SHARP HEALTH PLAN
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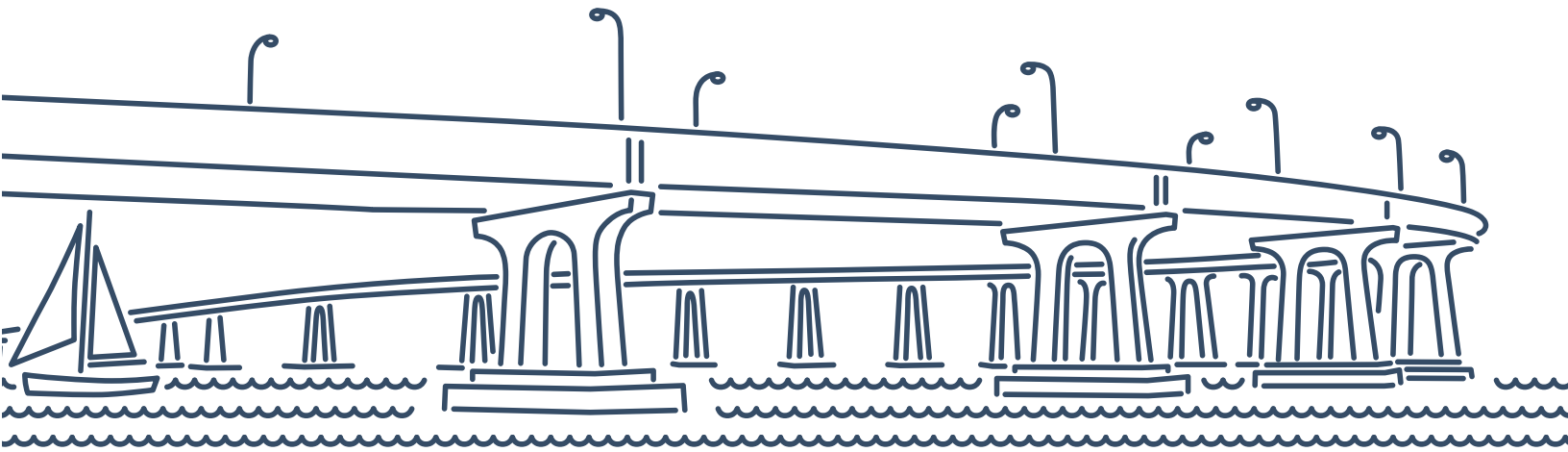
Point of Service (POS)

2021 Member Handbook



Combined Evidence of Coverage and Disclosure Form for Large Group Point of Service (POS) Plans without Outpatient Prescription Drug Coverage

Effective January 1, 2021

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 Sharp Health 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 Sharp Health Plan, notwithstanding any provisions in the Group Agreement that may be less favorable to Members.

This Member Handbook provides you with information on 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 carefully read 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: 1-858-499-8300 or toll-free at 1-844-483-9011
8 a.m. to 6 p.m., Monday to Friday

sharphealthplan.com

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The Health Plan Benefits and Coverage Matrix, which is part of this Member Handbook, is enclosed.

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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. If you have any questions about your Member Handbook or your Sharp Health Plan benefits, please visit sharphealthplan.com or email customer.service@sharp.com. You can also call us at 1-858-499-8300 or toll-free at 1-844-483-9011. 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 locally based, not-for-profit health plan that has been serving San Diegans for over 25 years. Sharp Health Plan offers San Diegans access to high-quality and affordable health insurance. We continue to be recognized nationally and locally for our award-winning health care for San Diegans of all ages. Visit sharphealthplan.com/honors to learn more.

Important Health Plan Information

We will provide you with important health plan information, including this Member Handbook, the Health Plan Benefits and Coverage Matrix, a Provider Directory and a Member Resource Guide, to help you better understand and use your benefit plan. It is very important that you read this information to understand your benefit plan and how to access care. We recommend keeping this information for reference. This information is also available online at sharphealthplan.com.

Member Handbook

This Member Handbook explains your health plan membership, how to use your benefit plan and access care, and who to call if you have questions. This Member Handbook also describes your Covered Benefits and any exclusions or limitations. For easier reading, we capitalized words throughout this Member Handbook to let you know that you can find their meanings in the **GLOSSARY** section. To access this Member Handbook online, log in to your Sharp Connect at sharphealthplan.com/login.

Health Plan Benefits and Coverage Matrix

Your Health Plan Benefits and Coverage Matrix outlines the applicable Deductible(s), Coinsurances, Copayments and Out-of-Pocket Maximums that apply to the benefit plan your Employer purchased. The Health Plan Benefits and Coverage Matrix, also commonly referred to as the Summary of Benefits, is considered part of this Member Handbook.

Provider Directory

The Provider Directory is a listing of Plan Physicians, Plan Hospitals and other Plan Providers in your Plan Network. When selecting your Primary Care Physician (PCP) who will coordinate all of your care, you must choose a provider who is in your Plan

Network. You will receive all non-emergency Covered Benefits from the Plan Providers in your Plan Network. For your convenience, your Plan Network is listed on your Sharp Health Plan Member identification card. Our Provider Directories are available online sharphealthplan.com/findadoctor. You may also request a printed directory by calling Customer Care.

Member Resource Guide

We distribute our Member Resource Guide annually to all Subscribers. The guide includes information about accessing care, our Member Advisory Committee (also called the Public Policy Advisory Committee), health education (prevention and wellness information), and how to get the most out of your health plan benefits.

How Does The Plan Work?

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT 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 get the most out of your health plan 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.

How Your Point of Service (POS) Plan Works

With a POS benefit plan, you can choose the providers and the level of coverage that works best for you.

- When you use providers in your Plan Medical Group, your PCP coordinates your care and you have the lowest out-of-pocket costs. This is called the HMO Benefit Level.
- When you choose providers who are not part of your Plan Medical Group, your out-of-pocket costs will be higher. No referral from your PCP is required, but some services do require Precertification. This is called the Out-of-Network Benefit Level.
- The Deductibles, Copayments and Coinsurance for the HMO Benefit Level and the Out-of-Network Benefit Level of your POS benefit plan are listed on your Health Plan Benefits and Coverage Matrix.

Choosing a Primary Care Provider (PCP)

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

- Although you are not required to receive care from a doctor or hospital affiliated with Sharp Health Plan, it is very important to choose a PCP. By choosing a PCP in your Plan Network, you will ensure that your care is appropriately coordinated when you receive services at the HMO Benefit Level.

- The Plan has several physician groups (called Plan Medical Groups or PMGs) from which you choose your PCP and through which you receive specialty physician care or access to hospitals and other facilities at the HMO benefit level. If your Plan Network is the "Choice" network, you can also select a PCP who is directly contracted 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. Family members may select different PCPs and PMGs to meet their individual needs. If you need help selecting a PCP, please call Customer Care.
- Write your PCP selection on your enrollment form and give it to your Employer.
- If you are unable to select a PCP 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 select a PCP who best meets your needs.
- You and your Dependents obtain Covered Benefits at the HMO Benefit Level through your PCP and from the Plan Providers who are affiliated with your PMG. If you need to be hospitalized, your PCP will generally direct your care to the Plan Hospital or facility where he/she has admitting privileges. Since PCPs do not usually maintain privileges at all facilities, you may want to check with your PCP to see where he/she 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 at the HMO Benefit Level

- Call your PCP for all your health care needs. Your PCP's name and telephone number is 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 him/her 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 for triage and screening services to assess your health concerns and symptoms. If your PCP is not available or if it is after regular office hours, a message will be taken and your call will be returned within a medically appropriate time frame. A qualified health professional trained to screen you for the purposes of determining the urgency of your need for care must return your call within 30 minutes.
- If you need specialist care, your PCP will refer you to a physician who is part of the same PMG.
- 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.
- Your PMG or Sharp Health Plan will handle all of the claims for services you received at the HMO Benefit Level. You are responsible only for your Copayments or other out-of-pocket costs, as identified on your Health Plan Benefits and Coverage Matrix.

When You Use Out-of-Network Providers

- No PCP referrals are necessary when you receive care from a doctor or facility that is not part of the Sharp Health Plan Network. You can use any licensed health care provider for Covered Benefits.
- Some services require Precertification. Precertification is a required review of the necessity and appropriateness of certain services. If you fail to receive Precertification when required, your coverage will be reduced. Call Customer Care to request Precertification. See your Health Plan Benefits and Coverage Matrix to determine which services require Precertification and follow the instructions under **Obtain Precertification for OON Benefit Level Services**.
- At the Out-of-Network Benefit Level, most providers will submit the claim for payment to Sharp Health Plan. Some providers may require you to submit a claim on your own. To do so, follow the instructions under **What If You Get a Medical Bill?**

Present Your Member ID Card and Pay Your Cost

Always present your Member ID card when you receive health care services. 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 applicable Deductible, Copayment or Coinsurance specified on the Health Plan Benefits and Coverage Matrix. For convenience, some Copayments and Coinsurance are also shown on your Member ID card.

Call us with questions at 1-858-499-8300 or toll-free at 1-844-483-9011, 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 prior to 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

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. Your PCP can tell you how to obtain a standing referral if you need one.

If you fail to obtain Authorization from your PCP or Plan, care you receive will be covered at the OON Benefit Level. 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 in your Plan Network.

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. The OON Benefit Level applies to any care not provided by Plan Providers affiliated with your PMG, unless your PMG or Plan has Authorized the service in advance or it is an Emergency Service.

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 require are not available at a Plan Hospital affiliated with your PMG, 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. The OON Benefit Level applies to any care that is not provided by Plan Hospitals affiliated with your PMG, unless your PMG or Plan has Authorized the service in advance or it is an Emergency Service.

Schedule Appointments

When it is time to make an appointment, simply call the doctor that you have selected as your PCP. Your PCP's name and phone number is shown on the Member ID card that you receive when you enroll as a Sharp Health Plan Member.

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: 1-844-483-9011. 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 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 the 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 Cost Share identified at the HMO Benefit Level.

Changing Your PCP

It is a good idea to stay with a PCP so he/she can get to know your health needs and medical history. However, you have the option to change your PCP to a different doctor in your Plan Network for any reason. If you select a PCP in a different PMG, you will have access to a different group of specialists, hospitals, and other providers. Your new PCP may also need to submit Authorization requests for specialty care, Durable Medical Equipment or other Covered Benefits you need. See the section below titled **Obtain Required Authorization** for more information. 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 or email.

Obtain Required Authorization for HMO Benefit Level Services

Except for PCP services, outpatient mental health or chemical dependency office visits, MinuteClinic services, 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.

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.

If you change to a new PMG as a result of a PCP change, you will need to ask your new PCP to submit Authorization requests for any specialty care, Durable Medical Equipment or other Covered Benefits you need. The Authorizations from your previous PMG will no longer be valid. Be sure to contact your new PCP promptly if you need Authorization for a specialist or other Covered Benefits.

If services requiring prior Authorization are obtained without the necessary Authorization, you may be responsible for the entire cost.

Access Health Care Services at the OON Benefit Level

When you receive care from a doctor or facility that is not part of your PMG, you simply call the doctor that you have selected for an appointment. No PCP referral is required. However, some services may require Precertification.

Obtain Precertification for OON Benefit Level Services

You are responsible for obtaining valid Precertification before you receive certain

Covered Benefits. If you do not receive Precertification when required, you will be required to pay as much as 50% of the amount Sharp Health Plan pays the provider for that service, rather than the Out-of-Network Benefit Level Coinsurance amount listed for that service on the Health Plan Benefits and Coverage Matrix. In addition, these payments will not apply toward your Deductible or annual Out-of-Pocket Maximum. The amount Sharp Health Plan pays the Out-of-Network Provider is based on a discounted rate of the provider's billed charges, as negotiated between Sharp Health Plan and the provider. If services are received out-of-network without the required Precertification and Plan determines that the services were not Medically Necessary, you will be responsible for 100% of the Out-of-Network Provider's billed charges. These payments will not apply toward your Deductible or Out-of-Pocket Maximum.

It is very important to refer to your Health Plan Benefits and Coverage Matrix to determine which services require Precertification. To obtain Precertification, you or your doctor must complete the Precertification Form found on sharphealthplan.com and fax or mail it to Sharp Health Plan. If you have any questions about the Precertification process or would like to request a copy of the Precertification Form, please call Customer Care.

A decision will be made on the Precertification request within five business days. 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 Precertification request. A letter will be sent to you within two business days of the decision. If we do not receive enough information to make a decision regarding the Precertification 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 Precertification 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 Precertification 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.

Sharp Health 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 in order for your HMO Benefit Level to apply. 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 your Plan Network. If there is no qualified provider within your Plan Network, you may request Authorization for a second opinion from a provider outside your Plan Network. If Plan determines that there is no qualified provider within your Plan Network to perform the second opinion and grants prior Authorization for a second opinion from an Out-of-Network Provider, the Out-of-Network Provider consultation will be covered at the HMO Benefit Level, in accordance with the terms of the Authorization. Any additional tests, procedures, follow-up treatment or other services provided by the Out-of-Network Provider will be subject to the Out-of-Network Benefit Level, unless Plan grants prior Authorization for such services at the HMO Benefit Level. If you seek a second opinion from a provider who is not affiliated with your PMG when there is one or more providers within your PMG who are qualified to perform such second opinion, or if you seek a second opinion outside your PMG without prior Authorization from your PMG or Plan, your Out-of-Network Benefit Level will apply.

Members and Plan Physicians request a second opinion through their PMG or through the Plan. Requests will be reviewed and facilitated through the PMG Authorization process or through the 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 Customer Care.

Telehealth Services

Telehealth is a way of delivering health care services via phone or video to facilitate diagnosis, consultation, treatment and other services. Telehealth services are intended to make it more convenient for you to receive health care services. You may receive Covered Benefits via Telehealth when available, determined by your Plan Provider to be medically appropriate, and provided by a Plan Provider. Medically Necessary health care services appropriately delivered via Telehealth are covered on the same basis

and to the same extent as coverage for the same services received through in-person visits. This means you have the same Cost-Share and Out-of-Pocket Maximum for in-person and Telehealth services. The same Authorization rules also apply. Coverage is not limited to services delivered by third-party Telehealth providers.

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; or
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.

All Emergency Services are covered at the HMO Benefit Level, even if provided by an Out-of-Network Provider.

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 business hours). Your PCP can help decide the best way to get treatment and can arrange for prompt emergency room 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 (San Diego and southern Riverside counties), 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.
- 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.
- 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.

Urgent Care Services

Urgent conditions are not emergencies, but may need prompt medical attention. Urgent Care Services are not a substitute for seeing your own 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.

All Urgent Care Services are covered at the HMO Benefit Level of care if approved by your PCP or if received outside the Plan's Service Area. However, if you are in the Plan's Service Area and access Urgent Care Services that are not Authorized, the OON Benefit Level will apply.

What to Do When You Require Urgent Care Services

If you need Urgent Care Services and are in the Plan's Service Area, you must use an urgent care facility within your PMG in order for your HMO Benefit Level to apply; however, you must call your PCP first. If, for any reason, you are unable to reach your PCP, please call Customer Care. You have access to a registered nurse evenings and weekends for immediate medical advice by calling our toll-free Customer Care number at 1-844-483-9011. They can talk with you about an illness or injury, help you decide where to seek care and provide advice on any of your health concerns.

Out-of-Area Urgent Care Services are considered Emergency Services and do not require an Authorization from your PCP. If you are outside the 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.

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 that are written in your preferred language. For free language assistance, please call us at 1-858-499-8300 or toll-free at 1-844-483-9011. We will 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:

- 1-800-735-2929 TTY
- 1-800-735-2922 Voice
- 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

Pre-existing conditions, including pregnancy, are covered with no waiting period or particular coverage limitations or exclusions, except for any benefit limitations or exclusions described in this Member Handbook. Upon the effective date of your enrollment, you and your Dependents are immediately covered for any pre-existing conditions.

Case Management

At the HMO Benefit Level, all of your medical care is coordinated by your PCP. However, Sharp Health Plan and your doctor have agreed that the Plan will be responsible for catastrophic case management. This is a service for very complex cases in which the Plan's case management nurses work closely with you and your doctor to develop and implement the most appropriate treatment plan for your medical needs.

Who Can You Call With Questions?

Customer Care

From questions about your benefits to inquiries about your physician, we are here to ensure that you have the best health care experience possible. You can call Customer Care by phone at 1-858-499-8300 or toll-free at 1-844-483-9011, or via email at customer.service@sharp.com. Our dedicated Customer Care team is available to support you from 8 a.m. to 6 p.m., Monday through Friday.

After-Hours Nurse Advice

After hours and on weekends, registered nurses are available through Sharp Nurse Connection™. They can talk with you about an illness or injury, help you decide where to seek care and provide advice on any of your health concerns. Call 1-844-483-9011 and select the appropriate prompt, 5 p.m. to 8 a.m., Monday to Friday and 24 hours on weekends.

Utilization Management

At Sharp Health Plan, our medical practitioners make Utilization Management decisions based only on appropriateness of care and service (after confirming health 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. Sharp Health Plan 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 will identify themselves by name, title and organization name.

What Do You Pay?

Premiums

Your Employer pays Premiums to Sharp Health Plan by the premium due date 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 if you or your Dependent(s) reach certain ages.

Copayments

A Copayment, sometimes referred to as a "copay", is a specific dollar amount (for example, $20) you pay for a particular Covered Benefit. If your benefit plan includes a Deductible, you may be required to satisfy the Deductible prior to paying the Copayment amount. Please see your Summary of Benefits for details. If the contracted rate for a Covered Benefit is less than the Copayment, you pay only the contracted rate. The example below illustrates how a Copayment is applied.

Example: If Sharp Health Plan's contracted rate for a specialist office visit is $100 and your Copayment is $50:

- If your benefit plan does not apply a Deductible to specialist office visits, or if you have paid your Deductible: You pay $50. Sharp Health Plan would cover the remaining $50.
- If your benefit plan applies a Deductible to specialist office visits and you have not met your Deductible: You pay the full amount of $100.

You are responsible to pay applicable Copayments for any Covered Benefit you receive. Copayments are due at the time of service. Sharp Health Plan is not responsible for the coordination and collection of Copayments. The provider is responsible for the collection of Copayments. Copayment amounts vary depending on the type of care you receive.

Copayment amounts are listed in your Summary of Benefits. For your convenience, HMO Benefit Level Copayments for the most commonly used benefits are also shown on your Member ID card. Copayments will not change during the Benefit Year. The Copayments listed on the Summary of Benefits apply to each Member (including eligible newborns).

Coinsurance

Coinsurance is the percentage of costs you pay (for example, 20%) for a Covered Benefit. If your benefit plan includes a Deductible, you may be required to satisfy the Deductible prior to paying the Coinsurance amount. Please see your Summary of Benefits for details. The example below illustrates how Coinsurance is applied.

Example: If Sharp Health Plan's contracted or negotiated rate for a specialist office visit is $100 and your Coinsurance is 20%:

- If your benefit plan does not apply a Deductible to specialist office visits, or if you have paid your Deductible: You pay $20 (20% of $100). Sharp Health Plan would cover the remaining $80.
- If your benefit plan applies a Deductible to specialist office visits and you have not

met your Deductible: You pay the full amount of $100.

You are responsible to pay applicable Coinsurance for any Covered Benefit you receive. Coinsurance payments are due at the time of service. Sharp Health Plan is not responsible for the coordination and collection of Coinsurance payments. The provider is responsible for the collection of the Coinsurance amount.

Coinsurance amounts may vary depending on the type of care you receive. The Coinsurance percentages are listed on your Summary of Benefits. For your convenience, HMO Benefit Level Coinsurance percentages for the most commonly used benefits are also shown on your Member ID card. Coinsurance percentages will not change during the Benefit Year. The Coinsurance amounts listed on the Summary of Benefits apply to each Member (including eligible newborns).

Deductibles

Some benefit plans include a Deductible. If you have a Deductible, it will be listed on your Summary of Benefits. Deductibles at the HMO Benefit Level and Out-of-Network Benefit Level are separate. In other words, expenses applied toward your Out-of-Network Benefit Level Deductible do not get applied to your HMO Benefit Level Deductible, and expenses applied toward your HMO Benefit Level Deductible do not get applied to your Out-of-Network Benefit Level Deductible.

A Deductible is the amount you must pay each Calendar Year, depending on the benefit plan you are enrolled in, for certain Covered Benefits before we will start to pay for those Covered Benefits. Deductibles will not change during the Benefit Year. The Deductible may not apply to all Covered Benefits. Please see your Summary of Benefits for details. 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 annual Deductible, you pay the applicable Copayment or Coinsurance for Covered Benefits, and we pay the rest. For most benefit plans, the Deductible starts over each Calendar Year. However, for some benefit plans, the Deductible will start over on the first day of your Benefit Year (i.e., the date on which your Employer renews coverage, as established between your Employer and Sharp Health Plan). Refer to your Summary of Benefits to see if your Deductible is applied each Calendar Year or Benefit Year.

The following expenses will not count towards the Deductible:

- Premium contributions,
- Charges for Covered Benefits that are not subject to the Deductible,
- Charges for services and Prescription Drugs not covered under the benefit plan (see the section titled **WHAT IS NOT COVERED?** for a list of exclusions and limitations), and
- Charges for services that exceed specific treatment limitations explained in this Member Handbook or noted in the Summary of Benefits.

How Does the Annual Deductible Work?

If you pay the Individual Deductible amount, no further Deductible payments are required from you for the specific Covered Benefits subject to that Deductible for the remainder of the Calendar Year (or Benefit Year, if you are enrolled in a benefit plan that applies the Deductible each Benefit Year). Premium contributions and any applicable Copayments and Coinsurance are still required.

If you have Family Coverage, your benefit plan includes a Family Deductible. Each Member, including a newborn Dependent, also has an Individual Deductible. Each individual in the family can satisfy the Deductible in one of two ways:

- If you meet your Individual Deductible, then Covered Benefits subject to that Deductible will be covered for you by Sharp Health Plan, subject to any applicable Coinsurance or Copayment, for the remainder of the Calendar Year or Benefit Year. The remaining enrolled family members must continue to pay the applicable Individual Deductible amount 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.
- If any number of covered family members collectively meet the Family Deductible, then Covered Benefits subject to that Deductible will be covered for the entire family by Sharp Health Plan, subject to any applicable Coinsurance or Copayment, for the remainder of the Calendar Year or Benefit Year.

The maximum amount that any one covered family member can contribute toward the Family Deductible is the amount applied toward the Individual Deductible. Any amount you pay for the specified Covered Benefits that would otherwise apply to your Individual Deductible, but which exceeds the Individual Deductible amount, will be refunded to you and will not apply toward your Family Deductible amount.

Deductibles at the HMO Benefit Level and Out-of-Network Benefit Level are separate. Therefore, if you satisfy the HMO Benefit Level Deductible, you will only be responsible for any applicable Copayments and Coinsurance for services received at the HMO Benefit Level; however, you will still be responsible to pay the Deductible for services received at the Out-of-Network Benefit Level until the Out-of-Network Benefit Level Deductible is met. If you first satisfy the Out-of-Network Benefit Level Deductible, you will still be required to pay the HMO Benefit Level Deductible for services received at the HMO Benefit Level until the HMO Benefit Level Deductible is met.

Annual Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the total amount of Copayments, Deductibles, and Coinsurance you pay each Calendar Year or Benefit Year, depending on the benefit plan you are enrolled in, for Covered Benefits, excluding supplemental benefits. The annual Out-of-Pocket Maximum amount is listed on your Summary of Benefits. For most benefit plans, the Out-of-Pocket Maximum starts over each Calendar Year. However, for some benefit plans, the Out-of-Pocket Maximum will start over on the first day of your Benefit Year (i.e., the date on which your Employer renews coverage, as established between your Employer and Sharp Health Plan). Refer to your Summary of Benefits to see if your Out-of-Pocket Maximum is applied each Calendar Year or Benefit Year.

Out-of-Pocket Maximums at the HMO Benefit Level and Out-of-Network Benefit Level are separate. In other words, Out-of-Network Benefit Level expenses will only apply toward your Out-of-Network Benefit Level Out-of-Pocket Maximum, and HMO Benefit Level expenses will only apply toward your HMO Benefit Level Out-of-Pocket Maximum.

The following expenses will not count towards satisfying the Out-of-Pocket Maximum:

- Premium contributions,
- Charges for services and Prescription Drugs not covered under the benefit plan (see the section titled **WHAT IS NOT COVERED?** for a list of exclusions and limitations),
- Charges for services that exceed specific treatment limitations explained in this Member Handbook or noted in the Summary of Benefits, and
- Copayments, Deductibles, and Coinsurance for supplemental benefits (e.g., acupuncture and chiropractic services).

How Does the Annual Out-of-Pocket Maximum Work?

All Copayments, Deductibles and Coinsurance amounts you pay for Covered Benefits, except supplemental benefits, count toward the Out-of-Pocket Maximum. If your total payments for Covered Benefits, excluding supplemental benefits, reach the Individual Out-of-Pocket Maximum amount, no further Copayments, Deductibles, or Coinsurance are required from you for Covered Benefits (excluding supplemental benefits) for the remainder of the Calendar Year. Premium contributions will continue to be required.

If you have Family Coverage, your benefit plan includes a Family Out-of-Pocket Maximum. Each Member also has an Individual Out-of-Pocket Maximum. Each individual in the family can satisfy the Out-of-Pocket Maximum in one of two ways:

- If you meet your Individual Out-of-Pocket Maximum, then Covered Benefits (excluding supplemental benefits) will be paid by Sharp Health Plan at 100% for you for the remainder of the Calendar Year or Benefit Year. The remaining enrolled family members must continue to pay applicable Deductibles, Copayments and Coinsurance amounts until either (a) the sum of Cost Shares paid by the family reaches the Family Out-of-Pocket Maximum amount or (b) each enrolled family member meets his/her Individual Out-of-Pocket Maximum amount, whichever occurs first.
- If any number of covered family members collectively meet the Family Out-of-Pocket Maximum, then Covered Benefits (excluding supplemental benefits) will be paid by Sharp Health Plan at 100% for the entire family for the remainder of the Calendar Year or Benefit Year.

The The maximum amount that any one covered family member can contribute toward the Family Out-of-Pocket Maximum is the amount applied toward the Individual Out-of-Pocket Maximum. Any amount you pay for covered services (excluding supplemental 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.

Out-of-Pocket Maximums at the HMO Benefit Level and Out-of-Network Benefit Level are separate. Therefore, if you satisfy the HMO Benefit Level Out-of-Pocket Maximum, Sharp Health Plan will pay for Covered Benefits received at the HMO Benefit Level at 100%. You will still be responsible to pay the applicable Cost Share for services received at the Out-of-Network Benefit Level until the Out-of-Network Benefit Level Out-of-Pocket Maximum is met. If you first satisfy the Out-of-Network Benefit Level Out-of-Pocket Maximum, you will still be required to pay the applicable Cost Share for services received at the HMO Benefit Level until the HMO Benefit Level Out-of-Pocket Maximum is met.

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

Please keep the receipts for all Copayments, Deductibles, and Coinsurance you pay for Covered Benefits. If you believe you have met your annual Out-of-Pocket Maximum, please contact Customer Care to request an audit. Please specify which family members you believe have met the Out-of-Pocket Maximum, or if you believe the Family Out-of-Pocket Maximum has been met. You will also be asked to mail or email in your receipts to Customer Care. The audit can take up to 60 days to complete.

To complete the Out-of-Pocket Maximum audit, we will review all claims received by Sharp Health Plan, based on the date received, to confirm that the Cost Shares applied are correct. We will send you a letter to confirm results of the audit. If you have met your Out-of-Pocket Maximum (or Deductible), the letter will identify any claims that need to be reprocessed. A letter will also be sent to your PMG giving them the date your Deductible or Out-of-Pocket Maximum was met and identifying any outstanding claims that need to be reprocessed for out-of-pocket overages. This letter will also ensure your PMG waives your Copayments, Deductibles, and Coinsurance for the remainder of the Calendar Year.

If you provided all required receipts, Sharp Health Plan will issue you a refund. If you were not able to provide receipts, we will notify your Plan Medical Group that the applicable claims should be reprocessed. The provider will be instructed to issue a refund of any overpayments to you. Please allow up to 90 days for claims to be reprocessed and refunds issued.

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. An HSA-qualified HDHP is one that meets IRS guidelines to allow you to contribute to an HSA. An HSA is a type of savings account that lets you set aside money on a pre-tax basis to pay for qualified medical expenses. You are not required to have an HSA if you are enrolled in an HSA-qualified HDHP. If you are unsure whether you are enrolled in an HDHP, please call Customer Care.

Self-Only Coverage Plan

If you are enrolled in an HSA-qualified HDHP for Self-Only Coverage, you must meet the Deductible for Self-Only Coverage and the Out-of-Pocket Maximum for Self-Only Coverage. These amounts are listed on your Summary of Benefits. Once you meet the Deductible for Self-Only Coverage, Covered Benefits subject to that Deductible are covered for you by the Plan, subject to any applicable Coinsurance or Copayment, for the remainder of the Calendar Year (or Benefit Year, if you are enrolled in a benefit plan that applies the Out-of-Pocket Maximum each Benefit Year). Once you meet the Out-of-Pocket Maximum for Self-Only Coverage, Sharp Health Plan covers Covered Benefits (excluding supplemental benefits) at 100% for you for the remainder of the Calendar Year (or Benefit Year). As described in the sections **How Does the Annual Deductible Work?** and **How Does the Annual Out-of-Pocket Maximum Work?**, the Deductibles and Out-of-Pocket Maximums for Self-Only Coverage at the

HMO Benefit Level and Out-of-Network Benefit Level are separate.

Family Coverage Plan

If you have Family Coverage, your benefit plan includes a Family Deductible and Family Out-of-Pocket Maximum. Each Member also has an Individual Deductible and Individual Out-of-Pocket Maximum. Each individual in the family can satisfy the Deductible in one of two ways:

- If you meet your Individual Deductible, then Covered Benefits, subject to that Deductible will be covered for you by Sharp Health Plan, subject to any applicable Coinsurance or Copayment, for the remainder of the Calendar Year (or Benefit Year, if you are enrolled in a benefit plan that applies the Out-of-Pocket Maximum each Benefit Year).
- If any number of covered family members collectively meet the Family Deductible, then Covered Benefits, subject to that Deductible will be covered for the entire family by Sharp Health Plan, subject to any applicable Coinsurance or Copayment, for the remainder of the Calendar Year (or Benefit Year).

The maximum amount that any one covered family member can contribute toward the Family Deductible is the amount applied toward the Individual Deductible.

Each individual in the family can satisfy the Out-of-Pocket Maximum in one of two ways:

- If you meet your Individual Out-of-Pocket Maximum, then Covered Benefits (excluding supplemental benefits) will be paid by Plan at 100% for you for the remainder of the Calendar Year (or Benefit Year).
- If any number of covered family members collectively meet the Family Out-of-Pocket Maximum, then Covered Benefits (excluding supplemental benefits) will be paid by Sharp Health Plan at 100% for the entire family for the remainder of the Calendar Year (or Benefit Year).

The maximum amount that any one covered family member can contribute toward the Family Out-of-Pocket Maximum is the amount applied toward the Individual Out-of-Pocket Maximum.

As described in the sections **How Does the Annual Deductible Work?** and **How Does the Annual Out-of-Pocket Maximum Work?**, the Deductibles and Out-of-Pocket Maximums for Family Coverage at the HMO Benefit Level and Out-of-Network Benefit Level are separate.

Deductible Credits

If you have already met part of the 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 or Benefit Year). That amount will also be counted towards your Out-of-Pocket Maximum on your Sharp Health Plan benefit plan. Deductible credit may only be applied toward the HMO Benefit Level Deductible and Out-of-Pocket Maximum. If you were enrolled in a benefit plan with out-of-network benefits through your previous health plan, any amounts applied toward your out-of-network Deductible and/or Out-of-Pocket Maximum with your previous health plan will not be applied as credit toward your Sharp Health Plan Deductible and/or Out-of-Pocket Maximum.

To request a Deductible credit, complete the Deductible Credit Request Form, available at sharphealthplan.com under "Member Forms" in the Member section of the website, and send the form with the most current copy of the explanation of benefits (EOB) from your previous health plan to Sharp Health Plan.

If you have any questions, please contact Customer Care at 1-844-483-9011 or customer.service@sharp.com.

What if You Get a Medical Bill?

You are only responsible for paying your contributions to the monthly Premium and any required Deductible, Copayments or Coinsurance 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. 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 stating 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.

In some cases, an Out-of-Network Provider may provide Covered Benefits 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 Benefits you receive at in-network facilities where we have Authorized you to receive care, except as described below.

As a Member enrolled in a POS benefit plan, an Out-of-Network Provider may bill or collect from you the out-of-network Cost Share for Covered Benefits received at an in-network facility where we have Authorized you to receive care only if you consent in writing and that written consent demonstrates satisfaction of all of the following criteria:

1. You provided written consent to receive services from the identified Out-of-Network Provider at least 24 hours in advance of the care.

2. The consent was obtained by the Out-of-Network Provider in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent was not obtained by the in-network facility or any representative of the in-network facility, and the consent was not obtained at the time of your admission or at any time when you were being prepared for surgery or any other procedure.
3. At the time your consent was provided, the Out-of-Network Provider provided you with a written estimate of your total out-of-pocket cost of care, based on the Out-of-Network Provider's billed charges for the service to be provided. The Out-of-Network Provider shall not attempt to collect more than the estimated amount without receiving separate written consent from you or your Authorized Representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate.
4. The consent advised you that you may elect to seek care from a Plan Provider or that you may contact Sharp Health Plan in order to arrange to receive the healthcare service from a Plan Provider for lower out-of-pocket costs.
5. The consent and estimate was provided to you in the language spoken by you, if your spoken language is a Medi-Cal threshold language, as defined in subdivision (d) of Section 128552 of the California Health and Safety Code.
6. The consent advised you that any costs incurred as a result of your use of the out-of-network benefit shall be in addition to in-network Cost Sharing amounts and may not count toward the annual Out-of-Pocket Maximum on in-network benefits or a Deductible, if any, for in-network benefits.

What Are Your Rights and 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.
- 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 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.
- 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.

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, including 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). 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, the 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.

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 the 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 notes, 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 Privacy Officer
8520 Tech Way, Suite 200
San Diego, CA 92123-1450
Toll-free: 1-844-483-9011

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 Sharp Health Plan has not protected your privacy, you may file a health information privacy complaint by contacting Sharp Health Plan or the U.S. Department of Health & Human Services' Office for Civil Rights (OCR) within 180 days of when you knew that the privacy incident occurred. Sharp Health Plan or the OCR may extend the 180-day period if you can show good cause.

You may file a health information privacy complaint with Sharp Health Plan in any of the following ways:

- Complete the Member Grievance form on our website at: sharphealthplan.com
- Call toll free at 1-844-483-9011
- Mail a letter to Sharp Health Plan:
  Attn: Appeal/Grievance Department
  8520 Tech Way, Suite 200
  San Diego, CA 92123-1450
- Fax a letter or your completed Member Grievance form to: 1-619-740-8572

You may file a health information privacy complaint with the OCR in any of the following ways:

- Online through the OCR Complaint Portal, available from the U.S. Department of Health & Human Services (HHS) website at: hhs.gov/hipaa/filing-a-complaint
- Mail a letter to the HHS:
  Attn: Centralized Case Management Operations
  200 Independence Avenue, S.W.
  Room 509F HHH Bldg.
  Washington, D.C. 20201
- Email your complaint to OCRComplaints@hhs.gov

What is the Grievance or Appeal Process?

If If you are having problems with a Plan Provider or with Sharp Health Plan, give us a chance to help. We 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 Appeal or Grievance process, you or your Authorized Representative can call, write or fax:

Sharp Health Plan
Attn: Appeal/Grievance Department
8520 Tech Way, Suite 200
San Diego, CA 92123-1450
Toll-free: 1-844-483-9011
Fax: 1-619-740-8572

If you prefer to send a written Grievance or Appeal, please send a detailed letter describing your concern, or complete the Member Grievance & Appeal Form that you can get from any Plan Provider or directly from a Plan representative. You can also complete the form online through 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. If the Grievance or Appeal involves Sharp Health Plan's cancellation, Rescission, or nonrenewal of your coverage, 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 that 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 the Employee Retirement Income Security Act (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 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 **1-844-483-9011** 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 **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's internet website **http://www.dmhc.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 days before submitting your Grievance to the department for review.

If you believe that your health care coverage, or your Dependent's coverage, has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a Grievance with the Department of Managed Health Care at the telephone numbers and Internet website 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 of Managed Health Care 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 California 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 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 situations described below.

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 Experimental or Investigational Service, 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 Condition or Seriously Debilitating Condition.
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 he/she certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your 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 it is an Experimental or Investigational Treatment.

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) above. An expedited review process will occur if your physician 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. If required, Authorized or Precertified in advance by your PCP, your PMG or Sharp Health Plan; and
4. Part of a treatment plan for Covered Benefits or required to treat medical conditions that are direct and predictable complications or consequences of Covered Benefits.

The Covered Benefits described in this Member Handbook do not include dental services (except as specifically described under the **Dental Services/Oral Surgical Services** benefit category of this section), vision, chiropractic and acupuncture services, assisted reproductive technologies or outpatient prescription drugs. These may be covered through supplemental benefits made available by your Employer and described in supplemental benefits brochures. Cost Share payments made for supplemental benefits do not apply toward the annual Out-of-Pocket Maximum.

The Member's Health Plan Benefits and Coverage Matrix lists applicable Deductibles, Copayments, Coinsurance and the annual Out-of-Pocket Maximum. Different Cost Shares and Out-of-Pocket Maximums apply at the HMO Benefit Level and the Out-of-Network Benefit Level.

Important exclusions and limitations are described in the section of this Member Handbook titled **WHAT IS NOT COVERED?** These exclusions or limitations do not apply to Medically Necessary services to treat Severe Mental Illness (SMI) or Serious Emotional Disturbance of a Child (SED).

Acute Inpatient Rehabilitation Facility Services

Acute inpatient medical rehabilitation facility services are covered. Authorization for these services will be based on the demonstrated ability for 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 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 advance by Plan. 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 five hours per day), individual and group chemical dependency counseling, medical treatment for withdrawal symptoms, partial hospitalization (programs usually more than five hours per day), and case management services.

Prior Authorization is not required for outpatient chemical dependency office visits.

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 Approved 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 disease or condition" means a 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 that meets at least one of the following:

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 Healthcare 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.
   g. The Department of Veterans Affairs.*
   h. The Department of Defense.*
   i. The Department of Energy.*

   *For those approved or funded by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy, the study or investigation must have been reviewed and approved through 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 United States 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 an Approved Clinical Trial include the following:

- Drugs, items, devices, and other health care services typically provided and covered under this Member Handbook absent a clinical trial.
- Drugs, items, devices, and other health care services required solely for the provision of the investigational drug, item, device or service.
- Drugs, items, devices, and other health care services required for the clinically appropriate monitoring of the investigational drug, item, device, or service.
- Drugs, items, devices, and other health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device or service.
- Drugs, items, devices, and other health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device or service, including diagnosis and treatment of complications.

Prior Authorization by Sharp Health Plan is required for any clinical trial in order for the services described above to be covered by Sharp Health Plan. Cost Sharing for routine health care costs for items and services furnished in connection with an Approved Clinical Trial will be the same as that applied to the same services not delivered in a clinical trial. If the clinical trial is not offered or available through a Plan Provider, routine health care costs for items and services furnished in connection with an Approved Clinical Trial provided by an Out-of-Network Provider will be covered at the HMO Benefit Level.

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 a Plan Provider. Sharp Health Plan may limit coverage to an Approved Clinical Trial in California, unless the clinical trial is not offered or available through a Plan Provider in California. In the case of covered health care services associated with an Approved Clinical Trial that are provided by a doctor who does not participate in the Member's Plan Network, Sharp Health Plan's payment will be limited to the negotiated rate otherwise paid to Plan Providers for the same services, less any applicable Member Cost Share. The Member will be responsible for any charges above the Sharp Health Plan negotiated rate. Any additional expenses the Member may have to pay beyond Sharp Health Plan's negotiated rate due to using a non-Plan Provider will not apply to the Member's Deductible, if any, or Out-of-Pocket Maximum.

Dental Services/Oral Surgical Services

Dental services 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.
- Biopsy of gums or soft palate.
- 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.
- 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 when Medically Necessary (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.
- 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 not covered under this benefit plan, but may be covered through separate outpatient prescription drug benefits, if offered by your Employer. Please contact your Employer for questions regarding outpatient 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 the **Professional Services** benefit category of this section.

Durable Medical Equipment (DME)

Durable Medical Equipment (DME) is covered. DME is a physical accessory designed to serve a repeated medical purpose and appropriate for use in the Member's home. DME does not include 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 is not considered Medically Necessary.

DME is limited to equipment and devices which are:

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

Sharp Health Plan reserves the right to determine if covered DME will be purchased or rented. 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.

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 medical attention, could reasonably be expected to result in:

1. Placing the patient's health in serious jeopardy; or

2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Out-of-Area medical services are covered at the HMO Benefit Level 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. Out-of-Area follow-up care for urgent and Emergency Services will be covered at the OON Benefit Level.

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 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.

Experimental or Investigational Services

Experimental or Investigational Treatment may be considered medically necessary and covered by Sharp Health Plan when all of the following criteria is met:

1. The Member has been diagnosed with a Life-Threatening Condition or Seriously Debilitating Condition.
2. The Member's Plan Physician certifies that he/she has a Life-Threatening Condition or Seriously Debilitating Condition for which standard therapies have not been effective in improving the Member's condition, for which standard therapies would not be medically appropriate for the Member, or for which there is no more beneficial standard therapy covered by Sharp Health Plan than the therapy proposed.
3. One of the following is true:
   - The Member's Plan Physician has recommended a drug, device, procedure or other therapy that the doctor certifies, in writing, is likely to be more beneficial than any available standard therapies; or
   - The Member, or the Member's physician who is a licensed, board-certified or board-eligible physician qualified to treat the Member's condition, has requested an Experimental or Investigational Treatment that, based on documentation from the medical and scientific evidence, is likely to be more beneficial for the Member than any available standard therapy. The physician certification must include a statement of the evidence relied upon by the physician in certifying his or her recommendation.
4. The specific drug, device, procedure or other therapy recommended is otherwise a Covered Benefit according to the terms of this Member Handbook.

Family Planning Services

The following family planning services are covered:

- All prescribed FDA-approved contraceptive drugs, supplies, devices and injections for women with reproductive capacity, including all FDA-approved contraceptive drugs, devices, and products available over-the-counter. Over-the-counter FDA-approved female contraceptive methods are covered only as prescribed by the Member's Plan Provider.

- Voluntary sterilization services.
- Interruption of pregnancy (abortion) services.
- FDA-approved emergency contraception when prescribed by a Plan Provider and dispensed by a Plan Pharmacy.
- FDA-approved emergency contraception dispensed by a non-Plan Provider, in the event of an Emergency Medical Condition.
- Counseling and education on contraception, in addition to those identified under the **Professional Services** benefit category of this section.

The Cost Share for family planning services is determined based on the type of service, location of service, and provider. For example, a service that takes place at an outpatient facility affiliated with your assigned PMG will result in an outpatient facility Cost Share at the HMO Benefit Level. Please see the Health Plan Benefits and Coverage Matrix.

Sharp Health Plan covers all FDA-approved contraceptive methods, sterilization procedures, and patent education and counseling for women, as recommended by the Health Resources and Services Administration (HRSA) guidelines, at the HMO Benefit Level without any Cost Sharing on the Member's part. Where the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, Sharp Health Plan is only required to cover at least one therapeutic equivalent without Cost Sharing. Cost Share will apply for contraceptive products and services if furnished by an Out-of-Network Provider. Contraceptive products prescribed for reasons other than contraceptive purposes and obtained through a pharmacy are not covered under this benefit plan, but may be covered through separate outpatient prescription drug benefits, if offered by your Employer. Please contact your Employer for questions regarding outpatient prescription drug coverage.

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 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:

1. Skilled nursing services of a registered nurse, public health nurse, licensed vocational nurse, and/or licensed home health aide.
2. Rehabilitation, physical, occupational and speech therapy services.
3. 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 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 home health agency.

4. Medical social service consultations provided by a qualified medical social worker.
5. Medical supplies, medicines, laboratory services, and Durable Medical Equipment when provided by a home health agency at the time services are rendered.
6. Drugs and medicines prescribed by a licensed 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 enrollees 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 an 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 or Coinsurance to the hospital for each hospitalization. The Member's share of the cost for inpatient services is determined by the benefit plan in effect on the day the Member was admitted to the hospital. 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.

Infertility Services

Infertility services, including treatment of the Member's infertility condition (other than conception by artificial means), are covered. 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 12 cycles of donor insemination; these 12 cycles are not covered by the Plan.

Infertility services must be provided by a Plan Provider affiliated with the Member's assigned PMG in order to be covered by Plan, unless otherwise Authorized by Plan or the Member's PMG. The Member pays Coinsurance equal to 50% of Sharp Health Plan's contracted rate of payment to each Plan Provider for all covered infertility services.

Conception by artificial means is not covered, unless supplemental benefits have been purchased by the Employer.

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 Cost Share for infusion therapy services is determined based on the type of service, the location of the service, and the provider. For example, if this service is provided by a Plan Provider affiliated with the Member's assigned PMG during an office visit, then the HMO Benefit Level office visit Cost Share will be charged. Please see the Health Plan Benefits and Coverage Matrix.

Injectable Drugs

Outpatient injectable drugs and self-injectable drugs are covered. Outpatient injectable drugs include those drugs or preparations which are not usually self-administered and which are given by the intramuscular or subcutaneous route. Outpatient injectable medications 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) and are approved by the FDA for self-administration and/or are packaged in patient-friendly injections devices along with instructions on how to administer. Epi-pens, self-injectable insulin, and GLP1 agents for diabetes are not covered under this benefit plan, but may be covered through separate outpatient prescription drug benefits, if offered by your Employer. Please contact your Employer for questions regarding outpatient prescription drug coverage. 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.

- Breastfeeding services and supplies. A breast pump and supplies required for breastfeeding are covered 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. Breastfeeding services and supplies must be provided by a Plan Provider affiliated with the Member's assigned PMG in order to be covered by Plan.
- Screening and treatment for a Maternal Health Condition for all women during pregnancy and during the postpartum period.

Prenatal and postnatal care recommended by the U.S. Preventive Services Task Force (USPSTF) with an A or B rating, or by the Health Resources and Services Administration (HRSA) is covered under the preventive benefit without Member Cost Share, if the Member receives the care from a Plan Provider affiliated with his/her assigned PMG. Such care includes, but is not limited to:

- Routine prenatal and postnatal obstetrical office visits.
- Certain lab services.
- Breastfeeding services and supplies (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal and postpartum periods.
- Tobacco use cessation counseling.
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP).
- Gestational diabetes mellitus screening.
- Human Immunodeficiency Virus (HIV) infection screening.

Prenatal services not covered under the preventive benefit include, but are not limited to, radiology services, delivery and high-risk/non-routine prenatal services (such as visits with a perinatologist/maternal-fetal medicines specialist). While radiology services, like obstetrical ultrasounds, may be part of routine prenatal care, they are not included under the USPSTF or HRSA recommendations. A Copayment, Coinsurance or Deductible may apply for these services.

Prenatal and postnatal office visit Cost Shares are separate from any hospital Cost Shares. For delivery, the Member pays the applicable Cost Share to the hospital facility at the time of admission. The Member Cost Share for the entire inpatient maternity stay is determined by the benefit plan in effect on the day you were admitted to the hospital. An additional hospital Cost Share applies if the newborn requires a separate admission from the mother because care is necessary to treat an ill newborn. The Member Cost Share for a newborn is based on the benefit plan the newborn is enrolled in on the date of admission.

Inpatient hospital care is covered for no less than 48 hours following a normal vaginal delivery and 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 mental health conditions identified as Mental Disorders in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV), and as amended in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders. The following services are covered when provided by licensed health care professionals acting within the scope of their license:

Outpatient Mental Health Services

- Individual office visits and group mental health evaluation and treatment.
- Psychological testing when necessary to evaluate a Mental Disorder.
- Screening and treatment for a Maternal Mental Health Condition for all women during pregnancy and during the postpartum period.
- 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 five hours per day).
- Partial hospitalization (programs usually more than five hours per day).
- Case management services.
- Electroconvulsive therapy.

Intensive Psychiatric Treatment Programs

- Short-term hospital-based intensive outpatient care (partial hospitalization).
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program.

Inpatient Mental Health Services

- Inpatient psychiatric hospitalization, including room and board, drugs, supplies, and services of licensed health care professionals acting within the scope of their license.
- Short-term treatment in a crisis residential program in a 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.

The Member Cost Share for the entire inpatient mental health stay is determined by the benefit plan in effect on the day you were admitted to the hospital. Members have direct access to licensed health care providers of mental health services without obtaining a PCP referral.

MinuteClinic®

As a Sharp Health Plan Member, you may receive the covered services listed below at any CVS MinuteClinic® ("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 Benefits at a MinuteClinic. The MinuteClinic providers may refer you to your Sharp Health Plan PCP if you need services other than those covered at MinuteClinic locations.

For more information about MinuteClinic services and age restrictions, please visit MinuteClinic.com. If you receive covered services at a MinuteClinic, your cost is equal to the PCP HMO Benefit Level Copayment or Coinsurance, as applicable to your benefit plan. A deductible may apply. There is no Cost Share for flu vaccinations. You have access to all MinuteClinic locations. To locate a participating MinuteClinic near you, visit MinuteClinic.com or call MinuteClinic directly at 1-866-389-ASAP (2727).

Ostomy and Urological Services

Ostomy and urological supplies prescribed in accordance 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 soft goods 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 your Plan Medical Group determines that they are Medically Necessary.

Outpatient Rehabilitation Therapy Services

Outpatient rehabilitation services, including occupational, physical and speech therapy, are covered. The Member pays an applicable Copayment to the Physician or other health care 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, such as hearing loss, chronic otitis media, brain tumor, cerebral palsy, cleft palate, or 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 physician, to the extent that the cost of these items exceeds the cost of a normal diet.
- Consultation with a physician who specializes in the treatment of metabolic diseases.

Preventive Care Services

Preventive care services are covered in accordance with:

- Recommendations made by the U.S. Preventive Services Task Force (USPSTF) with a rating of "A" or "B".
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).
- Health Resources and Services Administration (HRSA)-supported women's preventive services guidelines.
- Bright Futures guidelines for children and adolescents, developed by the HRSA with the American Academy of Pediatrics.

The USPSTF, ACIP or HRSA may update their recommendations and guidelines periodically. Any change in benefits required as a result of a new or updated recommendation or guideline will be effective for Benefit Years that begin on or after the date that is one year after the date the recommendation or guideline is issued. For example, if your Benefit Year begins January 1 of each year and the USPSTF issues a new recommendation with a rating of "A" on September 1, 2019, the benefit changes required would take effect January 1, 2021 (the start of your Benefit Year that begins one year after the USPSTF issued its recommendation). In the event of a safety recall or otherwise significant safety concern, or if the USPSTF downgrades a particular recommendation to a "D" rating, coverage of the affected item or service may cease prior to the end of your Benefit Year.

Covered preventive care services include, but are not limited to, the following:

- 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, human papillomavirus screening test, and prostate cancer screening.
- HIV testing, regardless of whether the testing is related to a primary diagnosis.
- Other preventive diagnostic tests that may be delivered in an outpatient surgical facility, including, but not limited to, colonoscopy and endoscopy.
- Screening for tobacco use.
- For those who use tobacco products, two tobacco cessation (quitting) attempts per year. A cessation attempt includes coverage for four tobacco counseling sessions, without prior Authorization.

All preventive care services listed above are provided at no Cost Share when such services are received from Plan Providers affiliated with the Member's assigned PMG. However, reasonable medical management techniques may be used to determine the frequency, method, treatment, or clinical setting for a recommended preventive service, to the extent not specified in the recommendation or guideline regarding that preventive service. If a provider who is not affiliated with the Member's assigned PMG renders preventive care services, Cost Share will apply according to the Out-of-Network Benefit Level described on the Summary of Benefits.

Professional Services

The following Professional Services (provided by a licensed health professional) are covered. The Cost Share for Professional Services is determined based on the type of service, the location of the service and the provider. Please see the Health Plan Benefits and Coverage Matrix.

- Physician office visits for consultation, treatment, diagnostic testing, etc.
- Surgery and assistant surgery.
- Inpatient hospital and Skilled Nursing Facility visits.
- Professional office visits.
- Physician 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 FDA and provided by and used at the doctor's 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 Bone Anchored Hearing Aides (BAHA) or processors) 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 from cerebral palsy, arthritis, polio, spinabifida, diabetes and foot disfigurement caused by accident or development disability.

Foot orthotics are covered for diabetic members. Coverage includes therapeutic shoes (depth or custom-molded) along with inserts Medically Necessary 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 or her license, and when not caused by misuse or loss. The applicable Cost Share, listed on 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).

The Cost Share for radiation therapy services is determined based on the type of service, the location of the service, and the provider. Please see the Health Plan Benefits and Coverage Matrix for more information. Gamma knife procedures and stereotactic procedures are covered under Outpatient Surgery for the purposes of determining Cost Share.

Radiology Services

Radiology services provided in the physician'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, or 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 Cost Share for reconstructive surgical services is determined based on the type

of service, the location of the service and the provider. 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 Calendar Year 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. Covered Benefits include:

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

Sterilization Services

Voluntary sterilization services are covered.

Termination of Pregnancy

Interruption of pregnancy (abortion) services are covered. The Cost Share for termination of pregnancy services is determined based on the type and location of the service. For example, if the service is provided in an outpatient surgery facility 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 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; and
3. Only anti-rejection drugs, biological products, and procedures that have been established as safe and effective, and no longer determined to be Experimental or Investigational Treatment, are covered.

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 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, 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, you must contact your PCP prior to accessing Urgent Care Services.

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 provider of the Member's choice.

What Is Not Covered?

Exclusions and Limitations

The services and supplies listed below 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 and limitations do not apply to Medically Necessary services to treat Severe Mental Illness (SMI) or Serious Emotional Disturbance of a Child (SED).

Exclusions include any services or supplies that are:

1. Not Medically Necessary;
2. In excess of the limits described in this Member Handbook or described in the Health Plan Benefits and Coverage Matrix;
3. Specified as excluded in this Member Handbook;
4. If required, not Authorized in advance by your PCP, your PMG or Sharp Health Plan (exception: Emergency Services do not require Authorization);
5. Part of a treatment plan for non-Covered Benefits; or
6. Received prior to the Member's effective date of coverage or after the Member's termination from coverage under this benefit plan.

Some services and supplies received by providers who are not affiliated with the Member's assigned PMG require Precertification. If the Member fails to obtain the required Precertification, the service or supply will be covered (if it is Medically Necessary and meets all other coverage provisions described in this Member Handbook), but the benefit will cost the Member as much as 50% of the amount Sharp Health Plan pays the provider for that service, rather than the Out-of-Network Benefit Level described in the Health Plan Benefits and Coverage Matrix. These payments will not apply toward the Member's Deductible, if any, or Out-of-Pocket Maximum. See the section **Obtain Precertification for OON Benefit Level Services** for more information.

Acupuncture and Acupressure

Acupuncture and acupressure services are not covered, unless provided as a supplemental benefit.

Alcoholism, Drug Addiction and Other Substance Abuse Rehabilitation

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

Ambulance and Medical Transportation Services

Ambulance services are 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 Member Handbook. Wheelchair transportation services (e.g., a private vehicle or taxi fare) are also not covered.

Chiropractic Services

Chiropractic services are not covered, unless provided as a supplemental benefit.

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.
- Drugs, items, devices and services provided solely to satisfy data collection and/or analysis needs and not used in the direct clinical management of the Member.
- Drugs, items, devices and other health care services that are otherwise excluded from coverage under this Member Handbook (other than those that are excluded on the basis that they are Experimental or Investigational Services).
- Drugs, items, devices and other health care services customarily provided by the research sponsor free of charge to a clinical trial participant.
- •The investigational drug, item, device, or service itself.
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Cosmetic Services and Supplies

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, except for services determined by Plan to be Medically Necessary for the treatment of morbid obesity. In no instance shall treatment for obesity be provided primarily for cosmetic reasons.

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. 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, 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.
- More than one piece of equipment that serves 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

Experimental or Investigational Services are not covered. This includes any evaluation, treatment, therapy, or device which involves the application, administration or use of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined by Sharp Health Plan, one of the following is true:

- Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not, in fact, been given at the time such service is furnished to the Member.
- Such evaluation, treatment, therapy or device is provided pursuant to a written protocol that describes among its objectives the following: determinations of safety, efficacy, toxicity, maximum tolerated dosage(s) or efficacy in comparison to the standard evaluation, treatment, therapy or device.
- Such evaluation, treatment, therapy or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations.
- Such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical trial, or experimental or research arm of a Phase III clinical trial.

- The consensus among experts, as expressed in published authoritative medical literature, is that further studies, research, or clinical investigations are necessary to determine maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the medical condition in question.
- There is no consensus among practicing physicians that the treatment, therapy, or device is safe and effective for the condition in question.
- Such evaluation, treatment, therapy or device is not yet considered the standard of care by a nationally recognized technology assessment organization, specialty society or medical review organization in treating patients with the same or similar condition.

This exclusion does not apply to the following:

- Medically necessary Experimental and Investigational Treatment for a Member with a Life-Threatening Condition or Seriously Debilitating Condition, as determined by Sharp Health Plan and described in the section titled **Experimental or Investigational Services** in the **WHAT ARE YOUR COVERED BENEFITS?** portion of this Member Handbook.
- Services covered under the section titled **Clinical Trials** or **Experimental or Investigational Services** in the **WHAT ARE YOUR COVERED BENEFITS?** portion of this Member Handbook.

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

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, Treatment and Counseling

Genetic testing, treatment and counseling are 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 benefit 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 was provided or Authorized by the Member's Primary Care Physician or Plan Medical Group in accordance with the terms of the Plan, or if the service was an Emergency Service or Urgent Care Service. This exclusion does not restrict the Plan's liability with respect to expenses for Covered Benefits solely because the expenses were incurred in a state or county hospital; however, the Plan's liability with respect to expenses for Covered Benefits provided in a state hospital is limited to the reimbursement that the Plan would pay for those Covered Benefits 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.

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:

- 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 that prepares the Member for non-covered ART procedures.
- Collection, preservation, or purchase of sperm, ova, or embryos. This exclusion does not apply to Medically Necessary Standard Fertility Preservation Services when a covered treatment may directly or indirectly cause Iatrogenic Infertility.
- 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 Member Handbook.

Massage Therapy Services

Massage therapy is not covered, unless the massage therapy services are part of a physical therapy treatment plan described as covered in this Member 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 Member 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 Severe Mental Illness (SMI) or Serious Emotional Disturbance of a Child (SED):

- Services for conditions that the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) identifies as something other than a Mental Disorder.
- Any service covered under the Member's Employee Assistance Program (EAP).
- 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 a developmental reading disorder, developmental arithmetic disorder, developmental language disorder, developmental articulation disorder, or other developmental disorder.*
- Diagnosis and treatment for learning disorders or those services primarily oriented toward treatment of social or learning disorders.*
- Counseling for activities of an educational nature.*
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- Counseling for relational problems (e.g., couples counseling or family counseling).
- I.Q. testing.
- Psychological testing of Children required as a condition of enrollment in school.*

Treatment for a mental health diagnosis other than a Severe Mental Illness or Serious Emotional Disturbance of a Child is not covered, unless added by your Employer as a supplemental benefit.

*These non-Covered Benefits do 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, pre-adoption, 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 in advance by the Plan.

Outpatient Prescription Drugs

Sharp Health Plan does not provide outpatient prescription drug coverage as a Covered Benefit, except for limited classes of prescription drugs that are integral to treatments covered as basic health care services and subject to the medical benefit. Members should contact their Employer for more information about supplemental prescription benefits.

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.
- 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 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. This exclusion includes, but is 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. Vision services that are not covered 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.
- Routine vision examinations.
- Eye refractions for the fitting of glasses.

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 extent that 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 later. 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, you 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 may receive Covered Benefits from Plan Providers affiliated with your PMG at the HMO Benefit Level. Covered Benefits received from providers who are not part of the Member's PMG will be covered at the OON Benefit Level, except for Emergency Services and Out-of-Area 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. Dependents may only enroll if the Eligible Employee is also enrolled or enrolls with the Dependent and are only eligible

for the same plan in which the employee is enrolled. 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;
- Children for whom the Enrolled Employee is required to provide health coverage pursuant to a qualified medical support order; or
- Children, not including foster Children, for whom the Enrolled Employee has assumed a parent-Child relationship, as indicated by intentional assumption of parental status, or assumption of parental duties, by the Enrolled Employee, and as certified by the Enrolled Employee at the time of enrollment of the Child and annually thereafter.

A grandchild of the Enrolled Employee is not eligible for enrollment, unless the Enrolled Employee has been appointed legal guardian of the grandchild(ren) or the Enrolled Employee has assumed a parent-Child relationship of the grandchild, as described above.

Dependent Children remain eligible up to age 26, regardless of student, married, 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 the month that the Dependent Child turns 26. The Dependent Child's coverage will end of the last day of the month that the Dependent Child turns 26 (i.e. their birthday month).

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. For the Purposes of this provision, a Child is considered Totally Disabled while the Child is and continues to meet both of the following criteria:

1. Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and
2. Chiefly dependent upon the Enrolled Employee for support and maintenance.

Sharp Health Plan will notify the Enrolled Employee at least 90 days prior to a Dependent Child attaining the limiting age of 26 that the Dependent Child's coverage will terminate. The notification will inform the Enrolled Employee that the Dependent Child's coverage will terminate upon attainment of the limiting age of 26, unless the Enrolled Employee requests continued coverage of the Totally Disabled Child within 60 days of the date the Enrolled Employee receives the notification. Such requests must include a written statement and supporting clinical documentation from your Dependent's Plan Physician describing the disability. Upon receipt of a request by the Enrolled Employee for continued coverage of the Child and the Plan Physician's documentation, Sharp Health Plan will determine if the Child meets the criteria described above. Coverage for such Child will continue until Sharp Health Plan makes its determination. Sharp Health Plan may request documentation to verify that the Child continues to meet the criteria above, but no more frequently than annually after the two-year period following the Child's reaching age 26.

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 may receive Covered Benefits from Plan Providers affiliated with his/her PMG at the HMO Benefit Level. Covered Benefits received from providers who are not part of the Member's PMG will be covered at the OON Benefit Level, except for Emergency Services and Out-of-Area Urgent Care Services.

Newborns

The newborn Child of an Enrolled Employee or an Enrolled Employee's Spouse or Domestic Partner is automatically covered for the first 31 calendar days from the date of the newborn's birth, and the adopted Child of an Enrolled Employee or an Enrolled Employee's Spouse or Domestic Partner is covered for 31 days from the date you are 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 31-day period, you must submit an Enrollment Change Form to your Employer within the 31-day period following the birth or legal 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.

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 are not eligible for enrollment, unless you have been appointed legal guardian of the grandchild(ren).

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 30 days after your other coverage ends and will be required to submit a Certificate of Creditable Coverage indicating the coverage termination date.

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 by submitting an Enrollment Change Form to your Employer within 30 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 30-day period, your Dependent(s) will not be covered and you will be responsible for payment of any services received.

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 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 toll-free at 1-844-483-9011 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% coverage.

Sharp Health 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 the primary health plan.

What if You Are Eligible for Medicare?

It is your 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.

In the event of an amendment to the Group Agreement that affects any Copayments, 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?

Termination of Membership

If your membership terminates, all rights to benefits end at midnight on the termination date (for example, if your termination date is January 1, 2021, your last moment of coverage was at 11:59 p.m. on December 31, 2020).

You will be billed as a non-Member for any Covered Services you receive after your membership terminates. When your membership terminates under this section, Sharp Health Plan and Plan Providers have no further liability or responsibility under this Agreement.

Termination by the Employee

You may terminate your coverage and/or your Dependent's coverage by contacting your Employer. Your coverage and/or your Dependent's coverage will end at 11:59 p.m. on the last day for which Premiums received by Sharp Health Plan from your Employer cover you and/or your Dependent(s). If you choose to terminate your coverage and/or your Dependent's coverage, you will not be able to enroll in a new benefit plan until the next Open Enrollment Period, unless you or your Dependent qualifies for a Special Enrollment Period.

Loss of Subscriber and Dependent 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.

- When your Employer otherwise determines that you no longer qualify for health coverage under the terms of your employment. Coverage will end on the last day of the month in which your eligibility for health coverage ends, 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).
- 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 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 or 30 days prior to the effective date of any Rescission. The notice will include information about your right to Appeal the decision. Your coverage may end retroactively to the date the fraud or misrepresentation occurred only if Sharp Health Plan identifies the act within your first 24 months of coverage. This type of retroactive termination is called a Rescission.

Cancellation of the Group Agreement for Nonpayment of Premiums

If the Group Agreement is cancelled because the Employer 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 the Notice of Start of Grace Period (sent to your Employer) is dated or on the day after the last date of paid coverage, whichever is later. If any required Premium is not paid by your

Employer on or before the due date, it must be paid and received by Sharp Health Plan during the Grace Period.

Sharp Health Plan will mail your Employer a Notice of Start of Grace Period at least 30 calendar days before any cancellation of coverage. This Notice of Start of Grace Period will provide your Employer with information regarding the consequences of failure to pay the Premiums due within 30 days of the start of the Grace Period. If payment is not received from your Employer within 30 days of the start of the Grace Period, Sharp Health Plan will cancel the Group Agreement and mail you and your Employer a Notice of End of Coverage, which will provide the following information:

- That the Group Agreement has been cancelled for Non-payment of Premiums.
- The specific date and time when the 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, (63 calendar days after the date Sharp Health Plan mails you the Notice of End of Coverage).
- Information about other health care coverage options and your potential eligibility for reduced-cost coverage through Covered California or no-cost coverage through Medi-Cal (a program that offers free or low-cost health coverage for children and adults with limited income and resources).
- Your rights under the law, including your right to submit a Grievance to Sharp Health Plan or to the California Department of Managed Health Care if you believe your benefit plan coverage has been improperly cancelled.

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 days of termination of the Group Agreement; however, you or your Dependent(s), as applicable, are 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 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 Cal-COBRA continuation coverage as described below.

Cal-COBRA Continuation Coverage

If your Employer consists of two 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 and your COBRA coverage began on or after January 1, 2003. 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 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% 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 Premium due date listed on your monthly invoice. If any Premium payment is not made within 30 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 or will be cancelled, rescinded, or not renewed due to health status or requirements for health care services, you have a right to submit a Grievance to Sharp Health Plan or to the Director of the Department of Managed Health Care, pursuant to Section 1365(b) of the California Health and Safety Code.

For information on submitting a Grievance to Sharp Health Plan, see the section titled **What Is the Grievance or Appeal Process?** in this Member Handbook. Sharp Health Plan will resolve your Grievance regarding an improper cancellation, Rescission or nonrenewal of coverage, or provide you with a pending status within three calendar days of receiving your Grievance. If you do not receive a response from Sharp Health Plan within three calendar days, or if you are not satisfied in any way with the response, you may submit a Grievance to the Department of Managed Health Care as detailed below.

If you believe your coverage or your Dependent's coverage has been, or will be, improperly cancelled, rescinded or not renewed, you may submit a Grievance to the Department of Managed Health Care without first submitting it to Sharp Health Plan or after you have received Sharp Health Plan's decision on your Grievance.

You may submit a Grievance to the Department of Managed Health Care online at:

WWW.HEALTHHELP.CA.GOV

You may submit a Grievance to the Department of Managed Health Care by mailing your written Grievance to:

Help Center
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, California 95814-2725

You may contact the Department of Managed Health Care for more information on filing a Grievance at:

- PHONE: 1-888-466-2219
- TDD: 1-877-688-9891
- FAX: 1-916-255-5241

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 for services otherwise covered in this Member Handbook when:

- You are receiving care from a non-Plan Provider for one of the conditions listed below and, at the time your coverage with Sharp Health Plan became effective, were receiving such care from that provider.

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

- Your Sharp Health Plan Network has changed; or
- Your 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 are in an active course of treatment for one of 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 from the health care provider's contract termination date or 12 months from the effective date of coverage for a newly enrolled Member
Pregnancy	Duration of the pregnancy, to include the three trimesters of pregnancy and the immediate post-partum period
Maternal Mental Health Condition	12 months from the Maternal Mental Health Condition diagnosis or from the end of pregnancy, whichever occurs later
Terminal Illness	Duration of the Terminal Illness
Pending surgery or other procedure	Must be scheduled within 180 days of the 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 from the health care provider's contract termination date or, if the child is a newly enrolled Member, 12 months from the child's effective date of coverage

Continuity of care is limited to Covered Benefits, as described in this Member Handbook, in connection with one or more of the conditions listed above. 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 are a newly enrolled Member and had the option to continue with your previous health plan or health care provider, but instead voluntarily chose to change health plans.
- Your health care provider's contract with Sharp Health Plan or your PMG has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, or fraud or other criminal activity.

Please contact Customer Care or go to sharphealthplan.com 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 physician 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, he/she 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.
- If you would like more information, please contact Customer Care. You can also obtain more information from your Plan 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, Sharp Health Plan provides Members, through the Member Newsletter, a description of its system for

Member participation in establishing Plan policy, and communicates material changes (updates and important information) 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 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
Attention: 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 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 (and the plural form of these words, when appropriate) throughout this Member Handbook and each of its attachments 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 or **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 request, by or on behalf of a Member, to re-evaluate a specific determination made by Sharp Health Plan or any of its delegated entities (e.g., Plan Providers).

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another life-threatening disease or condition that meets at least one of the following:

1. The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
    a. The National Institutes of Health.
    b. The federal Centers for Disease Control and Prevention.
    c. The Agency for Healthcare Research and Quality.
    d. The federal Centers for Medicare and Medicaid Services.
    e. A cooperative group or center of any of the entities described in clauses (i) to (iv), inclusive, the Department of Defense, or the United States Department of Veterans Affairs.
    f. A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
        i. The United States Department of Veterans Affairs.
        ii. The United States Department of Defense.
        iii. The United States Department of Energy.

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

3. The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

Authorization or **Authorized** means approval by the Member's Plan Medical Group (PMG) or Sharp Health 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, Qualified Autism Service Professional or Qualified Autism Service Paraprofessional contracted with Sharp Health 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 (6) months by a Qualified Autism Service Provider, modified whenever appropriate, and is consistent with the elements required under the law.

Benefit Year means a year of coverage under a benefit plan. If you enroll in your benefit plan on or before December 15 of the Open Enrollment Period, your Benefit Year begins January 1 of the following Calendar Year. Your Benefit Year may begin after January 1 if you enroll after December 15 or during a Special Enrollment Period. Your Benefit Year ends December 31, even if your coverage started after January 1.

Calendar Year means the 12-month period beginning January 1 and ending December 31 of the same year.

Child or **Children** means a Child or Children of the Subscriber including:

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

A Child remains eligible for coverage through the end of the month in which he/she turns 26 years of age. A covered Child is eligible to continue coverage beyond the age of 26 if the Child is and continues to be both:

- Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition; and
- Chiefly dependent upon the Subscriber for support and maintenance.

Coinsurance means a percentage of the cost of a Covered Benefit (for example, 20%) that a Member pays after the Member has paid the Deductible, if a Deductible applies to the Covered Benefit.

Copayment or **Copay** means a fixed dollar amount (for example, $20) that a Member pays for a Covered Benefit after the Member has paid the Deductible, if a Deductible applies to the Covered Benefit.

Cost Share or **Cost Sharing** means the amount of the Member's financial responsibility as specifically set forth in the Health Plan Benefits and Coverage Matrix (also referred to as the Summary of Benefits) attached to this Evidence of Coverage. Cost Share may include any combination of Deductibles, Coinsurance and Copayments, up to the Out-of-Pocket Maximum.

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

Deductible means the amount a Member must pay in a Calendar Year (or Benefit Year, if you are enrolled in a benefit plan that applies the Deductible amount each Benefit Year) for certain Covered Benefits before Sharp Health Plan begins payment for all or part of the cost of those Covered Benefits in that Calendar Year (or Benefit Year).

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 benefit plan, and for whom Sharp Health 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.

1. Both persons have chosen to share one another's lives in an intimate and committed relationship of mutual caring.
2. Neither person is married to someone else nor is a member of another domestic partnership that has not been terminated, dissolved, or adjudged a nullity.
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, except as follows:
   A person under 18 years of age who, together with the other proposed Domestic Partner, otherwise meets the requirements for a domestic partnership other than the requirement of being at least 18 years of age, may establish a domestic partnership upon obtaining a court order granting permission to the underage person or persons to establish a domestic partnership.

5. Both persons are capable of consenting to the domestic partnership.
6. Both file a Declaration of Domestic Partnership with the Secretary of State.

Durable Medical Equipment or **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 (as determined by the Employer), 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.

Experimental or **Investigational Treatment** or **Service** means any evaluation, treatment, therapy, or device which involves the application, administration or use of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined by Sharp Health Plan, one of the following is true:

- Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not, in fact, been given at the time such service is furnished to the Member.
- Such evaluation, treatment, therapy or device is provided pursuant to a written protocol that describes among its objectives the following: determinations of safety, efficacy, toxicity, maximum tolerated dosage(s) or efficacy in comparison to the standard evaluation, treatment, therapy or device.
- Such evaluation, treatment, therapy or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations.
- Such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical trial, or experimental or research arm of a Phase III clinical trial.
- The consensus among experts, as expressed in published authoritative medical literature, is that further studies, research, or clinical investigations are necessary to determine maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the medical condition in question.
- There is no consensus among practicing physicians that the treatment, therapy, or device is safe and effective for the condition in question.
- Such evaluation, treatment, therapy or device is not yet considered the standard of care by a nationally recognized technology assessment organization, specialty society or medical review organization in treating patients with the same or similar condition.

The sources of information that may be relied upon by Sharp Health Plan in determining whether a particular treatment is Experimental or Investigational include, but are not limited to, the following:

- The Member's medical records.
- Peer-reviewed scientific studies publishedin, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts.
- Peer-reviewed literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR).
- The Cochrane Library.
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the Social Security Act.
- The American Hospital Formulary Service's Drug Information.
- The American Dental Association Accepted Dental Therapeutics.

- Any of the following reference compendia, if recognized by the federal Centers for Medicare & Medicaid Services as part of an anticancer chemotherapeutic regimen: (A) The Elsevier Gold Standard's Clinical Pharmacology, (B) The National Comprehensive Cancer Network Drug and Biologics Compendium, or (C) The Thomson Micromedex DrugDex.
- Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.
- Peer-reviewed abstracts accepted for presentation at major medical association meetings.

Family Coverage means coverage for a Subscriber and one or more Dependents.

Family Deductible means the Deductible amount, if any, that applies each Calendar Year to a Subscriber and that Subscriber's Dependent(s) enrolled in Sharp Health Plan. With Family Coverage, Cost Share payments made by each individual in the family for Covered Benefits subject to the Deductible contribute to the Family Deductible.

Family Out-of-Pocket Maximum means the Out-of-Pocket Maximum that applies each Calendar Year to a Subscriber and that Subscriber's Dependent(s) enrolled in Sharp Health Plan.

Grace Period means:

1. For Members receiving advance payments of a Premium Tax Credit, California Premium Subsidy, or both, a period of three consecutive months, beginning no earlier than the first day after the last date of paid coverage, to allow a Subscriber to pay an unpaid Premium amount without losing healthcare coverage. To qualify for the three-month Grace Period, the Subscriber must be enrolled in a benefit plan through the Covered California Health Benefits Exchange, must be receiving advance payments of the Premium Tax Credit and/or the California Premium Subsidy, and must have paid at least one full month's Premium.
2. For Members not receiving a Premium Tax Credit or California Premium Subsidy, a period of at least 30 consecutive days, beginning the day the Notice of Start of Grace Period is dated or the day after the last date of paid coverage, whichever is later, to allow a Subscriber to pay an unpaid Premium amount without losing healthcare coverage. To qualify for the Grace Period, the Subscriber must have paid at least one full month's Premium for their benefit plan.

Grievance means a written or oral expression of dissatisfaction regarding Sharp Health Plan, a provider, and/or a pharmacy, including quality of care concerns.

Group Agreement means the written agreement between Sharp Health 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 Cost Shares for the specific benefit plan purchased by the Subscriber. 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.

Health Savings Account or **HSA** means a type of savings account that allows individuals to set aside money on a pre-tax basis to pay for qualified medical expenses if enrolled in a High Deductible Health Plan (HDHP).

High Deductible Health Plan or **HDHP** means a benefit plan that satisfies certain requirements with respect to minimum annual Deductible and Out-of-Pocket Maximum, as defined in section 223 of the Internal Revenue Code.

HMO Benefit Level means the Cost Share, Out-of-Pocket Maximum, and coverage provisions that apply to (i) Covered Benefits received from Plan Providers affiliated with the Member's assigned PMG; (ii) Covered Benefits received from Out-of-Network Providers, or providers not affiliated with the Member's assigned PMG, when Plan has granted prior Authorization for such Covered Benefits; (iii) Emergency Services; and (iv) Out-of-Area Urgent Care Services. Cost Shares and the Out-of-Pocket Maximum at the HMO Benefit Level are usually lower than Cost Shares and the Out-of-Pocket Maximum at the Out-of-Network Benefit Level. The Summary of Benefits lists the HMO Benefit Level and Out-of-Network Benefit Level.

Iatrogenic Infertility means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

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 a Life-Threatening Condition or Seriously Debilitating Condition, 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 each Calendar Year.

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

Life-Threatening Condition means either or both of the following:

- A disease or condition where the likelihood of death is high unless the course of the disease is interrupted.
- A disease or condition with potentially fatal outcomes, where the end point of clinical intervention is survival.

Maternal Mental Health Condition means a mental health condition that can impact a woman during pregnancy, peri or postpartum, that arises during pregnancy, in the peri or postpartum period, up to one year after delivery.

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 a Subscriber, or the Dependent of a Subscriber, who has enrolled in the Plan under the provisions of the Membership 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 (DSM) 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.

Nonpayment of Premium means failure of the Subscriber, having been duly notified and billed for the charge, to pay any Premium, or portion of Premium, when due to Plan. A Subscriber shall be considered duly notified and billed for the charge when billing information has been sent to the Subscriber that, at a minimum, itemizes the Premium amount due, the period of time covered by the Premium and the Premium due date.

Open Enrollment Period means a designated period of time each year during which individuals can enroll in a health plan or make changes to their coverage.

Out-of-Area means you are temporarily outside your Plan Network Service Area. Out-of-Area coverage includes Urgent Care Services and Emergency 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 care for the Urgent Care Service or Emergency Service must be Authorized by Sharp Health Plan and will be covered until it is clinically appropriate to transfer your care into the Service Area.

Out-of-Network Benefit Level means the Cost Share, Out-of-Pocket Maximum, and coverage provisions that apply to Covered Benefits received from Out-of-Network Providers or providers not affiliated with the Member's assigned PMG, except for the following: (i) Covered Benefits received from Out-of-Network Providers or providers not affiliated with the Member's assigned PMG when Plan has granted prior Authorization for such Covered Benefits; (ii) Emergency Services; and (iii) Out-of-Area Urgent Care Services. Covered Benefits described in (i), (ii) and (iii) are subject to the HMO Benefit Level. Cost Shares and the Out-of-Pocket Maximum at the Out-of-Network Benefit Level are usually more than Cost Shares and the Out-of-Pocket Maximum at the HMO Benefit Level. The Summary of Benefits lists the HMO Benefit Level and Out-of-Network Benefit Level.

Out-of-Network Providers means 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 not part of the Member's Plan Network.

Out-of-Pocket Maximum means the maximum total amount of expenses that a Member will pay for Covered Benefits in a Calendar Year before Sharp Health Plan pays Covered Benefits at 100%. All Member Cost Sharing (including Copayments, Deductibles and Coinsurance) for Covered Benefits contributes to the Out-of-Pocket Maximum.

Pervasive Developmental Disorder includes: Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified (including Atypical Autism), in accordance with the Diagnostic

and Statistical Manual for Mental Disorders – IV – Text Revision, and as amended in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders.

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 Sharp Health 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 Member, as indicated on the Member Identification Card.

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 Sharp Health Plan or as a member of a PMG, and that is included in the Member's Plan Network. Plan Physicians are listed in the Provider Directory.

Plan Providers or **Plan Providers** means the physician(s), hospital(s), Skilled Nursing Facility or Facilities, home health agency or agencies, pharmacy or pharmacies, medical transportation company or companies, laboratory or laboratories, radiology and diagnostic facility or facilities, Durable Medical Equipment supplier(s) and other licensed health care entities or professionals who are part of the Member's Plan Network or who provide Covered Benefits to Members through an agreement with Sharp Health Plan. Plan Provider(s) also include Qualified Autism Service Provider(s), Qualified Autism Service Professional(s), and Qualified Autism Service Paraprofessional(s) who are part of the Member's Plan Network, or who provide Covered Benefits to Members through an agreement with Sharp Health Plan. Plan Providers are listed in the Provider Directory.

Precertification means the approval by the Plan for Covered Benefits at the Out-of-Network Benefit Level. (A Precertification request may also be called a pre-service claim.)

Premium means the monthly amounts due and payable in advance to the Plan from the Subscriber 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 that are listed in this 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.

Qualified Autism Service Paraprofessional means an unlicensed and uncertified individual who meets all of the following criteria:

1. Is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice.
2. Provides treatment and implements services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider.
3. Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
4. Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers.
5. Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Qualified Autism Service Professional means an individual who meets all of the following criteria:

1. Provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider.
2. Is supervised by a Qualified Autism Service Provider.
3. Provides treatment pursuant to a treatment plan developed and approved by a Qualified Autism Service Provider.
4. Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.
5. Has training and experience in providing services for Pervasive Developmental Disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.
6. Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

Qualified Autism Service Provider means either of the following:

1. A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission

for Certifying Agencies, and who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the person who is nationally certified.

2. A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist, pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for Pervasive Developmental Disorder or autism, provided the services are within the experience and competence of the licensee.

Rescission or **Rescind** means a cancellation of coverage for fraud or intentional misrepresentation of material fact that has a retroactive effect.

Seriously Debilitating Condition means a disease or condition that causes major irreversible morbidity.

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 (2) 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.

      ii. The Mental Disorder and impairments have been present for more than six (6) months or are likely to continue for more than one (1) year if not treated.

   b. The Child displays one (1) 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.

Serious 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, worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration.

Service Area means the geographic area in which Sharp Health Plan is licensed to provide health services, as approved by the California Department of Managed Health Care. The Sharp Health Plan Service Area for individual and family plans includes certain ZIP codes in San Diego County, California and varies based on Plan Network. For more information about your Plan Network Service Area, please visit

our website at sharphealthplan.com, or call Customer Care.

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, and 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.

Standard Fertility Preservation Services means procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealths facilitates patient self-management and caregiver support for patients and includes:

- Synchronous interactions, defined as real-time interactions between a patient and a health care provider located at a distant site.
- Asynchronous store and forward transfers, defined as transmissions of a patient's medical information from an originating site to the health care provider at a distant site.

Terminal Illness means an incurable or irreversible condition that has a high probability of causing death within one year or less.

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, 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 means 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.

Nondiscrimination 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/TDD: 711) Fax: 1-619-740-8572

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/ TDD: 711), o por fax, al: 1-619-740-8572.

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).

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

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。

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

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

(Mon Khmer, Cambodian) ខ្មែរ
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ 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).

SHARP HEALTH PLAN

Consider us your personal health care assistant®

sharphealthplan.com
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1-844-483-9011