SHARP HEALTH PLAN
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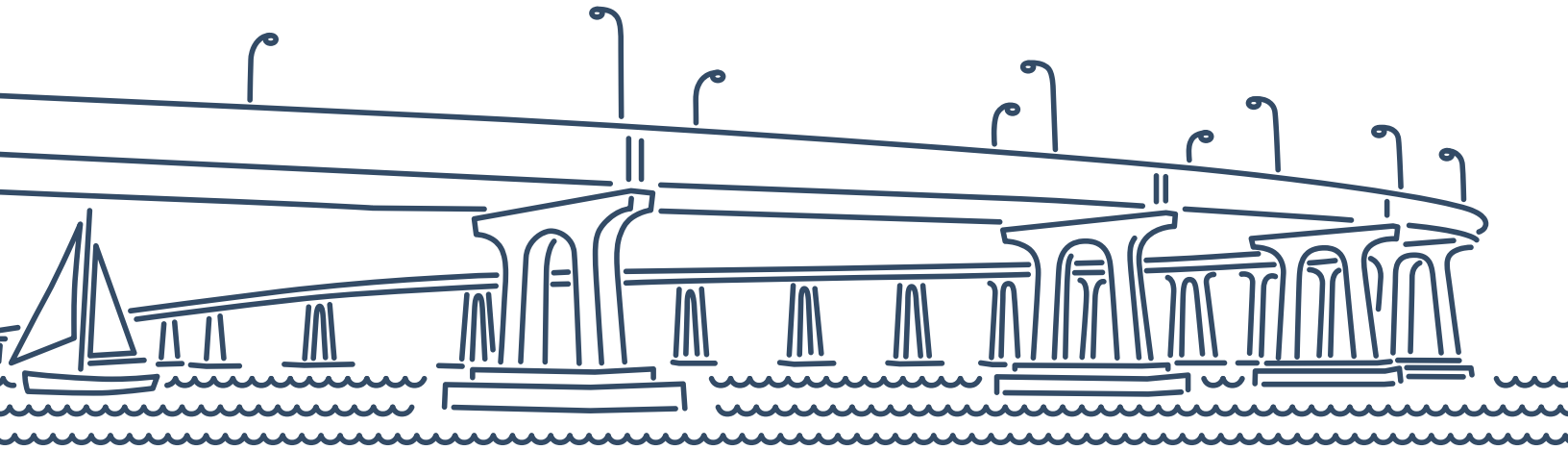
2019 Member Handbook Health Maintenance Organization (HMO)



Combined Evidence of Coverage and Disclosure Form for
Non-Grandfathered Small Group Plans

Effective January 1, 2019

CALIFORNIA*CHOICE*

SUPPLEMENT TO

EVIDENCE OF COVERAGE

WELCOME TO CALIFORNIA*CHOICE*

Your Employer has chosen to offer your health coverage to you and your fellow Employees through the California*Choice* Program. This Supplement is to Sharp Health Plan's ("PLAN") Evidence of Coverage, into which this California*Choice* Supplement is inserted. All of the provisions of that Evidence of Coverage are applicable to your health coverage. This Supplement explains certain details specific to the California*Choice* Program and may duplicate what is already stated in that document. In the case of inconsistencies between the attached Evidence of Coverage and this document, the provisions of this document will control.

WHAT IS THE CALIFORNIA*CHOICE* PROGRAM?

The California*Choice* Program is a program through which a number of California health care service plans and insurance carriers together offer various health benefits plans to employers for their employees' coverage. You as an Employee have the opportunity to select to receive your health benefits from one of these health plans or, in some circumstances, an insurance carrier. This gives you the sort of choice of health plans that typically has been enjoyed by only a few.

You have selected PLAN as the health care service plan from which you wish to receive your employer-sponsored medical benefits and you and your eligible Dependents have become members of PLAN.

IMPORTANT FEATURES OF THE CALIFORNIA*CHOICE* PROGRAM

Some of the important features of the California*Choice* Program which impact you as an Enrollee in PLAN are listed below.

1. <u>Participation Requirements</u>

   At least seventy percent (70%) of your fellow Employees will receive their medical coverage from one of the health plans or the insurance carrier participating in the California*Choice* Program.

2. <u>Eligibility Requirements</u>

   a. Employee Eligibility

      An Eligible Employee is one who lives or works in PLAN's Service Area, who is permanently and actively employed for compensation an average of 30 hours per

week over the course of a month, at the small employer's regular place of business, and who has met any applicable waiting period requirements.

- Provided that GROUP has been determined to be a "small employer" without counting them for purposes of making such determination, the term includes sole proprietors or partners of a partnership and their respective spouses, if they are actively engaged on a full-time basis in the small employer's business and included as employees under a health care service plan contract of a small employer, but does not include employees who work on a part-time, temporary or substitute basis.

- Permanent employees who work at least 20 hours but not more than 29 hours are eligible if all four of the following conditions apply:

  • They otherwise meet the definition of an Eligible Employee except for the number of hours worked

  • The employer offers the employees health coverage under a health benefit plan

  • All similarly situated employees are offered coverage under the health benefit plan

  • The employee must have worked at least 20 hours per normal work week for at least 50% of the weeks in the previous calendar quarter (documentation required upon request). Individuals who work on a part-time, temporary or substitute basis are not eligible. If you are accepted for enrollment in PLAN, your coverage will become effective on the first day of the month following your Employer's designated waiting period of 30 days.

b. Dependent Eligibility

A Dependent claiming eligibility hereunder as a spouse must be legally married to an Eligible Employee. A spouse may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of the Employer or following a proven triggering event as described in Paragraph (3.a) below.

A Dependent claiming eligibility hereunder as a domestic partner must be personally related to an Eligible Employee by a domestic partnership as defined below. A domestic partner may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of the Employer or following a proven triggering event as described in Paragraph (3.a) below.

Eligible Employee agrees to notify California*Choice* Benefit Administrators immediately upon termination of the marriage or domestic partnership.

A Dependent child claiming eligibility hereunder must be born to, a step-child of, a legal ward of, or adopted by the Eligible Employee or the Eligible Employee's spouse or domestic partner or is a child for whom the Eligible Employee has assumed a parent-child relationship, as indicated by intentional assumption of parental status or assumption of parental duties by the Eligible Employee, as certified by the Eligible Employee at the time of enrollment of the child and annually thereafter (but not to include foster children), subject to the following condition:

- Under age 26 (unless disabled, disability diagnosed prior to age 26)
- This "child" profile describes herein an "eligible dependent child."

A Dependent child who exceeds the age limit for Dependent children and is disabled, that is, who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition diagnosed as such by competent health care professionals prior to such Dependent's 26th birthday, and has remained continuously dependent on the Employee for at least 50% of his/her economic support since he/she became disabled, shall be eligible for coverage hereunder until such disability ceases. Proof of Dependent's disability must be received within 60 days after California*Choice* Benefit Administrators requests it.

California*Choice* Benefit Administrators will provide subscriber a 90-day notice that a dependent is about to reach the age limit for dependent children and will lose coverage unless subscriber provides written certification from a competent health care professional, within 60 days of receiving this 90-day warning notice, that the dependent meets the above conditions of being disabled.

California*Choice* Benefit Administrators or PLAN will determine if the child meets the conditions above prior to the child reaching the age limit. After two years following the child's reaching the limiting age, California*Choice* Benefit Administrators or PLAN may request proof of continuing incapacity and dependency, but not more often than yearly. If the Employee is enrolling a disabled child for new coverage, California*Choice* Benefit Administrators or PLAN may request initial proof of incapacity/dependency and then yearly, and the Employee must provide the requested information within 60 days of receipt of request.

If you are enrolling Dependents, they must also enroll in the same plan you have selected. Enrollees and their Dependents are, however, able to select different primary care physicians.

Formal proof of the required eligibility and existence of the relationship of any Dependent to the Employee may be requested at the time of enrollment, time of service authorization request or claim submission, but not more frequently than annually after the two-year period following a child's attainment of the limiting age.

New Dependents

(i) New Dependent - Spouse

An individual who becomes a new Dependent by virtue of marriage is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request form is submitted to the Employer within 45 days after such marriage, allowing the Employer sufficient time to submit the request to the California*Choice* Program within 60 days after such marriage. If California*Choice* Benefit Administrators receives all required documentation before the 16th day of the month of marriage, Premium is charged for the full month and coverage is effective as of the date of marriage. If California*Choice* Benefit Administrators receives all required documentation on or after the16th day of the month of marriage, the new spouse will be enrolled as of the 1st of the month following the date of receipt. The Employee enrollee requesting coverage for such new Dependent must provide a stamped copy of the marriage certificate. The Employee must agree to notify California*Choice* Benefit Administrators immediately upon termination of marriage.

(ii) New Dependent - Birth/Adoption/Legal Guardian

An individual who becomes a new Dependent by virtue of birth, adoption or placement for adoption or legal guardianship or is a child for whom the Eligible Employee has assumed a parent-child relationship is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request is submitted to the Employer within 45 days after such birth, adoption or placement for adoption or effective date of a guardianship order, or arrival at status of eligible dependent child, for coverage effective as of effective date of such event, allowing the Employer sufficient time to submit the request to the California*Choice* Program within 60 days after such birth, adoption or placement for adoption or legal guardianship or arrival at status of eligible dependent child, with coverage to be effective upon the date of the event. The first 30 days of coverage for such new or adopted child is automatic, regardless of whether the child is enrolled or not after this 30-day period. If the birth, adoption or placement for adoption or legal guardianship effective date occurs between the 1st and the 15th day of the month, Premiums are charged for the full month. If the birth, adoption or placement for adoption or legal guardianship effective date occurs between the 16th day and the end of the month, no Premiums are charged (copy of legal documentation may be required).

(iii) New Dependent - Stepchild

A child who comes to be the stepchild of an Enrollee is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request is submitted to the Employer within 45 days following marriage or establishment of a registered domestic partnership to the parent or legal guardian of the stepchild, allowing the Employer sufficient time to submit the request to the

California*Choice* Program within 60 days following the date of the Enrollee's marriage to or establishment of a registered domestic partnership with the parent or legal guardian of the stepchild (actual adoption by the stepparent Enrollee is not required, although a copy of the marriage certificate to, or a State-stamped copy of the Certificate of Registered Domestic Partnership with, the parent of the new stepchild may be required). If the marriage or creation of the domestic partnership occurs before the 16th day of the month, Premium is charged for the full month and coverage is effective as of the date of marriage or creation of the domestic partnership. If the marriage or creation of the domestic partnership occurs on or after the 16th day of the month, the stepchild will be enrolled effective as of the 1st of the month following the date of receipt.

(iv) New Dependent - Domestic Partner

In order for an Employee's domestic partner to be eligible for coverage, at the time of Employee eligibility for enrollment, the Employee and domestic partner must:

- Not be married under either statutory or common law or part of another domestic partnership;
- Both be 18 years of age or older and of the same or different sex;
- If of opposite sexes one or the other must be over age 62, and one or both must meet the Social Security eligibility requirements referenced in California Family Code Section 297 (b)(4)(B);
- If one is under 18 years of age meet the requirements and follow the procedures prescribed in California Family Code Section 297.1;
- Share an intimate and committed relationship of mutual caring;
- Both be mentally competent;
- Not related by blood to a degree of closeness that would prevent them from being married in this state;
- Agree to notify California*Choice* Benefit Administrators immediately upon termination of the domestic partnership.

The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State and at the time of filing both partners meet all of the requirements above.

An individual who becomes a new Dependent by virtue of becoming a registered domestic partner of the Employee is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request form is submitted to the Employer within 45 days after such domestic partnership is

created, allowing the Employer sufficient time to submit the request to the California*Choice* Benefit Administrators within 60 days after such event. If California*Choice* Benefit Administrators receives all required documentation before the 16th day of the month in which the domestic partnership was established, Premium is charged for the full month and coverage is effective as of the date of the event. If California*Choice* Benefit Administrators receives all required documentation on or after the 16th day of the month in which the domestic partnership was established, the new domestic partner will be enrolled as of the 1st of the month following the date of receipt. The Employee Enrollee requesting coverage for such new Dependent must provide a State-stamped copy of the Certificate of Registered Domestic Partnership within 45 days after such domestic partnership is created, allowing the Employer sufficient time to submit the request and Certificate to the California*Choice* Benefit Administrators within 60 days of its issuance. For purposes of this provision only, the domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State. The Employee must agree to notify California*Choice* Benefit Administrators immediately upon termination of the domestic partnership.

3. Special and Late Enrollment

a. Special Enrollment

Employees who did not enroll during the initial enrollment period or at the Employer's annual open enrollment may add newly acquired Dependents and themselves to the contract by submitting an application within 60 days from the date of acquisition of the Dependent:

- to add Employee and spouse or domestic partner following the birth of a newborn, adoption or placement for adoption of a child or arrival at status of eligible dependent child, coverage effective on the date of such event;

- to add Employee and spouse or registered domestic partner after marriage or creation of a domestic partnership. If all required documentation is received before the 16th day of the month of marriage/creation of domestic partnership, coverage for Employee and spouse or domestic partner is effective on the date of marriage or creation of the domestic partnership; If all required documentation is received on or after the 16th day of the month of marriage/creation of domestic partnership, coverage is effective on the 1st of the month following the date of receipt.

- to add Employee and Employee's newborn, eligible dependent child, or child placed for adoption, following birth, adoption or placement for adoption or arrival at status of eligible dependent child, coverage effective on effective date of such event;

- to add Employee and Employee's stepchild, if marriage or domestic partner registration occurs before the 16th day of the month, coverage effective as of the date of marriage or domestic partner registration; if marriage or domestic partner registration occurs on or after the 16th day of the month, stepchild will be enrolled effective as of the 1st of the month following date of receipt.

If an Employee did not enroll himself or herself or a Dependent at initial enrollment or at the Employer's annual open enrollment because the Employee or Dependent had coverage under another employer health plan, please see the "Late Enrollment" section below and the "Eligibility" section above for further information regarding rights to request enrollment at a later time.

b. Late Enrollment

Late enrollees (as defined in California Health & Safety Code section 1357.500(f)) must wait until open enrollment to be enrolled unless covered above under the "Special Enrollment" provisions. However, pursuant to H&S section 1357.500(f) and as further articulated in PLAN's Evidence of Coverage, if an Employee did not enroll, or enroll a Dependent, at initial enrollment or at annual open enrollment because Employee:

- or dependent loses minimum essential coverage, as described in California H&S Section 1399.849(d)(1)(A);
- gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption or arrival at status of eligible dependent child;
- is mandated to be covered as a dependent pursuant to a valid state or federal court order;
- has been released from incarceration;
- health coverage issuer substantially violated a material provision of the health coverage contract;
- gains access to new health benefit plans as a result of a permanent move;
- was receiving services from a contracting provider under another health benefit plan, for one of the conditions described in subdivision (c) of H&S Section 1373.96 and that provider is no longer participating in the health benefit plan;
- is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service; and

- demonstrates that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period because he or she was misinformed that he or she was covered under minimum essential coverage.

then if such a triggering event occurs, the Employee may enroll in PLAN by submitting an enrollment application to California*Choice* Benefit Administrators within 60 days of loss of other coverage or within 60 days of another triggering event listed immediately above, pursuant to H&S section 1357.500(f) and as articulated further in PLAN's EOC. Coverage with PLAN through California*Choice* Benefit Administrators to become effective 1st day of month following receipt of completed enrollment application.

4. Waiting Period

The waiting period for coverage, which shall be applicable for all Employees, is 0, 30 or 60 days plus the days until the first of the following month, not to exceed 90 days.

5. Benefits

Under the federal "Patient Protection and Affordable Care Act," your Employer is required to select one of four (4) "metal tier" options of benefits offered by PLAN, keyed to their "actuarial value" ("Bronze," "Silver," "Gold," "Platinum"). However, by participating in the California*Choice* Program, your Employer is able and may decide to offer to you two (2) neighboring metal tiers of benefits (Bronze/Silver, Silver/Gold, or Gold/Platinum) for you to choose from or even to offer three (3) neighboring metal tiers of benefits (Silver/Gold/Platinum) from which you could choose. Employees will then have the option to choose from the health plans and benefit plans offered within such metal tier options. The benefits you will have chosen to receive from PLAN are described in the Evidence of Coverage to which this Supplement is attached. You may not change your benefit plan within PLAN other than during its open enrollment period unless you experience a "triggering event" (see Paragraph 3 above). PLAN will make all benefit and coverage dispute determinations, although these determinations are subject to PLAN's grievance procedures.

a. Cal-COBRA and COBRA

PLAN has agreed to provide coverage for you if you are Cal-COBRA-eligible or COBRA-eligible, at rates which you can receive by requesting them from your employer. Please examine your options carefully before declining this coverage.

b. Co-payments

As noted in the attached Evidence of Coverage, certain covered services and benefits are subject to co-payments which you will be required to make.

c. Plan Materials

PLAN will provide you with an identification card and its Evidence of Coverage ("EOC") and this Supplement, and will distribute its federally-required "Summary of Benefits and Coverage" ("SBC"). California*Choice* Benefit Administrators will post on its website a copy of PLAN's current SBC. (In lieu of hard copies, PLAN may notify Enrollee of where to obtain electronic copies of the EOC and California*Choice* EOC Supplement.)

6. Termination for Nonpayment of Premiums

On the first day of the month prior to the coverage month, the Premium Notice that is sent to your Employer by California*Choice* Benefit Administrators will include the mandated regulatory statement contained in Rule 1300.65(a)(2), which states: "Your Health Plan is billing you for the cost of your health coverage. You must pay all amounts listed in this bill by the due date. If you do not pay this amount by the due date, your health coverage can be cancelled. You will receive a grace period before your Plan can cancel your coverage for not paying the amount due. You can file a complaint with your PLAN and with the California Department of Managed Health Care if you think there is a mistake. Learn more about your health care rights and responsibilities in your Plan Evidence of Coverage." Premium payments are due on or before the 20th day of the month prior to the month of coverage. If your Employer fails to pay the required Premiums when due, PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will mail your Employer a "Notice of Start of Grace Period" stating that the Employer has until the end of the Grace Period, which lasts at least 30 consecutive days, in which to pay the Premiums due before any cancellation of unpaid coverage contracts will take effect. This Notice will provide information to your Employer regarding the reason for cancellation(s), the effective date of cancellation(s), the dollar amount(s) due to PLAN, the date of the last day of paid coverage, the date the grace period begins and expires, any obligations of your Employer during the grace period, including your Employer's responsibility to promptly send you a copy of the Notice of Start of Grace Period, consequences for nonpayment of Premiums due within that timeframe, as well as the right of your Employer to submit a grievance to the PLAN and/or the California Department of Managed Health Care if your Employer believes coverage has been or will be improperly cancelled.

The Notice shall also inform your Employer that coverage will continue during a 30-day grace period that begins on the day the Notice of Start of Grace period is dated and lasts at least 30 consecutive days. For California*Choice* Program Plans, the Notice of Start of Grace Period will be dated and sent the first calendar day after the last day of paid coverage. If the Premium remains unpaid by the 14th day of the coverage month, California*Choice* Benefit Administrators on behalf of PLAN will send your Employer a "Second Notice of Grace Period" repeating the need to pay the Premium(s) and the consequences for not doing so. If Premium payment(s) is/are not received by the effective date of cancellation*, PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will cancel the membership agreement and coverage for you and all your Dependents will end on such date as is contained in the "Notice of End of Coverage" sent to your Employer . It is your Employer's responsibility to promptly send you a copy of the Notice of End of Coverage. (*The 30-day grace period begins the day

the Notice of Start of Grace period is dated and lasts at least 30 consecutive days. If the affected premium(s) is(are) not paid by the last day of the Grace Period, coverage under the Agreement will be terminated prospectively, which in most cases occurs on the last day of the coverage period. Since the month of February consists of only 28/29 days, Employers who do not pay February's premium(s) by the end of the 30-day grace period will have their coverage contacts(s) terminated on the last day of March).

PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will mail a separate Notice of End of Coverage to its affected individual Members that includes similar information provided in the Notice of End of Coverage that is sent to your employer. The Notice that is sent to your Employer would provide your Employer with the following information: (1) that the agreement for coverage has been cancelled for non-payment of premiums; (2) the specific date and time when the coverage ended; (3) how and when coverage may be reinstated; (4) the responsibility of the Employer to pay all Premiums due, including for coverage during the 30-day grace period provided; (5) the right of your Employer to submit a grievance to the PLAN and /or the California Department of Managed Health Care if your Employer believes coverage has been improperly cancelled and the right to reinstatement of the membership agreement if the Department rules in favor of the Employer in any such review; (6) the California*Choice* telephone number Members can call to obtain additional information, including whether your Employer obtained reinstatement of the Agreement; and (7) GROUP is responsible for notifying each affected individual Member of his or her right to purchase continuation coverage and that you would be sent a similar Notice of End of Coverage, which would include a State-approved notice regarding the possibility that you could secure coverage either through the "Covered California" State Exchange or in the State's Medi-Cal Program and also providing you toll-free contact telephone numbers and an Internet website where you could obtain additional information about these opportunities.

7. Partial Payment Protocol

If your Employer has subscribed to more than one health Plan or Carrier for your healthcare coverage through the California*Choice* Program and fails to make premium payments for every one of its coverage contracts, the application of such Partial Premium Payment as is submitted will be made to specific coverage contracts according to a priority articulated in the Group Service Agreement Supplement that is part of your Employer's contract with each Plan. If the Partial Payment is adequate to cover all the Medical coverage contracts the Employer has, then they will be maintained in place and the remainder of the Partial Payment will be applied to any Specialty coverage contracts your Employer may have through the Program, in a priority that goes dental-vision-chiropractic/acupuncture-life until the Partial Payment funds run out. If your Employer's Partial Payment is insufficient to cover certain of the Specialty contract premiums then those contracts will terminate at the end of the grace period. If there is not sufficient Partial Payment to cover the Medical premiums due, then that coverage will terminate at the end of the grace period and the Partial Payment will be applied to any Specialty coverage contracts the Employer has through the Program, in the above priority until the

Partial Payment funds run out. In either scenario, the premium-paid Specialty coverage contracts will terminate at the end of the contract period.

By way of illustration only, if a Group has two separate dental coverage options, Partial Payment shall be applied to the dental contract with the highest membership count first, unless the Partial Payment amount is insufficient to cover that dental contract's due premium. Whether it is sufficient to cover the first dental contract premium or not, Choice Administrators shall then apply the Partial Payment amount or the remainder of the Partial Payment amount to the dental contract premium with the next highest membership count. If at this point of application there remains a Partial Payment amount then that amount shall be applied to any remaining dental coverage contract premiums due, ranked by membership count. If after application to dental premiums due there remains a Partial Payment amount, then it shall be applied to the vision contract with the highest membership count, and any remaining Partial Payment amount shall then be applied to the premium due for the vision contract with the next highest membership. This progression of Partial Payment amount application shall continue down through the premiums due for additional vision coverage contracts, and then in similar fashion to premiums due for chiropractic/acupuncture coverage and then for life insurance coverage. If two contracts within the same line of coverage (*e.g*., dental) have the same membership count, Choice Administrators shall first apply available Partial Payment amounts to the coverage contract with the highest premium due.

Partial Payment Hierarchy:
1) All Medical contract(s) (all must be paid in full or all terminate)
2) Dental contract with highest membership count
3) Dental contract with next highest membership count (repeated through all dental contracts)
4) Vision contract with highest membership count
5) Vision contract with next highest membership count (repeated through all vision contracts)
6) Chiropractic/acupuncture contract with highest membership count
7) Chiropractic/acupuncture contract with next highest membership count (repeated through all chiropractic contracts)
8) Life contract with the highest membership count
9) Life contract with the next highest membership count (repeated through all life contracts)

Your Employer is required to inform you in the event it becomes involved in such a Partial Premium Payment situation so that you may plan for desired alternate coverage. If you have questions regarding this Partial Payment Protocol, you may contact your employer or the California*Choice* Program at 800-558-8003.

RENEWAL

If your Employer wishes to renew in PLAN through the California*Choice* Program upon the anniversary date of its contract with PLAN, your Employer must have a minimum of at least two (2) Eligible Employees (or such number as may come to be used in the Small Group Act to define a Small Group Employer) and seventy percent (70%) of those not covered elsewhere by a plan sponsored by your Employer must be enrolled in a health care service plan or insurance program participating in the California*Choice* Program. If your Employer does not meet such renewal requirements, it may renew at such later date as it meets such renewal qualification requirements.

THE REST IS THE SAME!

This Supplement merely describes the particular features of your coverage from PLAN because of PLAN's participation in the California*Choice* Program. You should refer to the Evidence of Coverage to which this is merely a Supplement for all other details regarding your membership in and receipt of health care services from PLAN.

SHARP HEALTH PLAN

make life better.®

This Member Handbook (including the enclosed Health Plan Benefits and Coverage Matrix) is your COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM that discloses the terms and conditions of coverage. Applicants have the right to view this Member Handbook prior to enrollment. This Member Handbook is only a summary of Covered Benefits available to you as a Sharp Health Plan Member. The Group Agreement signed by your Employer should be consulted to determine the exact terms and conditions of coverage. A specimen copy of the Group Agreement will be furnished to you by the Plan or your Employer upon request.

The Group Agreement and this Member Handbook may be amended at any time. In the case of a conflict between the Group Agreement and this Member Handbook, the provisions of this Member Handbook (including the enclosed Health Plan Benefits and Coverage Matrix) shall be binding upon the Plan notwithstanding any provisions in the Group Agreement that may be less favorable to Members.

This Member Handbook provides you with information about how to obtain Covered Benefits and the circumstances under which these benefits will be provided to you. We recommend you read this Member Handbook thoroughly and keep it in a place where you can refer to it easily. Members with special health care needs should read carefully those sections that apply to them.

For easier reading, we capitalized words throughout this Member Handbook to let you know that you can find their meanings in the "GLOSSARY" section.

Please contact us with questions about this Member Handbook.

Customer Care
8520 Tech Way, Suite 200
San Diego, CA 92123

Email: customer.service@sharp.com
Call: (858) 499-8300 or toll-free at 1-800-359-2002
8 a.m. to 6 p.m., Monday to Friday

sharphealthplan.com

Official Partner of

COVERED CALIFORNIA

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WELCOME TO SHARP HEALTH PLAN

Thank you for selecting Sharp Health Plan for your Health Plan Benefits. Your health and satisfaction with our service are most important to us. We encourage you to let us know how we may serve you better by calling us at (858) 499-8300 or toll-free at 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 you may have. Additionally, after hours and on weekends, you have access to a specially trained registered nurse for immediate medical advice by calling the same Customer Care phone number.

Sharp Health Plan is a San Diego-based health care service plan licensed by the State of California. We are a managed care system that combines comprehensive medical and preventive care in one Plan. You receive preventive care and health care services from a network of Providers who are focused on keeping you healthy. You have the added convenience of not submitting paperwork or bills for reimbursement.

Booklets and Information

We will provide you with booklets and information to help you understand and use your health plan. They include this Member Handbook, the Health Plan Benefits and Coverage Matrix, a Provider Directory and Member newsletters. It's very important that you read through this information to better understand your plan of benefits and how to access care, and then retain the booklets and information for reference. This information is also available online at **sharphealthplan.com**.

Member Handbook

The Member Handbook explains your health plan membership, how to use the Plan and whom to call if you need assistance. This Member Handbook is very important because it describes your Health Plan Benefits and explains how your health plan works. For easier reading, we capitalized words throughout this Member Handbook to let you know that you can find their meanings in the "GLOSSARY" section.

Health Plan Benefits and Coverage Matrix

This brochure outlines the applicable Copayments that apply to the medical benefit plan design your Employer purchased. The Health Plan Benefits and Coverage Matrix is considered part of the Member Handbook.

Provider Directory

This directory is a listing of Plan Physicians, Plan Hospitals and other Plan Providers in your Plan Network. This directory is very important because it lists the Plan Providers from whom you obtain all non-Emergency Services. You will find the name of the Plan Network that you are associated with on your Member identification card. It's very important to use the correct Plan Network. Use the correct directory to choose your Primary Care Physician, who will be responsible for providing or coordinating all of your health care needs. The directories are available online at **sharphealthplan.com**.You may also request a directory by calling Customer Care.

Member Newsletter

We distribute this newsletter to update you on Sharp Health Plan throughout the year. The newsletter may include information about health care, the Member Advisory Committee (also called the Public Policy Advisory Committee), health education classes and how to use your Health Plan Benefits.

HOW DOES THE PLAN WORK?

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHICH GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. ALL REFERENCES TO PLAN PROVIDERS, PLAN MEDICAL GROUPS, PLAN HOSPITALS AND PLAN PHYSICIANS IN THIS MEMBER HANDBOOK REFER TO PROVIDERS AND FACILITIES IN YOUR PLAN NETWORK, AS IDENTIFIED ON YOUR MEMBER IDENTIFICATION CARD.

Please read this Member Handbook carefully to understand how to maximize your Covered Benefits. After you have read the Member Handbook, we encourage you to call Customer Care with any questions. To begin, here are the basics that explain how to make the Plan work best for you.

Choice of Plan Physicians and Plan Providers

Sharp Health Plan Providers are located throughout San Diego and southern Riverside counties. The Provider Directory lists the addresses and phone numbers of Plan Providers, including PCPs, hospitals and other facilities.

- The Plan has several physician groups (called Plan Medical Groups or PMGs) from which you choose your Primary Care Physician (PCP) and through which you receive specialty physician care or access to hospitals and other facilities. In some Plan Networks, you can also select a PCP who is contracted directly with the Plan. If you choose one of these PCPs, your PMG will be "Independent."

- You select a PCP for yourself and one for each of your Dependents. Look in the Provider Directory for your Plan Network to find your current doctor or select a new one if your doctor is not listed. Family members may select different PCPs and PMGs to meet their individual needs, except as described in the next column. If you need help selecting a PCP, please call Customer Care.
- In most cases, newborns are assigned to the mother's PMG until the first day of the month following birth (or discharge from the hospital, whichever is later). You may select a different PCP or PMG for your newborn following the birth month by calling Customer Care.
- Write your PCP selection on your enrollment form and give it to your Employer.
- If you are unable to select a doctor at the time of enrollment, we will select one for you so that you have access to care immediately. If you would like to change your PCP, just call Customer Care. We recognize that the choice of a doctor is a personal one, and encourage you to choose a PCP who best meets your needs.
- You and your Dependents obtain Covered Benefits through your PCP and from the Plan Providers who are affiliated with your PMG. If you need to be hospitalized, your doctor will generally direct your care to the Plan Hospital or other Plan facility where your doctor has admitting privileges. Since doctors do not usually maintain privileges at all facilities, you may want to check with your doctor to see where your doctor admits patients. If you would like assistance with this information, please call Customer Care.
- Some hospitals and other Providers do not provide one or more of the following services that may be covered under your Plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, clinic or Customer Care to ensure that you can obtain the health care services that you need.

Call Your PCP When You Need Care

- Call your PCP for all your health care needs. Your PCP's name and telephone number are shown on your Member Identification (ID) card. You will receive your ID card soon after you enroll. If you are a new patient, forward a copy of your medical records to your PCP before you are seen, to enable your doctor to provide better care.
- Make sure to tell your PCP about your complete health history, as well as any current treatments, medical conditions, or other doctors who are treating you.
- If you have never been seen by your PCP, you should make an appointment for an initial health assessment. If you have a more urgent medical problem, don't wait until this appointment. Speak with your PCP or other health care professional in the office, and they will direct you appropriately.
- You can contact your PCP's office 24 hours a day. If your PCP is not available or if it is after regular office hours, a message will be taken. Your call will be returned by a qualified health professional within 30 minutes.
- If you are unable to reach your PCP, please call Customer Care. You have access to our nurse advice line evenings and weekends for immediate medical advice.
- If you have an Emergency Medical Condition, call "911" or go to the nearest hospital emergency room.
- All Members have direct and unlimited access to OB/GYN Plan Physicians as well as PCPs (family practice, internal medicine, etc.) in their Primary Care Physician's PMG for obstetric and gynecologic services.

Present Your Member ID Card and Pay Copayment

- Always present your Member ID card to Plan Providers. If you have a new ID card because you changed PCPs or PMGs, be sure to show your Provider your new card.
- When you receive care, you pay the Provider any Copayment specified on the Health Plan Benefits and Coverage Matrix. For convenience, some Copayments are also shown on your Member ID card.

Call us with questions at (858) 499-8300 or toll-free at 1-800-359-2002, or email us at **customer.service@sharp.com**.

HOW DO YOU OBTAIN MEDICAL CARE?

Use Your Member ID Card

The Plan will send you and each of your Dependents a Member ID card that shows your Member number, benefit information, certain Copayments, your Plan Network, your PMG, your PCP's name and telephone number, and information about obtaining Emergency Services. Present this card whenever you need medical care and identify yourself as a Sharp Health Plan Member. Your ID card can only be used to obtain care for yourself. If you allow someone else to use your ID card, the Plan will not cover the services and may terminate your coverage. If you lose your ID card or require medical services before receiving your ID card, please call Customer Care. You can also request an ID card or print a temporary ID card online at **sharphealthplan.com** by logging onto Sharp Connect.

Access Health Care Services Through Your Primary Care Physician

Call Your PCP for All Your Health Care Needs

Your PCP will provide the appropriate services or referrals to other Plan Providers. If you need specialty care, your PCP will refer you to a specialist. All specialty care must be coordinated through your PCP. You may receive a standing referral to a specialist if your PCP determines, in consultation with the specialist and the Plan, that you need continuing care from a specialist.

If you fail to obtain Authorization from your PCP, care you receive may not be covered by the Plan and you may be responsible for paying for the care. Remember, however, that women have direct and unlimited access to OB/GYNs as well as PCPs (family practice, internal medicine, etc.) in their Primary Care Physician's PMG for obstetric and gynecologic services. You will not be required to obtain Prior Authorization for sexual and reproductive health services within your Plan Medical Group.

Use Sharp Health Plan Providers

You receive Covered Benefits from Plan Providers who are affiliated with your PMG and who are part of your Plan Network. To find out which Plan Providers are affiliated with your PMG and part of your Plan Network, refer to the Provider Directory for your Plan Network or call Customer Care. If Covered Benefits are not available from Plan Providers affiliated with your PMG, you will be referred to another Plan Provider to receive such Covered Benefits. Availability of Plan Providers will be assessed based on your specific medical needs, provider expertise, geographic access, and appointment availability. You are responsible to pay for any care not provided by Plan Providers affiliated with your PMG, unless your PMG has Prior-Authorized the service or unless it is an emergency.

Schedule Appointments

When it is time to make an appointment, you simply call the doctor that you have selected as your PCP. Your PCP's name and phone number are shown on the Member ID card that you receive when you enroll as a Sharp Health Plan Member. Remember, only Plan Providers may provide Covered Benefits to Members. You are responsible to pay for any care not provided by a Plan Provider who is part of your Plan Network, unless the care has been Prior-Authorized by your PMG or unless it is an emergency.

Timely Access to Care

Making sure you have timely access to care is extremely important to us. Check out the charts below to plan ahead.

Appointment wait times

Urgent Appointments	Maximum wait time after request
PCP, no prior authorization required	48 hours
Prior authorization required	96 hours

Non-Urgent Appointments	Maximum wait time after request
PCP (Excludes preventive care appointments)	10 business days
Non-physician mental health care provider (e.g. psychologist or therapist)	10 business days
Specialist (Excludes routine follow-up appointments)	15 business days
Ancillary services (e.g. X-rays, lab tests, etc. for the diagnosis and treatment of injury, illness, or other health conditions)	15 business days

Exceptions to appointment wait times

Your wait time for an appointment may be extended if your health care provider has determined and noted in your record that the longer time wait will not be detrimental to your health.

Your appointments for preventive and periodic follow up care services (e.g. standing referrals to specialists for chronic conditions, periodic visits to monitor and treat pregnancy, cardiac, or mental health conditions, and laboratory and radiological monitoring for recurrence of disease) may be scheduled in advance, consistent with professionally recognized standards of practice, and exceed the listed wait times.

Telephone wait times

Service	Maximum wait time
Sharp Health Plan Customer Care (Monday to Friday, 8 a.m. to 6 p.m.)	10 minutes
Triage or screening services (24 hours/day and 7 days/ week)	30 minutes

Interpreter services at scheduled appointments

Sharp Heath Plan provides free interpreter services at scheduled appointments. For language interpreter services, please call Customer Care: 1-800-359-2002. The hearing and speech impaired may dial "711" or use California's Relay Service's toll-free numbers to contact us:

- 1-800-735-2922 Voice
- 1-800-735-2929 TTY
- 1-800-855-3000 Voz en español y TTY (teléfono de texto)

Members must make requests for face-to-face interpreting services at least three (3) days prior to the appointment date. In the event that an interpreter is unavailable for face-to-face interpreting, Customer Care can arrange for telephone interpreting services.

Referrals to Non-Plan Providers

Sharp Health Plan has an extensive network of high quality Plan Providers throughout the Service Area. Occasionally, however, Plan Providers may not be able to provide services you need that are covered by the Plan. If this occurs, your PCP will refer you to a provider where the services you need are available. You should make sure that these services are Authorized in advance. If the services are Authorized, you pay only the Copayments you would pay if the services were provided by a Plan Provider.

Use Sharp Health Plan Hospitals

If you need to be hospitalized, your Plan Physician will admit you to a Plan Hospital that is affiliated with your PMG and part of your Plan Network. If the hospital services you need are not available at this Plan Hospital, you will be referred to another Plan Hospital to receive such hospital services. To find out which Plan Hospitals are affiliated with your PMG, please check the provider directory online at **sharphealthplan.com** or call Customer Care. You are responsible to pay for any care that is not provided by Plan Hospitals affiliated with your PMG, unless it is Authorized by your PMG or unless it is an emergency.

Changing Your PCP

It is a good idea to stay with a PCP so your doctor can get to know your health needs and medical history. However, you can change to a different PCP in your Plan Network for any reason. If you wish to change your PCP, please call or email Customer Care. One of our Customer Care Representatives will help you choose a new doctor. In general, the change will be effective on the first day of the month following your call.

Obtain Required Authorization

Except for PCP services, outpatient mental health or chemical dependency office visits, Emergency Services and obstetric and gynecologic services, you are responsible for obtaining valid Authorization before you receive Covered Benefits. To obtain a valid Authorization:

1. Prior to receiving care, contact your PCP or other approved Plan Provider to discuss your treatment plan.
2. Request Prior Authorization for the Covered Benefits that have been ordered by your doctor. Your PCP or other Plan Provider is responsible for requesting Authorization from Sharp Health Plan or your Plan Medical Group.
3. If Authorization is approved, obtain the expiration date for the Authorization. You must access care before the expiration date with the Plan Provider identified in the approved Authorization.

You are responsible to pay for all care that is rendered without the necessary Authorization.

A decision will be made on the Authorization request in a timely fashion based on the nature of your medical condition, but no later than five business days. A letter will be sent to you within two business days of the decision.

If waiting five days would seriously jeopardize your life or health or your ability to regain maximum function or, in your doctor's opinion, it would subject you to severe pain that cannot be adequately managed without the care or treatment that is being requested, you will receive a decision no later than 72 hours after receipt of the Authorization request.

If we do not receive enough information to make a decision regarding the Authorization request, we will send you a letter within five days to let you know what additional information is needed. We will give you or your provider at least 45 days to provide the additional information. (For urgent Authorization requests, we will notify you and your provider by phone within 24 hours and give you or your provider at least 48 hours to provide the additional information.)

If you receive Authorization for an ongoing course of treatment, we will not reduce or stop the previously Authorized treatment before providing you with an opportunity to Appeal the decision to reduce or stop the treatment.

The Plan uses evidence based guidelines for Authorization, modification or denial of services as well as Utilization Management, prospective, concurrent and retrospective review. Plan specific guidelines are developed and reviewed on an ongoing basis by the Plan Medical Director, Utilization Management Committee and appropriate physicians to assist in determination of community standards of care. A description of the medical review process or the guidelines used in the process will be provided upon request.

Second Opinions

When a medical or surgical procedure or course of treatment (including mental health or chemical dependency treatment) is recommended, and either the Member or the Plan Physician requests, a second opinion may be obtained. You may request a second opinion for any reason, including the following:

1. You question the reasonableness or necessity of recommended surgical procedures.
2. You question a diagnosis or plan of care for a condition that threatens loss of life, limb or bodily function, or substantial impairment, including, but not limited to, a serious Chronic Condition.
3. The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and you would like to request an additional diagnosis.
4. The treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis and plan of care, and you would like a second opinion regarding the diagnosis or continuance of the treatment.
5. You have attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.
6. You or the Plan Physician who is treating you has serious concerns regarding the accuracy of the pathology results and requests a specialty pathology opinion.

A second opinion about care from your PCP must be obtained from another Plan Physician within your PMG. If you would like a second opinion about care from a specialist, you or your Plan Physician may request Authorization to receive the second opinion from any qualified Provider within the Plan's Network. If there is no qualified provider within the Plan's Network, you may request Authorization for a second opinion from a provider outside the Plan's Network. If a Provider outside the Plan's Network provides a second opinion, that Provider should not perform, assist, or provide care, as the Plan does not provide reimbursement for such care.

Members and Plan Physicians request a second opinion through their PMG or through the Plan. Requests will be reviewed and facilitated through the PMG or Plan Authorization process. If you have any questions about the availability of second opinions or would like a copy of the Plan's policy on second opinions, please call or email Customer Care.

Emergency Services and Care

Emergency Services are not a substitute for seeing your PCP. Rather, they are intended to provide emergency needed care in a timely manner when you require these services.

Emergency Services means those Covered Benefits, including Emergency Services and Care, provided inside or outside the Service Area, that are medically required on an immediate basis for treatment of an Emergency Medical Condition. Sharp Health Plan covers 24 hour emergency care. An Emergency Medical Condition is a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services and Care means:

1. Medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or Active Labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and
2. An additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition within the capability of the facility.

What To Do When You Require Emergency Services

If you have an Emergency Medical Condition, call "911" or go to the nearest hospital emergency room. It is not necessary to contact your PCP before calling "911" or going to a hospital if you believe you have an Emergency Medical Condition.

- If you are unsure whether your condition requires Emergency Services, call your PCP (even after normal office hours). Your PCP can help decide the best way to get treatment and can arrange for prompt emergency care. However, do not delay getting care if your PCP is not immediately available. Members are encouraged to use the "911" emergency response system appropriately when they have an Emergency Medical Condition that requires an emergency response.
- If you go to an emergency room and you do not have an emergency, you may be responsible for payment.
- If you are hospitalized in an emergency, please notify your PCP or Sharp Health Plan within 48 hours or at the earliest time reasonably possible. This will allow your Plan Physician to share your medical history with the hospital and help coordinate your care. If you are hospitalized outside of the Service Area, your Plan Physician and the Plan may arrange for your transfer to a Plan Hospital if your medical condition is sufficiently stable for you to be transferred.
- Paramedic ambulance services are covered when provided in conjunction with Emergency Services.
- If you need follow-up care after you receive Emergency Services, call your PCP to make an appointment or for a referral to a specialist. Do not go back to the hospital emergency room for follow-up care, unless you are experiencing an Emergency Medical Condition.

- You are not financially responsible for payment of Emergency Services, in any amount the Plan is obligated to pay, beyond your Copayment and/or Deductible. You are responsible only for applicable Copayments or Deductibles, as listed on the Health Plan Benefits and Coverage Matrix.
- Some non-Plan Providers may require that you pay for Emergency Services and seek reimbursement from the Plan. On these occasions, obtain a complete bill of all services rendered and a copy of the emergency medical report, and forward them to the Plan right away for reimbursement.

Urgent Care Services

Urgent conditions are not emergencies, but may need prompt medical attention. Urgent Care Services are not a substitute for seeing your PCP. They are intended to provide urgently needed care in a timely manner when your PCP has determined that you require these services or you are outside the Plan's Service Area and require Urgent Care Services.

What to Do When You Require Urgent Care Services

- Your PCP must Authorize Urgent Care Services if you are in the Plan's Service Area. If you need Urgent Care Services and are in the Plan's Service Area, you must call your PCP first.
- Out-of-Area Urgent Care Services are considered Emergency Services and do not require an Authorization from your PCP. If you are outside Plan's Service Area and need Urgent Care Services, you should still call your PCP. Your PCP may want to see you when you return in order to follow up with your care.
- If, for any reason, you are unable to reach your PCP, please call Customer Care. You have access to a nurse evenings and weekends for immediate medical advice by calling our toll-free Customer Care telephone number at 1-800-359-2002.

Language Assistance Services

Sharp Health Plan provides free interpreter and language translation services for all Members. If you need language interpreter services to help you talk to your doctor or health plan or to assist you in obtaining care, please call Customer Care. Let us know your preferred language when you call. Customer Care has representatives who speak English and Spanish. We also have access to interpreting services in over 100 languages. If you need someone to explain medical information while you are at your doctor's office, ask them to call us. You may also be able to get materials written in your language. For free language assistance, please call us at (858) 499-8300 or toll-free at 1-800-359-2002. We'll be glad to help. The hearing and speech impaired may simply dial "711" or use the California Relay Service's toll-free telephone numbers to contact us:

- 1-800-735-2922 Voice
- 1-800-735-2929 TTY
- 1-800-855-3000 Voz en español y TTY (teléfono de texto)

Access for the Vision Impaired

This Member Handbook and other important Plan materials will be made available in alternate formats for the vision impaired, such as on a computer disk where text can be enlarged or in Braille. For more information about alternative formats or for direct help in reading the Member Handbook or other materials, please call Customer Care.

Pre-existing Conditions

Subject to the limitations described in the section of this Member Handbook entitled, "HOW DO YOU ENROLL IN SHARP HEALTH PLAN?", pre-existing conditions, including pregnancy, are covered with no waiting period or particular coverage limitations or exclusions. Upon the effective date of your enrollment, you and your Dependents are immediately covered for any pre-existing conditions.

Case Management

While all of your medical care is coordinated by your PCP, the Plan and your doctor have agreed that the Plan or PMG will be responsible for catastrophic case management. This is a service for very complex cases in which the case management nurses work closely with you and your doctor to develop and implement the most appropriate treatment plan for your medical needs.

HOW DO YOU USE YOUR PEDIATRIC DENTAL BENEFITS?

Your benefit plan includes pediatric dental benefits for Members under the age of 19. Sharp Health Plan's pediatric dental benefits are provided through the Plan's dental provider Access Dental Plan. Included with this Member Handbook is your Access Dental Plan schedule of benefits that sets forth applicable benefit and cost-sharing information for the pediatric dental benefits included with this plan. Beginning on page 48 of this Member Handbook, you will find information about your covered pediatric dental benefits, how to obtain those benefits, and your rights and responsibilities pertaining to your pediatric dental benefits.

Cost-sharing for covered pediatric dental benefits will contribute towards the Out-of-Pocket Maximum amount under your Sharp Health Plan medical benefit plan.

WHO CAN YOU CALL WITH QUESTIONS?

Customer Care

From questions about your benefits, to inquiries about your doctor or filling a prescription, we are here to ensure that you have the best health care experience possible. You can reach us by phone at (858) 499-8300 or toll-free at 1-800-359-2002, or email **customer.service@sharp.com.** Our dedicated San Diego-based Customer Care team is available to support you from 8 a.m. to 6 p.m., Monday to Friday.

Sharp Nurse Connection®

After regular business hours, you can contact Sharp Nurse Connection directly at 1-800-767-4277, or by calling Customer Care and selecting the appropriate prompt. This after-hours telephone service will put you in touch with registered nurses who can provide medical advice and direction regarding health care questions or concerns. They are available to assist you 5 p.m. to 8 a.m., Monday to Friday and 24 hours a day on weekends.

Utilization Management

Our medical practitioners make Utilization Management decisions based only on appropriateness of care and service (after confirming benefit coverage). Medical practitioners and individuals who conduct utilization reviews are not rewarded for denials of coverage for care and service. There are no incentives for Utilization Management decision-makers that encourage decisions resulting in underutilization of health care services. Appropriate staff is available from 8 a.m. to 5 p.m., Monday to Friday to answer questions from providers and Members regarding Utilization Management. After business hours, Members have the option of leaving a voicemail for a return call by the next business day. When returning calls our staff is identified by name, title and organization name.

WHAT DO YOU PAY?

Premiums

Your Employer pays Premiums to the Plan by the first day of each month for you and your Dependents. Your Employer will notify you if you need to make any contribution to the Premium or if the Premium changes. Often, your share of the cost will be deducted from your salary. Premiums may change at renewal, if your Employer changes the benefit plan, or at certain ages.

Copayments

A Copayment is a fee you pay for a particular Covered Benefit at the time you receive it.

You are responsible to pay applicable Copayments for any Covered Benefit you receive. Copayment amounts vary depending on the type of care you receive.

Copayments may be either a set dollar amount, such as $20 for a primary care office visit, or a percentage of the cost Sharp Health Plan pays for the care, such as 20 percent of contracted rates for inpatient services (also called “Coinsurance”). These specific Copayments can be found in the Health Plan Benefits and Coverage Matrix included with this Member Handbook. For a quick reference and for your convenience, Copayments for the most commonly used benefits are also shown on your Member ID card. Copayments, coinsurance, and deductibles will not change during the calendar year.

Deductibles

Some, but not all, benefit plans include one or more Deductibles. If you have a Deductible, it will be listed on the Health Plan Benefits and Coverage Matrix. You may have one Deductible for medical services and a separate Deductible for brand name prescription drugs, or you may have a combined Deductible for medical services and prescription drugs.

A Deductible is the amount you must pay each calendar year for certain Covered Benefits before we will start to pay for those Covered Benefits. The amounts you are required to pay for the Covered Benefits subject to a Deductible are based upon Sharp Health Plan’s cost for the Covered Benefit. Once you have met your yearly Deductible, you pay the applicable Copayment for Covered Benefits and we pay the rest. The Deductible starts over each year.

How Does the Annual Deductible Work?

- If a Member satisfies the Individual Deductible amount, no further Deductible payments are required for that Member for the specified Covered Benefits for the remainder of the year. Premium payments are still required.
- Once a Member in a family satisfies the Individual Deductible amount for the specified Covered Benefits, the remaining enrolled family members must continue to pay applicable Deductible amounts until either (a) the sum of Deductibles paid by the family reaches the Family Deductible amount or (b) each enrolled family member meets his/her Individual Deductible amount, whichever occurs first.
- When the sum of Deductibles paid for all enrolled Members for the specified Covered Benefits equals the Family Deductible amount, no further Deductibles for the specified Covered Benefits are required from any enrolled Member of that family for the remainder of the calendar year.
- Only amounts that are applied to the Individual Deductible amount may be applied to the Family Deductible amount. Any amount you pay for the specified Covered Benefits for yourself that would otherwise apply to your Individual Deductible amount but which exceeds the Individual Deductible amount will be refunded to you, and will not apply toward your Family Deductible amount. Individual Members

cannot contribute more than their Individual Deductible amount to the Family Deductible amount.

Annual Out-of-Pocket Maximum

There is a maximum total amount of Copayments, Deductibles, and Coinsurance you pay each year for Covered Benefits, excluding supplemental benefits. The annual Out-of-Pocket Maximum amount is listed on the Health Plan Benefits and Coverage Matrix and is renewed at the beginning of each calendar year. Copayments, Deductibles, and Coinsurance for supplemental benefits (e.g., chiropractic services) do not apply to the annual Out-of-Pocket Maximum.

How Does the Annual Out-of Pocket Maximum Work?

- If a Member pays amounts for Covered Benefits that equal the Individual Out-of-Pocket Maximum, no further Copayments, Deductibles, or Coinsurance are required for that Member for Covered Benefits (excluding supplemental benefits) for the remainder of the year. Premium contributions are still required.
- Once a Member in a family satisfies the Individual Out-of-Pocket Maximum, the remaining enrolled family members must continue to pay applicable Copayments, Deductibles, and Coinsurance until either (a) the sum of the Copayments, Deductibles, and Coinsurance paid by the family reaches the Family Out-of-Pocket Maximum or (b) each enrolled family member meets his/her Individual Out-of-Pocket Maximum, whichever occurs first.
- When the sum of the Copayments, Deductibles, and Coinsurance paid for all enrolled Members equals the Family Out-of-Pocket Maximum, no further Copayments, Deductibles, or Coinsurance are required from any enrolled Member of that family for the remainder of the calendar year.
- Only amounts that are applied to the Individual Out-of-Pocket Maximum may be applied to the Family Out-of-Pocket Maximum. Any amount you pay for Covered Benefits for yourself that would otherwise apply to your Individual Out-of-Pocket Maximum but which exceeds the Individual Out-of-Pocket Maximum will be refunded to you, and will not apply toward your Family Out-of-Pocket Maximum. Individual Members cannot contribute more than their Individual Out-of-Pocket Maximum amount to the Family Out-of-Pocket Maximum.

Exceptions to the Annual Out-of-Pocket Maximum

The following payments do not apply to the Out-of-Pocket Maximum. You are required to continue to pay the payments listed below even if the annual Out-of-Pocket Maximum has been reached.

- Payments for services or supplies that the Plan does not cover, e.g., excluded drugs, cosmetic surgery, unauthorized non-Emergency Services. (See the section titled “WHAT IS NOT COVERED?” for additional exclusions.)
- Copayments for supplemental benefits such as assisted reproductive technologies, chiropractic services and hearing aids.

How to Inform the Plan if You Reach the Annual Out-of-Pocket Maximum

Keep the receipts for all Copayments, Deductibles, and Coinsurance you pay. If you meet or exceed your annual Out-of-Pocket Maximum, mail your receipts to Customer Care. We will make arrangements for your Copayments, Deductibles, and Coinsurance to be waived for the remainder of the calendar year. If you have exceeded your annual Out-of-Pocket Maximum, we will reimburse you the difference within sixty (60) days of verification of the amount.

Sharp Health Plan will also keep track of payments you have made towards your annual Out-of Pocket Maximums. When you pay a Deductible for a Covered Service, we will send you a statement called an “Explanation of Benefits” (EOB). Your EOB will include a statement summarizing the amounts you have paid to date toward your Deductible and the annual Out-of-Pocket Maximum.

You can also call Customer Care to obtain your most recent Out-of-Pocket and/or Deductible totals.

Health Savings Account (HSA) Qualified High Deductible Health Plans

If you are enrolled in an HSA-qualified high deductible health plan (HDHP), your Deductible and Out-of-Pocket Maximum will work differently. If you are unsure whether you are enrolled in this type of HDHP, please call Customer Care.

Self-Only Coverage Plan

In HDHPs linked to HSAs, you must meet the Self-Only Deductible and the Self-Only Out-of-Pocket Maximum. Once you meet the Self-Only Deductible, the Plan will pay for your services.

Family Plan

Each individual in the family must meet the Individual Deductible until the Family Deductible is met. The Individual Deductible in an HSA family plan must be at least $2,700 in 2019 under IRS rules. Once the individual meets the Individual Deductible, the Plan will pay for services for that individual in the family plan. Once the Family Deductible is met, the Plan will pay for services for the entire family.

All family members have met the family Out-of-Pocket Maximum when the family’s combined Deductibles, Copayments, and Coinsurance equal the family Out-of-Pocket Maximum.

Deductible Credits

If you have already met part of the year’s calendar year Deductible with a previous health plan, Sharp Health Plan will give you a credit toward your Sharp Health Plan Deductible for approved amounts that were applied toward your Deductible with your previous health plan (for the same calendar year). That amount will also be counted towards your Out-of-Pocket Maximum on your Sharp Health Plan benefit plan.

You must provide the most current explanation of benefits (EOB) from your previous health plan with your request. To request a Deductible credit, please call Customer Care.

You can also find the Deductible credit Request form at **sharphealthplan.com** under “Member Forms” in the Member section of the website.

What if You Get a Medical Bill?

You are only responsible for paying your contributions to the monthly Premiums and any required Deductibles or Copayments for the Covered Benefits you receive. Contracts between Sharp Health Plan and its Plan Providers state that you will not be liable to Plan Providers for sums owed to them by the Plan. You should not receive a medical bill from a Plan Provider for Covered Benefits unless you fail to obtain Authorization for non-Emergency Services. If you receive a bill in error, call the provider who sent you the bill to make sure they know you are a Member of Sharp Health Plan. If you still receive a bill, contact Customer Care as soon as possible.

Some doctors and hospitals that are not contracted with Sharp Health Plan (for example, emergency departments outside Sharp Health Plan’s Service Area) may require you to pay at the time you receive care. In some cases, a non-plan provider may provide covered services at an in-network facility where we have authorized you to receive care. You are not responsible for any amounts beyond your cost share for the covered services you receive at plan facilities where we have authorized you to receive care.

If you pay for Covered Benefits, you can request reimbursement from Sharp Health Plan. Go to **sharphealthplan.com** or call Customer Care to request a member reimbursement form. You will also need to send written evidence of the care you received and the amount you paid (itemized bill, receipt, medical records). We will reimburse you for Covered Benefits within 30 calendar days of receiving your complete information. You must send your request for reimbursement to Sharp Health Plan within 180 calendar days of the date you received care. If you are unable to submit your request within 180 calendar days from the date you received care, please provide documentation showing why it was not reasonably possible to submit the information within 180 days.

We will make a decision about your request for reimbursement and, as applicable, send you a reimbursement check within 30 calendar days of receiving your complete information. If any portion of the reimbursement request is not covered by Sharp Health Plan, we will send you a letter explaining the reason for the denial and outlining your Appeal rights.

WHAT ARE YOUR RIGHTS & RESPONSIBILITIES AS A MEMBER?

As a Sharp Health Plan Member, you have certain rights and responsibilities to ensure that you have appropriate access to all Covered Benefits.

You have the right to:

- Be treated with dignity and respect.
- Have your privacy and confidentiality maintained.
  A STATEMENT DESCRIBING SHARP HEALTH PLAN’S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.
- Review your medical treatment and record with your health care provider.
- Be provided with explanations about tests and medical procedures.
- Have your questions answered about your care.
- Have a candid discussion with your health care provider about appropriate or Medically Necessary treatment options, regardless of cost or benefit coverage.
- Participate in planning and decisions about your health care.
- Agree to, or refuse, any care or treatment.
- Voice complaints (Grievances) or Appeals about Sharp Health Plan or the services you receive as a Sharp Health Plan Member.
- Receive information about Sharp Health Plan, our services and providers, and Member rights and responsibilities.
- Make recommendations about these rights and responsibilities.

You have the responsibility to:

- Provide information (to the extent possible) that Sharp Health Plan and your doctors and other providers need to offer you the best care.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Ask questions if you do not understand explanations and instructions.
- Respect provider office policies and ask questions if you do not understand them.
- Follow advice and instructions agreed-upon with your provider.
- Report any changes in your health.
- Keep all appointments and arrive on time. If you are unable to keep an appointment, cancel 24 hours in advance, if possible.
- Notify Sharp Health Plan of any changes in your address or telephone number.
- Let your health care provider or Sharp Health Plan know if you have any suggestions, compliments or complaints.
- Notify Sharp Health Plan of any changes that affect your eligibility, include no longer working or residing in the Plan’s Service Area.

Security of Your Confidential Information (Notice of Privacy Practices)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Sharp Health Plan provides health care coverage to you. We are required by state and federal law to protect your health information. We have internal processes to protect your oral, written and electronic protected health information (PHI). And we must give you this Notice that tells how we may use and share your information and what your rights are. We have the right to change the privacy practices described in this Notice. If we do make changes, this new Notice will be available upon request in our office and on our website.

Your information is personal and private.
We receive information about you when you become eligible and enroll in our health plan. We also receive medical information from your doctors, clinics, labs and hospitals in order to approve and pay for your health care.

A. HOW WE MAY USE AND SHARE INFORMATION ABOUT YOU

Sharp Health Plan may use or share your information for reasons directly connected to your treatment, payment for that treatment or health plan operations. The information we use and share includes, but is not limited to: Your name, address, personal facts, medical care given to you and your medical history.

Some actions we take as a health plan include: checking your eligibility and enrollment; approving and paying for health care services; investigating or prosecuting fraud; checking the quality of care that you receive; and coordinating the care you receive. Some examples include:

For treatment: You may need medical treatment that requires us to approve care in advance. We will share information with doctors, hospitals and others in order to get you the care you need.

For payment: Sharp Health Plan reviews, approves and pays for health care claims sent to us for your medical care. When we do this, we share information with the doctors, clinics and others who bill us for your care. And we may forward bills to other health plans or organizations for payment.

For health care operations: We may use information in your health record to judge the quality of the health care you receive. We also may use this information in audits, fraud and abuse programs, planning and general administration. We do not use or disclose PHI that is genetic information for underwriting purposes.

B. OTHER USES FOR YOUR HEALTH INFORMATION

1. Sometimes a court will order us to give out your health information. We also will give information to a court, investigator, or lawyer under certain circumstances. This may involve fraud or actions to recover money from others.
2. You or your doctor, hospital and other health care providers may Appeal decisions made about claims for your health care. Your health information may be used to make these Appeal decisions.
3. We also may share your health information with agencies and organizations that check how our health plan is providing services.
4. We must share your health information with the federal government when it is checking on how we are meeting privacy rules.
5. We may share your information with researchers when an Institutional Review Board (IRB) has reviewed and approved the reason for the research, and has established appropriate protocols to ensure the privacy of the information.
6. We may disclose health information, when necessary, to prevent a serious threat to your health or safety or the health and safety of another person or the public. Such disclosures would be made only to someone able to help prevent the threat.
7. We provide Employers only with the information allowed under the federal law. This information includes summary data about their group and information concerning Premium and enrollment data. The only other way that we would disclose your Protected Health Information to your Employer is if you Authorized us to do so.

C. WHEN WRITTEN PERMISSION IS NEEDED

If we want to use your information for any purpose not listed in this notice, we must get your written permission. If you give us your permission, you may take it back in writing at any time.

D. WHAT ARE YOUR PRIVACY RIGHTS?

- You have the right to ask us not to use or share your personal health care information in the ways described in this notice. We may not be able to agree to your request.
- If you pay for a service or a health care item Out-of-Pocket in full, you can ask your Provider not to share that information with us or with other health insurers.
- You have the right to ask us to contact you only in writing or at a different address, post office box, or by telephone. We will accept reasonable requests when necessary to protect your safety.
- You and your personal representative have the right to get a copy of your health information. You will be sent a form to fill out and may be charged a fee for the costs of copying and mailing records. (We may keep you from seeing certain parts of your records for reasons allowed by law.)
- You have the right to ask that information in your records be amended if it is not correct or complete. We may refuse your request if:
  (i) the information is not created or kept by Sharp Health Plan, or (ii) we believe it is correct and complete. If we do not make the changes you ask, you may ask that we review our decision. You also may send a statement saying why you disagree with our records, and that statement will be kept with your records.
  Important: *Sharp Health Plan does not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.*
- When we share your health information after April 14, 2003, you have the right to request a list of what information was

shared, with whom we shared it, when we shared it and for what reasons. This list will not include when we share information: with you; with your permission; for treatment, payment, or health plan operations; or as required by law.

- You have a right to receive written notification if we discover a breach of your unsecured PHI, and determine through a risk assessment that notification is required.
- You have a right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing, for most uses or disclosures of psychotherapy notices, or if we intend to sell your PHI.
- You may revoke an authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.
- You have a right to request a copy of this Notice of Privacy Practices. You also can find this Notice on our website at: **sharphealthplan.com**.
- You have the right to complain about any aspect of our health information practices, per Section F.

E. HOW DO YOU CONTACT US TO USE YOUR RIGHTS?

If you want to use any of the privacy rights explained in this Notice, please call or write us at:

Sharp Health Plan
Attn: Privacy Officer
8520 Tech Way, Suite 200
San Diego, CA 92123
Toll-free at 1-800-359-2002

Sharp Health Plan cannot take away your health care benefits or do anything to get in the way of your medical services or payment in any way if you choose to file a complaint or use any of the privacy rights in this Notice.

F. COMPLAINTS

If you believe that we have not protected your privacy and you wish to complain, you may file a complaint (or Grievance) by contacting:

- **Sharp Health Plan** by sending a letter to the address shown in Section E or by calling us toll-free at 1-800-359-2002.
- **U.S. Department of Health and Human Services, Office for Civil Rights** by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling: 1-877-696-6775, or by visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

WHAT IS THE GRIEVANCE OR APPEAL PROCESS?

If you are having problems with a Plan Provider or your health plan, give us a chance to help. Sharp Health Plan can assist in working out any issues. If you ever have a question or concern, we suggest that you call Customer Care. A Customer Care Representative will make every effort to assist you.

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. You can obtain a copy of the Plan's Grievance and Appeal Policy and Procedure from your Plan Provider or by calling Customer Care. To begin the Grievance process, you or your Authorized Representative can call, write or fax Sharp Health Plan at:

Attn: Sharp Health Plan
Appeal/Grievance Department
8520 Tech Way, Suite 200
San Diego, CA 92123-1450
Toll-free at 1-800-359-2002
Fax: (619) 740-8572

If you prefer to send a written Grievance or Appeal, please send a detailed letter describing your concern, or complete the Grievance Form that you can get from any Plan Provider or directly from a Plan representative. You can also complete the online Grievance/Appeal form on the Plan's website, **sharphealthplan.com**. You can include any information you think is important for your Grievance or Appeal. Please call Customer Care if you need any assistance in completing the form.

There are separate processes for clinical and administrative Grievances and Appeals. Clinical cases are those that require a clinical body of knowledge to render a decision. Only a physician or committee of physicians can render a decision about a clinical Grievance or Appeal. The person who reviews and decides your Appeal will not be the same person who made the initial decision or that person's subordinate.

We will acknowledge receipt of your Grievance or Appeal within five days, and will send you a decision letter within 30 calendar days. If the Grievance or Appeal involves an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life, limb or major bodily function, we will provide you with a decision within 72 hours.

Binding Arbitration – Voluntary

If you have exhausted the Plan's Appeal process and are still unsatisfied, you have a right to resolve your Grievance through voluntary binding arbitration, which is the final step for resolving complaints. Any complaint which may arise, with the exception of medical malpractice, may be resolved through binding arbitration rather than a lawsuit. Binding arbitration means that you agree to waive your rights to a jury trial. Medical malpractice issues are not subject to the arbitration process.

You may begin the arbitration process by submitting a demand for arbitration to Sharp Health Plan. Sharp Health Plan will utilize a neutral arbiter from an appropriate entity. Arbitration will be

conducted in accordance with the rules and regulations of the arbitration entity. Upon receipt of your request, we will forward to you a complete copy of the Arbitration Rules from the arbitration entity and a confirmation that we have submitted a request to the arbitration entity for a list of arbitrators.

If Sharp Health Plan determines that the request for arbitration is applicable under ERISA rules, then the cost of arbitration expenses will be borne by the Plan. If we determine the request for arbitration is not applicable under ERISA rules, then the cost of arbitration expenses will be mutually shared between you and Sharp Health Plan. In cases of extreme hardship, Sharp Health Plan may assume all or a portion of your arbitration fees. The existence of extreme hardship will be determined by the arbitration entity. Please contact Customer Care for more information on qualifying for extreme hardship.

If you do not initiate the arbitration process outlined above, you may have the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) if your Appeal has not been approved.

Additional Resources

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 toll-free 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 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-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet website **www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

If your case is determined by the Department of Managed Health Care to involve an imminent and serious threat to your health, including but not limited to severe pain, the potential loss of life, limb, or major bodily function, or if for any other reason the Department determines that an earlier review is warranted, you will not be required to participate in the Plan's Grievance process for 30 calendar days before submitting your Grievance to the Department for review.

If you believe that your or your Dependent's coverage was terminated or not renewed because of health status or requirements for benefits, you may request a review of the termination by the Director of the Department of Managed Health Care, pursuant to Section 1365(b) of the California Health and Safety Code, at the telephone numbers and Internet websites listed above.

Mediation

You may request voluntary mediation with the Plan prior to exercising your right to submit a Grievance to the Department of Managed Health Care. In order to initiate mediation, you and Sharp Health Plan must both voluntarily agree to mediation. The use of mediation services does not exclude you from the right to submit a Grievance to the Department upon completion of mediation. Expenses for mediation are shared equally between you and the Plan.

Independent Medical Reviews (IMR)

If care that is requested for you is denied, delayed or modified by Sharp Health Plan or a Plan Medical Group, you may be eligible for an Independent Medical Review (IMR). If your case is eligible as described below, and you submit a request for IMR to the Department of Managed Health Care (DMHC), information about your case will be submitted to a medical specialist who will make an independent determination on your case. You will receive a copy of the determination. If the IMR specialist so determines, the Plan will provide coverage for the health care service.

The IMR process is in addition to any other procedures or remedies that may be available to you. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the Plan regarding the care that was requested. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. For cases that are not urgent, the IMR organization designated by the DMHC will provide its determination within 30 calendar days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization will provide its determination within three business days. At the request of the experts, the deadline can be extended by up to three days if there is a delay in obtaining all necessary documentation. IMR is available in the following situations:

Denial of Experimental or Investigational Treatment for Life-Threatening or Seriously Debilitating Conditions

If a service is denied by Sharp Health Plan or a Plan Medical Group because it is deemed to be an investigational or experimental therapy, you may be entitled to request an IMR of this decision. To be eligible for an IMR under this section all of the following conditions must be true:

1. You must have a life-threatening or seriously debilitating condition. "Life-threatening" means either or both of the following: (a) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or (b) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity.
2. Your Plan Physician must certify that you have a condition, as described in paragraph (1) above, for which standard therapies have not been effective, or for which standard therapies would not be medically appropriate, or for which there is no more beneficial standard therapy covered by the Plan than the proposed therapy.
3. Either (a) your Plan Physician has recommended a drug, device, procedure or other therapy that the doctor certifies in writing is likely to be more beneficial to you than any available standard therapies or (b) you or your specialist Plan Physician (board eligible or board certified) has requested a therapy that, based on documentation from the medical and scientific evidence, is likely to be more beneficial than any available standard therapy.
4. You have been denied coverage by the Plan for a drug, device, procedure or other therapy recommended or requested as described in paragraph (3) above.
5. The specific drug, device, procedure or other therapy recommended would be a Covered Benefit, except for the Plan's determination that the therapy is experimental or investigational.

If there is potential that you would qualify for an IMR under this section, the Plan will send you an application within five days of the date services were denied. If you would like to request an Independent Medical Review, return your application to the DMHC. Your physician will be asked to submit the documentation that is described in paragraph (3).

An expedited review process will occur if your doctor determines that the proposed therapy would be significantly less effective if not promptly initiated. In such cases the analyses and recommendations of the experts on the panel shall be rendered within seven days of the request for independent review.

Denial of a Health Care Service as Not Medically Necessary

You may request an Independent Medical Review of disputed health care services from the DMHC if you believe that health care services have been improperly denied, modified, or delayed by Sharp Health Plan or a Plan Medical Group. A "disputed health care service" is any health care service eligible for coverage and payment under your Group Agreement that has been denied, modified, or delayed, in whole or in part, because the service is not Medically Necessary.

The Plan will provide you with an IMR application form with any Appeal findings letter that denies, modifies or delays health care services because the service is not Medically Necessary. If you would like to request an IMR, return your application to the DMHC.

Your application for IMR must be submitted to the DMHC within six months and meet all of the following conditions:

1. (a) Your Plan Provider has recommended a health care service as Medically Necessary; (b) You have received an Urgent Care or Emergency
   Service that a provider determined was Medically Necessary, or (c) You have been seen by a Plan Provider for the diagnosis or treatment of the medical condition for which you seek IMR;
2. The disputed health care service has been denied, modified or delayed by the Plan or a Plan Medical Group, based in whole or in part on a decision that the health care service is not Medically Necessary; and
3. You have filed an Appeal with the Plan and the Plan's decision was upheld or your Appeal remains unresolved after 30 days. If your Appeal requires expedited review, you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow the Plan's Grievance process in extraordinary and compelling cases.

For more information regarding the IMR process or to request an application form, please call or email Customer Care.

WHAT ARE YOUR COVERED BENEFITS?

Covered Benefits

As a Member, you are entitled to receive Covered Benefits subject to all the terms, conditions, exclusions and limitations described in this Member Handbook. Covered Benefits are described below and must be:

1. Medically Necessary;
2. Specifically described in this Member Handbook;
3. Provided by Plan Providers;
4. Prescribed by a Plan Physician and, if required, Authorized in advance by your PCP, your PMG or Sharp Health Plan; and
5. Part of a treatment plan for Covered Benefits or required to treat medical conditions which are direct and predictable complications or consequences of Covered Benefits.

The Covered Benefits described in this Member Handbook do not include dental services for members age 19 and older except as specifically described under **"Dental Services/Oral Surgical Services,"** chiropractic services or assisted reproductive

technologies. These may be covered through supplemental benefits made available by your Employer and described in supplemental benefits brochures. Copayments made for supplemental benefits do not apply toward the annual Out-of-Pocket Maximum.

The Member's Health Plan Benefits and Coverage Matrix details applicable Deductible and Copayments that the Member pays for Covered Benefits, and also includes the Member's annual Out-of-Pocket Maximum.

Important exclusions and limitations are described in the section of this Member Handbook entitled, "WHAT IS NOT COVERED?"

These exclusions or limitations do not apply to Medically Necessary services to treat severe mental illness (SMI) or severe emotional disturbances of a child (SED).

Acupuncture Services

Acupuncture services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain) are a Covered Benefit.

Acute Inpatient Rehabilitation Facility Services

Acute inpatient medical rehabilitation facility services are covered. Authorization for these services will be based on the demonstrated ability of the Member to obtain highest level of functional ability.

Ambulance and Medical Transportation Services

Medical transportation services provided in connection with the following are covered:

- Emergency Services.
- An Authorized transfer of a Member to a Plan Hospital or Plan Skilled Nursing Facility or other interfacility transport.
- Emergency Services rendered by a paramedic without emergency transport.
- Nonemergency ambulance and psychiatric transport van services in the Service Area if the Plan or a Plan Provider determines that your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from Covered Benefits.

Blood Services

Costs of processing, storage and administration of blood and blood products are covered. Autologous (self-directed), donor-directed and donor-designated blood processing costs are covered as ordered by a Plan Physician.

Bloodless Surgery

Surgical procedures performed without blood transfusions or blood products, including Rho(D) Immune Globulin for Members who object to such transfusion, are covered.

Chemical Dependency and Alcoholism Treatment

The following services are covered:

- Inpatient detoxification: Short-term acute drug or alcohol detoxification is covered as an Emergency Medical Condition. Hospitalization in a Plan Hospital for medical management of withdrawal symptoms, including room and board, Plan Physician services, drugs, dependency recovery services, education, case management, counseling, and aftercare programs.
- Transitional residential recovery services: chemical dependency treatment in a nonmedical transitional residential recovery setting if Authorized in writing by Psychiatric Centers at San Diego. These settings provide counseling and support services in a structured environment.
- Outpatient chemical dependency care: day-treatment programs, intensive outpatient programs (programs usually less than 5 hours per day), individual and group chemical dependency counseling, medical treatment for withdrawal symptoms, partial hospitalization (programs usually more than 5 hours per day), and case management services.

Prior Authorization is not required for outpatient chemical dependency office visits obtained through Plan Providers in your Plan Network.

Chemotherapy

Chemotherapy is covered. Outpatient chemotherapy is covered without additional Copayments as part of a comprehensive treatment plan. If the Member is admitted for inpatient chemotherapy, the applicable inpatient services Copayment applies.

Circumcision

Routine circumcision is a Covered Benefit only when the procedure is performed in the Plan Physician's office, outpatient facility or prior to discharge during the neonatal period. The neonatal period is defined as the period immediately following birth and continuing through the first 28 days of life. For a premature infant, requiring inpatient care due to a medical condition, routine circumcision is covered for the duration of the inpatient stay, and for three months post-hospital discharge.

Non-routine circumcision performed as treatment for a Medically Necessary indication is covered at any age.

Clinical Trials

Routine health care services associated with a Member's participation in an eligible clinical trial are covered. To be eligible for coverage, the Member must meet the following requirements:

1. The Member is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition. The term "life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
2. Either (a) the referring health care professional is a Plan Provider and has concluded that the Member's participation

in such trial would be appropriate based upon the Member meeting the conditions of the clinical trial;
or (b) the Member provides medical and scientific information establishing that the Member's participation in the clinical trial would be appropriate based upon the Member meeting the conditions of the clinical trial.

The clinical trial must meet the following requirements:

The clinical trial must be a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition; and

1. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

   a) The National Institutes of Health.
   b) The Centers for Disease Control and Prevention.
   c) The Agency for Health Care Research and Quality.
   d) The Centers for Medicare & Medicaid Services.
   e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs;
   f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
   g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.

2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

3. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Covered Benefits for clinical trials include the following:

- Health care services typically provided absent a clinical trial.
- Health care services required for the provision of and clinically appropriate monitoring of the investigational drug, item, device, or service.
- Services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.
- Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service.

If any Plan Providers participate in the clinical trial and will accept the Member as a participant in the clinical trial, the Member must participate in the clinical trial through the Plan Provider unless the clinical trial is outside the state where the Member lives.

Dental Services/Oral Surgical Services

Your benefit plan includes pediatric dental benefits for Members under the age of 19. Sharp Health Plan's pediatric dental benefits are provided through the Plan's dental provider Access Dental Plan. Attached with this Member Handbook is your Access Dental Plan schedule of benefits that sets forth the applicable benefit and cost-sharing information for the pediatric dental benefits included with this plan.

In addition to the pediatric dental benefits described in the Access Dental Plan schedule of benefits and the summary beginning on page 48, dental services for all Members are covered only as described below:

- Emergency Services for treatment of an accidental injury to sound natural teeth, jawbone, or surrounding tissues. Coverage is limited to treatment provided within 48 hours of injury or as soon as the Member is medically stable.
- Services required for the diagnostic testing and specifically approved medical treatment of medically indicated temporomandibular joint (TMJ) disease.

Oral surgical services are covered only as described below:

- Reduction or manipulation of fractures of facial bones.
- Excision of lesions of the mandible, mouth, lip or tongue.
- Incision of accessory sinuses, mouth, salivary glands, or ducts.
- Reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect or accidental injury.
- Oral or dental examinations performed on an inpatient or outpatient basis as part of a comprehensive workup prior to transplantation surgery.
- Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol.
- Biopsy of gums or soft palate.
- Fluoride trays and/or bite guards used to protect the teeth from caries and possible infection during radiation therapy.
- Reconstruction of a ridge that is performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes).
- Reconstruction of the jaw (e.g., radical neck or removal of mandibular bone for cancer or tumor).
- Ridge augmentation or alveoplasty when consistent with medical policies for reconstructive surgery or cleft palate policies.
- Tooth extraction prior to a major organ transplant or radiation therapy of neoplastic disease to the head or neck.
- Treatment of maxillofacial cysts, including extraction and biopsy.
- Custom-fitted and prefabricated oral appliances for obstructive sleep apnea patients who have mild sleep apnea and meet the criteria for coverage of continuous positive airway pressure (CPAP), but who are intolerant to CPAP.

General anesthesia services and supplies and associated facility charges, rendered in a hospital or surgery center setting, as outlined in sections titled **"Hospital Facility Inpatient Services"** and **"Professional Services,"** are covered for dental and oral surgical services only for Members who meet the following criteria:

1. Under seven years of age,
2. Developmentally disabled, regardless of age, or

3. Whose health is compromised and for whom general anesthesia is Medically Necessary, regardless of age.

Diabetes Treatment

Supplies, equipment and services for the treatment and/or control of diabetes are covered even when available without a prescription, including:

- Blood glucose monitors and testing strips.
- Blood glucose monitors designed for the visually impaired.
- Insulin pumps and all related necessary supplies.
- Ketone urine testing strips.
- Lancets and lancet puncture devices.
- Pen delivery systems for the administration of insulin, if Member meets criteria.
- Podiatric devices to prevent or treat diabetes-related complications.
- Insulin syringes.
- Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin.
- Self-management training, education and medical nutrition therapy.
- Laboratory tests appropriate for the management of diabetes.
- Dilated retinal eye exams.

Insulin, glucagon and other prescription medications for the treatment of diabetes are covered under the prescription drug benefit.

Disposable Medical Supplies

Disposable Medical Supplies are medical supplies that are consumable or expendable in nature and cannot withstand repeated use or use by more than one individual, such as bandages, support hose and garments, elastic bandages and incontinence pads. Disposable Medical Supplies are only covered when provided in a hospital or physician office or by a home health professional as set forth under **"Professional Services."**

Durable Medical Equipment

Durable Medical Equipment (DME) is covered. Coverage is limited to the standard item of equipment that adequately meets your medical needs. Sharp Health Plan reserves the right to determine if covered DME will be purchased or rented.

DME is limited to equipment and devices that are:

1. Intended for repeated use over a prolonged period;
2. Not considered disposable, with the exception of ostomy bags;
3. Ordered by a licensed health care provider acting within the scope of his/her license;
4. Intended for the exclusive use of the Member;
5. Not duplicative of the function of another piece of equipment or device already covered for the Member;
6. Generally not useful to a person in the absence of illness or injury;
7. Primarily serving a medical purpose;
8. Appropriate for use in the home; and
9. Lowest cost item necessary to meet the Member's needs.

Medically Necessary repair or replacement of DME is covered when prescribed by a Plan Physician or ordered by a licensed health care provider acting within the scope of his/her license, and when not caused by misuse or loss. Applicable Copayments apply for authorized DME replacement. No additional Copayments are required for repair of DME.

Inside our Service Area, we cover the following DME for use in your home (or another location used as your home):

- For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets and lancet devices).
- Infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other drugs).
- Standard curved handle or quad cane and replacement supplies.
- Standard or forearm crutches and replacement supplies.
- Dry pressure pad for a mattress.
- Nebulizer and supplies.
- Peak flow meters.
- IV pole.
- Tracheostomy tube and supplies.
- Enteral pump and supplies.
- Bone stimulator.
- Cervical traction (over door).
- Phototherapy blankets for treatment of jaundice in newborns.

After you receive appropriate training at a dialysis facility designated by the Plan, we cover equipment and medical supplies required for hemodialysis and home peritoneal dialysis inside the Service Area.

Emergency Services

Hospital emergency room services provided inside or outside the Service Area that are Medically Necessary for treatment of an Emergency Medical Condition are covered. An Emergency Medical Condition means a medical condition, manifesting itself by symptoms of sufficient severity, including severe pain, which, in the absence of immediate attention, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Out-of-Area medical services are covered only for urgent and Emergency Medical Conditions resulting from unforeseen illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member returns to the Service Area. Out-of-Area medical services will be covered to meet your immediate medical needs. Follow-up care must be Authorized by Sharp Health Plan. Follow-up care for urgent and Emergency Services will be covered until it is clinically appropriate to transfer your care into the Plan's Service Area.

The Member pays an applicable Copayment to the hospital for Emergency Services provided in a hospital emergency room. The Member pays the same Copayment for Emergency Services whether the hospital is a Sharp Health Plan contracted hospital (please note lowercase "hospital") or not. The Copayment is waived if the Member is admitted to the hospital from its emergency room. Emergency services and care include both physical and psychiatric emergency conditions, and active labor.

Family Planning Services

The following family planning services are covered:

- Prescription contraceptive supplies, devices and injections.
- Voluntary sterilization services.
- Interruption of pregnancy (abortion) services.
- Emergency contraception when dispensed by a contracting pharmacist.
- Emergency contraception when dispensed by a non-contracted provider, in the event of a medical emergency.
- Counseling services, in addition to those identified under **"Professional Services."**

The Copayment and/or Deductible for family planning services are determined based on the type and location of the service. For example, a service that takes place at an outpatient facility will result in an outpatient facility Copayment. Please see the Health Plan Benefits and Coverage Matrix.

If you are enrolled in a non-grandfathered plan*, the Plan covers all FDA approved contraceptive methods, sterilization procedures and patient education and counseling for women, as recommended by the Health Resources and Services Administration (HRSA) guidelines, These services are covered without any cost-sharing on the Member's part.

* A grandfathered plan is a plan that has been in existence prior to, and without significant changes since, March 23, 2010.

Habilitative Services

Habilitative Services are health care services and devices that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical therapy and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Sharp Health Plan covers Habilitative Services under the same terms and conditions that are applied to Rehabilitative Services under the plan.

Health Education Services

Sharp Health Plan offers Members a variety of health education and intervention programs provided at convenient locations throughout San Diego County. Additional programs may be available through Plan Providers. Please contact Customer Care for more information.

Home Health Services

Home health services are services provided at the home of the Member and provided by a Plan Provider or other Authorized health care professional operating within the scope of his/her license. This includes visits by registered nurses, licensed vocational nurses and home health aides for physical, occupational, speech and respiratory therapy when prescribed by a Plan Provider acting within the scope of his/her licensure.

Visits on a short-term, intermittent basis are covered for the usual and customary time required to perform the particular skilled service(s), including diagnosis and treatment, for the following services:

- Skilled nursing services of a registered nurse, public health nurse, licensed vocational nurse and/or licensed home health aide.
- Rehabilitation, physical, occupational and speech therapy services.
- Home health aide services, consisting primarily of caring for the Member and furnished by appropriately trained personnel functioning as employees of, or under arrangements with, a Plan home health agency. Such home health aide services will be provided only when the Member is receiving the services specified above and only when such home health aide services are ordered by a physician and supervised by a registered nurse as the professional coordinator employed by a Plan home health agency.
- Medical social service consultations provided by a qualified medical social worker.
- Medical supplies, medicines, laboratory services and Durable Medical Equipment, when provided by a home health agency at the time services are rendered.
- Drugs and medicines prescribed by a Plan Physician and related pharmaceutical services and laboratory services to the extent they would be covered under the Plan if the Member were in the hospital.

Except for a home health aide, each visit by a representative of a home health agency will be considered one home health care visit. A visit of four hours or less by a home health aide will be considered one home health visit.

A Member is eligible to receive home health care visits if the Member:

1. Is confined to the home (Home is wherever the Member makes his or her home, but does not include acute care, rehabilitation or Skilled Nursing Facilities.);
2. Needs Medically Necessary skilled nursing visits or needs physical, speech or occupational therapy; and
3. The home health care visits are provided under a plan of care established and periodically reviewed and ordered by a Plan Provider.

Hospice Services

Hospice services are covered for Members who have been diagnosed with a terminal illness and have a life expectancy of twelve months or less, and who elect hospice care for the illness instead of restorative services covered by Sharp Health Plan. Covered Benefits are available on a 24-hour basis, during periods of crisis, to the extent necessary to meet the needs

of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions.

Covered Benefits include:

- Nursing care.
- Medical social services.
- Home health aide services, skilled nursing services and homemaker services under the supervision of a qualified registered nurse.
- Physician services.
- Drugs.
- Pharmaceuticals, medical equipment and supplies.
- Counseling and social services with medical social services provided by a qualified social worker. Dietary counseling by a qualified provider shall also be provided when needed.
- Bereavement services.
- Physical, occupational and speech therapy as described in this section for short-term inpatient care for pain control and symptom management or to enable the Member to maintain Activities of Daily Living and basic functional skills.
- Interdisciplinary team care with development and maintenance of an appropriate plan of care.
- Medical direction with the medical director being also responsible for meeting the general medical needs of the Member to the extent that these needs are not met by the attending physician.
- Volunteer services.
- Short-term inpatient care arrangements.

Special coverage is also provided for:

- Periods of Crisis: Nursing care services are covered on a continuous basis for 24 hours a day during periods of crisis as necessary to maintain a, enrollee at home. Hospitalization is covered when the interdisciplinary team makes the determination that inpatient skilled nursing care is required at a level that cannot be provided in the home. Either homemaker or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis, but the care provided during these periods must be predominantly nursing care. A period of crisis is a period in which the Member requires continuous care to achieve palliation or management of acute medical symptoms.
- Respite Care: Respite care is short-term inpatient care provided to the Member only when necessary to relieve the family members or other persons caring for the Member. Coverage for respite care is limited to an occasional basis and to no more than five consecutive days at a time.

Hospital Facility Inpatient Services

Hospital facility inpatient services are covered. After the Deductible (if any) has been paid, the Member pays an applicable Copayment to the hospital for each hospitalization.

Hospital inpatient services may include:

- A hospital room of two or more beds, including meals, services of a dietitian and general nursing care.
- Intensive care services.
- Operating and special treatment rooms.
- Surgical, anesthesia and oxygen supplies.
- Administration of blood and blood products.
- Ancillary services, including laboratory, pathology and radiology.
- Administered drugs.
- Other diagnostic, therapeutic and rehabilitative services as appropriate.
- Coordinated discharge planning including planning of continuing care, as necessary.

Hospital Facility Outpatient Services

Hospital facility outpatient services such as outpatient surgery, radiology, pathology, hemodialysis and other diagnostic and treatment services are covered with various or no Copayments paid to the hospital facility.

- Outpatient surgery services are provided during a short-stay, same-day or when services are provided as a substitute for inpatient care. These services include, but are not limited to colonoscopies, endoscopies, laparoscopic and other surgical procedures.
- Acute and chronic hemodialysis services and supplies are covered.

Infusion Therapy

Infusion therapy refers to the therapeutic administration of drugs or other prepared or compounded substances by the intravenous route and is covered by Sharp Health Plan. The infusions must be administered in the Member's home, in a physician's office or in an institution, such as board and care, custodial care, assisted living facility, or infusion center, that is not a hospital or institution primarily engaged in providing skilled nursing services or rehabilitation services.

The Copayments and Deductibles for infusion therapy services are determined based on the type and location of the service. For example, if this service is provided during an office visit then the office visit Copayment will be charged. Please see the Health Plan Benefits and Coverage Matrix.

Injectable Drugs

Outpatient injectable medications and self-injectable medications are covered. Outpatient injectable medications include those drugs or preparations which are not usually self-administered and which are given by the intramuscular or subcutaneous route. Outpatient injectable medications (except insulin) are covered when self-administered or administered as a customary component of a Plan Physician's office visit and when not otherwise limited or excluded (e.g., certain immunizations, infertility drugs, or off-label use of covered injectable drugs).

Self-administered drugs are drugs that are injected subcutaneously (under the skin) that are approved by the FDA for self-administration and/or are packaged in patient friendly injections devices along with instructions on how to administer. Self-injectable insulin and GLP1 agents for diabetes are covered under the outpatient prescription drug benefit, most other self-administered injectable drugs are covered as part of the medical benefit.

Maternity and Pregnancy Services

The following maternity and pregnancy services are covered:

- Prenatal and postnatal services, including but not limited to Plan Physician visits.
- Laboratory services (including the California Department of Health Services' Expanded Alpha Fetoprotein (AFP) Program).
- Radiology services.
- Prenatal diagnosis of genetic disorders of a fetus in high-risk pregnancy cases.
- Breast pump and supplies required for breast pumping within 365 days after delivery. (Optional accessories such as tote bags and nursing bras are not covered.) A new breast pump and supplies will be provided for subsequent pregnancies, but no more often than one every three years.

Prenatal and postnatal office visits Copayments may apply and are separate from hospital Copayments. For delivery, the Member pays the applicable Copayment to the hospital facility at the time of admission. An additional hospital Copayment applies if the newborn requires a separate admission from the mother because care is necessary to treat an ill newborn.

Inpatient hospital care is covered for no less than 48 hours following a normal vaginal delivery and ninety-six (96) hours following a delivery by cesarean section. The mother, in consultation with the treating physician, may decide to be discharged before the 48-hour or 96-hour time period. Extended stays beyond the 48-hour or 96-hour time period must be Authorized. Sharp Health Plan will also cover a follow-up visit within 48 hours of discharge when prescribed by the treating physician. The visit shall include parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating physician, in consultation with the mother, will determine whether the post-discharge visit shall occur at the home, at the hospital, or at the treating physician's office after assessment of the environmental and social risks and the transportation needs of the family.

Mental Health Services

Sharp Health Plan covers Mental Health Services only for the diagnosis or treatment of Mental Disorders.

The following services are covered:

Outpatient Mental Health Services

We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license:

- Individual office visits and group mental health evaluation and treatment.
- Psychological testing when necessary to evaluate a Mental Disorder.
- Outpatient services for the purpose of monitoring drug therapy.
- Behavioral Health Treatment for pervasive developmental disorders or autism.
- Intensive outpatient treatment (programs usually less than 5 hours per day).
- Partial hospitalization (programs usually more than 5 hours per day).
- Case management services.
- Electroconvulsive therapy

Prior Authorization is not required for outpatient mental health office visits obtained through Plan Providers in your Plan Network.

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs

- Inpatient psychiatric hospitalization. Coverage includes room and board, drugs and services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license.
- Intensive psychiatric treatment programs. Coverage includes short-term hospital-based intensive outpatient care (partial hospitalization), short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program, short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis and psychiatric observation for an acute psychiatric crisis.

Members have direct access to Plan Providers of mental health services without obtaining a PCP referral. Covered mental health benefits must be obtained through Plan Providers. Mental health services that are not provided by Plan Providers are not covered, and you will be responsible to pay for those services.

Please call Psychiatric Centers at San Diego toll-free at 1-877-257-7273 whenever you need mental health services. All calls are confidential.

MinuteClinic®

As a Sharp Health Plan Member, you may receive the covered services listed below at any MinuteClinic® location. These services are not an alternative to Emergency Services or ongoing care. These services are provided in addition to the Urgent Care Services available to you as a Sharp Health Plan Member. MinuteClinic is the walk-in medical clinic located inside select CVS/pharmacy® stores. MinuteClinic provides convenient access to basic care. It is staffed with certified family nurse practitioners and physician assistants and is the largest provider of retail health care in the United States. In addition, it was the first retail health care provider to receive accreditation (2006) and reaccreditation (2009, 2012 and 2015) from The Joint Commission, the national evaluation and certifying agency for nearly 20,000 health care organizations and programs in the United States.

The following services are covered by Sharp Health Plan at MinuteClinic:

- Diagnosis and treatment for common family illnesses such as strep throat, allergy symptoms, pink eye and infections of the ears, nose and throat.
- Flu vaccinations.
- Treatment of minor wounds, abrasions and minor burns.
- Treatment for skin conditions such as poison ivy, ringworm and acne.

No appointment or Prior Authorization is necessary to receive covered services at a CVS MinuteClinic. The CVS MinuteClinic providers may refer you to your Sharp Health Plan PCP or request a Plan authorization for a referral to Plan specialist if you need services other than those covered at MinuteClinic locations.

For more information about these services and age restrictions, please visit **www.MinuteClinic.com**. If you receive these services at a MinuteClinic, your cost is equal to the PCP copayment. (Deductible may apply.) There is no copayment for flu vaccinations. You have access to all MinuteClinic locations, including 11 within San Diego County and over 600 other locations in 33 states. To locate a participating MinuteClinic near you visit **www.MinuteClinic.com** or call MinuteClinic directly at 1-866-389-ASAP (2727).

Ostomy and Urological Services

Ostomy and urological supplies prescribed in accord with the Plan's soft goods formulary guidelines are a Covered Benefit. Coverage is limited to the standard supply that adequately meets your medical needs.

The soft goods formulary includes the following ostomy and urological supplies:

- Adhesives – liquid, brush, tube, disc or pad.
- Adhesive removers.
- Belts – ostomy.
- Belts – hernia.
- Catheters.
- Catheter insertion trays.
- Cleaners.
- Drainage bags and bottles – bedside and leg.
- Dressing supplies.
- Irrigation supplies.
- Lubricants.
- Miscellaneous supplies – urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation syringes, bulbs and pistons; tubing; catheter clamps, leg straps and anchoring devices; penile or urethral clamps and compression devices.
- Pouches – urinary, drainable, ostomy.
- Rings – ostomy rings.
- Skin barriers.
- Tape – all sizes, waterproof and non-waterproof.

Sharp Health Plan's formulary guidelines allow you to obtain non-preferred ostomy and urological supplies (those not listed on the soft goods formulary for your condition) if they would otherwise be covered and the Plan or Plan Medical Group determines that they are Medically Necessary.

Outpatient Prescription Drugs

Outpatient prescription drugs are covered. You may obtain covered Outpatient Prescription Drug Benefits from any network retail or mail order Plan Pharmacies. Some prescription drugs are subject to restricted distribution by the United States Food and Drug Administration or require special handling, provider coordination, or patient education that can only be provided by a specific pharmacy. Except for Emergency Services and Out-of-Area Urgent Care Services, outpatient prescription drugs that are not obtained from a Plan Pharmacy or not obtained through your pharmacy benefits with your Sharp Health Plan Member ID card (for example: paid for by cash or with a coupon) are not covered and you will be responsible for payment. In addition, the amount paid will not count toward your Deductible or Out-of-Pocket Maximum only if prescription drugs are obtained without Prior Authorization from the Plan.

Look in your Provider Directory to find a Plan Pharmacy near you or consult our website at **sharphealthplan.com** and search for a pharmacy that is convenient for you by using the "Find a Pharmacy" function on the "Member Center" page. Always present your Sharp Health Plan Member ID card to the Plan Pharmacy. Ask them to inform you if something is not going to be covered.

You pay the Copayments, Coinsurance and/or Deductible for Covered Benefits as listed in your Health Plan Benefits and Coverage Matrix. If the retail price for your prescription drug is less than your Copayment, you will only pay the retail price. Cost-sharing for covered orally administered anticancer medications will not exceed $200 for an individual prescription of up to a 30-day supply. In addition, orally administered anticancer medications will not be subject to a Deductible unless you are enrolled in a HSA-compatible high Deductible health plan.

You or your doctor may request a partial fill of an oral, solid dosage form of a Schedule II prescription drug from a pharmacy. A partial fill is when you receive less than the full quantity prescribed by your doctor. A Schedule II drug is one that has a high potential for abuse, with use potentially leading to severe psychological or physical dependence. The plan will prorate your copayment for a partial fill; however if the pharmacy charges you two or more copayments for subsequent partial fills of the same prescription, the Plan will reimburse you for the excess copayments. Please see "What if You Get a Medical Bill" for information on how to request reimbursement.

Covered outpatient prescription medications include:

Tier 1: Most generic drugs and low cost preferred brands.

Tier 2: Non-preferred generic drugs, preferred brand name drugs, and any other drugs recommended by Sharp Health Plan's Pharmacy and Therapeutics committee based on safety, efficacy and cost.

Tier 3: Non-preferred brand name drugs or drugs that are recommended by Sharp Health Plan's Pharmacy and Therapeutics committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.

Tier 4: Drugs that are biologics, and drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost the health plan more than six hundred dollars ($600) net of rebates for a one-month supply.

PV: Select drugs covered with no copayment, including certain contraceptives for women.

MB: Drugs typically covered under the medical benefit.

Please consult your Health Plan Benefits and Coverage Matrix for specific information about your benefit. For additional information about your Copayments, Coinsurance and/or Deductible, please consult the benefits information available online by logging onto SharpConnect at **sharphealthplan.com**. When you create an account at Sharp Connect, you can access your benefits information online 24 hours a day, 7 days a week.

When a generic is available, the pharmacy is required to fill your prescription with the generic equivalent unless Prior Authorization is obtained and the brand name drug is determined to be medically necessary. The Food and Drug Administration (FDA) applies rigorous standards for identity, strength, quality, purity and potency before approving a generic drug. Generics are required to have the same active ingredient, strength, dosage form, and route of administration as their brand-name equivalents.

Some drugs are commercially available as both a brand and a generic version. It is the policy of Sharp Health Plan that when a generic is available, Sharp Health Plan does not cover the corresponding brand-name drug. If a generic version of a drug is available, the brand version will not be listed and will require Prior Authorization. The Plan requires the dispensing pharmacy to dispense the generic drug unless Prior Authorization for the brand is obtained. The amount of drug you may receive at any one time is limited to a 30-day supply or, if the treatment is for less than 30 days, for the medically necessary amount of the drug, unless the prescription is for a maintenance drug dispensed through mail order. This limitation does not apply to FDA-approved, self-administered hormonal contraceptives, which are available in a 12-month supply. For more information about maintenance drugs, see the "HOW DO I OBTAIN MAINTENANCE DRUGS BY MAIL ORDER?" below.

SHARP HEALTH PLAN DRUG LIST

The Sharp Health Plan Drug List (also known as a Formulary) was developed to identify the safest and most effective drugs for Members while attempting to maintain affordable pharmacy benefits.

The Drug List is updated regularly, based on input from the Sharp Health Plan Pharmacy & Therapeutics (P&T) Committee, which meets quarterly. The Committee members are clinical pharmacists and actively practicing physicians of various medical specialties. Voting members are recruited from the Plan's provider network based on experience, knowledge and expertise. In addition, the P&T Committee frequently consults with other medical experts to provide input to the Committee.

Updates to the Drug List and drug usage guidelines are made as new clinical information and new drugs become available. In order to keep the Drug List current, the P&T Committee evaluates clinical effectiveness, safety and overall value through:

- Medical and scientific publications
- Relevant utilization experience; and
- Physician recommendations.

Some drugs are commercially available as both a brand and a generic version. It is the policy of Sharp Health Plan that when a generic is available, Sharp Health Plan does not cover the corresponding brand-name drug. If a generic version of a drug is available, the brand version will not be listed and will require Prior Authorization. The Plan requires the dispensing pharmacy to dispense the generic drug unless Prior Authorization for the brand is obtained. If the brand-name drug is Medically Necessary and prior Authorization is obtained from Sharp Health Plan, the Member must pay the cost share for the corresponding tier.

To obtain a copy of Sharp Health Plan's current Drug List, please visit our website at **sharphealthplan.com** or call Sharp Health Plan Customer Service at 1-800-359-2002.

WHAT IS THE OUTPATIENT PRESCRIPTION DRUG PRIOR AUTHORIZATION PROCESS?

Drugs with the PA symbol next to the drug name in the Drug List are subject to Prior Authorization. This means that your doctor must contact Sharp Health Plan to obtain advance approval for coverage of the drug. To request Prior Authorization, your doctor must fill out a Prior Authorization form including information to demonstrate medical necessity and submit it to Sharp Health Plan. Sharp Health Plan processes routine and urgent requests from doctors in a timely fashion. Sharp Health Plan processes routine requests within 72 hours and urgent request within 24 hours of Sharp Health Plan's receipt of the information reasonably necessary and requested by Sharp Health Plan to make the determination. Information reasonably necessary to make a determination includes information the Plan has requested to make a determination, as appropriate and medically necessary for the nature of the member's condition. Urgent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function Upon receiving your physician's request for Prior Authorization, Sharp Health Plan will evaluate the information submitted and make a determination based on established clinical criteria for the particular drug.

If Sharp Health Plan denies your doctor's request for Prior Authorization, you will receive a letter that explains the specific reason(s) for the denial and your right to appeal or file a grievance as set forth in the section "What is the Grievance or Appeal Process?"

WHAT ARE OPIATE DOSAGE THRESHOLDS?

Certain classes, categories, doses or combinations of opiate drugs may require Prior Authorization when the dosage is at or above a threshold considered unsafe in the professional clinical judgment of your pharmacist. If your pharmacist deems that an opiate dosage above the threshold is Medically Necessary for you, your provider may need to submit a Prior Authorization request to support the medical necessity for coverage.

WHAT IS STEP THERAPY?

Drugs with the ST symbol next to the drug name in the Drug List are subject to step therapy. This means that a Member must try an alternative prescription drug first that Sharp Health Plan determines will be clinically effective. There may be a situation where it may be medically necessary for a Member to receive certain medications without first trying an alternative drug. In these instances, your Provider may request Prior Authorization by calling or faxing Customer Care. The list of prescription drugs subject to step therapy is subject to change by Sharp Health Plan.

The criteria used for Prior Authorization and step therapy are developed and based on input from the Sharp Health Plan P&T Committee as well as physician specialist experts. Your physician may contact Sharp Health Plan to obtain the usage guidelines for specific drugs. In addition, your physician may log onto their account in Sharp Connect to view the usage guidelines.

If you have moved from another insurance plan to Sharp Health Plan and are taking a drug that your previous insurer covered,

Sharp Health Plan will not require you to follow step-therapy in order to obtain that drug. Your physician may need to submit a request to Sharp Health Plan in order to provide you with this continuity of coverage.

WHAT IS QUANTITY LIMIT?

Drugs with the QL symbol next to the drug name in the Drug List are subject to quantity limits. It is the policy of Sharp Health Plan to maintain effective drug utilization management procedures. Such procedures include quantity limits on prescription drugs. The Plan ensures appropriate review when determining whether or not to authorize a quantity of drug that exceeds the quantity limit. Quantity limits exist when drugs are limited to a determined number of doses based on criteria including, but not limited to, safety, potential overdose hazard, abuse potential, or approximation of usual doses per month, not to exceed the FDA maximally approved dose. Your doctor may follow the Prior Authorization process when requesting an exception to the Sharp Health Plan quantity limit for a drug.

WHAT IS THERAPEUTIC INTERCHANGE?

Sharp Health Plan employs therapeutic interchange as part of its prescription drug benefit. Therapeutic interchange is the practice of replacing (with the prescribing physician's approval) a prescription drug originally prescribed for a patient with a prescription drug that is its therapeutic equivalent. Using therapeutic interchange may offer advantages to the member such as value through improved convenience and affordability or improved outcomes or fewer side effects. Two or more drugs are considered therapeutically equivalent if they can be expected to produce similar levels of clinical effectiveness and sound medical outcomes in patients. If during the Prior Authorization process, the requested drug has a preferred therapeutic equivalent on the Plan Drug List, a request to consider the preferred medication may be faxed to the prescribing physician. The prescribing physician may choose to use therapeutic interchange and select a pharmaceutical that does not require Prior Authorization.

WHAT IS GENERIC SUBSTITUTION?

The Food and Drug Administration (FDA) applies rigorous standards for identity, strength, quality, purity and potency before approving a generic drug. Generics are required to have the same active ingredient, strength, dosage form, and route of administration as their brand-name equivalents. When a generic is available, the pharmacy is required to switch a brand name drug to the generic equivalent unless Sharp Health Plan has authorized the brand name drug due to medical necessity.

WHAT IF A DRUG IS NOT LISTED IN THE DRUG LIST?

Sharp Health Plan offers an open formulary which means unless your drugs is listed as a plan exclusion it will be included in our formulary. New drugs that are not yet listed in the Drug List are not excluded from coverage and are available on Tier 3 or Tier 4 unless the drug is specifically identified as a plan exclusion. In some cases, these drugs may require prior authorization. If you do not see your drug on our formulary, you can contact Customer Care to find out how your drug is covered. There may be times when it is medically necessary for you to receive a drug that is not listed on Sharp Health Plan's Drug List. In these instances, your doctor may request Prior Authorization as described above.

Additional information about specific prescription drug benefits and drug benefit exclusions can be found in your Sharp Health Plan Summary of Benefits and Evidence of Coverage.

HOW DO I OBTAIN MAINTENANCE DRUGS BY MAIL ORDER?

Mail order is a convenient, cost-effective way to obtain maintenance drugs. Maintenance drugs are those prescribed on a regular, ongoing basis to maintain health. Most maintenance drugs in Tier 1, Tier 2, Tier 3 and PV can be obtained for a 90-day supply at mail or retail. To use this service:

1. Have your doctor write a prescription for up to a 90-day supply of your maintenance drug.
2. Complete the mail service order form brochure that you received with your New Member materials. If you did not receive a mail order form brochure you can call customer care at 1-800-359-2002 to have one mailed to you.
3. Mail your original prescription along with the Copayment, using the pre-addressed, postage-paid envelope attached to the order form. Your prescription will arrive at your home in two to three weeks.
4. If your prescription includes refills, you can re-order by phone. Simply call the toll free number on your prescription bottle to order a refill. If you have any questions or do not have a brochure, contact our Customer Services Department by calling (858) 499-8300 or 1-800-359-2002 or via e-mail at customer.service@sharp.com.

Maintenance drugs available through mail are listed in the drug formulary. Please check the listing of mail order medications in your drug formulary. Please check the searchable Drug List tool at www.sharphealthplan.com to determine if your drug is available through mail order, or call Customer Care.

HOW DO I OBTAIN SPECIALTY DRUGS?

Specialty drugs are high-cost drugs that may require specialized delivery and administration on an ongoing basis. They are often for chronic conditions and involve complex care issues that need to be managed. Examples include Harvoni, Sovaldi, Xeloda, Temodar, Sensipar, and Zortress. Other criteria that would classify a drug as a specialty drug are as follows: the Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or; Self administration requires training, clinical monitoring or; Drug was manufactured using biotechnology or; the Plan's cost (net of rebates) is more than $600.

Specialty drugs are available for a maximum of a 30-day supply. Please consult your Health Plan Benefits and Coverage Matrix for the 30-day Copayment or Coinsurance that applies to specialty drugs.

All specialty medications require Prior Authorization from Sharp Health Plan. Upon approval of your specialty drug, you will receive information on which retail and mail pharmacies can supply your drug.

HOW ARE DEDUCTIBLES, COPAYMENTS, AND COINSURANCE APPLIED FOR MY COVERED OUTPATIENT PRESCRIPTION DRUG BENEFITS?

The following copayments apply to prescription drugs prescribed by a Plan Provider and dispensed by a Plan Pharmacy and to prescription drugs prescribed and dispensed for Emergency Services or out-of-area urgent care services. Please see your Health Plan Benefits and Coverage Matrix for the copayment amount for each tier.

A. Retail Pharmacy

1. For up to a 30-day supply of a Tier 1 drug on the Drug List, you pay **one Tier 1 Copayment or Coinsurance**.
2. For up to a 30-day supply of a Tier 2 drug on the Drug List, you pay **one Tier 2 Copayment or Coinsurance**.
3. For up to a 30-day supply of a Tier 3 drug on the Drug List, you pay **one Tier 3 Copayment or Coinsurance**.
4. For up to a 30-day supply of a Tier 4 drug on the Drug List, you pay **one Tier 4 Coinsurance** amount
5. Medications on PV are available at $0 cost-share and are not subject to a Deductible.
6. Medications on MB are obtained through your medical benefit and are subject to the charges applicable under your medical benefit.

B. Mail Order Pharmacy

1. For up to a 90-day supply of a Tier 1 maintenance drug that is obtained through the Prescription Home Delivery Service, you pay **two Tier 1 Copayments**.
2. For up to a 90-day supply of a Tier 2 maintenance drug that is obtained through the Prescription Home Delivery Service, you pay **two Tier 2 Copayments**.
3. For up to a 90-day supply of a Tier 3 maintenance drug that is obtained through the Prescription Home Delivery Service, you pay **two Tier 3 Copayments**.
4. Medications on Tier 4 are only available for a 30 day supply per fill, you pay **one Tier 4 Coinsurance amount**.
5. For up to a 90-day supply of a PV maintenance drug that is obtained through the Prescription Home Delivery Service (if covered), you pay **no Copayment or Coinsurance**.

Some benefit plans also have a Deductible that applies to drugs covered by Sharp Health Plan or have a combined pharmacy and medical Deductible. If your benefit plan includes a Deductible, you are responsible for paying all costs for the covered drugs or the combined pharmacy and medical Deductible, if applicable, each calendar year, up to the amount of the Deductible, before Sharp Health Plan will cover those drugs at the applicable Copayment or Coinsurance amount. Please see your Health Plan Benefits and Coverage Matrix for further detail. You may receive a 12-month supply of an FDA-approved, self-administered hormonal contraceptive, such as birth control pills, dispensed at one time at no copayment or coinsurance.

WHEN CAN I REFILL MY PRESCRIPTION?

Sharp Health Plan allows you to refill your prescription after you have used at least 70% of the prescribed amount. For a 30-day supply, this means you can get a refill 22 days after you last filled the prescription. For a 90-day supply, you can get a refill 64 days after you last filled the prescription. If you try to order a refill at the pharmacy too soon, you will be asked to wait until the allowable refill date. A prescription cannot be refilled if there are no refills left or if the prescription has expired. If that is the case, please speak with your doctor.

Exceptions to filling a drug before the approved refill date can be made in certain circumstances. If your doctor increases your daily dose, the pharmacy or prescribing physician can submit a Prior Authorization form to Sharp Health Plan requesting that the Plan override the “refill too soon” denial. If you need to refill a medication early because you are going on an extended vacation, you can call Sharp Health Plan to request a “vacation override”. Please allow 72 hours for Sharp Health Plan to review your request and make a decision.

If you have any questions regarding when your prescription is eligible to be refilled, please call Sharp Health Plan Customer Care at (858) 499-8300 or 1-800-359-2002.

DRUGS, SERVICES AND SUPPLIES COVERED UNDER YOUR MEDICAL BENEFIT

The following services and supplies are covered as described elsewhere in this Member Handbook. These Covered Benefits are not subject to the Deductibles, Copayments, Coinsurance, exclusions, or limitations that apply to your outpatient prescription drug benefits.

Please refer to the applicable sections of your Member Handbook for specific information about the Deductibles, Copayments, Coinsurance, exclusions, and limitations that apply to these Covered Benefits.

1. Medically necessary formulas and special food products prescribed by a Plan physician to treat phenylketonuria (PKU) provided that these formulas and special foods exceed the cost of a normal diet.
2. Medically necessary injectable and non-injectable drugs and supplies that are administered in a physician’s office and self-injectable drugs covered under the medical benefit.
3. FDA approved medications used to induce spontaneous and non-spontaneous abortions that may only be dispensed by or under direct supervision of a physician.
4. Immunization or immunological agents, including but not limited to, biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
5. Equipment and supplies for the management and treatment of diabetes, including insulin pumps and all related necessary supplies, blood glucose monitors, testing strips, and lancets and lancet puncture devices. Insulin, glucagon and insulin syringes are covered under the outpatient prescription drug benefits.
6. Items that are approved by the FDA as a medical device. Please refer to the Member Handbook under Disposable Medical Supplies, Durable Medical Equipment, and Family Planning for information about medical devices covered by Sharp Health Plan.

Outpatient Rehabilitation Therapy Services

Outpatient rehabilitation services, including occupational, physical and speech therapy, are covered. The Member pays an applicable Copayment to the Plan Physician or other health professional for each visit. Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, Skilled Nursing Facility, or home. The goal of rehabilitation therapy is to assist Members to become as independent as possible, using appropriate adaptations if needed to achieve basic Activities of Daily Living including bathing, dressing, feeding, toileting and transferring (e.g., moving from the bed to a chair).

Speech therapy is covered when there is a delay in obtaining services through the school system and when additional services are determined to be Medically Necessary, i.e., where injury, illness or congenital defect is documented (e.g., hearing loss, chronic otitis media, brain tumor, cerebral palsy, cleft palate, head trauma). Sharp Health Plan will require periodic evaluations of any therapy to assess ongoing medical necessity.

Phenylketonuria (PKU)

The diagnosis and treatment of phenylketonuria are covered as follows:

- Medically Necessary formulas and special food products prescribed by a Plan Physician, to the extent that the cost of these items exceeds the cost of a normal diet.
- Consultation with a doctor who specializes in the treatment of metabolic diseases.

Preventive Care Services

The following preventive care services are covered:

- Well child physical examinations (including vision and hearing screening in the PCP's office), all periodic immunizations, related laboratory services, and screening for blood lead levels in children of any age who are at risk for lead poisoning, as determined by a Sharp Health Plan physician and surgeon, if the screening is prescribed by a Sharp Health Plan health care provider, in accordance with the current recommendations from the American Academy of Pediatrics, U.S. Preventive Services Task Force, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the Health Resources and Services Administration and the American Academy of Family Physicians.
- Well adult physical examinations, episodic immunizations and related laboratory services in accordance with the current recommendations from the U.S. Preventive Services Task Force, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the Health Resources and Services Administration and Sharp Health Plan medical policies.
- Routine gynecological examinations, mammograms and cervical cancer screening tests, in accordance with the guidelines of the American College of Obstetrics and Gynecology and the Health Resources and Services Administration. Members may directly access OB/GYN care within their PMG without a referral from their PCP.
- All generally accepted cancer screening tests, as determined by the United States Preventive Services Task Force and approved by the federal Food and Drug Administration, including the conventional Pap test, any cervical cancer screening test and human papillomavirus screening test and prostate cancer screening.
- Other preventive diagnostic tests that may be delivered in an outpatient surgical facility, including but not limited to colonoscopy and endoscopy.
- HIV testing regardless of whether the testing is related to a primary diagnosis.
- Screening for tobacco use.
- For those who use tobacco products:
  - All FDA-approved tobacco cessation medications (including over-the-counter medications) when prescribed by a health care provider, without Prior Authorization.

Preventive Care Services are provided at no cost-share to Members; however, reasonable medical management techniques may be used to determine the frequency, method, treatment or setting for a recommended preventive service, to the extent not specified in the recommendation or guideline regarding that preventive service.

Professional Services

The following Professional Services (provided by a Plan Physician or other licensed health professional) are covered. The Copayments and Deductibles for Professional Services are determined based on the type and location of the service. Please see the Health Plan Benefits and Coverage Matrix.

- Doctor office visits for consultation, treatment, diagnostic testing, etc.
- Surgery and assistant surgery.
- Inpatient hospital and Skilled Nursing Facility visits.
- Professional office visits.
- Doctor visits in the Member's home when the Member is too ill or disabled to be seen during regular office hours.
- Anesthesia administered by an anesthetist or anesthesiologist.
- Diagnostic radiology testing.
- Diagnostic laboratory testing.
- Radiation therapy and chemotherapy.
- Dialysis treatment.
- Supplies and drugs approved by the Food and Drug Administration and provided by and used at the doctor office or facility.

Prosthetic and Orthotic Services

Prosthetic and certain orthotic services are covered if all of the following requirements are met:

- The device is in general use, intended for repeated use and primarily and customarily used for medical purposes.
- The device is the standard device that adequately meets your medical needs.

These services include corrective appliances, artificial aids and therapeutic devices, including fitting, repair, replacement and maintenance, as well as devices used to support, align, prevent or correct deformities of a movable part of the body (orthotics); devices used to substitute for missing body parts (prosthesis); medical pressure garments; devices implanted surgically (such as cochlear implants) and prosthetic devices relating to laryngectomy or mastectomy.

The following external prosthetic and orthotic devices are covered:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx. (This coverage does not include electronic voice-producing machines, which are not prosthetic devices.)

- Prostheses needed after a Medically Necessary mastectomy and up to three brassieres required to hold a breast prosthesis every 12 months
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral and parenteral nutrition: enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding supply kits; enteral nutrition infusion pump; enteral tubing; gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; parenteral nutrition solutions; stomach tube; and supplies for self-administered injections
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

Orthopedic shoes, foot orthotics or other supportive devices of the feet, are not covered except under the following conditions:

- A shoe that is an integral part of a leg brace and included as part of the cost of the brace.
- Therapeutic shoes furnished to selected diabetic Members.
- Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care.
- Prosthetic shoes that are an integral part of a prosthesis.
- Special footwear needed by persons who suffer from foot disfigurement including disfigurement from cerebral palsy, arthritis, polio, spinabifida, diabetes and foot disfigurement caused by accident or developmental disability.

Foot orthotics are covered for diabetic Members, which includes therapeutic shoes (depth or custom-molded) and inserts for Members with diabetes mellitus and any of the following complications involving the foot:

- Peripheral neuropathy with evidence of callus formation.
- History of pre-ulcerative calluses.
- History of previous ulceration.
- Foot deformity.
- Previous amputation of the foot or part of the foot.
- Poor circulation.

Repair or replacement of prosthetics and orthotics are covered when prescribed by a Plan Physician or ordered by a licensed health care provider acting within the scope of his/her license, and when not caused by misuse or loss. The applicable Copayment per the Health Plan Benefits and Coverage Matrix applies for both repair and replacement.

Radiation Therapy

- Radiation therapy (standard and complex) is covered.
- Standard photon beam radiation therapy is covered.
- Complex radiation therapy is covered. This therapy requires specialized equipment, as well as specially trained or certified personnel to perform the therapy. Examples include, but are not limited to: brachytherapy (radioactive implants), conformal photon beam radiation and intensity-modulated radiation therapy (IMRT). Gamma knife procedures and stereotactic procedures are covered under Outpatient Surgery for the purposes of determining Copayments.

Radiology Services

Radiology services provided in the doctor's office, outpatient facility, or inpatient hospital facility are covered. Advanced radiology services are covered for the diagnosis and ongoing medical management of an illness or injury. Examples of advanced radiology procedures include, but are not limited to CT scan, PET scan, magnetic resonance imaging (MRI), magnetic resonance angiography (MRA) and nuclear scans.

Reconstructive Surgical Services

Plastic and reconstructive surgical services are covered only as described below.

- Reconstructive surgical services following a mastectomy or lymph node dissection are covered. The length of a hospital stay associated with a mastectomy or lymph node dissection is determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes. There is no Prior Authorization required in determining the length of hospital stay following these procedures. Members who elect to have breast reconstruction after a mastectomy are covered for all complications of the mastectomy and reconstructive surgery, prostheses for, and reconstruction of, the affected breast, and reconstructive surgery on the other breast as may be needed to produce a symmetrical appearance.
- Reconstructive surgical services, performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors, disease or Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered when performed to improve function or create a normal appearance, to the extent possible.

The Copayments and Deductibles for reconstructive surgical services are determined based on the type and location of the service. Please see the Health Plan Benefits and Coverage Matrix.

Skilled Nursing Facility Services

Skilled Nursing Facility services are covered for up to a maximum of 100 days per benefit period in a semi-private room (unless a private room is Medically Necessary). Covered Benefits for skilled nursing care are those services prescribed by a Plan Provider and provided in a qualified licensed Skilled Nursing Facility. A benefit period begins the day you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. The benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 days in a row. If you go into a hospital or a Skilled Nursing Facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. A prior 3-day stay in the acute care hospital is not required to commence a benefit period.

Covered Benefits include:

- Physician and skilled nursing on a 24-hour basis.
- Room and board.
- Imaging and laboratory procedures.
- Respiratory therapy.
- Short term physical, occupational and speech therapy.
- Prescribed drugs and medications.
- Medical supplies, appliances and equipment normally furnished by the Skilled Nursing Facility.
- Behavioral Health Treatment for pervasive developmental disorder or autism.
- Blood, blood products and their administration.
- Medical social services.

Sterilization Services

Voluntary sterilization services are covered. Reversal of sterilization services is not covered.

Termination of Pregnancy

Interruption of pregnancy (abortion) services are covered. The Copayments and Deductibles for termination of pregnancy services are determined based on the type and location of the service. For example, if the service is provided in an outpatient surgery setting, the outpatient surgery cost-share will apply. If the service is provided in an inpatient hospital setting, the inpatient hospital cost-share will apply. The Plan does not vary cost-sharing based on the reason for the service.

Transplants

Non-experimental/non-investigational human organ or bone marrow transplant services are covered. These services include:

- Organ and bone marrow transplants that are not experimental or investigational in nature.
- Reasonable professional and hospital expenses for a live donor if the expenses are directly related to the transplant for a Member.
- Charges for testing of relatives as potential donors for matching bone marrow or organ transplants.
- Charges associated with the search and testing of unrelated bone marrow or organ donors through a recognized Donor Registry.
- Charges associated with the procurement of donor organs or bone marrow through a recognized Donor Transplant Bank, if the expenses directly relate to the anticipated transplant of the Member.

Transplant services include professional and hospital services for a live donor who specifically designates the Member recipient if the services are directly related to the transplant, other than corneal, subject to the following restrictions:

1. Preoperative evaluation, surgery and follow-up care must be provided at Plan centers having documented skills, resources, commitment and record of favorable outcomes to qualify the centers to provide such care.
2. Patients are selected by the patient-selection committee of the Plan facilities.
3. Only anti-rejection drugs, biological products and procedures that have been established as safe and effective, and no longer experimental or investigational, are covered.

Sharp Health Plan provides certain donation-related services for a donor, or an individual identified by the Plan Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for the Member, which may include certain services for harvesting the organ, tissue, or bone marrow and for treatment of complications. We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members).

There are no age limitations for organ donors. The factor deciding whether a person can donate is the person's physical condition, not the person's age. Newborns as well as senior citizens have been organ donors. Donate Life California allows you to express your commitment to becoming an organ, eye and tissue donor. The Donate Life California Registry guarantees your plans will be carried out when you die.

Individuals who renew or apply for a driver's license or ID with the DMV, now have the opportunity to also register their decision to be a donor in the Donate Life California Registry, and the pink "DONOR" dot symbol is pre-printed on the applicant's driver license or ID card. You have the power to donate life. Sign up today at www.donatelifecalifornia.org to become an organ and tissue donor.

Urgent Care Services

Urgent Care Services means those services performed, inside or outside the Plan's Service Area, that are medically required within a short timeframe, usually within 24 hours, in order to prevent a serious deterioration of a Member's health due to an illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgently needed services include maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the Member's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the Member returns to the Plan's Service Area. If you are outside the Plan's Service Area, Urgent Care Services do not require an Authorization from your PCP. However, if you are in the Plan's Service Area and access Urgent Care Services that are not Authorized, then those services will not be paid for by Sharp Health Plan and you will be responsible to pay for the care.

Vision Services

Only those vision services described below are covered by Sharp Health Plan.

The following special contact lenses are covered:

- Up to two contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris).
- Up to six aphakic contact lenses per eye (including fitting and dispensing) per calendar year to treat aphakia (absence of the crystalline lens of the eye).

Pediatric Vision Services

The following services are a Covered Benefit for Children up to the age of 19:

- Routine vision exam (with refraction). One exam every calendar year (including dilation, if professionally indicated) at no cost to the Member.
- Lenses for glasses. One pair of lenses covered in full (no cost to the Member) every calendar year, including single vision, bifocal, trifocal and lenticular; choice of glass, plastic, or polycarbonate.
- Frames for glasses. Standard frames with a generic collection of choices are covered in full (no cost to the Member) once each calendar year.
- Contact lenses. Contact lenses are covered once every calendar year, in lieu of eyeglasses (unless medically necessary) as follows:
  • Standard (one pair annually)
  • Monthly (six-month supply)
  • Bi-weekly (three-month supply)
  • Dailies (three-month supply)
- Medically Necessary contact lenses. Medically Necessary contact lenses are covered. Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.
- Low vision services. Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for Members with low vision. Covered low vision services will include one comprehensive low vision evaluation every year, approved low vision aids, such as high-power spectacles, magnifiers and telescopes are covered in full.

Wigs or Hairpieces

A wig or hairpiece (synthetic, human hair or blends) is covered if prescribed by a physician as a prosthetic for hair loss due to injury, disease, or treatment of a disease (except for androgenetic alopecia). Sharp Health Plan will reimburse a Member up to $300 per calendar year for a wig or hairpiece from a Plan Provider.

WHAT IS NOT COVERED?

Exclusions and Limitations

The services and supplies listed in this section are exclusions (not Covered Benefits) or are covered with limitations (Covered Benefits only in specific instances) in addition to those already described in this Member Handbook. Additional limitations may be specified in the Health Plan Benefits and Coverage Matrix. These exclusions or limitations do not apply to Medically Necessary services to treat severe mental illness (SMI) or serious emotional disturbances of a child (SED).

Exclusions include any services or supplies that are:

1. Not Medically Necessary;
2. Not specifically described as covered in this Member Handbook or supplemental benefit materials;
3. In excess of the limits described in this Member Handbook or described in the Health Plan Benefits and Coverage Matrix;
4. Specified as excluded in this Member Handbook;
5. Not provided by Plan Providers (except for Emergency Services or Out-of-Area Urgent Care Services);
6. Not prescribed by a Plan Physician and, if required, Authorized in advance by your PCP, your PMG or the Plan (Note: Emergency Services do not require Authorization);
7. Part of a treatment plan for non-Covered Benefits; or
8. Received prior to the Member's effective date of coverage or after the Member's termination from coverage under this Plan.

Ambulance and Medical Transportation Services

Ambulance service is not covered when a Member does not reasonably believe that his or her medical condition is an Emergency Medical Condition that requires ambulance transport services, unless for a nonemergency ambulance service listed as covered in this Handbook. Wheelchair transportation service (e.g., a private vehicle or taxi fare) is also not covered.

Chemical Dependency Services

Services in a specialized facility for alcoholism, drug abuse, or drug addiction are not covered except as otherwise described in this Member Handbook.

Chiropractic Services

Chiropractic services are not covered, unless provided as a supplemental benefit. Copayments made for supplemental benefits do not apply toward the annual Out-of-Pocket Maximum. The Plan offers supplemental benefits for chiropractic services for only Plan's non-exchange related products.

Clinical Trials

The following are not Covered Benefits:

- The provision of non FDA approved drugs or devices that are the subject of the trial.
- Services other than health care services, such as for travel, housing and other non-clinical expenses that the Member may incur due to participation in the trial.

- Any items or services that are provided solely to satisfy data collection and/or analysis needs and that are not used in the clinical management of the Member.
- Health care services that are otherwise excluded from coverage (other than those that are excluded on the basis that they are experimental or investigational).
- Health care services that are customarily provided by the research sponsors free of charge for enrollees in the trial.
- The investigational item, device, or service itself.
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Cosmetic Surgical Services

The following are not Covered Benefits:

- Cosmetic services or supplies that retard or reverse the effects of aging or hair loss or alter or reshape normal structures of the body in order to improve appearance.
- Treatment of obesity by medical and surgical means. Treatment of morbid obesity is covered when medically necessary.

Custodial Care

Custodial care, domiciliary care, or rest cures, for which facilities of a general acute care hospital are not medically required, are not covered. Custodial care is care that does not require the regular services of trained medical or health professionals, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered.

Dental Services/Oral Surgical Services

The following dental services are not Covered Benefits unless covered under the pediatric dental benefit for Members under the age of 19. Dental services are defined as all services required for treatment of the teeth or gums.

- Oral exams, X-rays, routine fluoride treatment, plaque removal and extractions.
- Treatment of tooth decay, periodontal disease, dental cysts, dental abscess, granuloma, or inflamed tissue.
- Crowns, fillings, inlays or onlays, bridgework, dentures, caps, restorative or mechanical devices applied to the teeth and orthodontic procedures.
- Restorative or mechanical devices, dental splints or orthotics (whether custom fit or not) or other dental appliances, and related surgeries to treat dental conditions, except as specifically described under Covered Benefits.
- Dental implants (materials implanted into or on bone or soft tissue) and any surgery to prepare the jaw for implants or other dental services associated with surgery on the jawbone.
- Follow-up treatment of an injury to sound natural teeth as a result of an accidental injury regardless of reason for such services.
- Oral surgical services not specifically listed as covered in this Member Handbook.
- Dental treatment anesthesia provided or administered in a dentist's office or dental clinic.

Disposable Medical Supplies

Disposable Medical Supplies that are not provided in a hospital or physician office or by a home health professional are not covered.

Durable Medical Equipment (DME)

The following items are not covered:

- Equipment that basically serves comfort or convenience functions (e.g., physical fitness equipment, trays, backpacks, wheelchair racing equipment).
- DME that is primarily for the convenience of the Member or caretaker.
- Exercise and hygiene equipment.
- Experimental or research equipment.
- Devices not medical in nature such as sauna baths and elevators or modifications to the home or automobile.
- Generators or accessories to make home dialysis equipment portable for travel.
- Deluxe equipment such as items for comfort, convenience, upgrades or add-ons.
- More than one piece of equipment that serve the same function, when the additional DME is not medically necessary.
- Replacement of lost or stolen DME.

Emergency Services

Emergency facility and Professional Services that are not required on an immediate basis for treatment of an Emergency Medical Condition are not covered.

Experimental or Investigational Services

Medical, surgical or other procedures, services, products, drugs or devices (including implants) are not covered if either:

1. Experimental or investigational, or not recognized in accordance with generally accepted standards as being safe and effective for the use in question; or
2. Outmoded or not efficacious, such as those defined by the federal Medicare and state Medicaid programs, or drugs or devices that are not approved by the Food and Drug Administration.

If a service is denied because it is deemed to be an investigational or experimental therapy, a terminally ill Member may be entitled to request an external independent review of this coverage decision. If you would like more information about the decision criteria, or would like a copy of the Plan's policy regarding external independent reviews, please call Customer Care.

Please see the section titled **"Clinical Trials"** in the "WHAT ARE YOUR COVERED BENEFITS?" portion of this Handbook for information about coverage of experimental or investigational treatments that are part of an eligible clinical trial.

Family Planning Services

The following services are not Covered Benefits:

- Reversal of voluntary sterilization.
- Nonprescription contraceptive supplies.

Foot Care

Routine foot care, including, but not limited to, removal or reduction of corns and calluses and clipping of toenails, is not covered.

Genetic Testing or Treatment

Genetic testing or treatment is not covered for any of the following:

- Individuals who are not Members of Sharp Health Plan.
- Solely to determine the gender of a fetus.
- Non-medical reasons (e.g., court-ordered tests, work-related tests, paternity tests).
- Screening to determine carrier status for inheritable disorders when there would not be an immediate medical benefit or when results would not be used to initiate medical interventions/treatment.
- Members who have no clinical evidence or family history of a genetic abnormality.

Government Services and Treatment

Any services that the Member receives from a local, state or federal governmental agency are not covered, except when coverage under this health Plan is expressly required by federal or state law or as noted below.

Services required for injuries or illnesses experienced while under arrest, detained, imprisoned, incarcerated or confined pursuant to federal, state or local law are not covered. However, the Plan will reimburse Members their Out-of-Pocket expenses for services received while confined/incarcerated, or, if a juvenile, while detained in any facility, if the service were provided or Authorized by the Member's Primary Care Physician or Plan Medical Group in accordance with the terms of the Plan or were Emergency Services or Urgent Care Services. This exclusion does not restrict the Plan's liability with respect to expenses for Covered Services solely because the expenses were incurred in a state hospital; however, the Plan's liability with respect to expenses for Covered Services provided in a state or county hospital is limited to the reimbursement that the Plan would pay for those Covered Services if provided by a Plan Hospital.

Hearing Services

Hearing aids and routine hearing examinations are not covered except as specifically listed as covered in this Member Handbook or unless provided as a supplemental benefit. Copayments made for supplemental benefits do not apply toward the annual Out-of-Pocket Maximum. The Plan offers supplemental benefits for hearing aids for only Plan's non-Exchange related products.

Hospital Facility Inpatient and Outpatient Services

Personal or comfort items or a private room in a hospital, unless Medically Necessary, are not covered.

Immunizations and Vaccines

Immunizations and vaccines for travel and/or required for work, insurance, school, marriage, adoption, immigration, camp, volunteer work, licensure, certification or registration, sports or recreational activities are not covered. Immunizations that are not specifically listed on the most current version of the Recommended Childhood and Adolescent Immunization Schedule/United States and Recommended Adult Immunization Schedule/United States or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are not covered.

Infertility Services

The following services are not Covered Benefits:

- Infertility services, including treatment of the Member's underlying infertility condition. Infertility is defined as (1) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual intercourse without contraception, or (2) the presence of a demonstrated condition recognized by a physician as a cause of infertility. A woman without a male partner who is unable to conceive may be considered infertile if she is unable to conceive or produce conception after at least twelve (12) cycles of donor insemination; these 12 cycles are not covered by the Plan.
- Assisted Reproductive Technologies (ART) procedures, otherwise known as conception by artificial means, including but not limited to artificial insemination, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), multi-cell embryo transfer (TET), intracytoplasmic sperm injections (ICSI), blastocyst transfer, assisted hatching and any other procedures that may be employed to bring about conception without sexual intercourse, unless provided as a supplemental benefit. Copayments made for supplemental benefits do not apply toward the annual Out-of-Pocket Maximum.
- Any service, procedure, or process which prepares the Member for noncovered ART procedures.
- Collection, preservation, or purchase of sperm, ova, or embryos.
- Reversal of voluntary sterilization.
- Testing, services or supplies for conception by a surrogate who is not enrolled in Sharp Health Plan. If the surrogate is enrolled in Sharp Health Plan, medical expenses related to the pregnancy will be covered by the Plan, subject to the lien described in the **"What Happens if you Enter Into a Surrogacy Arrangement?"** section of this Handbook.

Massage Therapy Services

We do not cover massage therapy, except that this exclusion does not apply to massage therapy services that are part of a physical therapy treatment plan and covered under "Hospital Facility Inpatient Services," "Outpatient Rehabilitation Therapy

Services," "Home Health Services, "Hospice Services," or "Skilled Nursing Facility Care" sections of this Handbook. .

Maternity and Pregnancy Services

The following services are not Covered Benefits:

- Testing, services or supplies for conception by a surrogate who is not enrolled in Sharp Health Plan. If the surrogate is enrolled in Sharp Health Plan, medical expenses related to the pregnancy will be covered by the Plan, subject to the lien described in the **"What Happens if you Enter Into a Surrogacy Arrangement?"** section of this Handbook.
- Devices and procedures to determine the sex of a fetus.
- Elective home deliveries.

Mental Health Services

The following services are not Covered Benefits except when medically necessary to treat a Serious Mental Illness (SMI) or Serious Emotional Disturbance of a Child (SED):

- Services for conditions that the most recent edition of the DSM identifies as something other than a Mental Disorder.
- Any service covered under the Member's Employee Assistance Program (EAP).
- Counseling for activities of an educational nature.*
- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation, custody, or visitation.
- Diagnosis and treatment of developmental disorders, developmental reading disorder, developmental arithmetic disorder, developmental language disorder, or developmental articulation disorder that do not qualify as a mental health condition identified as a "mental disorder" in the most recent edition of the DSM.*
- Diagnosis and treatment for learning disorders or those services primarily oriented toward treatment of social or learning disorders.*
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- Counseling for marital problems.
- I.Q. testing.
- Psychological testing on Children required as a condition of enrollment in school.*
- Services for conditions that the most recent edition of the DSM identifies as something other than a Mental Disorder.

* This non-Covered Benefit does not include Behavioral Health Treatment for pervasive development disorder or autism, which is a Covered Benefit.

Non-Preventive Physical or Psychological Examinations

Physical or psychological examinations required for court hearings, travel, premarital, preadoption, employment or other non-preventive health reasons are not covered. Court-ordered or other statutorily required psychological evaluation, testing and treatment are not covered unless Medically Necessary and Authorized by the Plan.

Ostomy and Urological Supplies

Comfort, convenience, or luxury equipment or features are not covered.

Outpatient Prescription Drugs

EXCLUSIONS AND LIMITATIONS TO THE OUTPATIENT PRESCRIPTION DRUG BENEFIT

The services and supplies listed below are exclusions and limitations to your outpatient prescription drug benefits and are not covered by Sharp Health Plan:

1. Drugs dispensed by other than a Plan Pharmacy, except as Medically Necessary for treatment of an Emergency or urgent care condition.
2. Drugs when prescribed by non-contracting providers that are not authorized by the Plan except when coverage is otherwise required in the context of Emergency Services.
3. Over-the-counter medications or supplies, even if written on prescription, except as specifically identified as covered in the Sharp Health Plan Drug Formulary. This exclusion does not apply to over-the-counter products that we must cover as a "preventive care" benefit under federal law with a prescription or if the prescription legend drug is medically necessary due to a documented treatment failure or intolerance to the over-the-counter equivalent or therapeutically comparable drug.
4. Drugs dispensed in institutional packaging (such as unit dose) and drugs that are repackaged.
5. Drugs that are packaged with over-the-counter drugs or other non-prescription items/supplies.
6. Vitamins (other than pediatric or prenatal vitamins listed on the Drug List).
7. Drugs and supplies prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. (Drugs for mental performance are not excluded from coverage when they are used to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.)
8. Herbal, nutritional and dietary supplements.
9. Drugs prescribed solely for the purpose of shortening the duration of the common cold.
10. Drugs prescribed by a dentist or when prescribed for a dental treatment.
11. Drugs and supplies prescribed in connection with a service or supply that is not a covered benefit unless required to treat a complication that arises as a result of the service or supply.
12. Please refer to the Member Handbook under Disposable Medical Supplies, Durable Medical Equipment, and Family Planning for information about medical devices covered by Sharp Health Plan.

13. Infertility drugs are excluded, unless added by the employer as a supplemental benefit.
14. Drugs obtained outside of the United States unless they are furnished in connection with urgent care or an Emergency.
15. Drugs that are prescribed solely for the purposes of losing weight, except when medically necessary for the treatment of morbid obesity. Members must be enrolled in a Sharp Health Plan approved comprehensive weight loss program prior to or concurrent with receiving the weight loss drug and meet Plan criteria for coverage.
16. Off-label use of FDA approved prescription drugs unless the drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or the safety and effectiveness of use for this indication has been adequately demonstrated by at least two studies published in a nationally recognized, major peer reviewed journal.
17. Replacement of lost, stolen, or destroyed medications.
18. Compounded medications, unless Prior Authorization is obtained and determined to be medically necessary.
19. Brand name drugs when a generic equivalent is available.
20. Any prescription drug for which there is an over-the-counter product which has the identical active ingredient and dosage as the prescription drug.

The exclusions listed above do not apply to:

1. Coverage of an entire class of prescription drugs when one drug within that class becomes available over the counter.
2. Drugs listed on Sharp Health Plan's formulary.
3. Over-the-counter products that are specifically covered and listed as a Preventive Care benefit under California State or federal law. Covered preventive drugs include FDA-approved tobacco cessation drugs and FDA-approved contraceptive drugs. Preventive drugs are provided at $0 cost sharing subject to certain exceptions. For more information regarding coverage of certain over-the-counter drugs as preventive drugs, please see the Plan Formulary and your Family Planning and Preventive Care Services sections of this member handbook.
4. Insulin, glucagon and insulin syringes. These items are covered when medically necessary, even if they are available without a prescription. Please see the Member Handbook under Diabetes Treatment for information about equipment and supplies for the management and treatment of diabetes.
5. Items that are approved by the FDA as a medical device. Please refer to the Disposable Medical Supplies, Durable Medical Equipment, and Family Planning sections for information about medical devices covered by Sharp Health Plan.

Some drugs are commercially available as both a brand and a generic version. It is the policy of Sharp Health Plan that when a generic is available, Sharp Health Plan does not cover the corresponding brand-name drug. If a generic version of a drug is available, the brand version will not be listed in this document and will require Prior Authorization. The Plan requires the dispensing pharmacy to dispense the generic drug unless Prior Authorization for the brand is obtained.

Private-Duty Nursing Services

Private-duty nursing services are not covered. Private-duty nursing services encompass nursing services for recipients who require more individual and continuous assistance with Activities of Daily Living than is available from a visiting nurse or routinely provided by the nursing staff of a Hospital or Skilled Nursing Facility.

Prosthetic and Orthotic Services

Orthopedic shoes, foot orthotics or other supportive devices of the feet are not covered except under the following conditions:

- A shoe that is an integral part of a leg brace and is included as part of the cost of the brace.
- Therapeutic shoes furnished to select diabetic Members.
- Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care.
- A prosthetic shoe that is an integral part of a prosthesis.
- Special footwear needed by persons who suffer from foot disfigurement including disfigurement from cerebral palsy, arthritis, polio, spinabifida, diabetes and foot disfigurement caused by accident or developmental disability.
- Foot orthotics for diabetic Members. Therapeutic shoes (depth or custom-molded) along with inserts are covered for Members with diabetes mellitus and any of the following complications involving the foot:
    1. Peripheral neuropathy with evidence of callus formation.
    2. History of pre-ulcerative calluses.
    3. History of previous ulceration.
    4. Foot deformity.
    5. Previous amputation of the foot or part of the foot.
    6. Poor circulation.

Corrective shoes and arch supports, except as described above, are not covered. Non-rigid devices such as elastic knee supports, corsets and garter belts are not covered. Dental appliances and electronic voice producing machines are not covered. More than one device for the same part of the body is not covered. Upgrades that are not Medically Necessary are not covered. Replacements for lost or stolen devices are not covered.

Sexual Dysfunction Treatment

Treatment of sexual dysfunction or inadequacy is not covered, including but not limited to medicines/drugs, procedures, supplies and penile implants/prosthesis.

Sterilization Services

Reversal of sterilization services is not covered.

Vision Services

Vision services are not covered unless specifically listed as covered in this Member Handbook or provided as a supplemental benefit. Copayments made for supplemental benefits do not

apply toward the annual Out-of-Pocket Maximum. Vision services that are specifically not covered for Members age 19 and older without a supplemental benefit include, but are not limited to:

- Eye surgery for the sole purpose of correcting refractive error (e.g., radial keratotomy).
- Orthoptic services (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Eyeglasses or contact lenses (for adults 19 and older).
- Routine vision examinations (for adults 19 and older).
- Eye refractions for the fitting of glasses.
- Cosmetic materials, including anti-reflective coating, color coating, mirror coating, scratch coating, blended lenses, cosmetic lenses, laminated lenses, oversize lenses, polycarbonate lenses, photochromic lenses, tinted lenses except Pink #1 and Pink #2, progressive multifocal lenses, UV (ultraviolet) protected lenses.
- Plano lenses (less than ± .50 diopter power).
- Lenses and frames that are lost or stolen except at the normal intervals when services are otherwise available.

Other

- Any services received prior to the Member's effective date of coverage or after the termination date of coverage are not covered.
- Any services or supplies covered under any workers' compensation benefit plan are not covered.
- Any services requested or ordered by a court of law, employer, or school are not covered.
- In the event of any major disaster, act of war, or epidemic, Sharp Health Plan and Plan Providers shall provide Covered Benefits to Members to the extent Sharp Health Plan and Plan Providers deem reasonable and practical given the facilities and personnel then available. Under such circumstances, Sharp Health Plan shall use all Plan Providers available to provide Covered Benefits, regardless of whether the particular Members in question had previously selected, been assigned to or received Covered Benefits from those particular Plan Providers. However, neither Sharp Health Plan nor any Plan Provider shall have any liability to Members for any delay in providing or failure to provide Covered Benefits under such conditions to the extentthat Plan Providers are not available to provide such Covered Benefits.
- The frequency of routine health examinations will not be increased for reasons unrelated to the medical needs of the Member. This includes the Member's desire or request for physical examinations, and reports or related services for the purpose of obtaining or continuing employment, licenses, insurance, or school sports clearance, travel licensure, camp, school admissions, recreational sports, premarital or pre-adoptive purposes, by court order, or for other reasons not Medically Necessary.
- Benefits for services or expenses directly related to any condition that caused a Member's Total Disability are excluded when such Member is Totally Disabled on the date of discontinuance of a prior carrier's policy and the Member is entitled to an extension of benefits for Total Disability from that prior carrier.

HOW DO YOU ENROLL IN SHARP HEALTH PLAN?

When Is an Employee Eligible to Enroll in Sharp Health Plan?

If you are an employee, you may enroll during your initial enrollment period or during your Employer's open enrollment period, provided you live or work within the Service Area, meet certain eligibility requirements and complete the required enrollment process. Your initial enrollment period begins the day you become an Eligible Employee and ends 31 days after it begins. If you do not enroll within 31 calendar days of first becoming eligible, you may enroll only during an annual open enrollment period established by your Employer and Sharp Health Plan. Enrollment begins at 12:01 a.m. on the date established by your Employer and the Plan.

To enroll in Sharp Health Plan, employees must meet all eligibility requirements established by your Employer and Sharp Health Plan. The following outlines the Plan's eligibility requirements. Please contact your Employer for information about the eligibility requirements specific to your Employer.

As the employee, you are eligible if you:

- Are an employee of an Employer;
- Are actively engaged on a full-time basis at the Employer's regular place of business, and
- Work a normal workweek of at least the number of hours required by your Employer.

Eligible Employees do not include employees who work on a part-time, temporary, substitute or contracted basis unless agreed to by the Plan and your Employer. If an Eligible Employee is not actively at work on the date coverage would otherwise become effective (excluding medical leave status), coverage will be deferred until the date the Eligible Employee returns to an active work status.

As the employee, you must live or work within Sharp Health Plan's Service Area for at least nine out of every twelve consecutive months. A Member who resides outside the Service Area must select a PCP within the Service Area and must obtain all Covered Benefits from Plan Providers inside the Service Area, except for Out-of-Area Emergency or Urgent Care Services.

When Is a Dependent Eligible to Enroll in Sharp Health Plan?

Dependents (Spouse, Domestic Partner and Children) become eligible when the Eligible Employee is determined by the Employer to be eligible. Dependents may enroll during the Eligible Employee's initial enrollment period or during the Employer's open enrollment period. Enrollment begins at 12:01 a.m. on the date established by your Employer and the Plan. For purposes of eligibility, Children of the Enrolled Employee include:

- The naturally born Children, legally adopted Children, or stepchildren of the Enrolled Employee;
- Children for whom the Enrolled Employee has been appointed a legal guardian by a court; or
- Children for whom the Enrolled Employee is required to provide health coverage pursuant to a qualified medical support order.
- Children for whom the Enrolled Employee has assumed a parent-Child relationship as indicated by intentional assumption of parental duties by the Enrolled Employee as certified by the Enrolled Employee at the time of enrollment of the Child and annually thereafter up to the age of 26 unless the Child is Totally Disabled.

Grandchildren of the Enrolled Employee are not eligible for enrollment, unless the Enrolled Employee has been appointed legal guardian of the grandchild(ren).

Dependent Children remain eligible up to age 26 regardless of student, marital, or financial status. An enrolled Dependent child who reaches age 26 during a benefit year may remain enrolled as a dependent until the end of that benefit year. The dependent coverage shall end on the last day of the benefit year during which the Dependent child becomes ineligible.

A Dependent Child who is Totally Disabled at the time of attaining the maximum age of 26 may remain enrolled as a Dependent until the disability ends. The Plan may request a written statement from your Dependent's Plan Physician describing the disability.

Dependents are not required to live with the Enrolled Employee. However, Dependents must maintain their Primary Residence or work within Sharp Health Plan's licensed Service Area unless enrolled as a full-time student at an accredited institution or unless coverage is provided under a medical support order. A Member who resides outside the Service Area must select a PCP within the Service Area and must obtain all Covered Benefits from Plan Providers inside the Service Area, except for Out-of-Area Emergency or Urgent Care Services.

Can You or Your Dependents Enroll Outside Your Initial or Open Enrollment Period?

If you decline enrollment for yourself or your eligible Dependents because of other group medical coverage, you may be able to enroll yourself and your eligible Dependents in Sharp Health Plan if you involuntarily lose eligibility for that other coverage. However, you must request enrollment within sixty days after your other coverage ends.

You and your eligible Dependents may also be able to enroll in Sharp Health Plan if you or your Dependent becomes eligible for a Premium assistance subsidy under Medi-Cal or Healthy Families. You must request enrollment within 60 days after the date that eligibility for Premium assistance is determined.

If you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents outside of your Employer's open enrollment period. However, you must request enrollment within 60 calendar days after the marriage, birth, adoption or placement for adoption.

Your Employer is responsible for notifying the Plan to enroll or disenroll your eligible Dependents. If notification of the status change is not received by your Employer within the 60-day period, your Dependent(s) will not be covered and you will be responsible for payment of any services received.

- To add a new Spouse to your coverage, you must complete and submit an Enrollment Change Form to your Employer within the 60-day period following your marriage.

Newborns

An Enrolled Employee's newborn child is automatically covered for the first thirty-one (31) days from the date of the newborn's birth, and an adopted child is covered for thirty-one (31) days from the date an Enrolled Employee is legally entitled to control the health care of the adopted child. If you wish to continue coverage for your newborn or adopted child beyond the initial thirty-one (31) day period, you must submit an Enrollment application for the child to your Employer within the initial thirty-one (31) day period following birth or adoption. A birth or adoption certificate may be required as proof of Dependent status. If applicable, Sharp Health Plan may coordinate the cost of care if the child is also covered by another health insurance carrier.

Premium charges for a newborn or adopted child will be as follows:

- Premium charges for a newborn or adopted child will be charged beginning the month following the month of birth or adoption.

You must submit an Enrollment Application to Your Employer for a newborn or adopted child even if you currently have Dependent coverage. Grandchildren of the Subscriber are not eligible for enrollment, unless the Enrolled Employee has been appointed legal guardian of the grandchild(ren).

An Eligible Employee who declined enrollment in the Plan at the time of the initial or open enrollment period and who does not meet the criteria stated above must wait until their Employer's next renewal date to obtain coverage. Your Employer's renewal date occurs once every 12 months.

How Do You Update Your Enrollment Information?

Please notify your Employer of any changes to your enrollment application within 30 calendar days of the change. This includes changes to your name, address, telephone number, marital status, or the status of any enrolled Dependents. Your Employer will notify Sharp Health Plan of the change.

If you wish to change your Primary Care Physician or Plan Medical Group, please contact Customer Care at (858) 499-8300 or toll-free at 1-800-359-2002 or by email at **customer.service@sharp.com.**

What if You Have Other Health Insurance Coverage?

In some families, both adults are employed and family members are covered by more than one health plan. If you are covered by more than one health plan, the secondary health plan will coordinate your health insurance coverage so that you will receive up to, but not more than 100 percent coverage.

The Plan uses the "Birthday Rule" in coordinating health insurance coverage for Children. When both parents have different health plans that cover their Child Dependents, the health plan of the parent whose birthday falls earliest in the calendar year will be the primary health plan for the Child Dependents.

In coordinating health insurance coverage for your Spouse or Domestic Partner, the insurance policy in which the Spouse/ Domestic Partner is the Subscriber will be his/her primary health plan.

If you have purchased a supplemental pediatric dental benefit plan on the Covered California Health Benefits Exchange, pediatric dental benefits covered under this plan will be paid first, with the supplemental pediatric plan covering non-covered services and or cost sharing as described in your pediatric dental plan.

What if You Are Eligible for Medicare?

It is the Member's responsibility to apply for Medicare coverage once reaching age 65 or otherwise becoming eligible. Please notify Sharp Health Plan promptly if you or any of your covered Dependents become eligible for Medicare.

What if You Are Injured at Work?

The Plan does not provide Covered Benefits to you for work-related illnesses or injuries covered by workers' compensation. The Plan will advance Covered Benefits at the time of need, but if you or your Dependent receives Covered Benefits through the Plan that are found to be covered by workers' compensation, the Plan will pursue reimbursement through workers' compensation. You are responsible to notify Sharp Health Plan of any such occurrences and are required to cooperate to ensure that the Plan is reimbursed for such benefits.

What if You Are Injured by Another Person?

If you or your Dependent are injured in an event caused by a negligent or intentional act or omission of another person, the Plan will advance Covered Benefits at the time of need subject to an automatic lien by agreement to reimburse the Plan from any recoveries or reimbursement you receive from the person who caused your injury. You are responsible to notify Sharp Health Plan of any such occurrences and are required to cooperate to ensure that the Plan is reimbursed for such benefits.

When Can Your Coverage Be Changed Without Your Consent?

The Group Agreement between Sharp Health Plan and your Employer is renewed annually. The Group Agreement may be amended, canceled or discontinued at any time and without your consent, either by your Employer or by the Plan. Your Employer will notify you if the Agreement is terminated or amended. Your Employer will also notify you if your contribution to Premiums changes. If the Group Agreement is canceled or discontinued, you will not be able to renew or reinstate the group coverage; however, you may be able to purchase individual coverage. Please call Customer Care for assistance.

In the event of an amendment to the Group Agreement that affects any Covered Benefits, services, exclusions or limitations described in this Member Handbook, you will be given a new Member Handbook or amendments to this Member Handbook updating you on the change(s). The services and Covered Benefits to which you may be entitled will depend on the terms of your coverage in effect at the time services are rendered.

When Will Your Coverage End?

Loss of Subscriber Eligibility

Coverage for you and your Dependents will end at 11:59 p.m. on the earliest date of the following events triggering loss of eligibility:

- When the Group Agreement between your Employer and the Plan is terminated. If you are in the hospital on the effective date of termination, you will be covered for the remainder of the hospital stay if you continue to pay all applicable Premiums and Copayments, unless you become covered earlier under other group or COBRA coverage.
- When your employment is terminated. Coverage will end on the last day of the month in which your employment is terminated unless otherwise determined by your Employer. You may be eligible to continue coverage through COBRA (your Employer will advise you if you are eligible) or Cal-COBRA (the Plan will advise you if you are eligible). Members of the United States Military Reserve and National Guard who terminate coverage as a result of being ordered to active duty may have their coverage reinstated without waiting periods or exclusion of coverage for preexisting conditions. Please contact Customer Care for information on how to apply for reinstatement of coverage following active duty as a reservist. If your Employer is providing your health coverage through Covered California for Small Business (CCSB), please contact Covered California for information about how to apply for reinstatement.
- When your Employer terminates coverage with the Plan. Coverage will end on the last day of the month in which your Employer terminated.
- When you no longer meet any of the other eligibility requirements under your Plan contract. Coverage will end on the last day of the month in which your eligibility ended.

Coverage for your Dependent will end when a Dependent no longer meets the eligibility requirements, including divorce, no longer living or working inside of the Service Area or termination of Total Disability status. Coverage will end on the last day of the

month in which eligibility ends. The Dependent may be eligible to elect COBRA or Cal-COBRA coverage.

Fraud or Intentional Misrepresentation of Material Fact

Coverage for you or your Dependent(s) will also end if either you or that Dependent(s) commit(s) an act of fraud or intentional misrepresentation of a material fact to circumvent state or federal laws or the policies of the Plan, such as allowing someone else to use your Member ID card, 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, or disability status.

In this case, Sharp Health Plan will send you a written notice 30 days before your coverage will end. In addition, Sharp Health Plan may decide to retroactively end your coverage to the date the fraud or misrepresentation occurred, but only if Sharp Health Plan identifies the act within your first 24 months of coverage. This type of retroactive termination is called a rescission. If your coverage is retroactively terminated, Sharp Health Plan will send you the written notice 30 days prior to the effective date of the rescission. The notice will include information about your right to Appeal the decision.

Cancellation of the Group Agreement for Nonpayment of Premiums

If the Group Agreement is cancelled because the Group failed to pay the required Premiums when due, then coverage for you and your Dependents will end at the end of your Employer's 30 day grace period, effective on the 31st day after notice for nonpayment of Premiums.

Sharp Health Plan will mail your Employer a grace period notice at least 30 calendar days before any cancellation of coverage. This Prospective Notice of Cancellation will provide information to your Employer regarding the consequences of your Employer's failure to pay the Premiums due within 30 days of the date the notice was mailed. If payment is not received from your Employer within 30 days of the date the Prospective Notice of Cancellation is mailed, Sharp Health Plan will cancel the Group Agreement and mail you a Notice Confirming Termination of Coverage, which will provide you with the following information:

- That the Group Agreement has been cancelled for non-payment of Premiums.
- The specific date and time when your group coverage ended.
- Sharp Health Plan's telephone number to call to obtain additional information, including whether your Employer obtained reinstatement of the Group Agreement.
- An explanation of your options to purchase continuation coverage, including coverage effective as of the termination date so you can avoid a break in coverage, and the deadline by which you must elect to purchase such continuation coverage, which will be 63 calendar days after the date the Plan mails you the Notice Confirming Termination of Coverage.
- Information about other health care coverage options and rights under the law.

INDIVIDUAL CONTINUATION OF BENEFITS

Total Disability Continuation Coverage

If the Group Agreement between Sharp Health Plan and your Employer terminates while you or your Dependent are Totally Disabled, Covered Benefits for the treatment of the disability may be temporarily extended. Application for extension of coverage and evidence of the Total Disability is required to be provided to the Plan within 90 calendar days of termination of the Group Agreement; however, the Member is covered during this 90-day period.

You are required to furnish the Plan with evidence of the Total Disability upon request. The Plan has sole authority for the approval of the extension of Covered Benefits. The extension of Covered Benefits will continue for the treatment of the disability until the earlier of:

- When the Member is no longer Totally Disabled.
- When the Member becomes covered under any other group health insurance that covers the disability.
- A maximum of 12 consecutive months from the date coverage would have normally terminated.

COBRA Continuation Coverage

If your Employer has 20 or more employees, and you or your Dependents would otherwise lose coverage for benefits, you may be able to continue uninterrupted coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 and its amendments (referred to as COBRA), subject to your continuing eligibility and your payment of Premiums. COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependent(s) could become qualified beneficiaries if coverage under the group plan is lost because of the qualifying event. Please contact your Employer for details about whether you qualify, how to elect COBRA coverage, how much you must pay for COBRA coverage and where to send your COBRA Premiums. Coverage will be effective on the first day following the loss of coverage due to the qualifying event. No break in coverage is permitted.

COBRA continuation coverage consists of the coverage under the company health plan that you and other qualified beneficiaries had immediately before your coverage terminated. If your Employer or Sharp Health Plan changes benefits, Premiums, etc., your continuation coverage will change accordingly. If the contract between the Employer and Sharp Health Plan terminates while you are still eligible for COBRA, you may elect to continue COBRA coverage under the Employer's subsequent group health plan.

If you are no longer eligible for COBRA continuation coverage and your COBRA coverage was less than 36 months, you may be eligible for your own Individual Plan Policy. Please call Customer Care for assistance.

Cal-COBRA Continuation Coverage

If your Employer consists of one to 19 employees and you or your Dependents would lose coverage under Sharp Health Plan due to a "qualifying event" as described below, you may be able to continue your company health coverage upon arrangement with Sharp Health Plan through the California Continuation Benefits Replacement Act (referred to as Cal-COBRA), subject to your continuing eligibility and your payment of monthly Premiums to Sharp Health Plan.

Continuation coverage consists of the coverage under the company health plan that you and other qualified beneficiaries had immediately before your coverage terminated. If your Employer or Sharp Health Plan changes benefits, Premiums, etc., your continuation coverage will change accordingly. If the contract between the Employer and Sharp Health Plan terminates while you are still eligible for Cal-COBRA, you may elect to continue Cal-COBRA coverage under the Employer's subsequent group health plan. If you fail to comply with all the requirements of the new plan (including requirements pertaining to enrollment and Premium payments) within 30 days of receiving notice of termination from the Plan, Cal-COBRA coverage will terminate. If you move out of the Plan's Service Area, Cal-COBRA coverage will terminate.

If a qualifying event occurs, it is the Member's responsibility to notify his/her Employer within 60 days of the date of the qualifying event. The notification must be in writing and delivered to the Employer by first class mail or other reliable means of delivery. If you do not notify your Employer within 60 days of the date of the qualifying event, you are not eligible for coverage under Cal-COBRA.

Qualifying Events

If you lose coverage due to one of the qualifying events listed below and you were enrolled in Sharp Health Plan at the time of the loss of coverage, you are considered a qualified beneficiary entitled to enroll in Cal-COBRA continuation coverage.

- As an Enrolled Employee, you may be eligible for Cal-COBRA continuation coverage if you would lose group health plan coverage due to the termination of your employment (for reasons other than gross misconduct) or due to a reduction in your work hours.
- As a Member who is the Dependent of an Enrolled Employee, you may be eligible for Cal-COBRA continuation coverage if you would lose group health plan coverage under Sharp Health Plan for any of the following reasons:
    1. Death of the Enrolled Employee.
    2. Termination of the Enrolled Employee's employment (for reasons other than gross misconduct) or a reduction in the Enrolled Employee's work hours.
    3. Divorce or legal separation from the Enrolled Employee.
    4. Enrolled Employee's Medicare entitlement.
    5. Your loss of Dependent status.
- A Member who has exhausted COBRA continuation coverage may be eligible for Cal-COBRA continuation coverage if your COBRA coverage was less than 36 months. COBRA and Cal-COBRA continuation coverage is limited to a combined maximum of 36 months.

After the Employer notifies the Plan of a qualifying event, the Plan will, within 14 calendar days, provide all of the information that is needed to apply for Cal-COBRA continuation coverage, including information on benefits and Premiums, and an enrollment application.

How to Elect Cal-COBRA Coverage

If you wish to elect Cal-COBRA coverage, you must complete and return the enrollment application to Sharp Health Plan. This must be done within 60 calendar days after you receive the enrollment application or 60 calendar days after your company health coverage terminates, whichever is later. Failure to have the enrollment application postmarked on or before the end of the 60-day period will result in the loss of your right to continuation coverage under Cal-COBRA. Coverage will be effective on the first day following the loss of coverage due to the qualifying event. No break in coverage is permitted.

Adding Dependents to Cal-COBRA

The qualified beneficiary who elects coverage can enroll a Spouse or Dependents at a later date when one of the following events occurs:

- Open enrollment.
- Loss of other coverage.
- Marriage.
- Birth of a Dependent.
- Adoption.

The new Dependent will not be considered a qualified beneficiary and will lose coverage when the qualified beneficiary is no longer enrolled in Sharp Health Plan.

Premiums for Cal-COBRA Coverage

The Member is responsible for payment to Sharp Health Plan of the entire monthly Premium for continuation coverage under Cal-COBRA. The initial Premium payment must be made on or before the 45th calendar day after election of Cal-COBRA coverage and must be delivered by first-class mail, certified mail, or other reliable means of delivery to the Plan. The Premium rate you pay will not be more than 110 percent of the rate charged by the Plan for an employee covered under the Employer. The Premium rate is subject to change upon your previous Employer's annual renewal.

If the full Premium payment (including all Premiums due from the time you first became eligible) is not made within the 45-day period, Cal-COBRA coverage will be cancelled. Subsequent Premium payments are due on the first of each month for that month's Cal-COBRA coverage. If any Premium payment is not made within 30 calendar days of the date it is due, Cal-COBRA coverage will be cancelled. No claims for medical services received under continuation coverage are paid until the Premium for the month of coverage is paid. If, for any reason, a Member receives medical benefits under the Plan during a month for which the Premium was not paid, the benefits received are not covered by the Plan and the Member will be required to pay the provider of service directly.

If you have any questions regarding continuation coverage under Cal-COBRA, please call Customer Care.

What Can You Do if You Believe Your Coverage Was Terminated Unfairly?

Sharp Health Plan will never terminate your coverage because of your health status or your need for health services. If you believe that your coverage or your Dependent's coverage was terminated or not renewed due to health status or requirements for health care services, you may request a review of the termination by the Director of the Department of Managed Health Care. The Department has a toll-free telephone number (**1-888-HMO-2219)** to receive complaints regarding health plans.The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **(1-800-735-2929 (TTY))** or **(1-888-877-5378 (TTY))** to contact the Department. The Department's Internet website **(www.hmohelp.ca.gov)** has complaint forms and instructions online.

What are Your Rights for Coverage After Disenrolling From Sharp Health Plan?

HIPAA

Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. California law provides similar and additional protections.

If you lose group health insurance coverage and meet certain criteria, you are entitled to purchase individual health coverage (non-group) from any health plan that sells individual coverage for hospital, medical or surgical benefits. Every health plan that sells individual coverage for these benefits must offer individual coverage to an eligible person under HIPAA. The health plan cannot reject your application if you are an eligible person under HIPAA; you agree to pay the required Premiums; and you live or work inside the Plan's service area.

To be considered an eligible person under HIPAA you must meet the following requirements:

- You have 18 or more months of creditable coverage without a break of 63 calendar days or more between any of the periods of creditable coverage or since your most recent coverage was terminated;
- Your most recent creditable coverage was a group, government or church plan that provided hospital, medical or surgical benefits. (COBRA and Cal-COBRA are considered group coverage);
- You were not terminated from your most recent creditable coverage due to nonpayment of Premiums or fraud;
- You are not eligible for coverage under a group health plan, Medicare or Medicaid (Medi-Cal);
- You have no other health insurance coverage; and
- You have elected and exhausted any continuation coverage you were offered under COBRA or Cal-COBRA.

There are important choices you need to make in a very short time frame regarding the options available to you following termination of your group health care coverage. You should read carefully all available information regarding HIPAA coverage so you can understand fully the special protections of HIPAA coverage and make an informed comparison and choice regarding available coverage. For more information, please call Customer Care. If the Plan is unable to assist or you feel your HIPAA rights have been violated, you may contact the Department of Managed Health Care at 1-888-HMO-2219 or visit the Department's web site at www.hmohelp.ca.gov.

OTHER INFORMATION

When Do You Qualify for Continuity of Care?

Continuity of care means continued services, under certain conditions, with your current health care provider until your health care provider completes your care.

As a *newly* enrolled Sharp Health Plan Member, you may receive continuity of care services when

- You are receiving care from a non-Sharp Health Plan provider; or
- Your previous coverage terminated due to your health plan either withdrawing from the market in your service area or ceasing to offer the applicable health benefit plan in your service area.

As a *current* Sharp Health Plan Member, you may also obtain continuity of care benefits when your

- Sharp Health Plan Network has changed; or
- Sharp Health Plan Medical Group, hospital, or health care provider is no longer contracted with Sharp Health Plan.

Continuity of care may be provided for the completion of care when you or your family member is in an active course of treatment for the following conditions:

Condition	Length of time for continuity of care
Acute condition	Duration of acute condition
Serious chronic condition	No more than 12 months
Pregnancy	Three trimesters of pregnancy and immediate post-partum period
Terminal illness	As long as the member lives
Pending surgery or other procedure	Must be scheduled within 180 days of health care provider's contract termination or member's enrollment in Sharp Health Plan
Care of newborn child between birth and age 36 months	No more than 12 months

Please note: Your requested health care provider must agree to provide continued services to you, subject to the same contract terms and conditions and similar payment rates to other similar health care providers contracted with Sharp Health Plan. If your health care provider does not agree, Sharp Health Plan cannot provide continuity of care.

You are not eligible for continuity of care coverage in the following situations:

- You are a newly enrolled Member and had the opportunity to enroll in a health plan with an out-of-network option.
- You had the option to continue with your previous health plan, but instead voluntarily chose to change health plans.
- You have an Individual, Medicare, CalChoice, or CCSB (Covered California for Small Business) policy, and had the ability to choose a plan that allowed you to stay with your health care provider.

Please contact Customer Care to request a continuity of care benefits form. You may also request a copy of Sharp Health Plan's medical policy on continuity of care for a detailed explanation of eligibility and applicable limitations.

What Is the Relationship Between the Plan and Its Providers?

- Most of our Plan Medical Groups receive an agreed-upon monthly payment from Sharp Health Plan to provide services to you. This monthly payment is a fixed dollar amount for each Member. The monthly payment typically covers Professional Services directly provided by the medical group, and may also cover certain referral services.
- Some doctors receive a different agreed-upon payment from us to provide services to you. Each time you receive health care services from one of these providers, the doctor receives payment for that service.
- Some hospitals in our network receive an agreed-upon monthly payment in return for providing hospital services for Members. Other hospitals are paid on a fee-for-service basis or receive a fixed payment per day of hospitalization.
- On a regular basis, we agree with each Plan Medical Group and some of our contracted hospitals on the monthly payment from Sharp Health Plan for services, including referral services, under the program for any Plan Members treated by the PMG/Hospital.
- At the end of the year, the actual cost of services is compared to the agreed upon budget. If the actual cost of services is less than the agreed upon budget, the PMG/hospital may share in the savings as an incentive to continue providing quality health care services to Plan Members.
- If you would like more information, please contact Customer Care. You can also obtain more information from your health care provider or the PMG you have selected.

How Can You Participate in Plan Policy?

The Plan has established a Member advisory committee (called the Public Policy Advisory Committee) for Members to participate in making decisions to assure patient comfort, dignity and convenience from the Plan's Providers that provide health care services to you and your family. At least annually, the Plan provides Members, through the Member Newsletter, a description of its system for Member participation in establishing Plan policy, and communicates material changes affecting Plan policy to Members.

What Happens if You Enter Into a Surrogacy Arrangement?

A surrogacy arrangement is one in which you agree to become pregnant and to surrender the baby to another person or persons who intend to raise the Child. You must pay us for any amounts paid by the Plan for Covered Benefits you receive related to conception, pregnancy, delivery or newborn care in connection with a surrogacy arrangement ("Surrogacy Health Services"). Your obligation to pay us for Surrogacy Health Services is limited to the compensation you are entitled to receive under the surrogacy arrangement.

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments. Those payments shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 calendar days after entering into a surrogacy arrangement, you must send written notice of the arrangement, including the names and addresses of the other parties to the arrangement, and a copy of any contracts or other documents explaining the arrangement, to:

Sharp Health Plan Customer Care
Attn: Third Party Liability
8520 Tech Way, Suite 200
San Diego, CA 92123-1450

You must complete and send us all consents, releases, authorizations, lien forms and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "What Happens if You Enter Into a Surrogacy Arrangement?" section and to satisfy those rights. You must not take any action prejudicial to our rights.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

GLOSSARY

Because we know health plan information can be confusing, we capitalized these words throughout all Sharp Health Plan materials and information to let you know that you can find their meanings in this glossary.

Active Labor means a labor at a time at which either of the following would occur:

1. There is inadequate time to effect safe transfer to another hospital prior to delivery; or
2. A transfer may pose a threat to the health and safety of the patient or the unborn child.

Activities of Daily Living (ADLs) means the basic tasks of everyday life, such as eating, bathing, dressing, toileting and transferring (e.g., moving from the bed to a chair).

Acute Condition means a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration.

Appeal means a written or oral expression requesting a re-evaluation of a specific determination made by the Plan or any of its authorized Subcontractors (Plan Medical Groups). The determination in question may be a denial or modification of a requested service. (It may also be called an adverse benefit determination.)

Authorization means the approval by the Member's Plan Medical Group (PMG) or the Plan for Covered Benefits. (An Authorization request may also be called a pre-service claim.)

Authorized Representative means an individual designated by the Member to receive Protected Health Information about the Member for purposes of assisting with a claim, an Appeal, a Grievance or other matter. The Authorized Representative must be designated by the Member in writing on a form approved by Sharp Health Plan.

Behavioral Health Treatment means Professional Services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with pervasive developmental disorder or autism and that meet all of the following criteria:

1. The treatment is prescribed by a licensed Plan Provider;
2. The treatment is provided by a qualified autism service provider, professional or paraprofessional contracted with the Plan;
3. The treatment is provided under a treatment plan that has measurable goals over a specific timeline that is developed and approved by the qualified autism service provider for the specific patient being treated; and
4. The treatment plan is reviewed at least every six months by a qualified autism service provider and modified whenever appropriate, and is consistent with the elements required under the law.

Child or Children means a Child or Children of the Enrolled Employee including:

- The naturally born Children, legally adopted Children, or stepchildren of the Enrolled Employee;
- Children for whom the Enrolled Employee has been appointed a legal guardian by a court; or
- Children for whom the Enrolled Employee is required to provide health coverage pursuant to a qualified medical support order.

- Children for whom the Enrolled Employee has assumed a parent-child relationship as indicated by intentional assumption of parental duties by the Enrolled Employee as certified by the Enrolled Employee at the time of enrollment of the Child and annually thereafter up to the age of 26 unless the Child is Totally Disabled.

Chronic Condition means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration.

Coinsurance means your share of the costs of a Covered Benefit, calculated as a percent (for example, 20%) of the Plan's contracted rate with a Plan Provider. For example, if the Plan's contracted rate with a Plan Provider for an office visit is $100 and you've met your deductible, your Coinsurance payment of 20% would be $20.

Copayment means a fee which a Plan Provider, or its subcontractors, may collect directly from a Member, and which a Member is required to pay, for a particular Covered Benefit at the time service is rendered.

Covered Benefits means those Medically Necessary services and supplies that Members are entitled to receive under a Group Agreement and which are described in the Member Handbook.

Covered California means the online marketplace established by the State of California to provide access to health plans and health insurance, and access to financial assistance to help pay for health coverage. Also called the Exchange.

Covered California for Small Business (CCSB) (formerly known as Small Business Health Options Program or SHOP) means the program offered by Covered California to provide health insurance and health plan choices to small businesses and their employees.

Deductible means the amount a Member must pay in a calendar year under some plans for certain Covered Benefits before the Plan will start to pay for those Covered Benefits in that calendar year. Once the Member has met either the family or individual yearly Deductible, the Member pays the applicable Copayment or Coinsurance for Covered Benefits, and the Plan pays the rest.

Dependent means an Enrolled Employee's legally married Spouse, registered Domestic Partner or Child, who meets the eligibility requirements set forth in this Member Handbook, who is enrolled in the Plan, and for whom the Plan receives Premiums.

Disposable Medical Supplies means medical supplies that are consumable or expendable in nature and cannot withstand repeated use by more than one individual, such as bandages, elastic bandages, incontinence pads and support hose and garments.

Domestic Partner means a person who has established a domestic partnership as described in Section 297 of the California Family Code by meeting all of the following requirements. All Employers who offer coverage to the Spouses of employees must also offer coverage to Registered Domestic Partners.

1. Both persons agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership.
2. Neither person is married or a member of another domestic partnership.
3. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
4. Both persons are at least 18 years of age.
5. Both persons are capable of consenting to the domestic partnership.
6. Either of the following:
    a) Both persons are members of the same sex.
    b) One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42 U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both persons are over the age of 62.
7. Neither person has previously filed a Declaration of Domestic Partnership with the Secretary of State pursuant to this division that has not been terminated under Section 299.
8. Both file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division.

If documented in the Group Agreement, Domestic Partner also includes individuals who meet criteria 1-5 above and sign an affidavit attesting to that fact.

Drug Formulary means the continuously updated list of drugs that are covered by the Plan. A Drug Formulary enhances quality of care by encouraging the use of those prescription medications that are demonstrated to be safe and effective, and produce superior patient outcomes. Sharp Health Plan's Pharmacy and Therapeutics Committee, composed of Plan Providers and Pharmacists, meets quarterly to evaluate the Drug Formulary and ensure that it is as useful and effective as possible.
The Formulary is a tool for your doctor to use when determining the most appropriate course of treatment. The presence of a drug on the Formulary does not guarantee that it will be prescribed by your doctor for a particular condition.

Durable Medical Equipment (DME) means medical equipment appropriate for use in the home which is intended for repeated use; is generally not useful to a person in the absence of illness or injury; and primarily serves a medical purpose.

Eligible Employee means any employee, employed for a specified period of time, who is actively engaged on a full-time basis (at least 30 hours per week) in the conduct of the business of the Employer at the Employer's regular place or places of business.

The term includes sole proprietors or partners in a partnership, if they are actively engaged on a full-time basis in the Employer's business and included as employees under the Group Agreement, but does not include employees who work on a temporary, substitute or contract basis. Employees who waive coverage on the grounds that they have other Employer sponsored health coverage or coverage under Medicare shall not be considered or counted as Eligible Employees.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means those Covered Benefits, including Emergency Services and Care, provided inside or outside the Service Area, that are medically required on an immediate basis for treatment of an Emergency Medical Condition.

Emergency Services and Care means:

1. Medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or Active Labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and
2. An additional screening, examination and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition within the capability of the facility.

Employer means any person, firm, proprietary or nonprofit corporation, partnership, or public agency that is actively engaged in business or service, which was not formed primarily for purposes of buying health care service plan contracts and in which a bona-fide employer-employee relationship exists.

Enrolled Employee (also known as "Subscriber") means an Eligible Employee of the Employer who meets the applicable eligibility requirements, has enrolled in the Plan under the provisions of a Group Agreement, and for whom Premiums have been received by the Plan.

Exchange means the California Health Benefits Exchange or Covered California.

Family Deductible means the Deductible amount, if any, that applies to a Subscriber and that Subscriber's Dependents enrolled in Sharp Health Plan.

Family Out-of-Pocket Maximum means the Out-of-Pocket Maximum that applies to a Subscriber and that Subscriber's Dependents enrolled in Sharp Health Plan.

Grievance means a written or oral expression of dissatisfaction regarding the Plan and/or Provider, including quality of care concerns.

Group Agreement means the written agreement between the Plan and an Employer that provides coverage for Covered Benefits to be provided to Members whose eligibility is related to that Employer.

Health Plan Benefits and Coverage Matrix is a list of the most commonly used Covered Benefits and applicable Copayments for the specific benefit plan purchased by the Employer. Members receive a copy of the Health Plan Benefits and Coverage Matrix along with the Member Handbook. The Health Plan Benefits and Coverage Matrix may also be called the Summary of Benefits.

Independent Medical Review or IMR means review by a DMHC designated medical specialist. IMR is used if care that is requested is denied, delayed or modified by the Plan or a Plan Provider, specifically, for denial of experimental or investigational treatment for life-threatening or seriously debilitating conditions or denial of a health care service as not Medically Necessary. The IMR process is in addition to any other procedures made available by the Plan.

Individual Deductible means the Deductible amount, if any, that applies to an individual Subscriber or Dependent enrolled in Sharp Health Plan.

Individual Out-of-Pocket Maximum means the Out-of-Pocket Maximum that applies to an individual Subscriber or Dependent enrolled in Sharp Health Plan.

Medically Necessary means a treatment or service necessary to protect life; to prevent illness or disability; to diagnose, treat, or control illness, disease, or injury; or to alleviate severe pain. The treatment or service should be:

1. Based on generally accepted clinical evidence,
2. Consistent with recognized standards of practice,
3. Demonstrated to be safe and effective for the Member's medical condition, and
4. Provided at the appropriate level of care and setting based on the Member's medical condition.

Member means an Enrolled Employee, or the Dependent of an Enrolled Employee, who has enrolled in the Plan under the provisions of the Group Agreement and for whom the applicable Premiums have been paid.

Mental Disorder means a mental health condition identified as a "mental disorder" in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. Mental Disorders include, but are not limited to, Serious Mental Illness of a person of any age and Serious Emotional Disturbance of a Child under age 18.

Out-of-Area means services received while a Member is outside the Service Area. Out-of-Area coverage includes Urgent or Emergent services for the sudden onset of symptoms of sufficient severity to require immediate medical attention to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member returns to the Service Area. Out-of-Area medical services will be covered to meet your immediate medical needs. Applicable follow-up for the Urgent or Emergent service must be Authorized by Sharp Health Plan and will be covered until it is clinically appropriate to transfer your care into the Plan's Service Area.

Out-of-Pocket Maximum means the maximum total amount for Copayments, Deductibles, and Coinsurance you pay each year for Covered Benefits, excluding supplemental benefits.

Plan means Sharp Health Plan.

Plan Hospital means an institution licensed by the State of California as an acute care hospital that provides certain Covered Benefits to Members through an agreement with the Plan and that is included in the Member's Plan Network.

Plan Medical Group or PMG means a group of physicians, organized as or contracted through a legal entity, that has met the Plan's criteria for participation and has entered into an agreement with the Plan to provide and make available Professional Services and to provide or coordinate the provision of other Covered Benefits to Members on an independent contractor basis and that is included in the Member's Plan Network.

Plan Network means that network of providers selected by the Employer or the Member, as indicated on the Member Identification Card.

Plan Pharmacy means any pharmacy licensed by the State of California to provide outpatient prescription drug services to Members through an agreement with the Plan. Plan Pharmacies are listed in the Provider Directory.

Plan Physician means any doctor of medicine, osteopathy, or podiatry licensed by the State of California who has agreed to provide Professional Services to Members, either through an agreement with the Plan or as a member of a PMG, and that is included in the Member's Plan Network.

Plan Providers means the physicians, hospitals, Skilled Nursing Facilities, home health agencies, pharmacies, medical transportation companies, laboratories, X-ray facilities, Durable Medical Equipment suppliers and other licensed health care entities or professionals who are part of the Member's Plan Network which or who provide Covered Benefits to Members through an agreement with the Plan.

Plan Providers also include qualified autism service providers, professionals, or paraprofessionals who are part of the Member's Plan Network with or who provide Covered Benefits to Members through an agreement with the Plan.

Premium means the monthly amounts due and payable in advance to the Plan from the Employer and/or Member for providing Covered Benefits to Member(s).

Primary Care Physician or PCP means a Plan Physician, possibly affiliated with a PMG, who is chosen by or for a Member from the Member's Plan Network; and who is primarily responsible for supervising, coordinating and providing initial care to the Member; for maintaining the continuity of Member's care; and providing or initiating referrals for Covered Benefits for the Member. Primary Care Physicians include general and family practitioners, internists, pediatricians and qualified OB-GYNs who have the ability to deliver and accept the responsibility for delivering primary care services.

Primary Residence means the home or address at which the Member actually lives most of the time. A residence will no longer be considered a Primary Residence if (a) Member moves without intent to return, (b) Member is absent from the residence for more than 90 days in any 12-month period (except for student Dependents).

Professional Services means those professional diagnostic and treatment services which are listed in the Member Handbook and supplemental benefits brochures, if applicable, and provided by Plan Physicians and other health professionals.

Provider Directory means a listing of Plan approved physicians, hospitals and other Plan Providers in the Member's Plan Network, which is updated periodically.

Self-Only Deductible means the Deductible amount, if any, that applies to an individual Subscriber enrolled in self-only coverage (Subscriber only with no Dependents) with Sharp Health Plan.

Self-Only Out-of-Pocket Maximum means the Out-of-Pocket Maximum that applies to an individual Subscriber enrolled in self-only coverage (Subscriber only with no Dependents) with Sharp Health Plan.

Serious Emotional Disturbance of a Child or SED means a Child who:

1. Has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), 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, and
2. Meets one or more of the following criteria:
   a) 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 occur:
      i) The Child is at risk of removal from the home or has already been removed from the home; or
      ii) 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.
   b) The Child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.
   c) The Child has been assessed pursuant to Article 2 (commencing with Section 56320) of Chapter 4 of Part 30 of Division 4 of Title 2 of the Education Code and determined to have an emotional disturbance, as defined in paragraph (4) of subdivision (c) of Section 300.8 of Title 34 of the Code of Federal Regulations.

Service Area means the geographic area of San Diego County, California (excluding the following ZIP codes: 91934, 92004, 92036, or 92066), and southern Riverside County, California as defined by specific ZIP codes. Plan offers southern Riverside County in connection with only Plan's off-Exchange health plans.

Severe Mental Illness means one or more of the following nine disorders in persons of any age: schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.

Skilled Nursing Facility or SNF is a comprehensive free-standing rehabilitation facility or a specially designed unit within a Hospital licensed by the state of California to provide skilled nursing care.

Spouse means an Enrolled Employee's legally married husband, wife, or partner. If coverage for Domestic Partners is specified by the Employer in the Group Agreement, it also means an Enrolled Employee's Domestic Partner.

Subscriber, also known as "Enrolled Employee," is the individual enrolled in the Plan for whom the appropriate Premiums have been received by Sharp Health Plan, and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

Totally Disabled means a Member who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and is chiefly dependent upon the Subscriber for support and maintenance. The determination as to whether a Member is Totally Disabled will be made based upon an objective review consistent with professionally recognized medical standards.

Urgent Care Services means services intended to provide urgently needed care in a timely manner when your PCP has determined that you require these services, or you are Out-of-Area and require Urgent Care Services. Urgent Care Services means those services performed, inside or outside the Plan's Service Area, which are medically required within a short timeframe, usually within 24 hours, in order to prevent a serious deterioration of a Member's health due to an illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgently needed services include maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the Member's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the Member returns to the Service Area.

Utilization Management is the evaluation of the appropriateness, medical need and efficiency of health care services and facilities according to established criteria or guidelines and under the provisions of the applicable health benefits plan.

PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFIT – ACCESS DENTAL PLAN

About the Dental Plan

Sharp Health Plan is proud to partner with Access Dental Plan to provide you with pediatric dental coverage for Sharp Health Plan Members under the age of 19. Good oral health is essential for overall well-being. We believe that a balanced diet, routine brushing and regular check-ups are necessary ingredients in achieving good oral health. The following Supplement provides you with information about your covered pediatric dental benefits, how to obtain those benefits, and your rights and responsibilities pertaining to your pediatric dental benefits.

Access Dental Plan (ADP) has a panel of dentists from whom you select to receive necessary dental care. Many dental procedures covered require no Copayment. In addition, ADP has made the process of dental treatment convenient by eliminating cumbersome claim forms when a Member receives routine care from his or her Primary Care Dentist. Please review the information included in this document and contact your Primary Care Dentist to arrange an immediate initial assessment appointment. If a Member moves, the Member should contact ADP's Member Service Representative to assist the Member in selecting a new Primary Care Dentist if the Member desires a Primary Care Dentist closer to the Member's new residence. If a Member moves temporarily outside of Sharp Health Plan's Service Area such as to attend school, the Member may obtain Emergency Care or Urgent Care from any dentist and ADP will reimburse the Member for the costs, less applicable Copayments. If you have any questions regarding the material you are reading or ADP, please contact ADP's Member Services toll-free number at 1-866-650-3660.

Please review the information included in this packet and contact your primary care dentist to arrange an immediate initial assessment appointment. This appointment is necessary if you have not received a dental treatment from a dentist within the last 12 months. If you have any questions regarding this appointment or the materials in this packet, please call ADP at (866) 650-3660.

Using the Dental Plan Facilities / Locations

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

ADP's Primary Care Dentists are located close to where you work or live.

You may obtain a list of Access Dental Plan's participating providers and their hours of availability by calling ADP at 1-866-650-3660. A list of ADP's participating providers can be found in the Provider Directory or online at www.premierlife.com.

Choosing a Primary Care Dental Provider

Members must select a Primary Care Dentist from the list of providers listed in the Provider Directory. The Member should indicate his/her choice of Primary Care Dentist on Sharp Health Plan's enrollment application.

Members from the same family may select different Primary Care Dentists. Should any Member fail to select a Primary Care Dentist at the time of enrollment, ADP may assign the Member to an available Primary Care Dentist, who practices in close proximity to where the Member resides. Each Member's Primary Care Dentist (in coordination with ADP) is responsible for the coordination of the Member's dental care. **Except for Emergency Dental Care, any services and supplies obtained from any provider other than the Member's Primary Care Dentist without an approved referral by ADP will not be paid by ADP**. To receive information, assistance, and the office hours of your Primary Care Dentist, Members should contact a Member Service Representative by calling 1-866-650-3660 during regular business hours.

As a Member of ADP, you are eligible for Covered Services from a Plan provider. To find out which providers and facilities contract with ADP, please refer to your Provider Directory. Except for Copayments, there is no charge for Covered Services provided by your Primary Care Dentist, or in the case of care provided by someone other than your Primary Care Dentist, approved by ADP, or when an Emergency Care condition exits.

Except for Copayments, you should not receive a bill for a Covered Service from a Plan provider. However, if you do receive a bill, please contact ADP's Member Services Department. ADP will reimburse a Member for Emergency Care or Urgent Care services (less any applicable Copayment). You will not be responsible for payments owed by ADP to contracted Plan providers. However, you will be liable for the costs of services to providers who are not contracted with ADP if you receive care without Prior Authorization (unless services are necessary as a result of an Emergency Care condition). If you choose to receive services, which are not Covered Services, you will be responsible for payment of those services.

Scheduling Appointments

Provider offices are open during normal business hours and some offices are open Saturday on a limited basis. If you cannot keep your scheduled appointment, you are required to notify the dental office at least 24 hours in advance. A fee may be charged by your Primary Care Dentist for failure to cancel an appointment without 24 hours prior notification. Members may call the provider directly to schedule an appointment or contact ADP and ADP will assist the Member in scheduling a dental appointment. If the Member requires specialty care, the Member's Primary Care Dentist will contact ADP who will arrange for such care.

Primary Care Dentists are required to provide Covered Services to Members during normal working hours and during such other hours as may be necessary to keep Member's appointment schedules on a current basis. Appointments for routine, preventive care and specialist consultation shall not exceed four weeks from the date of the request for an appointment.

Wait time in the Primary Care Dentist's office shall not exceed 30 minutes.

Changing Your Provider

A Member may transfer to another Primary Care Dentist by contacting ADP at 1-866-650-3660 and requesting such a transfer. A Member may change to another Primary Care Dentist as often as once each month. If ADP receives the request before the 25th of the month, the effective date of the change will be the first day of the following month. All requests for transfer are subject to the availability of the selected Primary Care Dentist.

Continuity of Care for New Members

Under some circumstances, ADP will provide continuity of care for new Members who are receiving dental services from a Non-Participating Provider when ADP determines that continuing treatment with a Non-Participating Provider is medically appropriate. If you are a new Member, you may request permission to continue receiving dental services from a Non-Participating Provider if you were receiving this care before enrolling in ADP and if you have one of the following conditions:

- An Acute Condition. Completion of Covered Services shall be provided for the duration of the Acute Condition.
- A serious chronic condition. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by ADP in consultation with you and the Non- Participating Provider and consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time you enroll with ADP.
- Performance of a surgery or other procedure that your previous plan authorized as part of a documented course of treatment and that has been recommended and documented by the Non- Participating Provider to occur within 180 days of the time you enroll with ADP.

Please contact ADP at 1-866-650-3660 to request continuing care or to obtain a copy of ADP's Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Eligibility is not based strictly upon the name of your condition. If your request is approved, you will be financially responsible only for applicable Copayments under this plan.

ADP will request that the Non-Participating Provider agree to the same contractual terms and conditions that are imposed upon Participating Providers providing similar services, including payment terms. If the Non-Participating Provider does not accept the terms and conditions, ADP is not required to continue that provider's services. ADP is not required to provide continuity of care as described in this section to a newly covered Member who was covered under an individual subscriber agreement and undergoing a treatment on the effective date of his or her Access Dental Plan coverage. Continuity of care does not provide coverage for Benefits not otherwise covered under this Supplement.

All such notifications by a Member may be made to any Plan office. All such notifications shall be forwarded to ADP's Dental Director for action. The Dental Director shall respond in writing to the Member within a dentally appropriate period of time given the dental condition involved, and in no event more than five (5) days after submission of such notification to ADP.

Continuity of Care for Termination of Provider

If your Primary Care Dentist or other dental care provider stops working with Access Dental Plan, ADP will let you know by mail 60 days before the contract termination date.

ADP will provide continuity of care for Covered Services rendered to you by a provider whose participation has terminated if you were receiving this care from this provider prior to the termination and if you have one of the following conditions:

- An Acute Condition. Completion of Covered Services shall be provided for the duration of the Acute Condition.
- A serious chronic condition. Completion of Covered Services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by ADP in consultation with you and the terminated provider and

consistent with good professional practice. Completion of Covered Services shall not exceed twelve (12) months from the time you enroll with ADP.

- Performance of a surgery or other procedure that ADP has authorized as part of a documented course of treatment and that has been recommended and documented by the terminated provider to occur within 180 days of the provider's contract termination date.

Continuity of care will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity. You must be under the care of the Participating Provider at the time of ADP's termination of the provider's participation. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions, including reimbursement rates, of his or her agreement with ADP prior to termination. If the provider does not agree with these contractual terms and conditions and reimbursement rates, ADP is not required to continue the provider's services beyond the contract termination date.

Please contact ADP at 1-866-650-3660 to request continuing care or to obtain a copy of ADP's Continuity of Care policy. Normally, eligibility to receive continuity of care is based on your medical condition. Continuity of care does not provide coverage for Benefits not otherwise covered under this Supplement. If your request is approved, you will be financially responsible only for applicable Copayments under this plan.

If ADP determines that you do not meet the criteria for continuity of care and you disagree with ADP's determination, see ADP's Grievance and Appeals Process in this Supplement.

If you have further questions about continuity of care, you are encouraged to contact the Department of Managed Health Care, which protects HMO consumers, by telephone at its toll-free telephone number, 1-888-HMO-2219; or at the TDD number for the hearing impaired, 1-877-688-9891; or online at www.hmohelp.ca.gov.

Prior Authorization for Services

Your Primary Care Dentist will coordinate your dental care needs and, when necessary, arrange Specialty Services for you. In some cases, ADP must authorize certain services and/or Specialty Services beforeyou receive them.

Your Primary Care Dentist will obtain the necessary referrals and authorizations for you. Some services, such as Emergency Care, do not require Prior Authorization before you receive them. If you see a specialist or receive Specialty Services before you receive the required authorization, you will be responsible to pay for the cost of the treatment. If ADP denies a request for Specialty Services, ADP will send you a letter explaining the reason for the denial and how you can appeal the decision if you do not agree with the denial.

Referrals to Specialists

Your Primary Care Dentist may refer you to another dentist for consultation or specialized treatment. Your Primary Care Dentist will submit a request to ADP for authorization to see a specialist. Once your Primary Care Dentist determines that you require the care of a specialist, your Primary Care Dentist will determine if you need an emergency referral or a routine referral. ADP processes emergency referrals immediately by calling a specialist to coordinate the scheduling of an appointment for you with the specialist. Routine referrals are processed in a timely fashion appropriate for your condition, not to exceed five (5) business days of receipt. Referrals affecting care where you face an imminent and serious threat to your health or could jeopardize your ability to regain maximum function shall be made in a timely fashion appropriate for your condition, not to exceed 72-hours after ADP's receipt of the necessary documentation requested by ADP to make the determination. Copies of authorizations for regular referrals are sent to you, the specialist and your Primary Care Dentist. Decisions resulting in denial, delay or modification of requested health care services shall be communicated to you in writing within two (2) days of the decision. ADP reserves the right to determine the facility and Plan provider from which Covered Services requiring specialty care are obtained.

All services must be authorized before the date the services are provided, except for services provided by your Primary Care Dentist for Emergency Care services. If the services are not authorized before they are provided, they will not be a Covered Services, even if the services are needed.

ADP covers Prior Authorized Specialty Services in Sharp Health Plan's Service Area. If you require Specialty Services, ADP will refer you to a Participating Provider who is qualified and has agreed to provide the required specialty dental care. If a Participating Provider is unavailable to provide the necessary Specialty Service, ADP will refer you to a non-Participating Provider, who is a specialist in the dental care you require. ADP will make financial arrangements with a non- Participating Provider to treat you. In both instances, you are financially obligated to pay only the applicable Copayment for the Covered Service. ADP will pay the dentist any amounts that are in excess of the applicable Copayment for the authorized Specialty Service.

This is a summary of ADP's referral policy. To obtain a copy of ADP's policy please contact ADP at 1-866-650-3660 (TDD/TTY for the hearing impaired at 1-800-735- 2929).

If your request for a referral is denied, you may appeal the decision by following ADP's Grievance and Appeal Process found in this Supplement.

Obtaining a Second Opinion

Sometimes you may have questions about your condition or your Primary Care Dentist's recommended treatment plan. You may want to get a Second Opinion. You may request a Second Opinion for any reason, including the following:

- You question the reasonableness or necessity of a recommended procedure.
- You have questions about a diagnosis or a treatment plan for a chronic condition or a condition that could cause loss of life, loss of limb, loss of bodily function, or substantial impairment.
- Your provider's advice is not clear, or it is complex and confusing.
- Your provider is unable to diagnose the condition or the diagnosis is in doubt due to conflicting test results.
- The treatment plan in progress has not improved your dental condition within an appropriate period of time.

- You have attempted to follow the treatment plan or consulted with your initial provider regarding your concerns about the diagnosis or the treatment plan.

Members or providers may request a Second Opinion for Covered Services. After you or your Primary Care Dentist have requested permission to obtain a Second Opinion, ADP will authorize or deny your request in an expeditious manner. If your dental condition poses an imminent and serious threat to your health, including but not limited to, the potential loss of life, limb, or other major bodily function or if a delay would be detrimental to your ability to regain maximum function; your request for a Second Opinion will be processed within 72 hours after ADP receives your request.

If your request to obtain a Second Opinion is authorized, you must receive services from a Plan provider within ADP's dental network. If there is no qualified provider in ADP's network, ADP will authorize a Second Opinion from a Non-Participating Provider. You will be responsible for paying any applicable Copayments for a Second Opinion.

If your request to obtain a Second Opinion is denied and you would like to appeal ADP's decision, please refer to ADP's Grievance and Appeals Process in this Supplement.

This is a summary of ADP's policy regarding Second Opinions. To obtain a copy of Our policy, please contact ADP at 1-866-650-3660.

Getting Urgent Care

Urgent Care services are services needed to prevent serious deterioration of your health resulting from an unforeseen illness or injury for which treatment cannot be delayed. ADP covers Urgent Care services any time you are outside Sharp Health Plan's Service Area or on nights and weekends when you are inside Sharp Health Plan's Service Area. To be covered by ADP, the Urgent Care service must be needed because the illness or injury will become much more serious, if you wait for a regular doctor's appointment. On your first visit, talk to your Primary Care Dentist about what he or she wants you to do when the office is closed and you feel Urgent Care may be needed.

To obtain Urgent Care when you are inside Sharp Health Plan's Service Area on nights and weekends, the Member must notify his or her Primary Care Dentist, describe the Urgent Condition, and make an appointment to see his or her Primary Care Dentist within 24 hours. If the Primary Care Dentist is unable to see the Member within the 24-hour period, the Member must immediately contact ADP at 1-866-650-3660 and ADP will arrange alternative dental care.

To obtain Urgent Care when you are outside Sharp Health Plan's Service Area, the Member should seek care from any Non-Plan Provider. Services that do not meet the definition of Urgent Care will not be covered if treatment was provided by a Non-Plan Provider. Non-Plan Providers may require the Member to make immediate full payment for services or may allow the Member to pay any applicable Copayments and bill ADP for the unpaid balance. If the Member has to pay any portion of the bill, ADP will reimburse the Member for services that meet the definition of Emergency Care or Urgent Care as defined above. If the Member pays a bill, a copy of the bill or invoice from the dentist who provided the care and a brief explanation of the circumstances that gave rise to the needed dental care should be submitted to the following address:

Access Dental Plan, Attention: Claims Department, P.O. Box: 659005, Sacramento, CA 95865-9005.

Once the Member has received Urgent Care, the Member must contact his or her Primary Care Dentist (if the Member's own Primary Care Dentist did not perform the dental care) for follow- up care. The Member will receive all follow-up care from his or her own Primary Care Dentist.

Getting Emergency Services

Emergency Care is available to you 7 days per week, twenty-four (24) hours a day, both inside and outside Sharp Health Plan's Service Area.

If you need Emergency Care during regular Provider office hours, Members may obtain care by contacting a Primary Care Dentist or any available dentist for Emergency Care. After business hours, Members should first attempt to contact his or her Primary Care Dentist if the Member requires Emergency Care or Urgent Care services. If a Member's Primary Care Dentist is unavailable, the Member may contact ADP's twenty-four (24) hour answering service at 1-866- 650-3660. The on-call operator will obtain information from the Member regarding the Emergency Care and relay the information to a dental provider. This provider will then telephone the Member as soon as possible but not to exceed one (1) hour from the time of the Members call to the answering service. ADP provider will assess the Emergency and take the appropriate action.

Benefits for Emergency Care not provided by the Primary Care Dentist are limited to a maximum of $100.00 per incident, less the applicable Copayment. If the maximum is exceeded, or the above conditions are not met, the Eligible enrollee is responsible for any charges for services by a provider other than their Primary Care Dentist.

If you seek emergency dental services from a provider located more than 25 miles away from your participating provider, you will receive emergency benefits coverage up to a maximum of $100, less any applicable copayments.

If you receive emergency dental services, you may be required to pay the provider who rendered such emergency dental service and submit a claim to ADP for a reimbursement determination. Claims for Emergency Care should be sent to ADP within 180 days of the end of treatment. Valid claims received after the 180-day period will be reviewed if the Eligible Enrollee can show that it was not reasonably possible to submit the claim within that time.

Decisions relating to payment or denial of the reimbursement request will be made within thirty (30) business days of the date of all information reasonably required to render such decision is received by ADP.

Non-Covered Services

ADP does not cover dental services that are not listed in the Schedule of Benefits and are not Emergency or Urgent Care if you reasonably should have known that an Emergency or Urgent Care situation did not exist. You will be responsible for all charges related to these services.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those

services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options you may call ADP's Member Service at 1-866-650-3660.

Follow-Up Care

After receiving any Emergency or Urgent Care services, you will need to call your Primary Care Dentist for follow-up care.

Copayments

Members are required to pay any Copayments listed in the Pediatric Dental Summary of Benefits directly to the provider. Charges for broken appointments (unless notice is received by the provider at least 24 hours in advance or a Dental Emergency prevented such notice) and charges for Emergency Care visits after normal visiting hours are also shown on the Pediatric Dental Summary of Benefits.

Member Liabilities

Generally, the only amount a Subscriber pays for covered services is the required copayment. However, you may be financially responsible for specialty services you receive without obtaining a referral or authorization. You may also be responsible for services you receive that are not covered services; non-emergency services received in the emergency room; non-emergency or non-urgent services received outside of ADP Sharp Health Plan's service area without Prior Authorization; and, unless authorized, services received that are greater than the limits specified in this Supplement. ADP is responsible to pay for coverage of emergency services. You are not responsible to pay the provider for any sums owed by the health plan.

If ADP does not pay a non-participating provider for covered services, you may be liable to the non-participating provider for the cost of the services. But, you may request reimbursement from ADP for your payment to the non-participating provider for sums owed by ADP for these covered services. You may also be liable for payment of non- covered services, whether received from a participating or non-participating provider.

In the event that ADP fails to pay a participating provider, you will not be liable to the participating provider for any sums owed by ADP for covered services you received while covered under your plan. This provision does not prohibit the collection of copayments or fees for any noncovered services rendered by a participating provider. In addition, if you choose to receive services from a noncontracted provider, you may be liable to the noncontracted provider the cost of services unless you received prior approval from Access Dental Plan, or in accordance with emergency care provisions.

Grievances and Appeals Process

ADP's commitment to you is to ensure not only quality of care, but also quality in the treatment process. This quality of treatment extends from the professional services provided by Plan providers to the courtesy extended you by ADP's telephone representatives.

If you have questions about the services you receive from a Plan provider, ADP recommends that you first discuss the matter with your provider. If you continue to have a concern regarding any service you received, call ADP's Member Service at 1-866-650-3660 (TDD/TTY for the hearing impaired at 1-800-735-2929).

Grievances

You may file a Grievance with Access Dental Plan at any time. You can obtain a copy of ADP's Grievance Policy and Procedure by calling ADP's Member Service number in the above paragraph. To begin the Grievance process, you can call, write, in person, or fax ADP at:

Address: Access Dental Plan Complaint/Grievance Dept.
P. O. Box: 659005 Sacramento, CA 95865-9005

Telephone: (866) 650-3660
Fax: (916) 646-9000
Website: www.premierlife.com
E-mail: GrievanceDept@Premeirlife.com

A Grievance form is available at ADP. Staff will be available at ADP to assist Members in completion of this form.

You may also file a written grievance via ADP's website at www.premierlife.com. There will be no discrimination against subscriber Member (including cancellation of the contract) on the grounds that the complainant filed a grievance.

ADP will acknowledge receipt of your Grievance within five (5) days. ADP will resolve the complaint and will communicate the resolution in writing within thirty (30) calendar days. If your Grievance involves an imminent and serious threat to your health, including but not limited to severe pain, potential loss of life, limb or major bodily function, you or your provider may request that ADP expedite its Grievance review.
ADP will evaluate your request for an expedited review and, if your Grievance qualifies as an urgent Grievance, ADP will process your grievance within three (3) days from receipt of your request.

You are not required to file a Grievance with ADP before asking the Department of Managed.

Health Care to review your case on an expedited review basis. If you decide to file a Grievance with ADP in which you ask for an expedited review, ADP will immediately notify you in writing that:

1. You have the right to notify the Department of Managed Health Care about your Grievance involving an imminent and serious threat to health, and
2. ADP will respond to you and the Department of Managed Health Care with a written statement on the pending status or disposition of the Grievance no later than 72 hours from receipt of your request to expedite review of your Grievance.

Independent Medical Review

If dental care that is requested for you is denied, delayed or modified by ADP or a Plan provider, you may be eligible for an Independent Medical Review (IMR). The IMR has limited application to your dental program. You may request IMR only if your dental claim concerns a life-threatening or seriously debilitating condition(s) and is denied or modified because it was deemed an Experimental procedure.

If your case is eligible and you submit a request for an IMR to the Department of Managed Health Care (DMHC), information about your case will be submitted to a specialist who will review the information provided and make an independent determination on your case. You will receive a copy of the determination. If the IMR specialist so determines, ADP will provide coverage for the dental services.

Independent Medical Review for Denials of Experimental / Investigational Services or services that are not Medically Necessary. You may also be entitled to an Independent Medical Review, through the Department of Managed Health Care, when ADP denies coverage for treatment ADP has determined to be Experimental /Investigational Service or not Medically Necessary.

- ADP will notify you in writing of the opportunity to request an Independent Medical Review of a decision denying an Experimental / Investigational or not Medically Necessary Service within five (5) business days of the decision to deny coverage.
- You are not required to participate in ADP's Grievance process prior to seeking an Independent Medical Review of ADP's decision to deny coverage of an Experimental/ Investigational or not Medically Necessary Service.
- If a physician determines that the proposed service would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within seven (7) days of the completed request for an expedited review.

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If a Member has a grievance against Sharp Health Plan, the Member should first telephone Sharp Health Plan at **1-800-359-2002** and use the health plan's grievance process before contacting the DMHC. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to Members. If a Member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the health plan, or a grievance that that has remained unresolved for more than 30 days, he/she may call the DMHC for assistance. The Member may also be eligible for an Independent Medical Review (IMR). If 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 DMHC also has a toll-free telephone number (**1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The DMHC Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

ADP's Grievance process and DMHC's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Coordination of Benefits

Coordination of Benefits (COB) is a process, regulated by law, which determines the financial responsibility for payment when a Member has coverage under more than one plan. The primary carrier pays up to its maximum liability and the secondary carrier considers the remaining balance for covered services up to, but not exceeding, the benefits that are available and the dentist's actual charge.

Determination of primary coverage is as follows:

For a Group Medical Insurance Qualified Health Plan: A Group Medical Insurance Qualified Health plan providing pediatric dental essential health benefits is the primary carrier for such covered services. This applies to plans provided on the California Health Benefit Marketplace and to plans provided outside such Marketplace.

For Dependent Children covered under Group Dental Plans: The determination of primary and secondary coverage for Dependent children covered by two parents' plans follows the birthday rule. The plan of the parent with the earlier birthday (month and day, not year) is the primary coverage. Different rules apply for the children of divorced or legally separated parents; contact the Member Services Department if you have any questions.

Coverage under Access Dental and another pre-paid dental plan: When an Access Dental Member has coverage under another prepaid dental plan, whether Access Dental is the primary or the secondary coverage, PCD may not collect more than the applicable Patient Charge from the Member.

Coverage under Access Dental and a traditional or PPO fee-for-service dental plan: When a Member is covered by Access Dental and a fee-for-service plan, the following rules will apply:

- When Access Dental is primary, Access Dental will pay the maximum amount required by its contract or policy with the Member when coordinating benefits with a secondary dental benefit plan.
- When Access Dental is secondary, Access dental will pay the lesser of either the amount that we would have paid in the absence of any other dental benefit coverage or the Member's total out-of-pocket cost payable under the primary

dental benefit plan for benefits covered under the secondary dental benefit plan.

Access Dental will not coordinate nor pay for the following:

- Any condition for which benefits of any nature are paid, whether by adjudication or settlement, under any Workers' Compensation or Occupational Disease law.
- Treatment provided by any public program, except Medicaid, or paid for or sponsored by any government body, unless we are legally required to provide benefits.

Definitions

Dentally Necessary: Necessary and appropriate dental care for the diagnosis according to professional standards of practice generally accepted and provided in the community. The fact that a dentist may prescribe, order, recommend or approve a service or supply does not make it Dentally Necessary. Access Dental Plan employs Dental Consultants who make the final determination on what is Dentally Necessary. Members are bound by the determination of what is considered Dentally Necessary by Access Dental Plan's Dental Consultants.

Emergency Care: A dental condition, including severe pain, manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the Member's dental health in serious jeopardy, or
- Causing serious impairment to the Member's dental functions, or
- Causing serious dysfunction of any of the Member's bodily organs or parts.

Exclusion: Any dental treatment or service for which the Plan offers no coverage.

Experimental or Investigational Service: Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies which are not recognized as being in accordance with generally accepted professional dental standards, or if safety and efficacy have not been determined for use in the treatment of a particular dental condition for which the item or service in question is recommended or prescribed.

Non-Participating Provider: A provider who has not contracted with Access Dental Plan to provide services to Members.

Primary Care Dentist: A duly licensed dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed. A dentist, who is responsible for providing initial and primary care to Members, maintains the continuity of patient care, initiates referral for specialist care, and coordinates the provision of all Benefits to Members in accordance with the policy.

Specialist (Specialty) Services: Services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics or pediatric dentistry and which must be preauthorized in writing by Access Dental Plan.

NON-DISCRIMINATION NOTICE

Sharp Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Information in other formats (such as large print, audio, accessible electronic formats, or other formats) free of charge
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Care at 1-800-359-2002.

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with our Civil Rights Coordinator at:

- Address: Sharp Health Plan Appeal/Grievance Department 8520 Tech Way, Suite 200 San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY: 711) Fax: (619) 740-8572

You can file a grievance in person or by mail, fax, or you can also complete the online Grievance/Appeal form on the Plan's website sharphealthplan.com. Please call our Customer Care team at 1-800-359-2002 if you need help filing a grievance. You can also file a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability, or sex with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

The California Department of Managed Health Care is responsible for regulating health care service plans. If your Grievance has not been satisfactorily resolved by Sharp Health Plan or your Grievance has remained unresolved for more than 30 days, you may call toll-free the Department of Managed Care for assistance:

- 1-888-HMO-2219 Voice
- 1-877-688-9891 TDD

The Department of Managed Care's Internet Web site has complaint forms and instructions online: http://www.hmohelp.ca.gov.

Sharp Health Plan cumple con las leyes de derechos civiles federales correspondientes y no discrimina por motivos de raza, color, nacionalidad, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad ni discapacidad. Tampoco excluye a las personas ni las trata de forma diferente por motivos de raza, color, nacionalidad, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad ni discapacidad.

Sharp Health Plan:

- Brinda ayuda y servicios gratuitos a personas con discapacidad para que puedan comunicarse con nosotros de manera eficaz, como los siguientes:
  - Intérpretes del lenguaje de señas calificados.
  - Información en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos) sin cargo.
- Brinda servicios de idiomas gratuitos a personas cuyo idioma primario no es el inglés, como los siguientes:
  - Intérpretes calificados.
  - Información escrita en otros idiomas.

Si necesita estos servicios, comuníquese con Servicio al Cliente al 1-800-359-2002.

Si cree que Sharp Health Plan no le ha brindado estos servicios o lo ha discriminado de alguna otra forma por motivos de raza, color, nacionalidad, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad o discapacidad puede presentar una reclamación ante nuestro coordinador de derechos civiles por los siguientes medios:

- Por correo, a Sharp Health Plan Appeal/Grievance Department 8520 Tech Way, Suite 200 San Diego, CA 92123-1450.
- Por teléfono, al 1-800-359-2002 (TTY: 711), o por fax, al: (619) 740-8572.

Puede presentar una reclamación personalmente, por correo o por fax. También puede completar el formulario de reclamación o apelación en el sitio web del plan, sharphealthplan.com. Si necesita ayuda para presentar una reclamación, comuníquese con nuestro equipo de Servicio al Cliente al 1 800 359 2002. También puede presentar una queja por discriminación, si cree que ha sido discriminado por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los EE. UU. de manera electrónica mediante el portal de quejas de la Oficina de Derechos Civiles, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. También puede presentar la queja por correo o teléfono a la siguiente dirección: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 u 800-537-7697 (TDD).

Los formularios de queja se encuentran disponibles en http://www.hhs.gov/ocr/office/file/index.html.

El Departamento de Atención Médica Administrada de California es responsable de regular los planes de atención de salud. Si su reclamación no fue resuelta satisfactoriamente por

Sharp Health Plan o su reclamación ha permanecido sin resolver durante más de treinta (30) días, puede llamar al Departamento de Atención Médica Administrada para recibir asistencia de manera gratuita a los siguientes números:

- 1-888-HMO-2219 (voz)
- 1-877-688-9891 (TDD)

En el sitio web del Departamento de Atención Médica Administrada, http://www.hmohelp.ca.gov, encontrará formularios de queja e instrucciones.

LANGUAGE ASSISTANCE SERVICES

English
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you.
Call 1-800-359-2002 (TTY:711).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY:711).

繁體中文 **(Chinese)**
注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-359-2002 (TTY:711)。

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY:711).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY:711).

한국어 **(Korean):**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY:711) 번으로 전화해 주십시오.

Հայերեն **(Armenian):**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռատիպ)՝ 711).

فارسی **(Farsi):**
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما
فراهم می باشد. با (TTY:711) 1-800-359-2002 تماس بگیرید.

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-359-2002 (телетайп: 711).

日本語（**Japanese):**
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-359-2002 (TTY:711) まで、お電話にてご連絡ください。

العربية **(Arabic):**
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-359-2002 (رقم هاتف الصم والبكم :711).

ਪੰਜਾਬੀ **(Punjabi):**
ਧਿਆਨ ਦਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY:711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon Khmer, Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-359-2002 (TTY:711)។

Hmoob (Hmong):
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

हिंदी **(Hindi):**
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY:711) पर कॉल करें।

ภาษาไทย **(Thai):**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY:711).

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Published January 2019

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