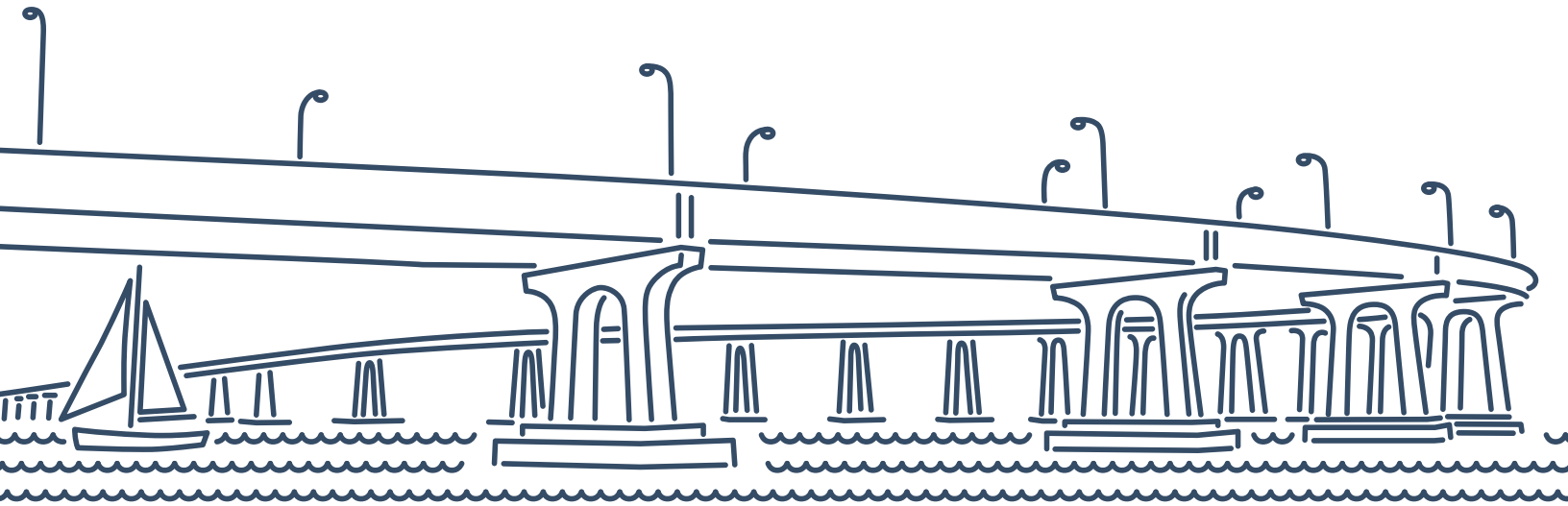
SHARP HEALTH PLAN

Group Administration Manual



Small and Large Group Manual

September 2020

Welcome

Welcome to Sharp Health Plan. We are pleased that you have selected Sharp Health Plan to provide health benefits to your employees. We value your business and strive to offer the highest level of service available in the marketplace.

Sharp Health Plan offers high-quality, personal, economical and convenient medical coverage for your employees and their families. Sharp Health Plan provides for the health care needs of your employees through a network of quality physicians, hospitals and other providers throughout San Diego and southern Riverside counties.

We have prepared this Group Administration Manual to assist you in the administration of Sharp Health Plan coverage. You will find this to be an important reference regarding health plan policies and procedures. This manual has been written with the Employer Group in mind. Your employees are provided with Member Handbooks (also called Evidence of Coverage) that similarly assist them in understanding their health plan benefits and policies.

Another resource is your Group Agreement, which constitutes the legal and contractual agreement between Sharp Health Plan and the Employer Group and lists any special agreements. A Group Agreement is provided to you upon the initial enrollment of the Group and during each subsequent renewal period.

In the event of any discrepancies between the Group Administration Manual and the Group Agreement, the Group Agreement will govern in all cases.

A dedicated Account Manager for you

Each Employer Group has its own Account Manager. Your Account Manager is able to provide you with personalized service and timely updates when you need it.

Personalized Customer Care team for your employees

Customer Care Representatives are available to provide personalized assistance and education for your employees. Members who need assistance should always contact the Customer Care team first. Customer Care Representatives are available from 8 a.m. to 6 p.m., Monday through Friday, toll-free at 1-800-359-2002. This phone number is also referenced on Member ID cards.

Mission statement

As a locally owned and operated health plan, our mission is to ensure that the health care services rendered to our enrollees are always appropriate, of high quality, meet or exceed community standards and are provided in a caring, convenient, cost-effective and accessible manner.

To accomplish our mission and be recognized as a leader in the San Diego managed care field, our commitments are to:

- Contribute to the integration of the Sharp HealthCare system;
- Create partnerships with employers, Members and physicians;
- Be responsive and sensitive to local needs and an active participant in the San Diego community; and
- Be proactive in promoting and improving the health status of our Members.

How to use this manual

The purpose of this manual is to help simplify the process of administering your Sharp Health Plan benefits program.

Using the table of contents

The table of contents lists each section by its title, then lists each subcategory within that section. Each section contains information on a specific procedure that you may encounter. Detailed instructions are included along with sample forms where applicable.

Using the tabs

Each tab represents a major category under which specific procedures are listed.

Using the sample forms and instructions

We have also included a sample of each of the most commonly used forms.

Updating your Group Administration Manual

Please keep this manual handy, as we update pages and sections as necessary. As you receive these updates, please be sure to remove any old pages.

Storing your current Group Agreement and rates

For convenience and ease of reference, we suggest that you store a copy of your fully executed Group Agreement and a copy of your Group's current rates behind the appropriate tabs provided in this manual.

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In this tab, you'll find copies of the most commonly used forms and instructions for their use.

SECTION 1
Enrollment and cancellation procedures

In this section, you will find information about:

Eligibility

New employees

To be eligible to enroll as a Member under Sharp Health Plan, an employee must:

- Be a full-time, active employee and satisfy the minimum hours per week requirement as defined in the Group Agreement.
- Have completed the waiting period defined by your employer.
  - Waiting periods are applied to:
    1. New full-time employees
    2. Employee status changes from part-time to full-time
    3. Rehired employees, unless otherwise defined by the Group Agreement
  - Sample waiting period calculation:
    4. Group waiting period is 90 days
    5. Employee hire date is May 3
    6. Waiting period will be completed on August 3 and
    7. Effective date of coverage for employee is September 1 (first day of following month)
- Work or reside within the Service Area of San Diego County and southern Riverside County for at least nine out of every 12 consecutive months.
- Satisfy all eligibility requirements as defined in your Group Agreement.
- Elect health care coverage through Sharp Health Plan by submitting eligibility details through a form approved by Sharp Health Plan within 31 days of the eligibility effective date.
- Never have had coverage terminated for cause by Sharp Health Plan.

Each enrollee should be provided an enrollment kit. Please contact your Account Manager for a supply of these kits.

Important reminder

Please send new enrollment notifications as they occur. Timely notification of enrollment changes will help Sharp Health Plan serve Members in the following ways:

- Member eligibility will be visible to providers.
- Members will be able to access care on their effective dates.
- Billing adjustments will be processed and appear sooner.
- Members will receive their Member identification cards in a timely manner.

Eligibility changes can only be made for qualifying events (e.g., marriage, birth). In these cases, coverage becomes effective the first day of the month after the qualifying event.

Rehired employees

Employees who have been rehired will be subject to the rehire waiting period as defined by the employer.

Dependents

A Dependent's eligibility for enrollment is contingent upon the Subscriber's eligibility for membership in Sharp Health Plan. Eligible Dependents include:

- The Spouse or Domestic Partner of an Enrolled Employee;
- The Dependent child of an Enrolled Employee or the Enrolled Employee's Spouse, who is either:
  - Under age 26; or
  - Who at the time of attaining age 26 is incapable of self-sustaining employment by reason of a physically or mentally disabling injury illness or condition and is chiefly dependent upon the Enrolled Employee for support and maintenance. Proof of incapacity and dependence must be furnished to Sharp Health Plan by the Enrolled Employee as outlined in the Group Agreement.
  - Any other person under age 26 for whom the Enrolled Employee or the Enrolled Employee's Spouse is (or was before the person's 18th birthday) the court-appointed guardian. The Plan may require the Eligible Employee to furnish evidence, on a periodic basis, of the IRS status, residency or guardianship of such person.

NOTE: An adult Dependent child enrolled in a grandfathered plan is only eligible for coverage as a Dependent with Sharp Health Plan if the adult child is not eligible for his or her own employer-sponsored coverage. A grandfathered plan is a health benefit plan that was in existence on March 23, 2010, and continuously covered someone in that same plan since that date.

Enrollment

Open Enrollment

Open Enrollment is generally held in the month preceding the effective date of your contract renewal. This is the time Eligible Employees may:

- Choose to enroll in Sharp Health Plan
- Add or delete family members to their coverage

As an Employer Group, you may also make changes to the current plan design (e.g., adding or deleting benefits, changing employer contributions, etc.) during this renewal period. Any changes made during Open Enrollment become effective on the renewal date.

To make Open Enrollment easier, your Account Manager is available to assist you, both in English and Spanish, by organizing the following activities:

- Presentation of benefits to employees
- On-site question and answer sessions
- Notices for distribution to employees
- Sharp Health Plan benefits comparison assistance
- Providing an efficient way to submit multiple eligibility changes

Regardless of how your company decides to communicate Open Enrollment information, Sharp Health Plan is available to assist you in giving your employees the opportunity to make an educated choice of health plans.

Initial enrollment

All newly Eligible Employees should be provided an enrollment kit at least 31 days prior to their effective date of coverage. If additional enrollment materials are needed, please contact your Sharp Health Plan Account Manager to request additional supplies.

Enrolling newly eligible Members and Dependents

Eligible Employees who wish to enroll themselves and their Dependents in Sharp Health Plan must complete, sign and date the Enrollment Application from one of Sharp Health Plan's approved Enrollment forms.

Approved forms for accepting Sharp Health Plan Enrollment records include 1) an Enrollment Application form, which will need to be signed and dated by the applicant or 2) an approved digital layout where the Group may submit multiple Eligible Employee Enrollment requests in bulk. For more information on a digital approach to Enrolling Eligible Members and Dependents, please contact your dedicated Account Manager.

- Please submit all completed forms to Sharp Health Plan. To avoid unnecessary delays in processing enrollment forms, please ensure that the Enrollment Application form and all forms are fully completed and include all of the following information: Group Information Plan Information Effective Date and Reason for Application (e.g., hire date or rehire)
- All required Employee-specific information, including:
  - Primary Care Physician (PCP) selection for Employee and any enrolling Dependents if Member has elected one (PCP may be different for each Member)
  - Dependent coverage selection and information
  - Employee signature in signature section at the bottom of the form if using the Enrollment Application form

Important reminder

Completed enrollment forms should be sent immediately to: SHPEnrollmentGeneralMail@sharp.com with a copy to your dedicated Account Manager. NOTE: Please keep a copy for your records.

A supply of Enrollment Application forms and enrollment kits can be requested from your Account Manager.

Adding Dependents to coverage

Newborns

The newborn child of a Subscriber is automatically covered for the first 31 days from the date of the newborn's birth. To continue coverage beyond the initial 31-day period, an Enrollment Application for the newborn child must be submitted to Sharp Health Plan within the initial 31-day period following birth. A birth certificate may be required as proof of Dependent status. If applicable, Sharp Health Plan may coordinate the cost of care if the newborn is also covered by another health insurance carrier.

Premium charges for a newborn will be as follows:

- The Member has 31 days from the newborn's date of birth to decide if they will add the newborn to their coverage. Once the newborn is added, their coverage is effective either as of their date of birth (DOB) or on the first of the month following their DOB, either way, coverage for the newborn is billed

the month following their DOB. (Typically, coverage for the newborn is effective as of their DOB if they are enrolling under the mother's plan, and typically, coverage for the newborn is effective on the first of the month following their DOB when enrolling on the Spouse's plan.)

- The newborn is covered automatically under the mother's plan for the first 31 days.
- If the Member wishes to add their newborn or adopted child to their coverage for more than the initial 31 calendar days, they must complete and submit an Enrollment Change form to their employer within the 31-day period following the birth or legal adoption. A Subscriber must complete an Enrollment Application for a newborn even if the Subscriber currently has Dependent coverage and the coverage does not require payment of any additional premiums.

Adoptees and legal custodians

Coverage for adopted children or children who have been placed in the legal custody of the Subscriber begins from the date physical custody of the child is obtained by the Subscriber as long as coverage for the child's medical expenses is not provided by a public or private agency or entity. The Dependent must be enrolled in Sharp Health Plan within 31 days of placement or adoption. Coverage is effective on the date that the adopted child's birth parent(s) or other appropriate legal authority provides a signed copy of one of the following:

- A health facility minor release report.
- A medical authorization form or relinquishment form that grants the Subscriber the right to control the health care of the adopted child.

In the absence of one of the documents listed above, coverage begins on the date that satisfactory evidence of the Subscriber's right to control the health care of the child exists.

Late enrollment

Employees or their Dependents initially eligible for enrollment who do not enroll during an Open Enrollment period or within 31 days* of first becoming eligible may enroll during the next Open Enrollment period.

If an employee or Dependent suffers an involuntary loss of other medical coverage, late enrollment is accepted if submitted within 30 days of loss of coverage. In this case, Sharp Health Plan requires proof of loss of coverage (e.g., letter from insurance carrier). Coverage would be effective the first day of the month following the loss of other medical coverage.

* For small-Group business (1-100 employees) the time frame may be 60 days.

Waiving coverage

Employees waiving coverage should complete the Enrollment Application, mark Decline Coverage in the "Reason for Application" section, and sign and date the bottom of the form. It is advised to keep a copy of signed forms on file for reference as needed.

Cancellation

Canceling employee and Dependent coverage

Sharp Health Plan will terminate coverage for your employee and/or their Dependents upon directive from you (the designated Benefits Coordinator). Any change that occurs after the initial enrollment must be submitted to Sharp Health Plan within 30 days of the change using the Enrollment Application form. Your Group will continue to be liable for premiums during the period between loss of eligibility and receipt of this notice by Sharp Health Plan. Sharp Health Plan will not terminate a Member's coverage retroactively for any period during which your Group has collected the Member's share toward Premiums. Your Group is responsible for ensuring that the Member has not paid the Member's share of Premiums before notifying Sharp Health Plan of any retroactive terminations.

Employee

Coverage for an Employee may be terminated for any of the following reasons:

- Employment has ended
- Employee has a reduction in hours resulting in loss of eligibility
- Employee voluntarily requests to terminate coverage
- Employee takes a leave of absence (Sharp Health Plan will allow an employee to retain coverage upon your Group leave of absence policy.)

Termination date of benefits is always the last day of the last month the employee was eligible (e.g., employee terminates employment June 3, health coverage ends June 30).

Spouses

Coverage for a Spouse of a Member may be terminated for any of the following:

- An employee voluntarily requests coverage to be terminated
- A divorce decree has been finalized
- The Spouse no longer resides or works in the Sharp Health Plan Service Area

Dependent children

Coverage for a Dependent child of a Member may be terminated for any of the following:

- An employee voluntarily requests coverage to be terminated
- The Dependent child no longer resides or works in the Sharp Health Plan Service Area, unless there is a standing health coverage court order
- The Dependent child reaches the maximum Dependent age as defined by the Group Agreement or ceases to meet other Dependent eligibility requirements

Canceling coverage for cause

A Member's eligibility in Sharp Health Plan ends when your Group policy coverage ends. However, individual membership may be terminated by Sharp Health Plan for any of the following reasons:

- Member commits an act of fraud or intentional misrepresentation of material fact to circumvent state or federal laws or the policies of the Plan, such as providing materially incomplete or incorrect enrollment or required updated information deliberately, including, but not limited to, incomplete or incorrect information regarding date of hire, date of birth, relationship to Enrolled Employee or Dependent, place of residence, other Group health insurance or workers' compensation benefits, disability or student status.
- Member allows someone else to use their Member ID card.
- If a Dependent is the sole offending party for any occurrence outlined above, then the Plan may terminate only the offending Dependent's coverage, and coverage for the remaining Members in the family unit will remain effective.

If membership is terminated, the Member will be notified in writing and will be informed of the termination date. If eligibility is lost due to fraud or deception, Sharp Health Plan may recover from the Member the charges paid by Sharp Health Plan for covered services provided to the Member, plus Sharp Health Plan's cost for recovering those charges, including fees for legal counsel.

A Member may file a grievance disputing the cancellation of coverage, as described in the "What is the grievance process?" section of the Member Handbook, within 180 working days after receiving notice that Sharp Health Plan has terminated or will terminate coverage for cause.

Under no circumstances will membership be terminated due to health status or need for health care services. If a Member believes coverage was terminated or not renewed because of health status, the Member may request a review of cancellation by the Department of Managed Health Care.

Terminating Group coverage

Your Group policy may be terminated by Sharp Health Plan under any of the following circumstances:

1. **The Group no longer meets the qualification requirements of Sharp Health Plan.**
    - If this occurs, Sharp Health Plan will notify you in writing and explain the disqualifying event(s), the date of termination and the final date of coverage. The Enrolled Employees and Dependents of your Group policy will be disenrolled within 15 days of your notification date.
2. **The Group fails to pay any amount due to Sharp Health Plan by the due date.** The Group policy is subject to termination if the Premium is not paid by that date.
    - Your Group may be eligible for reinstatement. Please contact your Account Manager to confirm your eligibility for reinstatement. If eligible, your Group will be required to pay all past due premiums to Sharp Health Plan within 15 days of being terminated.
    - If your Group wishes to reinstate coverage after the 15-day period, you must apply for coverage as a new Group. Sharp Health Plan may accept or reject such application at its sole discretion. Sharp Health Plan will reinstate the Group only once during any 12-month period.
3. **Your Group notifies Sharp Health Plan in writing of the intent to terminate coverage** at least 31 calendar days prior to the requested termination date. NOTE: As per California law (Health and Safety Code Section 1365), Sharp Health Plan is not permitted to retroactively terminate your Group for nonpayment of premium. Therefore, if your Group does not notify Sharp Health Plan of its intent to terminate coverage before the 25th day of the month before the coverage month

begins, your Group will be responsible for payment for that coverage month. Example: Payment for April coverage is due on March 25. Your Group asked Sharp Health Plan for a one-day extension to submit payment but then decided not to continue coverage. Your Group notifies Sharp Health Plan on April 2 of its decision and asks for coverage to be terminated retroactively to March 31. Since the April coverage month has already begun, Sharp Health Plan is required by law to continue coverage until April 30, and your Group will be responsible for payment of the full April premium.

4. **Your Group engages in fraud or deception** in the use of services or facilities of Sharp Health Plan, or knowingly permits another to engage in fraud or deception. Sharp Health Plan may terminate your Group policy immediately upon written notification of termination to your Group.

SECTION 2
Membership changes

In this section, you will find information about:

Membership changes

Change of Member's personal information

All Member name, address and Social Security Number changes should be reported to Sharp Health Plan as soon as possible. Your Employees can do this online at sharphealthplan.com or by submitting one of Sharp Health Plan's approved Enrollment forms. A permanent address change outside of the Sharp Health Plan Service Area terminates coverage for a Subscriber and/or eligible Dependent(s) 31 days following the change of address.

However, if the Subscriber or Dependent is working in the Service Area or there is a standing health coverage court order for a Dependent, the Subscriber or Dependent may remain eligible.

Change of Primary Care Physician

Your Employees may change their Primary Care Physician (PCP) online at sharphealthplan.com or by contacting our Customer Care Department. In most cases, Sharp Health Plan will change the Member's PCP effective the first day of the following month. Changes are subject to the following:

- A participating Sharp Health Plan physician must be selected.
- Members may change their PCP up to once per month.

Military reserve change of status

Active duty status is considered a qualifying COBRA event under USERRA provisions (Uniformed Services Employment and Reemployment Rights Act of 1994), so the Subscriber may elect to continue Group coverage. When the Subscriber returns to full-time employment, they are eligible to re-enroll for coverage without a waiting period.

SECTION 3
Member information

In this section, you will find information about:

Member information

Customer Care

Customer Care is designed to provide information and assistance to all Sharp Health Plan Members. The Customer Care Department telephone number is 1-800-359-2002. Our Customer Care Representatives are available Monday through Friday from 8 a.m. to 6 p.m. to answer any questions our Members have. Additionally, after hours and on weekends, Members have access to a specially trained registered nurse for immediate medical advice by calling the same Customer Care phone number. Email customer.service@sharp.com to contact Customer Care through email.

The following information and assistance is available from our Customer Care team:

- Eligibility and Benefit information
- Physician network updates and information
- Claim inquiries
- Sharp Health Plan policies and procedures
- Appeal and grievance procedures
- Group coverage information
- Primary Care Physician changes
- Language interpretation
- ID card replacement
- Sharp Connect inquiries
- Member information

Sharp Health Plan Member ID card

Sharp Health Plan Member ID cards are provided to all Members. The ID card contains the following information:

1. Member's Name
2. Member's Date of Birth
3. Member's Effective Date of Coverage
4. Member's ID Number
5. Member's Account Name
6. Member's Account Number
7. Member's Primary Care Physician (PCP)
8. Primary Care Physician's Phone Number
9. Medical Group of PCP
10. Plan Network
11. Deductible Amount
12. Cost Share for the following:

    PCP – Doctor Office Visit Copayment
    Specialist – Specialist Office Visit Copayment
    Hospital – Hospital Visit Copayment
    Urgent Care – Urgent Care Copayment
    ER – Emergency Room Copayment

The back of the ID card includes important information on how to use and access Plan providers and emergency services, and lists important telephone numbers.

Copayments

When a Member accesses care, Copayments are required at the time of service. The Copayments applicable to your Group are described in your Group Agreement. To protect Members from large out-of-pocket expenses, a limit called the Annual Maximum Copayment is placed on the dollar amount of Copayments a Member might have to pay during a calendar year. This maximum does not apply to supplemental benefits such as chiropractic services, assisted reproductive technologies or vision care.*

*Excludes Pediatric Dental for small-Group business.

A Member who refuses to pay a required Copayment may have coverage terminated at the discretion of Sharp Health Plan. In this case, charges for Covered Health Benefits may become the financial responsibility of the Member.

Claims information

All Providers contracted with the Plan are to bill Sharp Health Plan (or their contracted Medical Group) directly for covered benefits provided to Members. Members are not responsible for paying for covered benefits (except for Copayments and applicable deductibles and co-insurance amounts) unless a Member fails to obtain required prior authorization when required, for non-Emergency services, or has agreed in advance to pay for non-Covered benefits.

A Member may receive a bill under certain circumstances as follows:

- When a Member does not present a Sharp Health Plan ID card upon receiving care.
- When lab specimens and X-rays become separated from the HMO insurance information.
- When out-of-area medical care is provided.

If a Member receives a bill for a covered service, even though the Copayment was already paid, the most common reasons are:

- The Provider's files do not show that the Member is with Sharp Health Plan.
- The Provider is keeping the Member informed while they bill Sharp Health Plan.

A Member who receives a bill should call the physician's office number, which should be listed on the statement, and advise them that they are a Member of Sharp Health Plan. The Member should allow up to 90 days for the Provider to send the bill to Sharp Health Plan and for the claim to be processed and paid. If a Member receives a "final" bill or collection notice, the Member should immediately contact Sharp Health Plan's Customer Care Department at 1-800-359-2002. The Customer Care Department will advise the provider of the Member's insurance information and direct him/her to withdraw the account from collections.

Members who pay for services that should have been covered by the Plan can submit these charges for reimbursement via the Member reimbursement process. The completed form and all required documentation outlined on the form must be submitted within 180 days from the date of service to:

Sharp Health Plan
Attention: Claims Research
8520 Tech Way, Suite 200
San Diego, CA 92123-1450

Access to care for standard benefits

Access to care for standard benefits

Sharp Health Plan is a Health Maintenance Organization (HMO). In an HMO, Members have access to a network of medical providers for their health care. Sharp Health Plan has several physician Groups called Plan Medical Groups (PMGs) consisting of primary care and specialty physicians, and also contracts directly with physicians. Each Member selects a Primary Care Physician (PCP) from the Plan's Provider Directory. Subscribers and Dependents may select different PCPs.

The Member's PCP directs and arranges for all health care services. The Member's PCP will assess the Member's medical condition(s) that may require specialty care. If specialty care or hospitalization is required, the Member's PCP will coordinate services through their affiliated PMG network and/or with Sharp Health Plan.

Physicians within a PMG work together and are familiar with each other's practices and specialties. This ensures that the Member receives care from physicians who work together to develop an appropriate treatment plan. Only when the Member's PMG determines that it cannot provide the necessary specialty care will the Member be referred outside the PMG network. Any referral outside of a Member's PMG requires the approval of Sharp Health Plan and/or the PMG.

Referrals

It is very important that Members understand the physician referral process within their PMG. If the following guidelines are not adhered to, the Member may become financially responsible for medical care.

1. The Member must have a referral from their PCP for specialty services or services rendered other than through their PCP. Please note that some specialty services do not require a referral, such as OB/GYN services for women within their PMG, behavioral health services and supplemental benefit services (if applicable) such as chiropractic services, chemical dependency and vision services.
2. When the Member receives a referral from the PCP, the first visit must occur within 60 days from the date of the referral.
3. All referral visits must be completed within the time frame indicated by the PCP on the referral form. If referral visits are not completed, the Member must obtain a new referral from the PCP.
4. The Member must be referred to a participating provider unless the PCP has received authorization from Sharp Health Plan or the PMG to refer the Member elsewhere. All authorizations must be approved in advance, and all referrals and continuations of referrals must be coordinated through the PCP.
5. Referrals are valid only for the services specified. For example, if a referral states "consultation only" and a Member receives consultation and treatment, the Member may be responsible for payment associated with the treatment. All referral forms should be read carefully. A Member should consult with their PCP prior to obtaining services if a referral form is not issued to the patient.

6. If a Member changes a PCP while under the care of a specialist, all previous referrals become void. The Member must consult their new PCP to determine if additional referrals are Medically Necessary.
7. The PCP is responsible for notifying the Member of the status of a referral. Should the PCP's office fail to contact the Member, the Member should contact the PCP's office to follow up.

Emergency care

In an emergency, Members should call 911 or go to the nearest hospital emergency room.

An emergency room Copayment is due at the time of the visit, unless the visit results in a hospital admission. In this case, the emergency room Copayment is waived and any inpatient hospital Copayment will apply.

Emergency follow-up care

Members should not return to a hospital emergency room for follow-up care unless it is a new medical emergency or a Member is specifically instructed to do so by their PCP.

If these guidelines are not followed, charges for medical services may become the Member's responsibility.

Urgent care

Unforeseen injuries or acute illnesses that require immediate attention but are not life-threatening are considered urgent care situations. When an urgent care situation occurs, the Member must call their PCP for a referral prior to an urgent care visit except for situations that could jeopardize the Member's life or permanent health status.

An Urgent Care Copayment is due at the time of the visit.

Hospital services

Inpatient and outpatient hospital services are covered when provided by a Plan hospital (or other hospital in connection with Emergency Services) and authorized by Sharp Health Plan. A Copayment may be applicable, as defined by the Group Agreement.

Non-Emergency hospital services are covered if arranged by a Plan Physician and includes semi-private room and board (a private room when Medically Necessary), general nursing care (special duty nursing when Medically Necessary), and related services, facilities and supplies associated with a hospital admission.

Behavioral health

Sharp Health Plan provides coverage for the diagnosis and Medically Necessary treatment of mental illnesses, including, but not limited to Severe Mental Illnesses in Members of any age and Serious Emotional Disturbances in children.

Severe Mental Illnesses include: schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive development disorder, autism, anorexia nervosa and bulimia nervosa.

Serious Emotional Disturbance (SED) means one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and other pervasive developmental disorders

not otherwise specified (including Atypical Autism), in accordance with Diagnostic and Statistical Manual for Mental Disorders–IV-Text revisions (June 2000), other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. One or more of the following must also be true:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either of the following occurs:
   - The child is at risk of removal from the home or has already been removed from the home; or
   - The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year if not treated; or
2. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or
3. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Behavioral health benefits include inpatient hospital services, partial hospital services and outpatient services when ordered and performed by a participating behavioral health professional. Members may also have coverage for treatment of other behavioral health conditions. Please see your Group's Health Plan Benefits and Coverage Matrix and Supplemental Benefits for detailed descriptions.

Members have direct access to Plan Providers of behavioral health services without obtaining a Primary Care Physician referral. Covered behavioral health benefits must be obtained through Plan Providers. Behavioral health services that are not provided by Plan Providers are not covered, and the Member will be responsible to pay for those services.

Members should call our Customer Care Department at 1-800-359-2002 whenever they need behavioral health services. All calls are confidential.

*For grandfathered Groups, please refer to your plan summary of benefit for coverage details.

Grievances and appeals

What is the grievance process?

If Members are having problems with a Plan Provider or our health plan, we encourage them to give us a chance to help. Sharp Health Plan can assist in working out any issues. If Members ever have a question or concern, they can call our Customer Care Department toll-free at 1-800-359-2002 and a Customer Care Representative will make every effort to assist them.

Members may file a grievance with the Plan within 180 calendar days of the incident or action that is the subject of the Member's dissatisfaction. To begin the grievance process, Members can call toll-free, write or fax the Plan at:

Sharp Health Plan
Appeals and Grievances Department
8520 Tech Way, Suite 200
San Diego, CA 92123-1450

Toll-free: 1-800-359-2002
Fax: 1-619-740-8572

If Members prefer to send a written grievance, they can send a detailed letter describing the grievance or complete a Grievance Form, which is available on the Plan's website at sharphealthplan.com/grievance, from any Plan Provider or directly from a Plan representative. Members may also call our Customer Care Department, and we will assist them in completing the form over the telephone.

Please refer to the Member Handbook (included with this Group Administration Manual) for more detailed information about the Plan's grievance process, including a description of all the resources available to Members who have a grievance or appeal with the Plan.

Coordinating benefits

Coordinating benefits

If a Subscriber or enrolled Dependent is covered by both Sharp Health Plan and another health plan, Sharp Health Plan will coordinate benefits between the two plans. The goal of this kind of coordination is to maximize coverage for allowable expenses, minimize out-of-pocket costs and prevent any payment duplication. Total payment from all coverage should never exceed 100% of the allowable expenses.

Sharp Health Plan coordinates benefits in accordance with the National Association of Insurance Commissioners' guidelines and California law. So that proper coordination is ensured, Subscribers must inform Sharp Health Plan of any other health coverage for which they or their enrolled Dependents may be eligible. If Sharp Health Plan pays out more benefits than appropriate, it may choose to recover any excess payment from the Subscriber, the plan with primary responsibility, or any other person or entity that benefited from the overpayment.

Order of determination

Certain rules are used to determine which of the plans will pay benefits first. The following rules will be applied in the order given below:

1. A plan with no Coordination of Benefits (COB) provision will determine its benefits before a plan with a COB provision.
2. A plan that covers a person as a Subscriber, rather than as a Dependent, will determine its benefits first.
3. When a claim is made for a covered Dependent child who is covered by more than one plan, the method of determining the order of benefits is known as the "Birthday Rule." Benefits are paid under the Birthday Rule as follows:

The plan of the parent whose birthday falls earlier in the year pays first as the "primary payor." The year in which the parents were born is not a determining factor. If both parents have the same birthday, the plan that covered the parent longer will pay first as the primary payor.

Coordinating with Medicare

Subscribers will also need to advise Sharp Health Plan if they are eligible for Medicare benefits. Under certain circumstances, Sharp Health Plan may reduce its coverage to avoid duplication of benefits available from Medicare.

If the Group employs 20 or more employees and the Subscriber is actively at work, Sharp Health Plan will be the primary payor for End Stage Renal Disease (ESRD) services for a Medicare-eligible Member for the first 12 consecutive months that the Member is enrolled in Sharp Health Plan.

If the Group employs 100 or more employees, Sharp Health Plan will be the primary payor of Covered Health benefits provided to a Totally Disabled Member enrolled with Medicare for that disability as required by Medicare laws and regulations. Medicare will be the secondary payor of Covered Health benefits while the Subscriber remains employed by the Employer Group and the Totally Disabled Member is covered by Sharp Health Plan.

It should be noted that failure to cooperate with Sharp Health Plan in its efforts to coordinate benefits could result in termination of membership. If Members have any questions about benefit coordination, they should call the Customer Care Department.

Pharmaceutical benefits

Outpatient prescription drug benefit

Prescription drugs are covered if all of the following are met:

- They are prescribed as Medically Necessary by a Sharp Health Plan provider;
- They are included on the Sharp Health Plan drug formulary, or you have a 3-tier pharmacy rider allowing coverage for non-formulary medications; and
- They are purchased at a Plan pharmacy.

Please refer to your Group Agreement for prescription benefit coverage.

Drug formulary

Sharp Health Plan physicians use a comprehensive drug formulary. All medications on this broad list of drugs are reviewed and approved by Sharp Health Plan physicians and clinical pharmacists for use by Members. The Sharp Health Plan formulary includes brand-name and FDA-approved generic drugs. By purchasing generic drugs, Sharp Health Plan receives a quantity discount on a single drug instead of paying higher prices on small quantities of several different brands of the same drug. These savings help Sharp Health Plan keep the cost of medical care under control and maintain lower premiums for employers and employees.

In most cases, generic drugs will be prescribed unless a drug is specifically listed in the Sharp Health Plan drug formulary as “dispense brand name only.” Plan pharmacies will contact the prescribing Plan physician when a non-Covered drug has been prescribed in an effort to obtain an equivalent medication that is covered by Sharp Health Plan.

Members must obtain all covered prescription drugs through the Plan pharmacies listed in the Provider Directory.

Prescription drug copayments

Members pay a series of Copayments based on the appropriate tier and pharmacy benefit. The prescription drug Copayment is listed in the Member materials.

Maintenance drug mail-order service

Members can also have a prescription for Maintenance Drugs filled through the mail. This service saves Members time and money. Members can receive up to a 90-day supply of an approved formulary Maintenance Drug for a reduced copay. In other words, Members pay two Copayment(s) for a 90-day supply of a Maintenance Drug filled through the Mail-Order Service. Refer to your Group Agreement for pharmacy plan coverage information. For a list of the medications available through the Mail-Order Service, please go to our website at sharphealthplan.com.

Accessing the prescription drug benefit without a Member ID card

As a general rule, Members should always present their Member ID card to the pharmacy at the time a prescription is filled. In the event a Member has lost their Member ID card or not yet received an ID card and needs to access the prescription drug benefits, they should call the Customer Care Department for assistance. Our Customer Care Department will call the Plan pharmacist to verify eligibility or update the pharmacist's eligibility records online.

Chemical dependency services

Sharp Health Plan provides coverage to all Members for short-term acute drug or alcohol detoxification as an Emergency Medical Condition. Members have access to local facilities, supported by a wide variety of highly trained health care professionals such as psychiatrists, psychologists, clinical social workers and counselors.

To access chemical dependency services, Members may call Sharp Health Plan's Customer Care Department at 1-800-359-2002 for assistance. All calls are confidential.

Supplemental benefits

The following supplemental benefits may be applicable if you purchased the benefit riders described below. Refer to your Group Agreement to determine which supplemental benefits apply.

Chiropractic and acupuncture services

If you have purchased coverage for chiropractic and/or acupuncture services for your employees, all services will be provided through American Specialty Health Plans (ASHP). Covered services include office visits and chiropractic appliances.

Members may access their chiropractic benefits directly by calling a participating chiropractor from the American Specialty Health Plan directory or by contacting American Specialty Health Plan directly at 1-800-678-9133. Members may also visit sharphealthplan.com/chiro to find a participating provider.

Vision services*

If you have purchased vision benefits for your employees, all services will be provided through Vision Service Plan (VSP).

VSP has an extensive nationwide network of optometrists and ophthalmologists who provide comprehensive vision care and materials to Members. This supplemental benefit rider is designed to encourage Members to maintain their vision through preventive eye care, including a periodic vision examination. Your Plan may also provide an allowance for lenses, frames and contact lenses.

This is a direct access benefit. For a comprehensive list of providers in your area, please visit the Vision Service Plan website at vsp.com or contact them directly at 1-800-877-7195.

*Excludes pediatric vision for small Groups.

SECTION 4
Continuation of coverage

In this section, you will find information about:

Continuation of coverage

Cal-COBRA – applies to Groups with 2–19 Eligible Employees and Groups with 20+ Eligible Employees who have exhausted their federal COBRA*

California law requires that insurers and HMOs provide continuation coverage that is known as Cal-COBRA.

*You employed fewer than 20 Eligible Employees on at least 50% of your working days during the previous calendar year.

Your obligations

Notify Sharp Health Plan of Certain Qualifying Events:

You must notify Sharp Health Plan in writing within 30 days of an Enrolled Employee's Cal-COBRA Qualifying Event. Qualifying Events include:

- Termination of employment
- Reduction in hours worked

Notify current Cal-COBRA Qualified Beneficiaries of your intent to terminate the Group Service Agreement:

If you terminate the Group Agreement with Sharp Health Plan and replace it with other coverage through another insurance carrier, you must notify all Cal-COBRA Qualified Beneficiaries that they have the ability to choose to continue coverage through the new plan for the balance of their Cal-COBRA coverage. They may not continue coverage under Sharp Health Plan. Sharp Health Plan will provide you, upon request, with the names and last known addresses of enrolled Cal-COBRA Qualified Beneficiaries.

After you notify Sharp Health Plan of an Enrolled Employee's Cal-COBRA Qualifying Event in writing within 30 days of its occurrence, Sharp Health Plan will mail the Member a statement of Cal-COBRA rights and obligations along with the necessary premium information, enrollment forms and instructions regarding Cal-COBRA Continuation Coverage.

If the Qualified Beneficiary chooses to enroll in Cal-COBRA continuation coverage, he or she must apply for coverage within 60 days following the later of (1) the Qualifying Event or (2) the date they received a Cal-COBRA notice from Sharp Health Plan of his or her right to elect coverage or (3) the date that coverage through the employer plan terminated. The Member must mail or deliver the application to:

Sharp Health Plan
Enrollment Department
8520 Tech Way, Suite 200
San Diego, CA 92123-1450

Fax: 858-499-8399
Email: SHPEnrollmentGeneralMail@sharp.com

If the Member fails to apply for Cal-COBRA within 60 days of the event, that Member will be disqualified from receiving Cal-COBRA Continuation Coverage.

Who may choose Cal-COBRA

A Subscriber may choose Cal-COBRA for one or all of the family members who were enrolled at the time of the Qualifying Event. In other words, the Subscriber can elect coverage for the Spouse or one or more Dependent children without being covered under the Cal-COBRA continuation coverage as a Subscriber.

If a child is born or placed for adoption with the former Subscriber during the period of Cal-COBRA coverage, the child would be a Qualified Beneficiary and could be added to the Cal-COBRA policy.

Qualifying Event	**Eligible period of coverage**
Termination of employment	18 months*
Reduction in hours	18 months*
Transfer to an ineligible class	18 months*
Death of an employee	36 months
Divorce or legal separation	36 months
Employee becomes entitled to Medicare	36 months
Dependent child becomes ineligible (e.g., overage)	36 months

Payment for Cal-COBRA

The Member must pay Sharp Health Plan 110% of the applicable Group rate charged for employees and their Dependents.

The Member must remit the first payment within 45 days of submitting the completed enrollment form to Sharp Health Plan. The first payment must cover the period from the last day of prior coverage to the present. There can be no gap between prior coverage and Cal-COBRA continuation coverage.

All subsequent payments must be made by the premium due date listed on the Member's monthly invoice. If payment is not received by the premium due date listed on the Member's monthly invoice, Sharp Health Plan will send a letter warning that coverage may be terminated if payment is not received by Sharp Health Plan.

Changes in benefits under Cal-COBRA coverage

If a Subscriber or any Dependents elect Cal-COBRA coverage, benefits will remain the same as the benefits for active Members of your current Group policy. If you change the benefits provided to active Members enrolled in your current Group policy, benefits will also change for Subscribers and Dependents on COBRA.

COBRA (Consolidated Omnibus Budget Reconciliation Act)

The information presented below provides only a broad overview and is not intended to be legal advice or direction. COBRA contains complex rules and administrative procedures. You can obtain more information regarding COBRA administration from your legal counsel, broker, COBRA administrator or your regional office of the United States Department of Labor.

COBRA is a federal law that requires employers with 20 or more employees to allow employees and their Dependents to continue enrollment in their employer-sponsored health plan upon the occurrence of a Qualifying Event. Sharp Health Plan will make COBRA coverage available to Members who are qualified according to COBRA law. However, Sharp Health Plan does not ensure your organization's full compliance with COBRA law.

Eligibility

COBRA coverage is available to Employees and their Dependents who are covered under the Group plan at the time a Qualifying Event occurs. Members may elect to continue coverage immediately following one of the Qualifying Events listed below in the event that the Qualifying Event causes a loss of coverage.

Qualifying Event	Eligible period of coverage
End of employment	18 months*
Reduction in hours	18 months*
Transfer to an ineligible class	18 months*
Death of an employee	36 months
Divorce or legal separation	36 months
Employee becomes entitled to Medicare	36 months
Dependent child becomes ineligible (e.g., overage)	36 months

*If COBRA coverage was initially effective on or after January 1, 2003, and the eligible period of coverage is less than 36 months, Members may elect to continue coverage through Cal-COBRA for a period up to 36 months from the date that COBRA coverage was originally effective.

Members eligible for continuation coverage must submit a COBRA election form according to your own guidelines along with a Sharp Health Plan enrollment form. Members will have 60 days from notification of COBRA eligibility to make an election. This period is measured from the later of:

- The date the coverage is lost; or
- The date the COBRA election notice is sent.

If the Sharp Health Plan enrollment form identifying COBRA election is not received within the 60 days, the right to elect COBRA continuation coverage will cease.

COBRA billing

Sharp Health Plan offers two billing options. Please refer to the Execution Page of the Group Agreement for further details of your contract with Sharp Health Plan.

- **Premium Bill -** Sharp Health Plan will include COBRA premium dues on your regular billing statement for your Group policy.
- **Direct Bill** - Sharp Health Plan will bill COBRA enrollees directly. The Member will be charged a 2% administrative fee in addition to the standard premium for the direct bill option. For Members receiving an extension of coverage after the initial period because they are disabled, the premium for the additional period will be increased to 150% of the applicable Group rate.

Sharp Health Plan's billing options do not ensure your organization's full compliance with COBRA law.

COBRA notices

The Employer Group is responsible for sending all notices, letters and forms required under COBRA.

However, if you elect Direct COBRA services, Sharp Health Plan will send the following notices or letters to COBRA enrollees on your behalf (all other COBRA notices, letters and forms remain the responsibility of the Employer Group):

- Notice of Termination of COBRA Coverage: Notice sent when COBRA coverage terminates before the end of the maximum coverage period

COBRA benefit changes

If a Subscriber or any Dependents elect COBRA coverage, benefits will remain the same as the benefits for active Members of your Group policy. If benefits provided to active Members of the Group change, benefits will also change for Subscribers and Dependents on COBRA.

SECTION 5
Billing procedures

In this section, you will find information about:

Billing procedures

Monthly billing

Your bill is prepared on the 28th day, two months prior to the coverage month. Payment is due on or before the 25th day of the month before the coverage month as indicated on your statement.

Pay as billed method

You should always use the “pay-as-billed” payment method. This is the most accurate and efficient method for you and Sharp Health Plan. Review your bill report any changes and pay the total amount listed as due. Please do not alter your premium payment to account for changes. Any adjustments that you have made to your account will be reflected on the next billing cycle.

Premium payments

Group Statements are sent the 28th day, two months prior to the coverage month. Payment of the exact statement amount should be remitted to Sharp Health Plan and is due on or before the 25th calendar day of the month prior to the month in which Members are entitled to receive benefits. A past due letter will be sent to you if premiums are not received by the 25th of the month.

For our clients with age banded rates, when an employee enters a new age band midyear, the effective date of the increase in premium will be first of the month following the month of the employee’s birthday. Using the example of an employee with a birthday of September 17, the increase of premium resulting from the employee moving to a new age band would be effective October 1.

Please mail your premium payment to:

Sharp Health Plan
P.O. Box 57248
Los Angeles, CA 90074-7248

Submitting payment

Make your check payable to Sharp Health Plan. Please write your Group number on the face of the check. If you have any questions regarding your billing statement, please contact our billing department at: 1-858-499-8023.

SECTION 6
Forms and supplies

In this section, you will find a copy of the following forms:

- Enrollment / Change Form
- Declaration of Domestic Partnership
- Member Grievance / Appeal Form

SHARP HEALTH PLAN

Employee Enrollment Application

Submit
By Fax (sign and fax both pages): 1-858-499-8399

If you need assistance, we're here to help.
You can email Customer Care at customer.service@sharp.com or call 1-800-359-2002.

Employer use only

Group name:	Group number:	Effective date (MM/DD/YY):

Reason for this application

- ☐ New hire (date of hire) _____
- ☐ Rehire (date of rehire) _____
- ☐ Open enrollment
- ☐ Add dependent coverage (list names below)
- ☐ Delete dependent coverage (list name below)
- ☐ Cal-COBRA
- ☐ COBRA
- ☐ Qualifying event (attach proof)
- ☐ Name change (list change below)
- ☐ Address or phone change (list change below)
- ☐ Primary Care Physician change (list change below)
- ☐ Termination Coverage
  Termination date: _____
  Employer Signature: X_____

Indicate coverage below (check one coverage level)

☐ Employee only ☐ Employee and spouse / domestic partner ☐ Employee and children ☐ Employee and family

Plan and network selection

Plan:	Network: ☐ Choice ☐ Value ☐ Performance ☐ Premier

Employee information

First name:	Last name:	Middle initial:	Sex: ☐ M ☐ F

Social Security number:	Birth date (MM/DD/YY):	Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Registered Domestic Partnership (filed with CA Sec. of State or equivalent agency) ☐ Non-Registered Domestic Partnership (requires employer approval)

Home phone number:	Email address:	Preferred language:

Home address (P.O. Box is not allowed):

City:	State:	ZIP code:

Employment information

Employer's name:	Job title / occupation:	Number of work hours per week:	Are you actively at work? ☐ Yes ☐ No

Primary care information

To find a Sharp Health Plan-affiliated doctor who meets your needs, and their Provider NPI, please visit **sharphealthplan.com/findadoctor** or call Customer Care at 1-800-359-2002.

Primary Care Physician name (if left blank, Sharp Health Plan will assign):	Provider NPI:	Are you an existing patient with this doctor? ☐ Yes ☐ No

Dependent information

Last name, first name, M.I.:	Social Security number:	Birth date (MM/DD/YY):	Sex: M/F	Primary Care Physician (if left blank, Sharp Health Plan will assign):	Existing patient? Yes / No
Spouse:					
Domestic partner:					
Affidavit submitted? ☐ Yes ☐ No					
Child:					
Child:					
Child:					
Child:					

Do any of the dependents listed above have an address that is different from the employee? ☐ Yes ☐ No (If "yes" complete other address below.)

Names and addresses that are different:

Other medical coverage

Do you or your dependents intend to continue other medical or Medicare coverage? ☐ Yes ☐ No If "Yes" complete the following: ☐ Self ☐ Spouse ☐ Dependent

Name of insured:	Dependents enrolled with other medical coverage:	
Name of other Insurance Company:	Group number / Policy number:	Coverage start date (MM/DD/YY):

Disclosures and signatures

Please read the following carefully before signing.

Premier Access Dental

I understand that I am responsible for payment of the required premium and compliance with all of the provisions and conditions of the Disclosure Form / Contract.

I hereby authorize my medical or dental care institution or professional to release to a representative of Premier Access, any personal, privileged or medical records information including but not limited to, my patient records, charts, x-rays, diagnosis histories, billing records, clinical abstracts, or copies of consultations. The information authorized herein may be used for determination of benefits, quality assessment, utilization review, grievance resolution, or investigation or compliance with Premier Access provider agreements or local, state, or federal laws. The authorization is valid for the duration of the coverage.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage. Therefore, Premier Access Insurance Companies will not require that an HIV test be required as a condition of obtaining coverage. In accordance with California Health and Safety Code section 120980, Premier Access Insurance Company complies in all respects with the prohibition against the unauthorized disclosures of an HIV test.

RIGHT OF REIMBURSEMENT: I, on my behalf of my Dependent(s) listed on this Enrollment Application, hereby agree that in the event any dental services provided to me or my Dependent(s) covered by Premier are the primary financial responsibility of another party, because of other dental coverage, I will fully inform Premier and will execute such assignments, liens or other documents which may be necessary to enable Premier to recover the value of services and supplies provided.

NOTICE: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud and may be subject to fines and confinement in prison.

MANDATORY BINDING ARBITRATION: I understand that any dispute or contracting that may arise between me and Premier Access shall be submitted to binding arbitration held in accordance with the commercial arbitration rules of the American Arbitration Association in lieu of a jury or court trial, and that should any dispute arise, neither Premier Access or I may pursue any claims as a plaintiff or class member in any purported class or representative proceeding, and instead must pursue any such claims in an individual capacity. Both Premier Access and I expressly waive any right to initiate or arbitrate a class action against one another relative to any disputes relating to or arising in any way out of my enrollment with Premier Access or its affiliates. The arbitration proceeding will take place in Sacramento, California or, if that location is prohibitive or significantly inconvenient to the parties, at an alternate location selected by the American Arbitration Association.

Sharp Health Plan

ACKNOWLEDGEMENT: I authorize my employer to deduct from my earnings the contribution (if any) required to cover my share of the premium. I certify that I am working at the employer's place of business in permanent employment. For enrollment in Sharp Health Plan, I understand that my dependents and I must live or work in the Plan's service area.

I understand that my employer's application will determine coverage and that there is no coverage unless and until this application and an application made by my employer have been accepted and approved by Sharp Health Plan.

I understand that California law prohibits an HIV test from being required or used by health care plans as a condition of obtaining coverage.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION. PLEASE READ CAREFULLY BEFORE SIGNING BELOW. Sharp Health Plan is authorized to obtain and release medical information in compliance with the Confidentiality of Medical Information Act. Section 56 et seq. of the California Civil Code.

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee or representative of Sharp Health Plan, any and all records pertaining to medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purpose of review, investigation, or evaluation of any application or a claim. I authorize Sharp Health Plan, or agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer, any such medical information obtained if such disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect for 30 months to permit evaluation of this application, or for the term of coverage to allow the processing of claims. A photocopy of this authorization shall be as valid as the original.

MISREPRESENTATION: I have read and understood the provisions outlined within this form. All information I have provided on this form is true and correct. I understand that it is the basis on which coverage may be issued under the plan.

Arbitration Agreement

I represent that all the information supplied in this application is true and complete. I hereby agree to the conditions of enrollment of this application. I understand that any dispute or controversy that may arise regarding the performance, interpretation or breach of the agreement between myself (and/or any enrolled dependent) and Sharp Health Plan, whether arising in contract, tort or otherwise, must be submitted to arbitration in lieu of a jury or court trial if not satisfactorily resolved through Sharp Health Plan's grievance process.

Employee name (please print):	Employee signature: X	Date (MM/DD/YY):

Declination of coverage

I have been notified that I, and/or my eligible dependents, are eligible for enrollment in my employer's health benefits plan. By listing individuals for whom I am declining coverage and signing below, I voluntarily decline to enroll myself and / or those individuals and acknowledge that my decision not elect coverage permits my employer's health benefits plan to impose an exclusion from coverage until open enrollment, should I or these individuals later apply for coverage.

ENTER 1 OR 2 BELOW:
#1 - The individual declining coverage DOES have another employer health benefit plan, Medicare, Medi-Cal, Military,or cross-border coverage.
#2 - The individual declining coverage DOES NOT have one of the coverages listed in #1.

#	Name (Last, First, M.I.):
#	Name (Last, First, M.I.):
#	Name (Last, First, M.I.):

Employee signature: X	Date (MM/DD/YY):

SHARP HEALTH PLAN

Declaration of Domestic Partnership

Purpose

This form is needed to declare your domestic partnership to add your dependent to your plan.

Instructions

This form must be completed in its entirety and submitted along with your enrollment form.

Submit

Please submit the finished form by mail, in person, or fax:

By Mail or In Person:
8520 Tech Way Suite 200
San Diego CA 92123

By Fax:
(858) 499-8246

What happens next

Once completed application and declaration of domestic partnership is submitted, forms will be reviewed for processing.

If you need assistance, we're here to help.

You may contact us email at **shp.commercialsales@sharp.com** or phone at (858) 499-8009. We are available to assist you Monday through Friday, 8 a.m. to 5 p.m.

Declaration

We, (employee-print name) _____ and _____ , each certify and declare that we are domestic partners in accordance to the following criteria:

- Both persons have chosen to share one another's lives in an intimate and committed relationship of mutual caring.
- Neither person is married to someone else nor is a member of another domestic partnership that has not been terminated, dissolved, or adjudged a nullity.
- The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
- Both persons are at least 18 years of age except as follows:
  - A person under 18 years of age who, together with the other proposed Domestic Partner, otherwise meets the requirements for a domestic partnership other than the requirement of being at least 18 years of age, may establish a domestic partnership upon obtaining a court order granting permission to the underage person or persons to establish a domestic partnership.
- Both persons are capable of consenting to the domestic partnership.
- Both file a Declaration of Domestic Partnership with the Secretary of State.

Change in Domestic Partnership

- We have an obligation to notify (employer-print name) _____ if there is any change in our domestic partnership status as attested to in this Declaration that would terminate this Declaration (e.g., due to death of a partner, termination of the relationship, etc.) We will notify (employer-print name) _____ within thirty one (31) days of such change.
- We understand that termination of this coverage (obtained as a result of completion of this Declaration) will be effective on the date the relationship ends, providing coverage had not otherwise terminated due to standard policy provisions.

Acknowledgments

- We understand that a civil action may be brought against one or both of us for any losses (as well as attorney's fees and costs) due to any false statement contained in this Declaration or for failure to notify (employer-print name) _____ of changed circumstances as required in the "Change in Domestic Partnership" section above. I, the undersigned employee, further understand that falsification of information in this Declaration, or failure to notify (employer-print name) _____ , of changed circumstances pursuant to the "Change in Domestic Partnership" section above may lead to disciplinary action against me, including discharge from employment.
- We have provided the information in this Declaration for use by (employer-print name) _____ for the sole purpose of determining our eligibility for certain domestic partner benefits. We understand and agree that (employer-print name) _____ is not legally required to extend any such benefits. We understand that this information provided in this Declaration will be treated as confidential, but will be subject to disclosure; a) upon the express written authorization of the undersigned employee, b) upon request of the insurer or plan administrator, or c) if otherwise required by law.
- We understand that this Declaration may have legal implications relating, for example, to our ownership of property or to taxability of benefits provided, and that before signing this Declaration we should seek competent legal advice concerning such matters.

We affirm, under penalty of perjury, that the statements in this Declaration are true and correct.

Employee signature: X	Date of birth (MM/DD/YYYY): (/ /)	Date (MM/DD/YYYY): (/ /)
Domestic partner signature: X	Date of birth (MM/DD/YYYY): (/ /)	Date (MM/DD/YYYY): (/ /)

Employee & domestic partner home address:		
City:	State:	ZIP code:

SHARP HEALTH PLAN

Member Grievance & Appeal Form

Purpose

The purpose of this form is to ask Sharp Health Plan to initiate the Grievance or Appeals process.

Instructions

1. You may file a Grievance or Appeal with Sharp Health Plan up to 180 calendar days following any incident that is subject to your dissatisfaction. Your request will be acknowledged within 5 calendar days of receipt, and resolved within 30 calendar days.
2. If you feel this request is urgent in nature, please contact customer care at 1-800-359-2002.

   Examples of urgent requests may include:

   - An imminent and serious threat to your health, including but not limited to, severe pain and /or potential loss of life, limb, or major bodily function.
   - A concern related to cancellation, rescission or nonrenewal of coverage.
3. Briefly outline the specific details of the problem and identify when the event(s) occurred.
4. Be sure to sign, date and include a Sharp Health Plan member ID number as well as date of birth.
5. Send this completed form and all relevant documents to Sharp Health Plan. Please keep copies of all items sent to Sharp Health Plan for your records.

   Examples of relevant documents may include:

   - Statements: Premium billing statement or Provider bills
   - Proof of payment: Receipts, a copy of the front and back of a canceled check, or credit card statement
   - Correspondence: plan notices or enrollee correspondence

Submit

Please submit the finished form by mail, in person, or fax:

By Mail or In Person:
Attention: Appeals & Grievances
Sharp Health Plan
8520 Tech Way, Suite 200
San Diego, CA 92123

By Fax:
Attention: Appeals & Grievances
619-740-8572

If you believe this case is urgent, call Sharp Health Plan immediately toll-free at 1-800-359-2002.

Patient Information

First name:		Last name:	Middle initial:
Member ID#:	Plan medical group:	Birth date: MM/DD/YY / /	Gender: ☐ Male ☐ Female ☐ Other
Email address:		Daytime phone number: ( )	Evening phone number: ( )
Home address:			
City:		State:	ZIP code:

Mailing address:		
City:	State:	ZIP code:

Subscriber Information (If subscriber is different than patient)

First name:	Last name:	Middle initial:
Employer:	Plan medical group:	Birth date: MM/DD/YY / /
ID#:	Daytime phone number: ( )	Evening phone number: ( )
Home address:		
City:	State:	ZIP code:
Mailing address:		
City:	State:	ZIP code:

Provider Information

Doctor or provider:	Phone number: ( )
Address:	

City:	State:	ZIP code:

Description of Concern

Briefly outline the specific details of the problem and identify when the event(s) occurred. PLEASE BE SPECIFIC. Please include a statement regarding the outcome desired and what you believe the Plan can do to resolve your concern. If you have copies of documents, bills, checks, or other correspondence related to this problem that may help in the investigation and resolution, please include them with this form. If you need more pages to describe the issue, please attach them to this form.

Date enrollee received notice that coverage was or will end: (if applicable) / /	Are copies of enrollee correspondence with plan attached? (if applicable) ☐ Yes ☐ No
Are copies of proof of payment for the last paid coverage period attached? (if applicable) ☐ Yes ☐ No	Are copies of plan notices and correspondence received attached? (if applicable) ☐ Yes ☐ No

Subscriber name:	Subscriber signature: x	Date: / /
Parent / guardian name:	Parent / guardian signature: x	Date: / /

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-359-2002** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site **http://www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

I authorize the below named person to act as my representative in the disposition of this grievance. I understand this authorization will automatically expire upon completion of the appeal or grievance filed on my behalf.

Patient signature: x	Date: / /
Authorized representative:	Relationship to patient:
Home address:	

City:	State:	ZIP code:

If you need assistance, we're here to help.

You can call Customer Care at 1-858-499-8300 or toll-free at 1-800-359-2002.
We are available to assist you Monday through Friday, 8 a.m. to 6 p.m.