/or inflation and the resulting impact on investment income and interest expense. We do not hold financial instruments for trading purposes.

Interest Rate Risk

We are subject to interest rate risk in connection with the fair value of our investment portfolio, which consists of U.S. Treasury and agency securities, corporate notes, certificates of deposit, commercial paper and municipalities. Our primary market risk exposure is changes to prime rate-based interest rates. Interest rate risk is highly sensitive due to many factors, including U.S. monetary and tax policies, U.S. and international economic factors, and other factors beyond our control. Assuming a hypothetical and immediate 1% increase in interest rates at December 31, 2022, the fair value of our investments would decrease by approximately $8.5 million. Any declines in interest rates over time would reduce our investment income.

Item 8. Financial Statements and Supplementary Data

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Stockholders of Oscar Health, Inc.

Opinions on the Financial Statements and Internal Control over Financial Reporting

We have audited the accompanying consolidated balance sheets of Oscar Health, Inc. and its subsidiaries (the "Company") as of December 31, 2022 and 2021, and the related consolidated statements of operations, of comprehensive income, of stockholders' equity and of cash flows for each of the three years in the period ended December 31, 2022, including the related notes and financial statement schedule listed in the index appearing under Item 15(a)(2) (collectively referred to as the "consolidated financial statements"). We also have audited the Company's internal control over financial reporting as of December 31, 2022, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO).

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of the Company as of December 31, 2022, and 2021, and the results of its operations and its cash flows for each of the three years in the period ended December 31, 2022 in conformity with accounting principles generally accepted in the United States of America. Also in our opinion, the Company did not maintain, in all material respects, effective internal control over financial reporting as of December 31, 2022, based on criteria established in *Internal Control - Integrated Framework* (2013) issued by the COSO because a material weakness in internal control over financial reporting existed as of that date related to management not designing and maintaining effective controls over certain information technology (IT) general controls for information systems that are relevant to the preparation of the Company's consolidated financial statements. Specifically, management did not design and maintain (i) program change management controls for certain financial systems to ensure that IT program and data changes affecting certain IT applications and underlying accounting records were identified, tested, authorized and implemented appropriately, (ii) user access controls that adequately restrict user and privileged access to certain financial applications, programs and data to appropriate company personnel, and (iii) testing and approval controls for program development to ensure new software development is aligned with business and IT requirements.

A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the annual or interim financial statements will not be prevented or detected on a timely basis. The material weakness referred to above is described in the accompanying Management's Annual Report on Internal Control over Financial Reporting. We considered this material weakness in determining the nature, timing, and extent of audit tests applied in our audit of the 2022 consolidated financial statements, and our opinion regarding the effectiveness of the Company's internal control over financial reporting does not affect our opinion on those consolidated financial statements.

Basis for Opinions

The Company's management is responsible for these consolidated financial statements, for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting, included in management's annual report referred to above. Our responsibility is to express opinions on the Company's consolidated financial statements and on the Company's internal control over financial reporting based on our audits. We are a public accounting firm registered with the Public Company Accounting Oversight Board (United States) (PCAOB) and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free of material misstatement, whether due to error or fraud, and whether effective internal control over financial reporting was maintained in all material respects.

Our audits of the consolidated financial statements included performing procedures to assess the risks of material misstatement of the consolidated financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the consolidated financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements. Our audit of internal control over financial reporting included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, and testing and evaluating the design and operating effectiveness of internal control based on the assessed risk. Our audits also included performing such other procedures as we considered necessary in the circumstances. We believe that our audits provide a reasonable basis for our opinions.

Definition and Limitations of Internal Control over Financial Reporting

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the consolidated financial statements that were communicated or required to be communicated to the audit committee and that (i) relate to accounts or disclosures that are material to the consolidated financial statements and (ii) involved our especially challenging, subjective, or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Valuation of Benefits Payable - Incurred but not Reported ("IBNR") Benefits Payable for Low Dollar Claims and Potential Claims Disputes by Out-of-Network Providers

As described in Notes 2 and 9 to the consolidated financial statements, the Company's incurred but not reported ("IBNR") benefits payable was $937.7 million as of December 31, 2022, with a significant portion of this balance related to low dollar claims and potential claims disputes by out-of-network providers. IBNR is an actuarial estimate, determined by employing actuarial methods, that is based on claim payment patterns, medical cost inflation, historical developments such as claim inventory levels and claim receipt patterns, and other relevant factors. For low dollar incurred but not paid claims, for the months prior to the most recent two months, management uses the completion factor development method. Under this method, historical paid claims data is formatted into claim triangles, which compare claim incurred dates to the dates of claim payments. This information is analyzed to create historical completion factors that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period-end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims. For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather, they are primarily based on forecasted per member per month low dollar claims projections developed from the Company's historical experience and adjusted for emerging experience data in the preceding months, which may include adjustments for known changes in estimates of recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix, and workday seasonality. Further, management records as part of benefits payable, an estimate of the ultimate liability for potential claims disputes by out-of-network providers based on financial exposure, an estimated probability of dispute based on financial exposure and risk of litigation, expected settlement rates, a gross up factor to account for unprocessed claims, and a completion factor for the most recent year.

The principal considerations for our determination that performing procedures relating to the valuation of IBNR benefits payable for low dollar claims and potential claims disputes by out-of-network providers is a critical audit matter are the significant judgment by management when estimating the IBNR for low dollar claims and potential claims disputes by out-of-network providers, which in turn led to a high degree of auditor judgment, subjectivity, and effort in performing procedures to evaluate the actuarial methods used by management and the significant assumptions related to (i) completion factors and forecasted per member per month low dollar claims projections for low dollar incurred but not paid claims and (ii) the estimated probability of dispute based on financial exposure and risk of litigation, expected settlement rates, and a completion factor for the most recent year for potential claims disputes by out-of-network providers. In addition, the audit effort involved the use of professionals with specialized skill and knowledge.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to management's process over developing the reserve, including the assumptions, methodologies, and calculations. These procedures also included, among others, the involvement of professionals with specialized skill and knowledge to assist in developing an independent estimate of the IBNR for low dollar claims and comparing the independent estimate to management's estimate to evaluate the reasonableness of the estimate. Developing the independent estimate of the IBNR for low dollar claims involved the use of professionals with specialized skill and knowledge to (i) independently develop assumptions related to completion factors and forecasted per member per month low dollar claims projections and (ii) evaluate the appropriateness of the actuarial method used by management. Developing the independent estimate of the IBNR for low dollar claims also included testing the completeness and accuracy of data provided by management. For the liability for potential claims disputes by out-of-network providers, these procedures included, among others, testing the completeness and accuracy of the out-of-network data provided by management, and the involvement of professionals with specialized skill and knowledge to assist in evaluating (i) the appropriateness of the actuarial method used by management and (ii) the reasonableness of the significant assumptions used by management. Evaluating the reasonableness of management's significant assumptions related to the estimated probability of dispute based on financial exposure and risk of litigation, expected settlement rates, and a completion factor for the most recent year involved evaluating the accuracy of management's estimate based on settlement of historical disputes and whether the assumptions were consistent with evidence obtained in other areas of the audit.

Valuation of the Risk Adjustment Transfer Payable related to the Affordable Care Act's ("ACA") Risk Adjustment Program

As described in Note 2 to the consolidated financial statements, the Company's risk adjustment transfer payable was $1,517.5 million as of December 31, 2022. The Affordable Care Act ("ACA") risk adjustment program is administered federally by the Centers for Medicare and Medicaid Services ("CMS"). Under this program, each plan is assigned a risk score based upon demographic information and current year claims information related to its members. Plans with lower than average risk scores relative to the estimated market average risk score, when applied to the statewide average premium, will have a risk adjustment payable into the pool. Inversely, plans with higher than average risk scores relative to the estimated market average risk score, when applied to the statewide average premium, will have a risk adjustment receivable from the pool. Management develops its membership risk scores for the risk adjustment payable using actuarial methodologies and assumptions and by analyzing member data, including demographic and projections of claims data expected to be submitted by the Company to CMS for settlement. Generally, the estimated market average risk score and statewide average premium are obtained from third party surveys of other insurance plans. There is judgment in estimating the Company's membership risk scores and the estimated market average risk scores. Management refines its estimate as new information becomes available and the final report on actual market risk scores is received from CMS in June of the following year.

The principal considerations for our determination that performing procedures relating to the valuation of the risk adjustment transfer payable related to the ACA's risk adjustment program is a critical audit matter are the significant judgment by management when estimating the risk adjustment transfer payable for each plan, which in turn led to a high degree of auditor judgment, subjectivity, and effort in performing procedures to evaluate the actuarial methodologies used by management and the significant assumptions related to (i) projections of claims data expected to be submitted by the Company to develop the Company's membership risk scores and (ii) estimated market average risk scores and statewide average premium. In addition, the audit effort involved the use of professionals with specialized skill and knowledge.

Addressing the matter involved performing procedures and evaluating audit evidence in connection with forming our overall opinion on the consolidated financial statements. These procedures included testing the effectiveness of controls relating to management's process over developing the estimate, including the methodology, assumptions, and calculations. These procedures also included, among others, performing one of the following procedures, on a test basis, for each plan (i) developing an independent estimate of the risk adjustment transfer payable and comparing the independent estimate to management's estimate to evaluate the reasonableness of the risk adjustment transfer payable for the sampled plan or (ii) testing management's process for determining the estimate of the risk adjustment transfer payable for the sampled plan. Developing the independent estimate involved (a) the use of professionals with specialized skill and knowledge to independently develop the significant assumptions related to the projections of claims data expected to be submitted by the Company to develop the Company's membership risk scores and estimated market average risk scores and statewide average premium and (b) testing the completeness and accuracy of data provided by management. Testing management's process involved the use of professionals with specialized skill and knowledge to evaluate the appropriateness of the actuarial methodologies used by management for consistency with the federally developed risk adjustment methodology and evaluating the reasonableness of the significant assumptions related to projections of claims data expected to be submitted by the Company to develop the Company's membership risk scores and estimated market average risk scores and statewide average premium. Evaluating the reasonableness of management's significant assumptions related to projections of claims data expected to be submitted by the Company to develop the Company's membership risk scores and estimated market average risk scores and statewide average premium involved considering the current and past performance of the plans, consistency with market and industry data, and consistency with evidence obtained in other areas of the audit. Testing management's process also involved testing the completeness and accuracy of the data used by management.

/s/ PricewaterhouseCoopers LLP
Philadelphia, Pennsylvania
February 23, 2023

We have served as the Company's auditor since 2020, which includes periods before the Company became subject to SEC reporting requirements.

Oscar Health, Inc.
Consolidated Balance Sheets
(in thousands, except share and per share amounts)

	December 31, 2022	December 31, 2021
Assets:		
Current Assets:		
Cash and cash equivalents	$ 1,558,595	$ 1,103,995
Short-term investments	1,397,287	587,086
Premium and other receivables	216,475	138,414
Risk adjustment transfer receivable	49,861	40,659
Reinsurance recoverable	892,887	431,990
Other current assets	6,450	3,782
Total current assets	$ 4,121,555	$ 2,305,926
Property, equipment, and capitalized software, net	59,888	46,611
Long-term investments	222,919	844,476
Restricted deposits	27,483	28,085
Other assets	94,756	96,552
Total Assets	**$ 4,526,601**	**$ 3,321,650**
Liabilities and Stockholders' Equity		
Current Liabilities:		
Benefits payable	$ 937,727	$ 513,582
Risk adjustment transfer payable	1,517,493	794,398
Premium deficiency reserve	4,214	29,246
Unearned premiums	78,998	75,044
Accounts payable and accrued liabilities	297,841	234,788
Reinsurance payable	427,649	205,231
Total current liabilities	3,263,922	1,852,289
Long-term debt	297,999	—
Other liabilities	72,280	76,839
Total liabilities	**3,634,201**	**1,929,128**
Commitments and contingencies (Note 19)		
Stockholders' Equity		
Preferred stock, $0.00001 par value; 82,500,000 shares authorized, none issued or outstanding as of December 31, 2022 and 2021	—	—
Class A common stock, $0.00001 par value; 825,000,000 shares authorized, 181,176,239 and 175,212,223 shares issued and outstanding as of December 31, 2022 and 2021, respectively	2	2
Class B common stock, $0.00001 par value; 82,500,000 shares authorized, 35,115,807 shares issued and outstanding as of December 31, 2022 and 2021	—	—
Treasury stock (314,600 shares as of December 31, 2022 and 2021)	(2,923)	(2,923)
Additional paid-in capital	3,509,007	3,393,533
Accumulated deficit	(2,605,987)	(1,999,712)
Accumulated other comprehensive loss	(9,715)	(3,671)
Total Oscar Health, Inc. stockholders' equity	890,384	1,387,229
Noncontrolling interests	2,016	5,293
Total stockholders' equity	892,400	1,392,522
Total Liabilities and Stockholders' Equity	**$ 4,526,601**	**$ 3,321,650**

See the accompanying Notes to Consolidated Financial Statements

Oscar Health, Inc.
Consolidated Statements of Operations
(in thousands, except share and per share amounts)

	Year Ended December 31,		
	2022	**2021**	**2020**
Revenue			
Premiums before ceded reinsurance	$ 5,334,520	$ 2,712,988	$ 1,672,339
Reinsurance premiums ceded	(1,463,403)	(881,968)	(1,217,304)
Premiums earned	3,871,117	1,831,020	455,035
Administrative services revenue	61,047	5,394	—
Investment income and other revenue	31,474	2,301	7,766
Total revenue	**3,963,638**	**1,838,715**	**462,801**
Operating Expenses			
Claims incurred, net	3,280,798	1,623,995	309,353
Other insurance costs	706,439	410,363	216,534
General and administrative expenses	309,783	265,078	166,655
Federal and state assessments	281,518	139,085	81,458
Health insurance industry fee	—	—	19,251
Premium deficiency reserve release	(25,033)	(55,325)	71,816
Total operating expenses	4,553,505	2,383,196	865,067
Loss from operations	**(589,867)**	**(544,481)**	**(402,266)**
Interest expense	22,623	4,720	3,514
Other expenses (income)	(2,415)	1,201	—
Loss on extinguishment of debt	—	20,178	—
Loss before income taxes	**(610,075)**	**(570,580)**	**(405,780)**
Income tax expense (benefit)	(523)	846	1,045
Net loss	**(609,552)**	**(571,426)**	**(406,825)**
Less: Net income (loss) attributable to noncontrolling interests	(3,277)	1,180	—
Net loss attributable to Oscar Health, Inc.	**$ (606,275)**	**$ (572,606)**	**$ (406,825)**
Earnings (Loss) per Share			
Net loss per share attributable to Oscar Health, Inc., basic and diluted	**$ (2.85)**	**$ (3.20)**	**$ (14.16)**
Weighted average common shares outstanding, basic and diluted	**212,474,615**	**178,967,056**	**29,263,424**

See the accompanying Notes to Consolidated Financial Statements

Oscar Health, Inc.
Consolidated Statements of Comprehensive Income
(in thousands)

	Year Ended December 31,		
	2022	2021	2020
Net loss	**$ (609,552)**	**$ (571,426)**	**$ (406,825)**
Other comprehensive income (loss), net of tax:			
Net unrealized gains (losses) on securities available for sale	(6,044)	(4,550)	906
Comprehensive loss	**(615,596)**	**(575,976)**	**(405,919)**
Comprehensive income (loss) attributable to noncontrolling interests	(3,277)	1,180	—
Comprehensive loss attributable to Oscar Health, Inc.	**$ (612,319)**	**$ (577,156)**	**$ (405,919)**

See the accompanying Notes to Consolidated Financial Statements

Oscar Health, Inc.

Consolidated Statements of Stockholders' Equity

(in thousands, except share amounts)

	Convertible Preferred Stock		Common Stock (Series A/Series B)		Class A		Class B							
	Shares	Amount	Shares	Amount	Shares	Amount	Shares	Amount	Treasury Stock	Additional Paid-In Capital	Accumulated Deficit	Accumulated Other Comprehensive Income (Loss)	Non-controlling Interests	Total Stockholders' Equity (Deficit)
December 31, 2020	400,904,302	$ 1,744,911	31,409,202	$ 2	—	$ —	—	$ —	$ (2,923)	$ 133,255	$ (1,427,106)	$ 879	$ —	$ (1,295,893)
Conversion of pre-IPO shares to Class A and Class B common stock	(400,904,302)	(1,744,911)	(31,409,202)	(2)	130,280,651	1	35,115,807	—	—	1,744,911	—	—	—	1,744,910
Issuance of common stock upon IPO, net of underwriting discount	—	—	—	—	36,391,946	1	—	—	—	1,338,874	—	—	—	1,338,875
Issuance of common stock upon exercise of warrants and call options	—	—	—	—	1,115,973	—	—	—	—	37,071	—	—	—	37,071
Issuance of common stock from equity incentive plans	—	—	—	—	7,423,653	—	—	—	—	50,009	—	—	—	50,009
Stock-based compensation expense	—	—	—	—	—	—	—	—	—	86,296	—	—	—	86,296
Equity transaction with Subsidiary	—	—	—	—	—	—	—	—	—	3,117	—	—	4,113	7,230
Unrealized gains (losses) on investments, net	—	—	—	—	—	—	—	—	—	—	—	(4,550)	—	(4,550)
Net income (loss)	—	—	—	—	—	—	—	—	—	—	(572,606)	—	1,180	(571,426)
December 31, 2021	—	—	—	—	175,212,223	2	35,115,807	—	(2,923)	3,393,533	(1,999,712)	(3,671)	5,293	1,392,522
Issuance of common stock from equity incentive	—	—	—	—	5,964,016	—	—	—	—	1,299	—	—	—	1,299
Stock-based compensation expense	—	—	—	—	—	—	—	—	—	112,329	—	—	—	112,329
Joint venture contributions	—	—	—	—	—	—	—	—	—	1,846	—	—	—	1,846
Unrealized gains (losses) on investments, net	—	—	—	—	—	—	—	—	—	—	—	(6,044)	—	(6,044)
Net loss	—	—	—	—	—	—	—	—	—	—	(606,275)	—	(3,277)	(609,552)
December 31, 2022	—	$ —	—	$ —	181,176,239	$ 2	35,115,807	$ —	$ (2,923)	$ 3,509,007	$ (2,605,987)	$ (9,715)	$ 2,016	$ 892,400

See the accompanying Notes to Consolidated Financial

Oscar Health, Inc.
Consolidated Statements of Cash Flows
(in thousands)

	Year Ended December 31,		
	2022	**2021**	**2020**
Cash flows from operating activities:			
Net loss	$ (609,552)	$ (571,426)	$ (406,825)
Adjustments to reconcile net loss to net cash (used in) provided by operating activities:			
Deferred taxes	(165)	(101)	(67)
Net realized loss (gain) on sale of financial instruments	1,274	(209)	(1,246)
Loss on fair value of warrant liabilities	—	12,856	5,101
Depreciation and amortization expense	15,283	14,605	11,285
Amortization of debt issuance costs	713	329	327
Stock-based compensation expense	112,329	86,296	35,869
Investment amortization, net of accretion	2,480	8,031	2,588
Debt extinguishment loss	—	20,178	—
Changes in assets and liabilities:			
(Increase) / decrease in:			
Premium and other receivables	(78,061)	(66,953)	(35,254)
Risk adjustment transfer receivable	(9,202)	(9,502)	(6,035)
Reinsurance recoverable	(460,897)	147,403	(63,329)
Other assets	(243)	(11,299)	2,210
Increase / (decrease) in:			
Benefits payable	424,146	201,667	155,357
Unearned premiums	3,953	3,140	46,596
Premium deficiency reserve	(25,033)	(55,325)	71,816
Accounts payable and other liabilities	57,811	98,619	75,800
Reinsurance payable	222,418	(138,082)	(89,197)
Risk adjustment transfer payable	723,095	78,028	417,736
Net cash (used in) provided by operating activities	**380,349**	**(181,745)**	**222,732**
Cash flows from investing activities:			
Purchase of investments	(1,192,706)	(1,810,076)	(1,001,038)
Sale of investments	360,616	624,077	489,528
Maturity of investments	633,467	430,694	182,060
Purchase of property, equipment and capitalized software	(29,012)	(25,885)	(14,021)
Change in restricted deposits	1,116	6,675	(1,243)
Net cash used in investing activities	**(226,519)**	**(774,515)**	**(344,714)**
Cash flows from financing activities:			
Proceeds from long-term debt	305,000	—	147,000
Payments of debt issuance costs	(7,035)	—	(4,840)
Proceeds from joint venture contribution	1,846	—	—
Debt prepayment	—	(153,173)	—
Debt extinguishment costs	—	(12,994)	—
Proceeds from IPO, net of underwriting discounts	—	1,348,321	—
Offering costs from IPO	—	(9,447)	—
Convertible preferred stock and call option issuances	—	—	375,671
Proceeds from exercise of warrants and call options	—	9,191	74,581
Proceeds from partial sale of subsidiary to noncontrolling interest	—	7,230	—
Proceeds from exercise of stock options	1,299	49,584	19,295
Net cash provided by financing activities	**301,110**	**1,238,712**	**611,707**
Increase in cash, cash equivalents and restricted cash equivalents	454,940	282,452	489,725
Cash, cash equivalents, restricted cash and cash equivalents—beginning of period	1,125,557	843,105	353,380
Cash, cash equivalents, restricted cash and cash equivalents—end of period	**$ 1,580,497**	**$ 1,125,557**	**$ 843,105**
Cash and cash equivalents	1,558,595	1,103,995	826,326
Restricted cash and cash equivalents included in restricted deposits	21,902	21,562	16,779
Total cash, cash equivalents and restricted cash and cash equivalents	**$ 1,580,497**	**$ 1,125,557**	**$ 843,105**

Oscar Health, Inc.
Consolidated Statements of Cash Flows
(in thousands)
(Continued)

Supplemental Disclosures:			
Interest payments	$ 10,079	$ 4,256	$ —
Income tax payments	$ 1,893	$ 697	$ 1,525
Non-cash investing and financing activities:			
Conversion of redeemable convertible preferred stock to common stock upon initial public offering	$ —	$ 1,744,911	$ —
Net exercise of preferred stock warrants to preferred stock upon initial public offering	$ —	$ 28,248	$ —
Adjustment to fair value of preferred stock warrant liability upon initial public offering	$ —	$ 13,243	$ —

See the accompanying Notes to Consolidated Financial Statements

Notes to Consolidated Financial Statements

1. ORGANIZATION

Oscar Health, Inc. ("Oscar" or the "Company") is the first health insurance company built around a full stack technology platform and a relentless focus on serving its members. Headquartered in New York City, Oscar offers two complementary products: (1) innovative and consumer-oriented health plans are sold to Individual, Small Group and Medicare Advantage members and (2) via +Oscar, the Company leverages its technology platform to sell services to providers and payors to directly enable their shift to value-based care.

The Company operates as one segment to sell insurance to its members directly and through the federal and state-run health care exchanges formed in conjunction with the Patient Protection and Affordable Care Act via its health insurance subsidiaries and to sell services via its +Oscar offering. Individual plans are offered to individuals and families through Health Insurance Marketplaces. Small Group plans are offered to employees of companies with 50 - 100 full-time workers. Medicare Advantage is offered to adults who are age 65 and older and eligible for traditional Medicare but who instead select coverage through a private market plan. The Company has also partnered with Cigna through the Cigna + Oscar partnership, which unites Oscar's highly-differentiated member experience with Cigna's broad provider networks, to exclusively serve the Small Group employer market.

Initial Public Offering

On March 2, 2021, the Company's registration statement on Form S-1 (the "IPO Registration Statement") related to its initial public offering ("IPO") was declared effective and the Company's Class A common stock, par value $0.00001 per share (the "Class A common stock") began trading on the New York Stock Exchange on March 3, 2021. On March 5, 2021, the Company completed its IPO, in which the Company sold 36,391,946 shares of Class A common stock at a price to the public of $39.00 per share. The Company received aggregate net proceeds of $1.3 billion after deducting underwriting discounts and commissions of $71.0 million. The Company used a portion of the net proceeds of the IPO to repay in full outstanding borrowings, including fees and expenses, under the Term Loan Facility. Refer to Note 15 - Long-Term Debt for more information.

The Company's Class A common stock is traded on the New York Stock Exchange under the symbol "OSCR."

Reclassification and Reverse Stock Split

In connection with its IPO, on March 3, 2021, the Company filed an amended and restated certificate of incorporation (the "Amended and Restated Certificate of Incorporation") with the Secretary of State of the State of Delaware, which effected a reclassification of the Company's issued and outstanding share capital and a one-for-three reverse stock split. Upon conversion of all outstanding shares of convertible preferred stock, and upon filing of the Company's Amended and Restated Certificate of Incorporation, all outstanding shares of each series of the Company's convertible preferred stock and common stock issued and outstanding prior to the IPO converted and/or were reclassified into an aggregate of 132,760,639 shares of Class A common stock and 35,335,579 shares of Class B common stock, par value $0.00001 per share (the "Class B common stock"), and 943,800 shares of common stock held in treasury were reclassified into an aggregate of 314,600 shares of Class A common stock. In accordance with accounting principles generally accepted in the United States (" U.S. GAAP"), all shares of common stock and per share data that are presented in consolidated financial statements have been adjusted to reflect the reclassification and reverse stock split on a retroactive basis for all periods presented. Shares of convertible preferred stock presented in consolidated financial statements have not been adjusted for the reclassification or reverse stock split, as these shares were converted to common stock prior to the reclassification and reverse stock split. For additional information, see Note 16 - Stockholders' Equity.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation

The consolidated financial statements have been prepared in accordance with U.S. GAAP. The consolidated financial statements include the accounts of the Company, all of the controlled subsidiaries and variable interest entities of which the Company is the primary beneficiary. Noncontrolling interest consists of equity that is not attributable directly or indirectly to the Company. All material intercompany transactions have been eliminated in consolidation. Balances (except per share data) are presented in U.S. dollars and rounded, as indicated. In order to preserve the mathematical accuracy of the underlying calculations, immaterial footing differences may occur between the sum of individual balances and the total balances presented.

Use of Estimates

The preparation of financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Significant estimates inherent in the preparation of the accompanying audited consolidated financial statements include healthcare costs incurred but not yet reported (“IBNR”), premium deficiency reserve (“PDR”) and risk adjustment. Estimates are based on past experience and other considerations reasonable under the circumstances. Actual results may differ materially from these estimates.

Revenue Recognition

Premium Revenue

Premium revenue includes direct policy premiums collected directly from members and subsidies received from the Centers for Medicare & Medicaid Services ("CMS") as part of the Advanced Premium Tax Credit ("APTC") and Medicare Advantage programs, along with assumed premiums from the Company's coinsurance agreement. Premium revenue is adjusted for the estimated impact of the risk adjustment program required by CMS. Total premiums earned includes the effect of reinsurance premiums ceded as part of the Company's reinsurance agreements.

The Company receives a fixed premium per member per month and recognizes premium revenue during the period in which it is obligated to provide services to its members. For direct policy premiums received from CMS, revenue is recorded based on membership and eligibility criteria provided by CMS and is subject to monthly adjustment by CMS.

Administrative Services Revenue

The Company provides administrative services as part of +Oscar, its tech-driven platform offering designed to help providers and payors directly enable their shift to value-based care. Revenue is recognized in the period the contractual performance obligations are satisfied and measured in an amount that reflects the consideration the Company expects to be entitled to in exchange for performing the services. The timing of the Company's revenue recognition may differ from the timing of payment by customers. A receivable is recorded when revenue is recognized prior to payment and there is an unconditional right to payment. Alternatively, deferred revenue is recognized when payment is received before the performance obligations are satisfied.

Affordable Care Act (“ACA”)
The Company conducts business through the state-run health care exchanges formed in conjunction with ACA and is therefore subject to certain programs and fees established by ACA, such as:

- **Minimum Medical Loss Ratio ("MLR") Requirements:** The ACA established a minimum MLR ratio that requires insurers to pay rebates to customers when MLR is below established thresholds. The medical loss ratio represents medical costs as a percentage of premium revenue. Federal regulations define what constitutes medical costs and premium revenue for purposes of calculating the required minimum MLR. The Company records estimated MLR rebates as an adjustment to premium revenue.
- **Health Insurance Industry Fee (“HIF”):** Prior to 2021, the ACA included an annual, nondeductible insurance industry tax that was levied proportionally across the insurance industry for risk-based health insurance products. The calculation was based on a ratio of the Company’s applicable net premiums written compared to the total U.S. health insurance industry applicable net premiums written during the previous calendar year. The ACA temporarily suspended the fee in 2019 and resumed it in 2020. Beginning in 2021, the fee has been permanently repealed.
- **Risk Adjustment:** The ACA established a methodology that equates the health status of a person to a number, called a risk score, to predict healthcare costs in order to ensure that insurers receive sufficient compensation for members who are likely to incur higher medical costs.

Risk Adjustment
The Affordable Care Act (“ACA”) risk adjustment program is administered federally by the Centers for Medicare and Medicaid Services (“CMS”). Under this program, each plan is assigned a risk score based upon demographic information and current year claims information related to its members. Plans with lower than average risk scores relative to the estimated market average risk score, when applied to the statewide average premium, will have a risk adjustment payable into the pool. Inversely, plans with higher than average risk scores relative to the estimated market average risk score, when applied to the statewide average premium, will have a risk adjustment receivable from the pool.

Management develops its membership risk scores for the risk adjustment payable using actuarial methodologies and assumptions and by analyzing member data, including demographic and projections of claims data expected to be submitted by the Company to CMS for settlement. Generally, the estimated market average risk score and statewide average premium are obtained from third party surveys of other insurance plans. There is judgment in estimating the Company’s membership risk scores and the estimated market average risk scores. Management refines its estimate as new information becomes available and the final report on actual market risk scores is received from CMS in June of the following year.

In addition, CMS and the Office of Inspector General for Health and Human Services ("HHS") perform risk adjustment data validation (“RADV”) audits of health insurance plans to validate the coding practices of and supporting documentation maintained by health care providers, and such audits have in the past and may in the future result in adjustments to risk transfer payments.

Reinsurance
The Company enters into reinsurance agreements to manage its exposure to unexpected fluctuations in MLR and reduce its capital requirements. The Company enters into two different types of arrangements: quota share reinsurance contracts and excess of loss ("XOL") reinsurance contracts.

In quota share reinsurance, the reinsurer agrees to assume a specified percentage of the ceding company’s losses in exchange for a corresponding percentage of premiums (net of a ceding commission paid by the reinsurer to the ceding company to cover the ceding company's administrative expenses). All premiums and claims ceded under the Company’s quota share agreements are shared proportionally with the Company’s reinsurers. Reinsurance recoveries are recorded as a reduction to claims incurred, net. To the extent ceded premiums exceed ceded claims and ceding commissions and a specified margin, the Company receives an experience refund, which is recognized as revenue.

In XOL reinsurance, the reinsurer agrees to assume all or a portion of the ceding company’s losses in excess of a specified amount. Under XOL reinsurance, the premium payable to the reinsurer is negotiated by the parties based on losses on an individual member in a given calendar year and their assessment of the amount of risk being ceded to the reinsurer because the reinsurer does not share proportionately in the ceding company’s losses. Premiums under XOL reinsurance agreements are based on enrollment calculated on a per member per month basis. Reinsurance recoveries are recorded as reductions to claims incurred, net.

Our reinsurance contracts generally have a duration of one to three years, and we review them in advance of the contract's expiration to negotiate terms for new reinsurance contracts. During each renewal cycle, there are a number of factors considered when determining reinsurance coverage, including (1) plans to change the underlying insurance coverage offered by the Company, (2) trends in loss activity, (3) the level of the insurance subsidiaries' capital and surplus, (4) changes in the Company's risk appetite, and (5) the cost and availability of reinsurance coverage.

In addition to ceded reinsurance, an Oscar health insurance subsidiary partially reinsures the Cigna+Oscar small group offering through a quota share reinsurance arrangement. The Company records assumed premiums and assumed claims. Refer to Note 4 - Reinsurance for more information.

Premium Deficiency Reserve
Premium deficiency reserve liabilities are established when it is probable that expected future claims and maintenance expenses will exceed future premium and reinsurance recoveries based on existing insurance contract terms including consideration of net investment income. For purposes of determining premium deficiency reserves, contracts are grouped consistent with the Company's method of acquiring, servicing, and measuring the profitability of such contracts, which is generally on a line of business basis.

Change in Accounting Principle
For the year ended December 31, 2022, the Company elected to include anticipated net investment income in its determination of premium deficiency reserves. The accounting policy election to include net investment income is preferable because it best reflects the ultimate profitability of insurance contracts using all cash flows, inclusive of related investment income, and provides improved comparability with industry peers. This change is considered a change in accounting principle that requires retrospective application to all financial statement periods presented. However, because net investment income has historically been immaterial to the financial statements and to the premium deficiency reserve calculation, the effect of this change in accounting principle is immaterial to prior and current period balances. As a result, this change in accounting principle is being applied prospectively as of December 31, 2022.

Cash and Cash Equivalents
Cash and cash equivalents consists of highly liquid investments with original maturities of three months or less.

Restricted Deposits
The Company defines restricted deposits as restricted cash, cash equivalents and investments maintained on deposit or pledged primarily to various state agencies in connection with its insurance licensure. Statutory regulations require these amounts to remain on deposit indefinitely; therefore, the Company classifies these restricted deposits as long-term regardless of the contractual maturity date of the securities held. Restricted cash equivalents and investments are recorded at fair value.

Investments
The Company's investments are classified as available-for-sale and are carried at fair value. Short-term investments include securities with maturities between three months and one year. Long-term investments include securities with maturities greater than one year.

The Company adopted the current expected credit losses ("CECL") model as of January 1, 2021 and evaluates its available-for-sale debt investments for impairment by monitoring the difference between the carrying value and fair value of a security and whether declines in fair value are credit-related. If a security is in an unrealized loss position and the Company has the intent to sell, or it is more likely than not that the security will be sold before recovery of its amortized cost basis, the decline in fair value is recognized as a loss on the income statement. For securities in an unrealized loss position that the Company does not intend to sell, the Company performs an evaluation to determine what portion of the unrealized losses are credit-related; this portion is recognized on the income statement as an allowance for credit losses. The remaining non-credit-related portion of the decline in fair value is recognized as an unrealized loss in accumulated other comprehensive income (loss). Prior to the adoption of CECL, the Company applied the other-than-temporary impairment model for securities in an unrealized loss position, which required the Company to assess the severity of the loss relative to its original cost, the time that the market value had been less than its original cost and considered the Company's intent to retain the investments for a long enough period to allow for a sufficient market recovery.

Allowance for Credit Losses
Premium and other receivables primarily includes insurance premiums due from CMS and members, pharmaceutical rebates and other claims-related provider receivables and are reported net of any allowance for credit losses. Receivable balances are also recorded related to the Company's risk adjustment program, reinsurance program and value-based care arrangements. An allowance for credit losses is generally calculated based on historical collection experience, the counterparty's creditworthiness and consideration of current and future economic events.

Policy Acquisition Costs
Policy acquisition costs are those costs that relate directly to the successful acquisition of new and renewal insurance policies. Such costs include broker commissions, costs of policy issuance and underwriting, and other costs incurred to acquire new business or renew existing business. Policy acquisition costs, other than broker bonus commissions, are expensed in the period incurred. Broker bonuses are capitalized and amortized over the policy term. The Company's short-duration policies typically have a one-year term and may be canceled by the member upon 30 days' notice.

Benefits Payable
Benefits payable consists of liabilities for both claims incurred but not reported ("IBNR") and reported but not yet processed through our systems that are determined in the aggregate, employing actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. Actuarial Standards of Practice require that the claim liabilities be appropriate under moderately adverse circumstances. IBNR is an actuarial estimate, determined by employing actuarial methods, that is based on claim payment patterns, medical cost inflation, historical developments such as claim inventory levels and claim receipt patterns, and other relevant factors. A significant portion of this balance is related to low dollar claims and potential claims disputes by providers.

For low dollar incurred but not paid claims, for the months prior to the most recent two months, the Company typically uses the completion factor development method. This methodology is a detailed actuarial process that uses both historical claim payment patterns as well as emerging medical cost trends to project our best estimate of claim liabilities. Under this method, historical paid claims data is formatted into claim triangles, which compare claim incurred dates to the dates of claim payments. This information is analyzed to create historical completion factors that represent the average percentage of total incurred claims that have been paid through a given date after being incurred. Completion factors are applied to claims paid through the period-end date to estimate the ultimate claim expense incurred for the period. Actuarial estimates of incurred but not paid claim liabilities are then determined by subtracting the actual paid claims from the estimate of the ultimate incurred claims. A seriatim methodology is utilized for high dollar claims which is supplemented by case management data supplied by medical and claims operations areas.

For the most recent incurred months (typically the most recent two months), the percentage of claims paid for claims incurred in those months is generally low. This makes the completion factor methodology less reliable for such months. Therefore, incurred claims for recent months are not projected from historical completion and payment patterns; rather, they are primarily based on forecasted per member per month low dollar claims projections developed from the Company's historical experience and adjusted for emerging experience data in the preceding months, which may include adjustments for known changes in estimates of recent hospital and drug utilization data, provider contracting changes, changes in benefit levels, changes in member cost sharing, changes in medical management processes, product mix, and workday seasonality.

Because the reserve methodology is based upon historical information, it must be adjusted for known or suspected operational and environmental changes. These adjustments are made by our actuaries based on their knowledge and their estimate of emerging impacts to benefit costs and payment speed. Circumstances to be considered in developing our best estimate of reserves include changes in utilization levels, unit costs, member cost sharing, benefit plan designs, provider reimbursement levels, processing system conversions and changes, claim inventory levels, claim processing patterns, and claim submission patterns.

We regularly review and set assumptions regarding cost trends and utilization when initially establishing claim liabilities. We continually monitor and adjust the claims liability and benefit expense based on subsequent paid claims activity. If it is determined that our assumptions regarding cost trends and utilization are materially different from actual results, our income statement and financial position could be impacted in future periods. Adjustments of prior year estimates may result in additional benefit expense or a reduction of benefit expense in the period an adjustment is made. Further, due to the considerable variability of healthcare costs, adjustments to claim liabilities occur each period and are sometimes significant as compared to the net income recorded in that period. Prior period development is recognized immediately upon the actuary's judgment that a portion of the prior period liability is no longer needed or that an additional liability should have been accrued. That determination is made when sufficient information is available to ascertain that the re-estimate of the liability is reasonable.

Settlement Reserves
The Company also records as part of benefits payable, an estimate of the ultimate liability for actual and potential claims disputes by providers based on financial exposure, an estimated probability of dispute based on financial exposure and risk of litigation, and expected settlement rates, a gross up factor to account for unprocessed claims, and a completion factor for the most recent year. Since these liabilities are part of the overall claim reserve, they are proportionally ceded under the Company's reinsurance agreements for historical policy years with contracts in force. The settlement reserves included as part of the benefits payable balance was approximately $251.1 million and $137.7 million as of December 31, 2022 and 2021, respectively.

Unallocated Claims Adjustment Expenses
Claims adjustment expenses ("CAE") are costs incurred or expected to be incurred in connection with the adjustment and recording of health claims not subject to reinsurance. Such expenses include, but are not limited to, case management, utilization review, and quality assurance and are intended to reduce the number of health services provided or the cost of such services. CAE is included in other insurance costs and the related CAE payable is included in accounts payable and accrued liabilities.

Property, Equipment and Capitalized Software
Property, equipment and capitalized software are reported at cost less accumulated depreciation. Depreciation and amortization is calculated on a straight-line basis over the estimated useful lives of the related assets, which range from 3 to 10 years. Costs related to certain software projects for internal use incurred during the application development stage are capitalized. Costs related to planning activities and post-implementation activities are expensed as incurred. Internal-use software is amortized on a straight-line basis over its estimated useful life, which is generally three years. Property, Equipment and Capitalized Software are assessed for impairment whenever events or circumstances suggest that an asset's carrying value may not be fully recoverable.

Leases
The Company leases office space under operating leases expiring on various dates through 2032. On the lease commencement date, a right-of-use ("ROU") asset and lease liability are recognized on the balance sheet based on the present value of the future minimum lease payments over the lease term. Since the Company's lease agreements do not provide an implicit rate, an incremental borrowing rate, based on the information available at commencement date, is used to determine the present value of future payments. The calculation of the ROU asset is based on the lease liability and also includes any lease payments made and excludes lease incentives and initial direct costs incurred.

The Company determines if an arrangement is a lease or contains a lease at inception of the arrangement based on the terms and conditions in the contract. Options to extend or terminate a lease at the Company's discretion are factored into the calculation of the lease liabilities and ROU assets only if the Company is reasonably certain it will exercise those options. Short-term leases with an initial term of twelve months or less are not recorded on the balance sheet.

Lease expense for the Company's operating leases is calculated on a straight-line basis over the lease term. Lease and non-lease components are accounted for as a single lease component for all asset classes.

Earnings Per Share
Earnings (loss) per share ("EPS") is calculated using the two-class method, which is an earnings allocation model that treats participating securities as having rights to earnings that otherwise would have been available to common stockholders. Under the two-class method, earnings for the period are required to be allocated between common stock and participating securities based upon their respective rights to receive distributed and undistributed earnings. For EPS computation purposes, the Company's Class A and Class B common stock are considered one single class of common stock because both classes have the same dividend and liquidation rights. For the year ended December 31, 2020, the Company's Series A and Series B common stock were treated as one class for EPS purposes.

Variable Interest Entities
The Company enters arrangements with various entities that are deemed to be variable interest entities (“VIE”). A VIE is an entity that either (1) has equity investors that lack certain essential characteristics of a controlling financial interest (including the ability to control activities of the entity, the obligation to absorb the entity’s expected losses and the right to receive the entity’s expected residual returns) or (2) lacks sufficient equity to finance its own activities without financial support provided by other entities, which in turn would be expected to absorb at least some of the expected losses of the VIE. The Company is deemed a primary beneficiary of a VIE if it has (1) the power to direct the activities of the VIE that most significantly impact the economic performance of the VIE and (2) the obligation to absorb losses of, or the right to receive benefits from, the VIE that could be potentially significant to the VIE. If both conditions are present, the Company is required to consolidate the VIE into its financial results.

The Company has determined that it has a controlling financial interest in the medical professional corporations with which it has a business arrangement because, as part of its arrangement, the Company has guaranteed their debt, and the equity at risk is insufficient to finance their activities without additional subordinated financial support from the Company.

Accounting Pronouncements - Recently Adopted

EGC Status
Upon its IPO in March 2021, the Company qualified as an emerging growth company ("EGC") under the Jumpstart Our Business Startups Act of 2012 (the “JOBS Act”) which, amongst other things, allowed for reduced disclosure requirements and an extended transition period for the implementation of new or revised accounting pronouncements. The Company elected to use this extended transition period for complying with new or revised accounting standards that had different effective dates for public and private companies until the earlier of the date that it (i) is no longer an EGC or (ii) affirmatively and irrevocably opts out of the extended transition period provided in the JOBS Act. As of September 30, 2021, the Company exceeded the maximum annual revenue threshold for EGCs, resulting in loss of EGC status as of December 31, 2021. As a result, the Company is required to comply with public company disclosure requirements applicable to registrants that have exited EGC status and adopted previously deferred accounting pronouncements as of January 1, 2021.

3. REVENUE RECOGNITION

Premiums earned

Premium revenue includes direct policy premiums collected directly from members and from the Centers for Medicare & Medicaid Services ("CMS") as part of the Advanced Premium Tax Credit Program ("APTC") and Medicare Advantage programs, along with assumed premiums from the Company's reinsurance agreements. Premium revenue is adjusted for the estimated impact of the risk adjustment program required by CMS. Total premiums earned includes the effect of reinsurance premiums ceded as part of the Company's reinsurance agreements. Refer to Note 4 - Reinsurance for more information.

	Year Ended December 31,		
	2022	2021	2020
		(in thousands)	
Direct policy premiums	$ 6,704,330	$ 3,420,328	$ 2,287,319
Assumed premiums	138,109	16,298	299
Direct and assumed premiums	6,842,439	3,436,626	2,287,618
Risk adjustment and corridor, net	(1,507,919)	(723,638)	(615,279)
Premiums before ceded reinsurance	5,334,520	2,712,988	1,672,339
Reinsurance premiums ceded	(1,463,403)	(881,968)	(1,217,304)
Total premiums earned	**$ 3,871,117**	**$ 1,831,020**	**$ 455,035**

The following table summarizes the amounts of direct policy premiums received directly from CMS as part of APTC and Medicare Advantage for the year ended December 31, 2022:

	Year Ended December 31,		
	2022	2021	2020
		(in thousands)	
APTC	$ 5,675,794	$ 2,468,712	$ 1,351,379
Medicare Advantage	$ 54,355	39,562	17,269
Total paid by CMS	**$ 5,730,149**	**$ 2,508,274**	**$ 1,368,648**

Administrative services revenue

Administrative services revenue includes revenue earned for services provided under the Company's +Oscar offering. The Company leverages its technology platform to provide administrative services to providers and payors to directly enable their shift to value-based care. Revenue from contracts with customers is reported within administrative services revenue in the consolidated statements of operations.

As of December 31, 2022 and 2021, receivables from contracts with customers were $33.7 million and $2.8 million, respectively, and are reported within premiums and accounts receivable on the consolidated balance sheets.

4. REINSURANCE

The Company enters into reinsurance contracts under two different types of arrangements: quota share reinsurance contracts and XOL reinsurance contracts. In quota share reinsurance, the reinsurer assumes an agreed percentage of the underlying policies being reinsured and shares all premiums and incurred claims accordingly. In XOL reinsurance, the reinsurer agrees to assume all or a portion of the ceding company's losses in excess of a specified amount.

All premiums and claims ceded under the Company's quota share arrangements are shared proportionally with the reinsurers. As part of the agreements, the Company also receives ceding commissions, which are calculated based on a percentage of ceded premiums, and experience refunds (resulting from actual claims experience being lower than a specified threshold).

Reinsurance Contracts Accounted for under Reinsurance Accounting and Deposit Accounting
ASC 944: *Financial Services - Insurance* requires the substance of all reinsurance arrangements to be evaluated to ensure that significant risk is transferred by the ceding entity to the reinsurer. When significant risk is transferred, reinsurance accounting is required. Reinsurance contracts that do not meet the risk transfer requirements necessary to be accounted for under reinsurance accounting are accounted for under the deposit accounting method. The Company currently has quota share reinsurance arrangements with more than one counterparty with multiple state-level treaties. These arrangements are accounted for under both reinsurance accounting and deposit accounting.

Under reinsurance accounting, premiums paid to the reinsurer are recorded as ceded premiums (a reduction to premium revenue). Expected reimbursements from the reinsurer for claims incurred are recorded as a reduction to claims incurred and a corresponding reinsurance recoverable asset.

Under deposit accounting, a deposit asset or deposit liability is recorded based on the consideration paid or received, irrespective of the experience of the contract. Fees retained by the reinsurer are recognized within other insurance costs on the statement of operations. As a result, premiums earned and claims incurred that would have otherwise been ceded under reinsurance accounting are recorded on a net basis on the consolidated balance sheet as a deposit liability. The Company classifies deposit liabilities within accounts payable and other accrued liabilities on its consolidated balance sheets.

The tables below present information for the Company's reinsurance arrangements accounted for under reinsurance accounting.

The composition of total reinsurance premiums ceded and reinsurance premiums assumed, which are included as components of total premiums earned in the consolidated statement of operations, is as follows:

	Year Ended December 31,		
	2022	2021	2020
	(in thousands)		
Reinsurance premiums ceded, gross	$ (1,524,157)	$ (921,953)	$ (1,308,275)
Experience refunds	60,754	39,985	90,971
Reinsurance premiums ceded	(1,463,403)	(881,968)	(1,217,304)
Reinsurance premiums assumed	138,109	16,298	299
Total reinsurance premiums (ceded) and assumed	**$ (1,325,294)**	**$ (865,670)**	**$ (1,217,005)**

The Company records claims expense net of reinsurance recoveries. The following table reconciles the total claims expense to the net claims expense as presented in the consolidated statement of operations:

	Year Ended December 31,		
	2022	2021	2020
	(in thousands)		
Direct claims incurred	$ 4,428,000	$ 2,403,108	$ 1,364,432
Ceded reinsurance claims	(1,290,349)	(800,769)	(1,055,371)
Assumed reinsurance claims	143,147	21,656	292
Total claims incurred, net	**$ 3,280,798**	**$ 1,623,995**	**$ 309,353**

The Company records selling, general and administrative expenses net of ceding commissions. The following table reconciles total other insurance costs to the amount presented in the consolidated statement of operations:

	Year Ended December 31,		
	2022	2021	2020
	(in thousands)		
Other insurance costs, gross	$ 868,385	$ 492,609	$ 343,374
Ceding commissions	(161,946)	(82,246)	(126,840)
Other insurance costs, net	**$ 706,439**	**$ 410,363**	**$ 216,534**

The Company classifies reinsurance recoverable within current assets on its consolidated balance sheets. The composition of the reinsurance recoverable balance is as follows:

	December 31,	
	2022	2021
	(in thousands)	
Ceded reinsurance claim recoverables	$ 776,266	$ 406,017
Reinsurance ceding commissions	42,805	23,517
Experience refunds on reinsurance agreements	73,816	2,456
Reinsurance recoverable	**$ 892,887**	**$ 431,990**

Credit Ratings
The financial condition of the Company's reinsurers is regularly evaluated to minimize exposure to significant losses. A key credit quality indicator for reinsurance is the financial strength ratings issued by the credit rating agencies, which provide an independent opinion of a reinsurer’s ability to meet ongoing obligations to policyholders. The Company's reinsurers have most recently been issued financial strength ratings of A+ (A.M. Best).

The creditworthiness of each reinsurer is evaluated in order to assess counterparty credit risk and estimate an allowance for expected credit losses on the Company's reinsurance recoverable balances.

5. BUSINESS ARRANGEMENTS

Variable Interest Entities
In the normal course of business, the Company enters into business arrangements with integrated health systems and several medical professional corporations that employ health care providers to deliver telemedical healthcare services to its covered member population in various states. The financial results of these entities are consolidated into the Company's financial statements.

The following table presents the collective assets and liabilities of the Company's variable interest entities:

	As of December 31,	
	2022	2021
	(in thousands)	
Assets	$ 129,629	$ 123,524
Liabilities	$ 78,126	$ 70,165

6. RESTRICTED CASH AND RESTRICTED DEPOSITS

The Company maintains cash, cash equivalents and investments on deposit or pledged primarily to various state agencies in connection with its insurance licensure. The restricted cash and cash equivalents and restricted investments presented below are included in “restricted deposits” in the accompanying consolidated balance sheets.

	As of December 31,	
	2022	2021
	(in thousands)	
Restricted cash and cash equivalents	$ 21,902	$ 21,562
Restricted investments	5,581	6,523
Restricted Deposits	**$ 27,483**	**$ 28,085**

7. INVESTMENTS

The following tables provide summaries of the Company's investments by major security type as of December 31, 2022 and 2021:

	December 31, 2022			
	Amortized Cost	Unrealized Gains	Unrealized Losses	Fair Value
	(in thousands)			
U.S. treasury and agency securities	$ 1,160,430	$ 89	$ (5,237)	$ 1,155,282
Corporate notes	378,481	66	(4,098)	374,449
Municipalities	20,091	—	(428)	19,663
Certificate of deposit	38,082	—	—	38,082
Commercial paper	32,730	—	—	32,730
Total	**$ 1,629,814**	**$ 155**	**$ (9,763)**	**$ 1,620,206**

	December 31, 2021			
	Amortized Cost	Unrealized Gains	Unrealized Losses	Fair Value
	(in thousands)			
U.S. treasury and agency securities	$ 895,865	$ 34	$ (1,837)	$ 894,062
Corporate notes	454,416	2	(1,746)	452,672
Municipalities	50,366	10	(140)	50,236
Certificate of deposit	21,370	—	—	21,370
Commercial paper	13,222	—	—	13,222
Total	**$ 1,435,239**	**$ 46**	**$ (3,723)**	**$ 1,431,562**

The following table summarizes those available-for-sale investments that have been in a continuous loss position for less than 12 months at December 31, 2022 and 2021.

	December 31, 2022		
	Number of Securities	Fair Value	Gross Unrealized Losses
	(in thousands, except no. of securities)		
U.S. treasury and agency securities	165	$ 586,411	$ (973)
Corporate notes	138	135,133	(731)
Municipalities	5	$ 3,070	(71)
Total	**308**	**$ 724,614**	**$ (1,775)**

	December 31, 2021		
	Number of Securities	Fair Value	Gross Unrealized Losses
	(in thousands, except no. of securities)		
U.S. treasury and agency securities	108	$ 894,060	$ (1,837)
Corporate notes	357	452,672	(1,746)
Municipalities	108	$ 50,236	$ (140)
Total	**573**	**$ 1,396,968**	**$ (3,723)**

The following table summarizes those available-for-sale securities that have been in a continuous unrealized loss position for longer than twelve months as of December 31, 2022. The available-for-sale securities that have been in a continuous unrealized loss position for longer than twelve months as of December 31, 2021 are immaterial.

	December 31, 2022		
	Number of Securities	Fair Value	Gross Unrealized Losses
	(in thousands, except no. of securities)		
U.S. treasury and agency securities	45	$ 298,746	$ (4,264)
Corporate notes	189	200,745	(3,367)
Municipalities	57	$ 16,594	$ (357)
Total	**291**	**$ 516,085**	**$ (7,988)**

The Company monitors available-for-sale debt securities for credit losses and recognizes an allowance for credit losses when factors indicate a decline in the fair value of a security is credit-related. Certain investments may experience a decline in fair value due to changes in market interest rates, changes in general economic conditions, or a deterioration in the credit worthiness of a security's issuer. The Company has assessed the gross unrealized losses during the period and determined an allowance for credit losses is not necessary because the declines in fair value are believed to be due to market fluctuations and not due to credit-related events.

The amortized cost and fair value of the Company's fixed maturity securities as of December 31, 2022 by contractual maturity are shown below. Actual maturities of these securities could differ from their contractual maturities because issuers may have the right to call or prepay obligations, with or without penalties.

	December 31, 2022	
	Amortized Cost	Fair Value
	(in thousands)	
Due in one year or less	$ 1,405,937	$ 1,397,287
Due after one year through five years	223,877	222,919
Total	**$ 1,629,814**	**$ 1,620,206**

The following table presents disaggregated net investment income.

	Year Ended December 31,		
	2022	2021	2020
		(in thousands)	
Interest income	$ 31,306	$ 10,250	$ 8,014
Investment discount amortization, net of premium accretion	(2,438)	(8,067)	(2,571)
Net realized gains (losses)	(1,274)	212	1,239
Net Investment Income	**$ 27,594**	**$ 2,395**	**$ 6,682**

The accrued investment income balances presented below are included within “other current assets” in the consolidated balance sheets.

	December 31,	
	2022	2021
	(in thousands)	
Accrued investment income	$ 5,074	$ 3,782

8. FAIR VALUE MEASUREMENTS

Fair value represents the price that would be received to sell an asset, or paid to transfer a liability, in an orderly transaction between market participants. The Company's financial assets and liabilities measured at fair value on a recurring basis are categorized into a three-level fair value hierarchy based on the priority of the inputs used in the fair value valuation technique.

The levels of the fair value hierarchy are as follows:

- Level 1: Inputs utilize quoted (unadjusted) prices in active markets for identical assets or liabilities.
- Level 2: Inputs utilize other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly, for substantially the full term of the asset or liability.
- Level 3: Inputs utilized that are unobservable but significant to the fair value measurement for the asset or liability. The unobservable inputs are used to measure fair value to the extent that relevant observable inputs are not available. They typically reflect management’s own estimates about the assumptions a market participant would use in pricing the asset or liability.

The following tables summarize fair value measurements by level for assets and liabilities measured at fair value on a recurring basis:

	December 31, 2022			
	(Level 1)	(Level 2)	(Level 3)	Total Fair Value Measurement
	(in thousands)			
Assets				
Cash equivalents	104,456	13,998	—	118,454
Investments				
U.S. treasury and agency securities	—	1,155,282	—	1,155,282
Corporate notes	—	374,449	—	374,449
Certificate of deposit	—	38,082	—	38,082
Commercial paper	—	32,730	—	32,730
Municipalities	—	19,663	—	19,663
Restricted investments				
U.S. treasury securities	—	5,581	—	5,581
Total Assets	**$ 104,456**	**$ 1,639,785**	**$ —**	**$ 1,744,241**

	December 31, 2021			
	(Level 1)	(Level 2)	(Level 3)	Total Fair Value Measurement
	(in thousands)			
Assets				
Cash equivalents	$ 45,265	$ 1,001	$ —	$ 46,266
Investments				
U.S. treasury and agency securities	$ —	$ 894,062	$ —	$ 894,062
Corporate notes	—	452,672	—	452,672
Municipalities	—	50,236	—	50,236
Certificate of deposit	—	21,370	—	21,370
Commercial paper	—	13,222	—	13,222
Restricted investments				
U.S. treasury securities	—	6,523	—	6,523
Total Assets	**$ 45,265**	**$ 1,439,086**	**$ —**	**$ 1,484,351**

9. BENEFITS PAYABLE

Reserves for medical claims expenses are estimated using actuarial assumptions and recorded as a benefits payable liability on the consolidated balance sheet. The assumptions for the estimates and for establishing the resulting liability are reviewed, and any adjustments to reserves are reflected in the consolidated statement of operations in the period in which the estimates are updated.

The following table provides a rollforward of the Company's beginning and ending benefits payable and claims adjustment expenses ("CAE") payable balances for the years ended December 31, 2022 and 2021:

	As of December 31, 2022		
	Benefits Payable	Unallocated Claims Adjustment Expense	Total
		(in thousands)	
Benefits payable, beginning of the period	$ 513,582	$ 9,101	$ 522,683
Less: Reinsurance recoverable	159,180	—	159,180
Benefits payable, beginning of the period, net	**$ 354,402**	**$ 9,101**	**$ 363,503**
Claims incurred and CAE			
Current year	$ 3,279,460	$ 117,541	$ 3,397,001
Prior years	1,338	—	1,338
Total claims incurred and CAE, net	**$ 3,280,798**	**$ 117,541**	**$ 3,398,339**
Claims paid and CAE			
Current year	$ 2,726,912	$ 106,871	$ 2,833,783
Prior years	248,505	7,059	255,564
Total claims and CAE paid, net	**$ 2,975,417**	**$ 113,930**	**$ 3,089,347**
Benefits and CAE payable, end of period, net	$ 659,783	$ 12,712	$ 672,495
Add: Reinsurance recoverable	277,944	—	277,944
Benefits and CAE payable, end of period	**$ 937,727**	**$ 12,712**	**$ 950,439**

	As of December 31, 2021		
	Benefits Payable	Unallocated Claims Adjustment Expense	Total
		(in thousands)	
Benefits payable, beginning of the period	$ 311,914	$ 5,509	$ 317,423
Less: Reinsurance recoverable	132,658	—	132,658
Benefits payable, beginning of the period, net	**$ 179,256**	**$ 5,509**	**$ 184,765**
Claims incurred and CAE			
Current year	$ 1,640,247	$ 73,892	$ 1,714,139
Prior years	(16,252)	—	(16,252)
Total claims incurred and CAE, net	**$ 1,623,995**	**$ 73,892**	**$ 1,697,887**
Claims paid and CAE			
Current year	$ 1,346,870	$ 64,791	$ 1,411,661
Prior years	101,978	5,509	107,487
Total claims and CAE paid, net	**$ 1,448,848**	**$ 70,300**	**$ 1,519,148**
Benefits and CAE payable, end of period, net	$ 354,402	$ 9,101	$ 363,503
Add: Reinsurance recoverable	159,180	—	159,180
Benefits and CAE payable, end of period	**$ 513,582**	**$ 9,101**	**$ 522,683**

Amounts incurred related to prior periods vary from previously estimated liabilities as more claim information becomes available and claims are ultimately settled. Negative amounts reported for incurred related to prior years result from claims being ultimately settled for amounts less than originally estimated (favorable development).

Unallocated Claims Adjustment Expenses

Unallocated claims adjustment expenses ("CAE") are costs incurred or expected to be incurred in connection with the adjustment and recording of health claims not subject to reinsurance. Such expenses include, but are not limited to, case management, utilization review, and quality assurance and are intended to reduce the number of health services provided or the cost of such services. CAE is included in other insurance costs and the related CAE payable is included in accounts payable and accrued liabilities.

The following tables provide information about incurred and paid health care claims development and cumulative claims frequency. The claims development information for all periods preceding the most recent reporting period is considered required unaudited supplementary information. For claims frequency information summarized below, a claim is defined as the financial settlement of a single medical event in which remuneration was paid to the servicing provider. Total IBNR plus expected development on reported claims represents estimates for claims incurred but not reported and development on reported claims. The Company estimates its liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

The following table summarizes health care claims incurred, net of reinsurance:

Incurred Health Care Claims
Net of Reinsurance

	Year Ended December 31, (in thousands)			Cumulative number of reported claims (in thousands)
	Unaudited 2020	Unaudited 2021	2022	
Date of Service				
2020	$ 308,370	$ 295,506	$ 299,625	3,070
2021		1,640,247	1,648,358	5,553
2022			3,279,461	8,977
Total claims incurred			$ 5,227,444	

The following table summarizes health care claims paid, net of reinsurance:

Cumulative Paid Health Care Claims
Net of Reinsurance

	Year Ended December 31, (in thousands)		
	Unaudited 2020	Unaudited 2021	2022
Date of Service			
2020	$ 178,751	$ 258,949	$ 275,521
2021		1,346,870	1,576,846
2022			2,726,912
Total payment of incurred claims			4,579,279
All outstanding liabilities prior to 2020, net of reinsurance			11,618
Total benefits payable, net of reinsurance			**$ 659,783**

The following table reconciles total outstanding liabilities, net of reinsurance to benefits payable in the consolidated balance sheet:

	As of December 31, (in thousands)	
	2022	2021
Short-duration health care costs payable, net of reinsurance	$ 659,783	$ 354,402
Reinsurance recoverables	277,944	159,180
Total benefits payable	**$ 937,727**	**$ 513,582**

10. STOCK-BASED COMPENSATION

2012 Incentive Award Plan

Prior to the IPO, the Company maintained the 2012 Stock Plan (the "2012 Plan"), which provided for the grant of incentive stock options ("ISOs"), non-qualified stock options ("NSOs"), common stock of the Company, stock payments and restricted stock units. The 2012 Plan was initially adopted on December 6, 2012 and most recently amended and restated in March 2021. The 2012 Plan was terminated upon the effectiveness of the 2021 Incentive Award Plan in March 2021, and no further awards will be made under the 2012 Plan.

2021 Incentive Award Plan

In March 2021, the Company's board of directors adopted the 2021 Incentive Award Plan (the "2021 Plan"), which provides for the grant of NSOs, ISOs, stock appreciation rights ("SARs"), restricted stock, restricted stock units (including time-based restricted stock units ("RSUs") and performance-based restricted stock units ("PSUs")), dividend equivalents and other stock or cash awards to employees, consultants and non-employee directors. Under the 2021 Plan, there are 32.5 million shares authorized to be issued, with 1.6 million shares still available for future issuance as of December 31, 2022. The shares available for future issuance as of December 31, 2022 may be issued as either Class A common stock or Class B common stock.

2022 Inducement Incentive Award Plan

In April 2022, the Company's board of directors adopted the 2022 Employment Inducement Incentive Award Plan (the "2022 Plan"), which provides for the grant of NSOs, SARs, restricted stock, RSUs, PSUs, dividend equivalents and other stock or cash awards to prospective employees. Under the 2022 Plan, there are 5 million shares authorized to be issued, with 3.8 million shares still available for future issuance as of December 31, 2022. The shares available for future issuance as of December 31, 2022 may be issued as Class A common stock.

Stock-Based Compensation Expense

Stock-based compensation expense is recognized on a straight-line basis over the requisite service period. Forfeitures are accounted for as they occur. The following table summarizes the stock-based compensation expense for the years ended December 31, 2022, 2021 and 2020, which is included within the line items specified below in the consolidated statements of operations:

	Year Ended December 31,		
	2022	2021	2020
		(in thousands)	
Other insurance costs	$ 51,495	$ 42,295	$ 18,299
General and administrative expenses	60,834	44,001	17,570
Total stock-based compensation expense	**$ 112,329**	**$ 86,296**	**$ 35,869**

Stock Options

Stock options granted under the 2012 Plan and 2021 Plan include ISOs and NSOs, generally have a maximum contractual term of 10 years and typically vest over a four-year period.

The following table summarizes the stock option award activity under the 2012 Plan and 2021 Plan for the year ended December 31, 2022:

	Options			
	Number of Options	Weighted Average Exercise Price	Weighted Average Remaining Contractual Life (in years)	Aggregate Intrinsic Value (in thousands)
Options Outstanding - December 31, 2021	34,048,888	$ 10.27	6.95	$ 16,834
Options granted	—	—		
Options exercised	(313,684)	$ 3.92		$ 999
Options canceled	(5,006,315)	$ 12.17		
Options Outstanding - December 31, 2022	28,728,889	$ 10.01	5.81	$ 2,073
Options Exercisable at December 31, 2022	24,910,195	$ 9.31	5.50	$ 2,073

There were no stock options granted during the year ended December 31, 2022. The weighted average grant date fair value of options granted during the years ended December 31, 2021 and 2020 was $8.69 and $4.47, respectively. The aggregate intrinsic value of options exercised during the years ended December 31, 2022, 2021 and 2020 was $1.0 million, $111.0 million and $14.2 million, respectively.

Determination of Fair Value of Stock Options

The fair value of stock options is estimated on the grant date using the Black-Scholes option-pricing model, which takes into account significant assumptions such as the expected term of the option, stock price volatility and a risk-free rate of return. The Company has used the simplified method in calculating the expected term of all option grants based on the vesting period and contractual term.

The table below summarizes the assumptions used during the years ended December 31, 2021 and 2020. There were no stock options granted during the year ended December 31, 2022.

	December 31,	
	2021	2020
Term in years	5.01 - 6.07	5.00 - 6.11
Risk free rate of return	0.5% - 1.2%	0.2% - 0.8%
Expected volatility	39.2% - 44.5%	35.8% - 39.9%
Dividend yield	— %	— %

Compensation Expense – Stock Options

For the years ended December 31, 2022, 2021 and 2020, the Company recorded compensation expense of $21.5 million, $39.0 million and $35.4 million respectively. As of December 31, 2022, the amount of unrecognized compensation expense for stock options is $20.4 million, which is expected to be recognized over a weighted-average period of 1.9 years.

Restricted Stock Units

RSUs represent the right to receive shares of the Company's Class A or Class B common stock at a specified date in the future and typically have a vesting period of one to four years.

The following table summarizes RSU award activity for the year ended December 31, 2022:

	RSUs	
	Number of Shares	Weighted Average Grant Date Fair Value
Outstanding RSUs at December 31, 2021	8,983,941	$ 16.61
RSUs granted	18,268,480	$ 5.97
RSUs vested	(5,645,873)	$ 12.11
RSUs canceled	(4,010,678)	$ 10.64
Outstanding RSUs at December 31, 2022	17,595,870	$ 8.37

Determination of Fair Value of RSUs
The fair value of RSUs granted is determined on the grant date based on the fair value of the Company's common stock. The total fair value of RSUs vested during the years ended December 31, 2022 and 2021 was $68.4 million and $13.2 million, respectively. No RSUs vested in 2020.

Compensation Expense – RSUs
For the years ended December 31, 2022, 2021 and 2020, the Company recorded compensation expense of $65.5 million, $28.5 million and $0.5 million, respectively. As of December 31, 2022, the amount of unrecognized compensation expense for RSUs is $134.3 million, which is expected to be recognized over a weighted-average period of 2.3 years.

Performance-based Restricted Stock Units
Performance-based restricted stock units ("PSUs") represent the right to receive shares of the Company's Class A or Class B common stock at a specified date in the future based on pre-determined performance and service conditions and typically have a vesting period of one to seven years. PSUs granted include awards with market conditions that are eligible to vest based on the achievement of predetermined stock price goals and awards with performance conditions that are eligible to vest based on predetermined Company performance targets.

The following table summarizes PSU award activity for the years ended December 31, 2022:

	PSUs	
	Number of Shares	Weighted Average Grant Date Fair Value
Outstanding PSUs at December 31, 2021	7,082,432	$ 14.37
PSUs granted	1,659,598	$ 6.00
PSUs canceled	(277,453)	13.74
Outstanding PSUs at December 31, 2022	8,464,577	$ 12.75

Determination of Fair Value of PSUs
The fair value of PSUs with performance conditions is determined on the grant date based on the fair value of the Company's common stock.

PSUs with market conditions, which are referred to as the “Founders Awards,” were granted to the Company’s co-founders (the "Co-Founders") during the year ended December 31, 2021. The fair value of the Founders Awards is estimated on the grant date using a Monte Carlo simulation model, which utilizes multiple variables that determine the probability of satisfying the market conditions stipulated in the award. The weighted-average grant date fair value of the Founders Awards was determined to be $14.22 using the following assumptions:

	December 31, 2021
Grant date stock price	$ 39.00
Term in years	7.0
Expected volatility	45.00 %
Risk-free rate	1.14 %
Dividend yield	— %

Compensation Expense – PSUs
For the years ended December 31, 2022 and 2021, the Company recorded compensation expense of $25.3 million and $18.8 million, respectively. As of December 31, 2022, the amount of unrecognized compensation expense for PSUs is $62.9 million, which is expected to be recognized over a weighted-average period of 2.7 years.

Modifications
In 2020, the Company modified certain stock option awards to extend the post-termination exercise period for certain terminated employees, which resulted in stock-based compensation expense of $6.4 million for the year ended December 31, 2020. In 2020, the Company also modified a stock option award granted to an executive, which resulted in additional stock-based compensation expense of $4.7 million for the year ended December 31, 2020.

11. EARNINGS (LOSS) PER SHARE

The following table presents the computation of basic and diluted earnings per share:

	Year Ended December 31,		
	2022	2021	2020
	(in thousands, except share and per share data)		
Numerator:			
Net loss attributable to Oscar Health, Inc.	$ (606,275)	$ (572,606)	$ (406,825)
Deemed dividends	—	—	(7,418)
Total	$ (606,275)	$ (572,606)	$ (414,243)
Denominator:			
Weighted average shares of common stock outstanding, basic and diluted	212,474,615	178,967,056	29,263,424
Net loss per share attributable to Oscar Health, Inc., basic and diluted	**$ (2.85)**	**$ (3.20)**	**$ (14.16)**

In periods when the Company is in a net loss position, dilutive securities are excluded from the computation of diluted earnings per share because their inclusion would have an anti-dilutive effect. Thus, basic net loss per share is the same as diluted net loss per share.

The following potential shares of common stock, presented based on amounts outstanding at each period end, were excluded from the computation of diluted net loss per share attributable to Oscar Health, Inc. because including them would have had an anti-dilutive effect:

	Year Ended December 31,		
	2022	2021	2020
Stock options to purchase common stock	28,728,889	34,048,888	41,115,486
Restricted stock units	17,595,870	8,983,941	1,555,666
Performance-based restricted stock units	8,464,577	7,082,432	—
Shares underlying convertible notes (Note 15)	36,652,491	—	—
Total	**91,441,827**	**50,115,261**	**42,671,152**

Convertible Preferred Shares and Warrants Outstanding

As of December 31, 2020, there were 400,904,302 convertible preferred shares (pre-split) outstanding and 1,225,216 warrants outstanding that were excluded from the computation of diluted net loss per share because including them would have had an anti-dilutive effect. All convertible preferred shares and warrants outstanding were exercised in March 2021 in connection with the IPO.

During the year ended December 31, 2020, the Company recognized a deemed dividend due to the triggering of a beneficial conversion feature upon the issuance of convertible preferred stock. For additional information on the Company's convertible preferred stock, refer to Note 16 - Stockholders' Equity.

12. INCOME TAXES

The current income tax provision reflects the tax consequences of revenues and expenses currently taxable or deductible for the year reported. The deferred tax income tax provision or benefit reflects the differences between the financial and income tax reporting bases of the Company’s underlying assets and liabilities. The components of the provision for income taxes are as follows for the periods indicated:

	Years Ended December 31,		
	2022	2021	2020
		(in thousands)	
Current income tax:			
Federal	$ (358)	$ 947	$ 1,112
State	—	—	—
Total current income tax	$ (358)	$ 947	$ 1,112
Deferred income (benefit) tax:			
Federal	$ (165)	$ (101)	$ (67)
State	—	—	—
Total deferred tax	$ (165)	$ (101)	$ (67)
Total income tax	**$ (523)**	**$ 846**	**$ 1,045**

A reconciliation of the tax provision at the U.S. federal statutory tax rate to the provision for income taxes and the effective tax rate follows for the periods indicated:

	Year Ended December 31,		
	2022	**2021**	**2020**
Pre-tax book loss			
Income tax benefit at statutory rate	21.00 %	21.00 %	21.00 %
State taxes (net of federal income tax)	6.00 %	0.90 %	3.78 %
Change in valuation allowance	(23.27) %	(21.62) %	(25.99)%
Stock-based compensation adjustment	(1.92) %	1.81 %	(0.54)%
Revision to estimates	— %	— %	4.46 %
Non-deductible compensation	(1.56) %	(2.25) %	(0.98)%
Other permanent items	(0.16) %	0.01 %	(1.99)%
Total income tax	**0.09 %**	**(0.15)%**	**(0.26)%**

Deferred income tax assets and liabilities are recognized for the differences between the financial and income tax reporting bases of assets and liabilities based on enacted tax rates and laws. The components of deferred income tax assets and liabilities are as follows for the periods indicated:

	December 31,	
	2022	**2021**
	(in thousands)	
Deferred Tax Assets:		
NOL carryforwards	$ 529,293	$ 385,988
Premium deficiency reserves	798	6,142
Stock option	5,284	6,338
Claims reserves	16,021	10,581
Accrued bonus	4,991	4,217
Start-up costs	3,252	3,699
Unearned premium reserve	3,311	3,152
Business interest expense	1,242	—
Fixed assets	1,483	1,029
Investments	2,040	3,755
Other	1,972	1,162
Total deferred tax assets before valuation allowance	569,687	426,063
Valuation allowance	564,392	421,357
Total deferred tax assets, net of valuation allowance	$ 5,295	$ 4,706
Deferred Tax Liabilities:		
Prepaid expenses	3,485	3,249
Other	1,038	862
Total deferred tax liabilities	4,523	4,111
Net deferred tax assets	**$ 772**	**$ 595**

The Company evaluates the need for a valuation allowance against its deferred tax assets considering all available positive and negative evidence. Based on its analysis, the Company concluded that it is more likely than not that all or some portion of the deferred tax asset will not be realized. The Company has a valuation allowance of $564.4 million at December 31, 2022 against its deferred tax assets, including federal and state net operating losses, as the Company does not have a history of positive earnings. Valuation allowances will be provided until it becomes more likely than not that the benefit of the federal and state deferred tax assets will be realized.

Federal net operating loss carryovers are $2.2 billion, $1.32 billion which expire beginning in 2032 through 2042 and $839 million have indefinite carryforward periods. State net operating losses from group filings are approximately $940 million and from separate entity filings are $386 million; state net operating losses expire beginning in 2035.

Pursuant to I.R.C Section 382, the Company underwent a change in ownership in 2016. Based on the annual limitation, use of pre-change net operating losses will not be limited prior to expiration.

The Company evaluates tax positions to determine whether the benefits are more likely than not to be sustained on audit based on technical merits. The Company did not have any uncertain tax positions for the years ended December 31, 2022, 2021, and 2020. The Company does not expect any significant changes to unrecognized tax benefits in the next twelve months. The Company's policy is to classify interest accrued related to unrecognized tax benefits in interest expense while penalties are included in income tax expense. The Company had no interest or penalties related to uncertain tax positions.

The Company currently files income tax returns in the United States, various states, and localities. The majority of the Company's operating subsidiaries are included in a consolidated federal income tax return. The Company began operations in 2012 and has never been placed under income tax audit. Federal tax returns are open for examination for tax years from 2019. State tax returns are open for examination for tax years from 2018.

13. LEASES

The Company records right-of-use ("ROU") assets and lease liabilities for its real estate operating leases. Leases with an initial term of twelve months or less are not recorded on the balance sheet.

The following table presents the lease-related balances within the balance sheet:

		December 31,	
	Balance Sheet Classification	**2022**	**2021**
		(in thousands)	
Operating Leases			
Right-of-use assets	Other assets	$ 68,001	$ 72,960
Lease liabilities, current	Accounts payable and accrued liabilities	$ 12,824	$ 14,831
Lease liabilities, noncurrent	Other liabilities	$ 72,175	$ 76,839

Operating lease expense was $14.8 million and $15.2 million for the years ended December 31, 2022 and 2021, respectively, which includes variable lease expense. Rent expense was $14.4 million for the year ended December 31, 2020. Cash paid for amounts included in the measurement of lease liabilities was $14.8 million and $17.0 million for the years ended December 31, 2022 and 2021, respectively.

Future minimum rental payments under non-cancellable operating leases are estimated as follows:

Year Ended December 31,	**(in thousands)**
2023	$ 12,824
2024	14,175
2025	14,360
2026	16,445
2027	17,099
Thereafter	55,287
Total lease payments	**$ 130,190**
Less: Imputed interest	45,191
Present value of lease liabilities	**$ 84,999**

Additional Information:	**December 31, 2022**
Weighted-average remaining lease term	8.2
Weighted-average discount rate	10.64%

14. PROPERTY, EQUIPMENT AND CAPITALIZED SOFTWARE

The following table summarizes the balances of the Company's property, equipment and capitalized software:

	December 31,	
	2022	2021
	(in thousands)	
Property, equipment, and capitalized software		
Software and hardware	$ 87,252	$ 61,278
Leasehold improvements	25,301	25,754
Property and fixtures	4,719	1,680
Property, equipment, and capitalized software	117,272	88,712
Less: Accumulated depreciation and amortization	(57,384)	(42,101)
Property, equipment, and capitalized software, net	**$ 59,888**	**$ 46,611**

Depreciation and amortization expense for property, equipment and capitalized software for the years ended December 31, 2022, 2021 and 2020 was $15.3 million, $14.6 million, and $11.3 million, respectively.

15. LONG-TERM DEBT

Convertible Senior Notes

In February 2022, the Company issued $305.0 million in aggregate principal amount of convertible senior notes due 2031 (the "2031 Notes") in a private placement. The 2031 Notes bear interest at a rate of 7.25% per annum, payable in cash, semi-annually in arrears on June 30 and December 31 of each year, commencing on June 30, 2022. The 2031 Notes will mature on December 31, 2031, subject to earlier repurchase, redemption or conversion.

The 2031 Notes are our senior, unsecured obligations and are (i) equal in right of payment with the Company's existing and future senior, unsecured indebtedness; (ii) senior in right of payment to the Company's existing and future indebtedness that is expressly subordinated to the 2031 Notes; (iii) effectively subordinated to the Company's existing and future secured indebtedness, to the extent of the value of the collateral securing that indebtedness; and (iv) structurally subordinated to all existing and future indebtedness and other liabilities, including trade payables, and (to the extent the Company is not a holder thereof) preferred equity, if any, of our subsidiaries.

The 2031 Notes are convertible into the Company's Class A common stock at initial conversion rates of 120.1721 per $1,000 principal amount (equivalent to an initial conversion price of approximately $8.32 per share of Class A common stock), subject to customary adjustments upon the occurrence of certain events. In addition, upon the occurrence of a make-whole fundamental change, as defined in the Indenture governing the 2031 Notes (the "Indenture"), the Company will, in certain circumstances, increase the conversion rate by a number of additional shares for a holder that elects to convert its 2031 Notes in connection with such make-whole fundamental change. Upon conversion, the 2031 Notes will be settled, at the Company's election, in shares of Class A common stock, cash, or a combination of cash and shares of Class A common stock, subject to certain exceptions.

Upon the occurrence of a fundamental change as defined in the Indenture, holders of the 2031 Notes have the right to require the Company to repurchase all or some of their 2031 Notes for cash, subject to certain conditions. The repurchase price will be equal to the principal amount of the notes to be repurchased, plus accrued and unpaid interest, if any, to, but excluding, the applicable repurchase date. Additionally, the initial purchasers of the 2031 Notes have the right to require the Company to repurchase all of their Notes for cash, on each of June 30, 2027, June 30, 2028, June 30, 2029 and June 30, 2030, subject to certain notice requirements.

The Company may not redeem the 2031 Notes prior to December 31, 2026. The Company may redeem all, but not less than all, of the 2031 Notes, at the Company's option, on or after December 31, 2026 and on or before the 35th scheduled trading day immediately preceding the maturity date, for a cash purchase price equal to the redemption price, but only if the last reported sale price per share of Class A common stock exceeds 200% of the conversion price on each of at least 20 trading days (whether or not consecutive) during the 30 consecutive trading days ending on, and including, the trading day immediately before the date on which the Company sends the redemption notice for such redemption. The redemption price will be a cash amount equal to the principal amount of the 2031 Notes to be redeemed, plus accrued and unpaid interest, if any, to, but excluding, the redemption date.

The 2031 Notes include customary provisions relating to the occurrence of "Events of Default" (as defined in the Indenture), as well as customary covenants for convertible notes of this type, including restrictions on our ability to refinance the Company's indebtedness and incur additional indebtedness.

As of December 31, 2022, the net carrying amount of the 2031 Notes was $298.0 million, with unamortized debt discount and issuance costs of $7.0 million. The Company classified the fair value of the 2031 Notes as a level 3 measurement due to the lack of observable market data over fair value inputs such as our stock price volatility over the term of the 2031 Notes and the Company's cost of debt. The estimated fair value of the 2031 Notes as of December 31, 2022 was $190.8 million.

The following table presents the interest expense indicating an effective interest rate of 7.61% over the term of the 2031 Notes:

	December 31, 2022
	(in thousands)
Coupon interest expense	$ 20,270
Amortization of debt discount and issuance costs	713
Total interest expense	$ 20,983

Revolving Credit Facility

On February 21, 2021, the Company entered into a senior secured credit agreement (the "Revolving Credit Facility"), with certain lenders party thereto from time to time (the "Lenders"), and Wells Fargo Bank, National Association, as administrative agent, for a revolving loan credit facility in the aggregate principal amount of $200.0 million. The Revolving Credit Facility is guaranteed by Oscar Management Corporation and Oscar Management Corporation of Florida, each wholly owned subsidiaries of the Company, and all of the Company's future direct and indirect subsidiaries (subject to certain permitted exceptions, including exceptions guarantees that would require material governmental consents or in respect of a joint venture) (the "Guarantors"). The Revolving Credit Facility is secured by substantially all of the Company's and the Guarantors' assets (subject to certain exceptions). Proceeds are to be used solely for general corporate purposes of the Company.

The Company is permitted to increase commitments under the Revolving Credit Facility by an aggregate amount not to exceed $50.0 million, subject to certain conditions. The Revolving Credit Facility matures on February 21, 2024.

Under the terms of the Revolving Credit Facility, borrowings under the Revolving Credit Facility bear interest at a rate equal to, at the Company's option, either (a) a rate per annum equal to an adjusted London Inter-bank Offered Rate ("LIBOR"), plus an applicable margin of 4.50% (LIBOR is calculated based on one-, three- or six-month LIBOR, or such other period as agreed by all relevant Lenders, which is determined by reference to ICE Benchmark Administration Limited, but not less than 1.00%), or (b) a rate per annum equal to the Alternate Base Rate, as defined in the Revolving Credit Facility, plus the applicable margin of 3.50% (the Alternate Base Rate is equal to the highest of (i) the prime rate, (ii) the federal funds effective rate plus 0.50%, and (iii) LIBOR based on a one-month interest period, plus 1.00%). The Revolving Credit Facility also includes a commitment fee of 0.50% for available but undrawn amounts and other administrative fees that are payable quarterly. It also includes LIBOR replacement provisions in the event LIBOR becomes unavailable during the term of this facility. The Revolving Credit Facility is available until February 2024, provided the Company is in compliance with all covenants. Financial covenant requirements include (i) receiving specified levels of direct policy premiums (as defined in the Revolving Credit Facility) for each fiscal quarter, (ii) maintaining a minimum liquidity (as defined in the Revolving Credit Facility) of $150 million (or $200 million if the liquidity decreased by a specified amount over the prior six month period) as of the last day of each quarter, and (iii) not exceeding a maximum combined ratio (as defined in the Revolving Credit Facility) of 108% for fiscal year 2022 and 102% for fiscal year 2023, in each case, as of the last day of each quarter.

As of December 31, 2022, there were no outstanding borrowings under the Revolving Credit Facility.

Long-Term Debt

On October 30, 2020, the Company entered into a credit agreement with HPS Investment Partners, LLC ("HPSIP") whereby HPSIP agreed to provide a $150.0 million first lien term loan ("Term Loan"). The Term Loan had a variable interest rate equal to LIBOR plus 11.75%, per annum, which equated to 12.75% per annum during the period, and a maturity date of October 30, 2024, subject to certain conditions.

In March 2021, the Company used proceeds from its recently completed initial public offering (the "IPO") to repay the outstanding balance of $153.2 million on its Term Loan, which included $3.2 million of paid-in-kind interest. A loss on debt extinguishment of $20.2 million was recognized, which consisted of $13.0 million in prepayment penalties and $7.2 million in unamortized debt discount and debt issuance costs.

Warrants and Call Options

Prior to the IPO, the Company issued several rounds of warrants to purchase preferred stock. The warrants were accounted for as liabilities, with changes in fair value recognized in general and administrative expenses in the consolidated statement of operations at each reporting period. In connection with the IPO, all outstanding warrants and call options were exercised in full, resulting in the issuance of 1,115,973 shares of Class A common stock.

16. STOCKHOLDERS' EQUITY

Initial Public Offering

As described in Note 1 - Organization, in March 2021 the Company completed its IPO of 36,391,946 shares of Class A common stock at a par value of $0.00001 and a public offering price of $39.00 per share. The Company received aggregate net proceeds of $1.3 billion after deducting underwriting discounts and commissions of $71.0 million. The Company used a portion of the net proceeds of the IPO to repay in full outstanding borrowings, including fees and expenses, under the Term Loan Facility. Refer to Note 15 - Long-Term Debt.

Convertible Preferred Stock

Prior to the IPO, the Company issued several series of convertible preferred stock, collectively referred to as "Preferred Stock," that had been classified outside of stockholders' equity (deficit) on the consolidated balance sheet because the holders of such shares had liquidation rights that, in certain situations, were not solely within the control of the Company. In connection with the IPO, all outstanding convertible preferred stock was converted into shares of Series A and Series B common stock, as outlined below.

Reclassification and Stock Split

Conversion of Preferred Stock and Series B Common Stock to Series A Common Stock

In accordance with the terms and provisions of the Company's Thirteenth Amended and Restated Certificate of Incorporation (the "Prior Certificate of Incorporation"), which was in effect immediately prior to the filing of the Amended and Restated Certificate of Incorporation, the holders of 402,192,500 shares (pre-split) of the Company's convertible preferred stock effected a conversion of all shares of convertible preferred stock to 403,261,643 shares (pre-split) of Series A common stock, $0.00001 par value per share (the "Series A common stock") (the "Preferred Stock Conversion"), and the holders of 9,360,800 shares (pre-split) of the Company's Series B common stock, $0.00001 par value per share (the "Series B common stock"), effected a conversion of such shares of Series B common stock to 9,360,800 shares (pre-split) of the Company's Series A common stock (the "Series B Conversion"), in each case effective as of the pricing of the IPO on March 2, 2021.

Authorization of New Class of Shares and Conversion of Series A Common Stock and Stock Split

In connection with the IPO, on March 3, 2021, the Company filed its Amended and Restated Certificate of Incorporation which, among other things, provides for:

- the authorization of 825,000,000 shares of Class A common stock, 82,500,000 shares of Class B common stock, and 82,500,000 shares of preferred stock;

- the reclassification of each share of Series A common stock (other than shares of Series A common stock held by Thrive Capital Partners II, L.P., Thrive Capital Partners III, L.P., Thrive Capital Partners V, L.P., Thrive Capital Partners VI Growth, L.P., Claremount TW, L.P., Claremount VI Associates, L.P. and Claremount V Associates, L.P. (the "Thrive Series A common stock")) issued and outstanding or held in treasury immediately prior to the filing of the Amended and Restated Certificate of Incorporation into one share of Class A common stock (the "Class A Reclassification");

- the reclassification of each share of Series B common stock issued and outstanding or held in treasury immediately prior to the filing of the Amended and Restated Certificate of Incorporation and each share of Thrive Series A

common stock into one share of Class B common stock (the "Class B Reclassification" and, together with the Class A Reclassification, the "Reclassification");

- the reclassification of each three shares of Class A common stock issued and outstanding or held in treasury immediately following the Class A Reclassification into one validly issued, fully paid and non-assessable share of Class A common stock (the "Class A Stock Split"); and

- the reclassification of each three shares of Class B common stock issued and outstanding or held in treasury immediately following the Class B Reclassification into one validly issued, fully paid and non-assessable share of Class B common stock (the "Class B Stock Split" and, together with the Class A Stock Split, the "Stock Split").

No fractional shares of Class A common stock or Class B Common Stock were delivered as a result of the Stock Split.

Summary of IPO Share Transactions

As a result of the IPO, the Preferred Stock Conversion, the Series B Conversion, the Reclassification, and the Stock Split described above, the following activity occurred:

- 402,192,500 shares (pre-split) of convertible preferred stock were converted into 403,261,643 shares (pre-split) of Series A common stock;

- 9,360,800 shares (pre-split) of Series B common stock were converted into 9,360,800 shares (pre-split) of Series A common stock;

- 398,283,107 shares (pre-split) of Series A common stock were reclassified as 398,283,107 shares (pre-split) of Class A common stock;

- 60,127,163 shares (pre-split) of Series B Common Stock were reclassified as 60,127,163 shares (pre-split) of Class B common stock;

- 45,879,623 shares (pre-split) of Series A common stock were reclassified as 45,879,623 shares (pre-split) of Class B common stock;

- 398,283,107 shares (pre-split) of Class A common stock were reclassified as 132,760,639 shares (post-split) of Class A common stock;

- 106,006,786 shares (pre-split) of Class B common stock were reclassified as 35,335,579 shares (post-split) of Class B common stock;

- 219,772 shares (post-split) of Class B common stock converted to 219,772 shares (post-split) of Class A Common Stock in connection with a secondary sale in the IPO; and

- the Company issued 36,391,946 shares (post-split) of Class A common stock at a par value of $0.00001 and a public offering price of $39.00 per share.

Common Stock

The rights of the holders of Class A common stock and Class B common stock are identical, except with respect to voting, conversion, and transfer rights.

Voting Rights

Holders of the Company’s Class A common stock are entitled to one vote for each share held on all matters submitted to a vote of stockholders, and holders of the Company’s Class B common stock are entitled to 20 votes for each share held on all matters submitted to a vote of stockholders. The holders of the Company’s Class A common stock and Class B common stock will vote together as a single class, unless otherwise required by law or under the Amended and Restated Certificate of Incorporation.

Conversion and Transfer

Each outstanding share of Class B common stock is convertible at any time at the option of the holder into one share of Class A common stock. Each share of Class B common stock will convert automatically into one share of Class A Common Stock upon any transfer, except for certain permitted transfers described in the Amended and Restated Certificate of Incorporation. All outstanding shares of Class B common stock will automatically convert into shares of Class A common stock on a one-for-one basis upon the date that is the earlier of (i) the transfer of Class B common stock to a person or entity that is not in the transferor’s permitted ownership group, as described in the Amended and Restated Certificate of Incorporation, (ii) March 2, 2028, or (iii) upon the occurrence of certain other events as described in the Amended and Restated Certificate of Incorporation.

Dividends

Common stockholders are entitled to receive dividends, as may be declared by the board of directors, if any.

17. STATUTORY REGULATIONS

The Company's insurance subsidiaries prepare financial statements in accordance with Statutory Accounting Principles ("SAP") prescribed or permitted by the insurance departments of their states of domicile. SAP is focused on the solvency of insurance companies and is designed to ensure that insurers maintain sufficient capital and surplus to meet their insurance-related obligations.

The Company's insurance subsidiaries are regulated by the state insurance departments of the states in which they are domiciled. Statutory regulations include the establishment of minimum levels of statutory capital to be maintained by insurance subsidiaries and restrictions on dividend payments and other distributions made by the insurance subsidiaries to the parent company. Minimum statutory capital requirements differ by state and are based on minimum risk-based capital ("RBC") requirements developed by the National Association of Insurance Commissioners ("NAIC").

As of December 31, 2022 and 2021, the Company's insurance subsidiaries had an aggregate statutory capital and surplus of $701.5 million and $474.8 million, respectively. Individually, the Company's insurance subsidiaries have exceeded the minimum required statutory capital and surplus and RBC minimum requirements.

18. RELATED PARTY TRANSACTIONS

In February 2022, the Company issued the 2031 Notes to funds affiliated with or advised by Dragoneer Investment Group, LLC, Thrive Capital, LionTree Investment Management, LLC and Tenere Capital LLC (collectively, the "Purchasers"). See Note 15 - Long-Term Debt for additional information. In addition, pursuant to the Investment Agreement entered into with the Purchasers, the Company agreed to amend the Twelfth Amended and Restated Investors' Rights Agreement dated as of March 5, 2021 (the "Investors' Rights Agreement"), by and among the Company and the investors party thereto, to provide that the Notes and shares of Class A common stock issued or issuable upon conversion of any 2031 Notes held by entities affiliated with Thrive Capital will be subject to the registration rights contained in the Investors' Rights Agreement.

On May 3, 2022, the Investors' Rights Agreement was amended and restated to provide for, among other things, (i) registration rights as contemplated under the Investment Agreement, (ii) registration rights with respect to a number of additional shares of Class A common stock of the Company held by entities affiliated with Thrive Capital since prior to the IPO, as well as any additional shares of Class A common stock acquired after the IPO by entities affiliated with Thrive Capital with associated costs to be borne by the applicable affiliate(s) of Thrive Capital, and (iii) a partial extension to the maximum five-year term of the Investors' Rights Agreement to provide Thrive Capital and affiliated entities with registration rights in connection with any 2031 Notes held by those parties and shares of Class A common stock issued or issuable upon the conversion of any such 2031 Notes, so long as Thrive Capital is an "affiliate" of the Company at the time. Joshua Kushner, a member of the Company's Board of Directors and Vice Chairman of the Company, is the Managing Director of Thrive Capital. Thrive Capital, through affiliated entities, is a beneficial holder of more than 5% of the Company's capital stock.

19. COMMITMENTS AND CONTINGENCIES

The Company's current and past business practices are subject to review or other investigations by various state insurance and health care regulatory authorities and other state and federal regulatory authorities. These authorities regularly scrutinize the business practices of health insurance companies. These reviews focus on numerous facets of the Company's business, including claims payment practices, statutory capital requirements, provider contracting, risk adjustment, competitive practices, commission payments, privacy issues, utilization management practices, pharmacy benefits, access to care, and sales practices, among others. Some of these reviews have historically resulted in fines imposed on the Company and some have required changes to certain of the Company's practices. The Company continues to be subject to these reviews, which could result in additional fines or other sanctions being imposed on the Company or additional changes to certain of its practices.

The Company is also currently involved in, and may in the future from time to time become involved in, legal proceedings and other claims in the ordinary course of its business, including class actions and suits brought by the Company's members, providers, commercial counterparties, employees, and other parties relating to the Company's business, including management and administration of health benefit plans and other services. Such matters can include various employment claims, disputes regarding reinsurance arrangements and class action lawsuits, or other claims relating to the performance of contractual and non-contractual obligations to providers, members, employer groups, and others, including, but not limited to, the alleged failure to properly pay in-network and out-of-network claims and challenges to the manner in which the Company processes claims, and claims alleging that the Company has engaged in unfair business practices.

In addition, on May 12, 2022, a securities class action lawsuit against the Company, certain of its directors and officers, and the underwriters that participated in the Company's initial public offering was commenced in the United States District Court for the Southern District of New York, captioned Carpenter v. Oscar Health, Inc., et al., Case No. 1:22-CV-03885(S.D.N.Y.) (the "Securities Action"). On May 19, 2022, a substantially similar complaint was also commenced in the United States District Court for the Southern District of New York, captioned Chehebar v. Oscar Health, Inc., Case No. 1:22-CV-04103 (S.D.N.Y.), which was voluntarily dismissed without prejudice on June 7, 2022. The initial complaint in the Securities Action asserted violations of Sections 11 and 15 of the Securities Act based on the Company's purported failure to disclose in its IPO registration statement growing COVID-19 testing and treatment costs, the impact of significant Special Enrollment Period membership, and risk adjustment data validation results for 2019 and 2020. By Court orders dated September 27, 2022 and December 13, 2022, the Court appointed a lead plaintiff and lead counsel on behalf of the putative class. An amended complaint filed on December 6, 2022 asserts the same violations of Sections 11 and 15 of the Securities Act, but this time based on the Company's alleged failure to disclose in its IPO registration statement purportedly inadequate controls and systems in connection with the risk adjustment data validation audit for 2019, alleging that this purported omission caused losses and damages for members of the putative class. The amended complaint seeks unspecified compensatory damages as well as interest, fees and costs. The Company believes it has meritorious defenses to these claims. At this time, the Company cannot predict the outcome, or provide a reasonable estimate or range of estimates of the possible outcome or loss, if any, in this matter.

The Company records liabilities for its estimates of probable costs resulting from these matters where appropriate. Estimates of costs resulting from legal and regulatory matters involving the Company are inherently difficult to predict, particularly where the matters: involve indeterminate claims for monetary damages or may involve fines, penalties or punitive damages; present novel legal theories or represent a shift in regulatory policy; involve a large number of claimants or regulatory bodies; are in the early stages of the proceedings; or could result in a change in business practices. Accordingly, the Company is often unable to estimate the losses or ranges of losses for those matters where there is a reasonable possibility or it is probable that a loss may be incurred, the ultimate settlement of which could be material.

Given that such proceedings are subject to uncertainty, there can be no assurance that such legal proceedings, either individually or in the aggregate, will not have a material adverse effect on our business, results of operations, financial condition or cash flows.

Oscar Health, Inc.
Schedule I - Condensed Balance Sheets (Parent-Only)
(in thousands, except share and per share amounts)

	December 31, 2022	December 31, 2021
Assets:		
Current Assets:		
Cash and cash equivalents	$ 14,728	$ 57,608
Restricted deposits and investments	310,043	627,494
Investments in and advances to subsidiaries	857,649	689,573
Other assets	17,432	15,145
Total Assets	**$ 1,199,852**	**$ 1,389,820**
Liabilities and Stockholders' Equity		
Long-term debt	$ 297,999	$ —
Other liabilities	11,469	2,591
Total liabilities	**309,468**	**2,591**
Commitments and contingencies		
Stockholders' Equity		
Preferred stock, $0.00001 par value; 82,500,000 shares authorized, none issued or outstanding as of December 31, 2022 and 2021	—	—
Class A common stock, $0.00001 par value; 825,000,000 shares authorized, 181,176,239 and 175,212,223 shares issued and outstanding as of December 31, 2022 and 2021, respectively	2	2
Class B common stock, $0.00001 par value; 82,500,000 shares authorized, 35,115,807 shares issued and outstanding as of December 31, 2022 and 2021	—	—
Treasury stock (314,600 shares as of December 31, 2022and 2021)	(2,923)	(2,923)
Additional paid-in capital	3,509,007	3,393,533
Accumulated deficit	(2,605,987)	(1,999,712)
Accumulated other comprehensive loss	(9,715)	(3,671)
Total Oscar Health, Inc. stockholders' equity	890,384	1,387,229
Total Liabilities and Stockholders' Equity	**$ 1,199,852**	**$ 1,389,820**

Oscar Health, Inc.
Schedule 1 - Condensed Statements of Operations (Parent-Only)
(in thousands, except share and per share amounts)

	Year Ended December 31,		
	2022	**2021**	**2020**
Revenue			
Investment income and other revenue	$ 8,274	$ 3,225	$ 2,903
Total revenue	**8,274**	**3,225**	**2,903**
Operating Expenses			
General and administrative expenses	60,130	61,004	23,020
Interest expense	22,583	4,720	3,514
Other expenses (income)	(2,415)	1,201	—
Loss on extinguishment of debt	—	20,178	—
Loss before income tax (benefit) expense and equity in net loss of subsidiaries	(72,024)	(83,878)	(23,631)
Income tax (benefit) provision	2,703	(715)	—
Loss before equity in net loss of subsidiaries	**(74,727)**	**(83,163)**	**(23,631)**
Equity in net loss of subsidiaries	(531,548)	(489,443)	(383,194)
Net loss attributable to Oscar Health, Inc.	**$ (606,275)**	**$ (572,606)**	**$ (406,825)**

Oscar Health, Inc.

Schedule I - Consolidated Statements of Comprehensive Income (Parent-Only)

(in thousands)

	Year Ended December 31,		
	2022	**2021**	**2020**
Net loss attributable to Oscar Health, Inc.	**$ (606,275)**	**$ (572,606)**	**$ (406,825)**
Other comprehensive income (loss), net of tax:			
Net unrealized gains (losses) on securities available for sale	(6,044)	(4,550)	906
Comprehensive loss attributable to Oscar Health, Inc.	**(612,319)**	**(577,156)**	**(405,919)**

Oscar Health, Inc.
Schedule I - Condensed Statements of Cash Flows (Parent-Only)
(in thousands)

	Year Ended December 31,		
	2022	2021	2020
Net cash (used in) provided by operating activities	**$ (3,957)**	**$ (2,860)**	**$ 6,487**
Cash flows from investing activities:			
Investments in subsidiaries	(652,008)	(802,190)	(511,125)
Purchase of fixed maturity securities	(138,919)	(986,553)	(182,027)
Sale of investments	295,316	275,279	240,411
Maturity of investments	155,578	111,681	19,583
Net cash used in investing activities	**(340,033)**	**(1,401,783)**	**(433,158)**
Cash flows from financing activities:			
Proceeds from long-term debt	305,000	—	147,000
Proceeds from joint venture contribution	1,846	—	—
Proceeds from exercise of stock options	1,299	49,584	19,295
Debt extinguishment costs	—	(12,994)	—
Debt prepayment	—	(153,173)	—
Payment of debt issuance costs	(7,035)	—	(4,840)
Convertible preferred stock and call option issuances	—	—	375,671
Offering costs from IPO	—	(9,447)	—
Proceeds from exercise of warrants and call options	—	9,191	74,581
Proceeds from IPO, net of underwriting discounts	—	1,348,321	—
Net cash provided by financing activities	**301,110**	**1,231,482**	**611,707**
Increase (decrease) in cash, cash equivalents and restricted cash equivalents	(42,880)	(173,161)	185,036
Cash, cash equivalents, restricted cash and cash equivalents—beginning of period	57,608	230,769	45,733
Cash, cash equivalents, restricted cash and cash equivalents—end of period	**$ 14,728**	**$ 57,608**	**$ 230,769**

Item 9. Changes in and Disagreements with Accountants and Financial Disclosure

Not applicable.

Item 9A. Controls and Procedures

Evaluation of Disclosure Controls and Procedures

Disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) of the Exchange Act) are designed to ensure that information required to be disclosed by us in reports filed or submitted under the Exchange Act is recorded, processed, summarized and reported within the time periods specified in SEC rules and forms and that such information is accumulated and communicated to management, including its Chief Executive Officer and Chief Financial Officer, to allow timely decisions regarding required disclosures.

Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated, as of the end of the period covered by this Annual Report on Form 10-K, the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act). Based on that evaluation, and as a result of the material weakness described below, our Chief Executive Officer and Chief Financial Officer concluded that, as of December 31, 2022, our disclosure controls and procedures were not effective at the reasonable assurance level.

Notwithstanding our management's conclusion that our disclosure controls and procedures were not effective as of December 31, 2022 due to the material weakness, we believe that our consolidated financial statements included in this Annual Report on Form 10-K present fairly, in all material respects, our financial position and results of operations and cash flows as of each of the dates, and for each of the periods, presented therein in accordance with U.S. GAAP.

Management's Annual Report on Internal Control Over Financial Reporting

Management is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act. A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with GAAP. A company's internal control over financial reporting includes those policies and procedures that (i) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of our assets, (ii) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with GAAP, and that our receipts and expenditures are made only in accordance with authorizations of management and directors, and (iii) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of our assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

Our management, with the participation of our Chief Executive Officer and Chief Financial Officer, evaluated the effectiveness of our internal control over financial reporting as of December 31, 2022 using criteria established in Internal Control – Integrated Framework (2013) issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Based on that evaluation, management concluded that due to the material weakness described below, our internal control over financial reporting was not effective as of December 31, 2022.

A material weakness is a deficiency, or a combination of deficiencies, in internal control over financial reporting, such that there is a reasonable possibility that a material misstatement of the company's annual or interim financial statements will not be prevented or detected on a timely basis.

The effectiveness of our internal control over financial reporting as of December 31, 2022 has been audited by PricewaterhouseCoopers LLP, an independent registered public accounting firm. Refer to "Item 8. Financial Statements and Supplementary Data - Report of Independent Registered Public Accounting Firm" for their audit report.

Material Weakness in Internal Control Over Financial Reporting

A material weakness is a deficiency, or combination of deficiencies, in internal control over financial reporting such that there is a reasonable possibility that a material misstatement of our annual or interim financial statements will not be prevented or detected on a timely basis. Internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements in accordance with U.S. GAAP. In connection with our audit of consolidated financial statements for the year ended December 31, 2021, we identified certain control deficiencies in the design and operation of our internal control over financial reporting that constituted a material weakness.

We did not design and maintain effective controls over certain information technology ("IT") general controls for information systems that are relevant to the preparation of our financial statements. Specifically, we did not design and maintain (i) program change management controls for certain financial systems to ensure that IT program and data changes affecting certain IT applications and underlying accounting records are identified, tested, authorized and implemented appropriately, (ii) user access controls that adequately restrict user and privileged access to certain financial applications, programs and data to appropriate company personnel, and (iii) testing and approval controls for program development to ensure that new software development is aligned with business and IT requirements.

These IT deficiencies did not result in a material misstatement to the financial statements, however, the deficiencies, when aggregated, could impact the effectiveness of IT-dependent controls (such as automated controls that address the risk of material misstatement to one or more assertions, along with the IT controls and underlying data that support the effectiveness of system-generated data and reports) that could result in misstatements potentially impacting all financial statement accounts and disclosures that would not be prevented or detected. Accordingly, management has determined these deficiencies in the aggregate constitute a material weakness.

Remediation Plan for the Material Weakness

In order to address the material weakness in internal control over IT general controls, management has implemented enhanced policies, procedures and related internal controls to ensure business processes achieve the intended control objectives and provide for greater clarity, scalability and sustainability.

In addition, management's actions to remediate the material weakness include automating components of our change management and logical access processes, enhancing privileged access logging and monitoring reviews, and strengthening testing and approval controls for program development and change management to ensure that IT program and data changes affecting financial IT applications and underlying accounting records are identified, tested, authorized and implemented appropriately.

The implementation of these remediation efforts require validation and testing of the design and operating effectiveness of internal controls over a sustained period of financial reporting cycles. The actions that we are taking are subject to ongoing senior management review, as well as Audit Committee oversight. We will not be able to conclude whether the steps we are taking will fully remediate the material weakness in our internal control over financial reporting until we have completed our remediation efforts and subsequent evaluation of their effectiveness. We may also conclude that additional measures may be required to remediate the material weakness in our internal control over financial reporting, which may necessitate additional implementation and evaluation time. We will continue to assess the effectiveness of our internal control over financial reporting and take steps to remediate the known material weakness expeditiously.

Changes in Internal Control over Financial Reporting

We continue to update our design of internal controls to remediate the aforementioned material weakness and enhance our internal control environment. There were no changes in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) during the quarter ended December 31, 2022 that materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

Item 9B. Other Information

[None.]

Item 9C. Disclosure Regarding Foreign Jurisdictions that Prevent Inspections

Not applicable.

PART III

Item 10. Directors, Executive Officers and Corporate Governance

The information required by this item will be included in our definitive proxy statement for our 2023 Annual Meeting of Stockholders, and such information is incorporated herein by reference.

Item 11. Executive Compensation

The information required by this item will be included in our definitive proxy statement for our 2023 Annual Meeting of Stockholders, and such information is incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

The information required by this item will be included in our definitive proxy statement for our 2023 Annual Meeting of Stockholders, and such information is incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence

The information required by this item will be included in our definitive proxy statement for our 2023 Annual Meeting of Stockholders, and such information is incorporated herein by reference.

Item 14. Principal Accountant Fees and Services

The information required by this item will be included in our definitive proxy statement for our 2023 Annual Meeting of Stockholders, and such information is incorporated herein by reference.

PART IV

Item 15. Exhibits and Financial Statement Schedules

(a)(1) Financial Statements.

The financial statements required by this item are listed in Part II, Item 8 – "Financial Statements and Supplementary Data" attached hereto and are filed as part of this Annual Report on Form 10-K.

(a)(2) Financial Statement Schedules.

Schedule I. Condensed Financial Information of Parent Company
As of December 31, 2022 and 2021, and for the years ended December 2022, 2021 and 2020

Other than Schedule I included in Part II, Item 8 – "Financial Statements and Supplementary Data," all financial statement schedules have been omitted because they are not required, are not applicable or the required information is included in the consolidated financial statements or the notes thereto.

(a)(3) Exhibits.

The following is a list of exhibits filed as part of this Annual Report on Form 10-K.

Exhibit Number	Exhibit Description	Incorporated by Reference				Filed/ Furnished Herewith
		Form	File No.	Exhibit	Filing Date	
3.1	Amended and Restated Certificate of Incorporation.	8-K	001-40154	3.1	03/08/21	
3.2	Amended and Restated Bylaws.	8-K	001-40154	3.2	03/08/21	
4.1	Specimen Common Stock Certificate of Oscar Health, Inc.	S-1/A	333-252809	4.1	02/22/21	

4.2	Indenture, dated as of February 3, 2022, between Oscar Health, Inc. and U.S. Bank National Association, as Trustee.	8-K	001-40154	4.1	02/04/22	
4.3	Form of certificate representing the 7.25% Convertible Senior Notes due 2031 (included as Exhibit A to Exhibit 4.2).	8-K	001-40154	4.2	02/04/22	
4.4	Thirteenth Amended and Restated Investors' Rights Agreement, dated as of May 3, 2022, by and among Oscar Health, Inc. and the investors party thereto	10-Q	001-40154	4.2	08/12/22	
4.5	Description of Capital Stock.					*
10.1†	Oscar Health, Inc. Amended and Restated 2012 Stock Plan.	10-Q	001-40154	10.1	05/14/21	
10.2†	Oscar Health, Inc. 2021 Incentive Award Plan.	10-Q	001-40154	10.2	05/14/21	
10.3†	Form of Stock Option Award Agreement under 2021 Incentive Award Plan.	10-Q	001-40154	10.3	05/14/21	
10.4†	Form of Restricted Stock Unit Award Agreement under 2021 Incentive Award Plan.	S-1/A	333-252809	10.13	02/22/21	
10.5†	Form of Founders' Performance Restricted Stock Unit Award Agreement Under 2021 Incentive Award Plan.	S-1/A	333-252809	10.14	02/22/21	
10.6†	Oscar Health, Inc. 2021 Employee Stock Purchase Plan.	10-Q	001-40154	10.6	05/14/21	
10.7†	Oscar Health, Inc. 2022 Employee Inducement Incentive Award Plan	S-8	333-264205	99.1	04/08/22	
10.8†	Form of Restricted Stock Unit Award Agreement under 2022 Incentive Award Plan.					*
10.9†+	Employment Offer Letter, by and between Mulberry Health Inc. and Mario Schlosser, dated November 29, 2012.	S-1	333-252809	10.15	02/05/21	
10.10†+	Employment Agreement, by and between Oscar Health, Inc. (formerly Mulberry Management Corporation) and R. Scott Blackley, dated December 5, 2020.	S-1	333-252809	10.20	02/05/21	
10.11†	Amendment to Employment Agreement, by and between Oscar Health, Inc., Oscar Management Corporation and R. Scott Blackley, dated July 13, 2021.	10-Q	001-40154	10.1	08/13/21	
10.12†	Amendment to Employment Agreement, by and between Oscar Health, Inc., Oscar Management Corporation and R. Scott Blackley, dated November 8, 2022	10-Q	001-40154	10.2	11/09/22	
10.13†	Employment Agreement, by and between Oscar Health, Inc., Oscar Management Corporation (formerly Mulberry Management Corporation) and Alessandrea Quane, in effect as of March 1, 2021.	10-K	001-40154	10.11	02/25/22	
10.14†+	Letter Agreement, by and between Oscar Insurance Corporation, Oscar Health, Inc. (formerly Mulberry Health Inc.), and Siddhartha Sankaran, dated August 6, 2020.	10-K	001-40154	10.12	02/25/22	
10.15†	Amendment to Stock Option and Letter Agreement, by and between Oscar Health, Inc. and Siddhartha Sankaran, dated March 5, 2021.	10-K	001-40154	10.13	02/25/22	
10.16†	Letter Agreement, by and between Oscar Management Corporation and Siddhartha Sankaran, dated November 8, 2022	10-Q	001-40154	10.1	11/09/22	
10.17†	Employment Agreement, by and among Oscar Health, Inc., Oscar Management Corporation and Ranmali Bopitiya, effective January 31, 2022					*

10.18†	Consulting Agreement, by and between Oscar Health, Inc., Oscar Management Corporation and Dennis Weaver, dated December 19, 2022					*
10.19	Non-Employee Director Compensation Program.	S-1/A	333-252809	10.28	02/22/21	
10.20†	Form of Indemnification Agreement.	S-1	333-252809	10.28	02/05/21	
10.21	Deferred Compensation Plan for Directors.	10-K	001-40154	10.16	02/25/22	
10.22X	Investment Agreement, dated as of January 27, 2022, by and among Oscar Health, Inc. and Oasis FD Holdings, LP., Thrive Capital Partners VII Growth, L.P., Claremount VII Associates, L.P., LionTree Investment Fund, L.P. and Tenere Capital Master Fund, LP.	8-K	001-40154	10.1	01/28/22	
10.23X	Credit Agreement, dated as of February 21, 2021, as amended by the First Amendment to Credit Agreement, dated as of January 27, 2022, by and among Oscar Health, Inc., as borrower, the several lenders from time to time parties thereto, and Wells Fargo Bank, National Association, as administrative agent, among others.	8-K	001-40154	10.2	01/28/22	
21.1	List of Subsidiaries of Oscar Health, Inc.					*
23.1	Consent of PricewaterhouseCoopers LLP, Independent Registered Public Accounting Firm.					*
31.1	Rule 13a-14(a)/15d-14(a) Certification of Chief Executive Officer.					*
31.2	Rule 13a-14(a)/15d-14(a) Certification of Chief Financial Officer.					*
32.1	Section 1350 Certification of Chief Executive Officer.					**
32.2	Section 1350 Certification of Chief Financial Officer.					**
101.INS	Inline XBRL Instance Document - the instance document does not appear in the Interactive Data file because its XBRL tags are embedded within the Inline XBRL document.					*
101.SCH	Inline XBRL Taxonomy Extension Schema Document.					*
101.CAL	Inline XBRL Taxonomy Extension Calculation Linkbase Document.					*
101.DEF	Inline XBRL Taxonomy Extension Definition Linkbase Document.					*
101.LAB	Inline XBRL Taxonomy Extension Label Linkbase Document.					*
101.PRE	Inline XBRL Taxonomy Extension Presentation Linkbase Document.					*
104	Cover Page Interactive Data File (formatted in Inline XBRL and contained in Exhibit 101).					*

* Filed herewith.

** Furnished herewith.

† Indicates management contract or compensatory plan.

+ Certain portions of this exhibit (indicated by "####") have been redacted pursuant to Regulation S-K, Item 601(a)(6).

X Certain schedules (or similar attachments) to this exhibit have been omitted pursuant to Regulation S-K, Item 601(a)(5). The registrant agrees to furnish a copy of any omitted schedule (or similar attachment) to the Securities and Exchange Commission upon request.

Item 16. Form 10-K Summary

None.

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized.

OSCAR HEALTH, INC.

Date: February 23, 2023

By: /s/ Mario Schlosser
Mario Schlosser
Chief Executive Officer
(Principal Executive Officer)

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant in the capacities and on the dates indicated.

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Name	Title	Date
/s/ Mario Schlosser **Mario Schlosser**	Chief Executive Officer and Director *(principal executive officer)*	February 23, 2023
/s/ Siddhartha Sankaran **Siddhartha Sankaran**	Chief Financial Officer and Director *(principal financial officer)*	February 23, 2023
/s/ Victoria Baltrus **Victoria Baltrus**	Chief Accounting Officer *(principal accounting officer)*	February 23, 2023
/s/ Jeffery H. Boyd **Jeffery H. Boyd**	Chairman of the Board and Director	February 23, 2023
/s/ Joshua Kushner **Joshua Kushner**	Vice Chairman of the Board and Director	February 23, 2023
/s/ David Plouffe **David Plouffe**	Director	February 23, 2023
/s/ Elbert O. Robinson, Jr. **Elbert O. Robinson, Jr.**	Director	February 23, 2023
/s/ Laura Lang **Laura Lang**	Director	February 23, 2023
/s/ Vanessa A. Wittman **Vanessa A. Wittman**	Director	February 23, 2023
/s/ William Gassen, III **William Gassen, III**	Director	February 23, 2023

Corporate Information

Stock Listing

Oscar Health, Inc. Class A common stock is traded on the New York Stock Exchange under the ticker OSCR.

Corporate Headquarters

75 Varick Street, 5th Floor
New York, New York 10013

Transfer Agent

American Stock Transfer &
Trust Company, LLC
6201 15th Avenue
Brooklyn, NY 11219

Public Accountant Firm

PricewaterhouseCoopers LLC
300 Madison Avenue
New York, NY 10017

Corporate Website

www.hioscar.com

Investor Relations

www.ir.hioscar.com
ir@hioscar.com

Directors

Jeffery H. Boyd, Chairman of the Board

Joshua Kushner, Vice Chairman of the Board

Mark T. Bertolini

Mario Schlosser

Siddhartha Sankaran

William Gassen III

Laura Lang

David Plouffe

Elbert O. Robinson, Jr.

Vanessa A. Wittman

Executive Officers

Mark T. Bertolini, Chief Executive Officer

Mario Schlosser,
Co-Founder and President of Technology

Joshua Kushner,
Co-Founder and Vice Chairman of the Board

Siddhartha Sankaran, Interim Chief Financial Officer

R. Scott Blackley, Chief Transformation Officer

Ranmali Bopitiya, Chief Legal Officer

Alessandrea Quane, Chief Insurance Officer


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