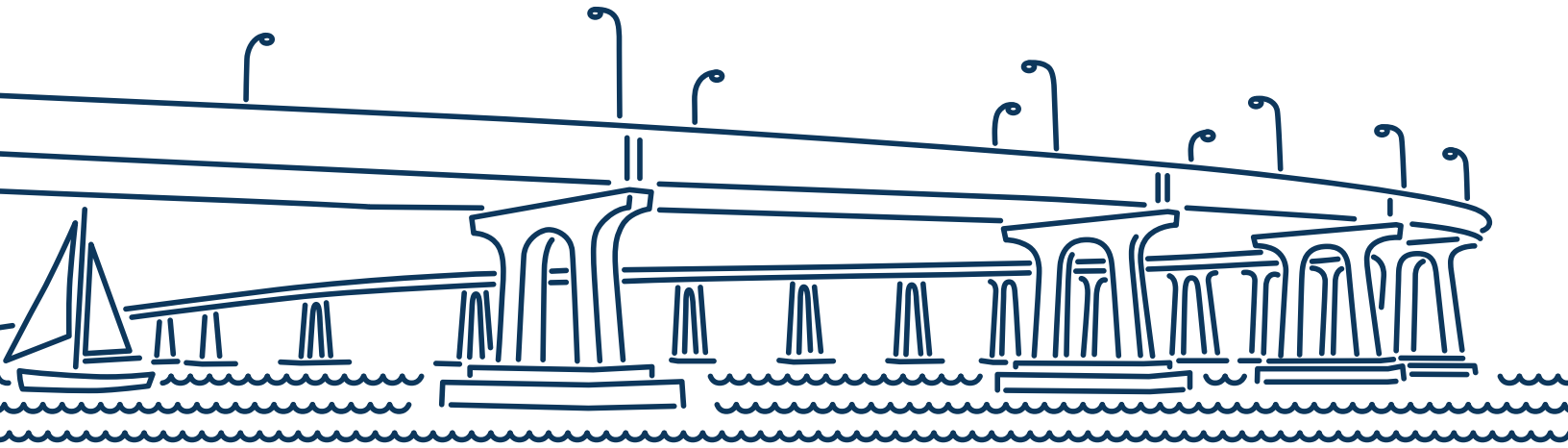
SHARP HEALTH PLAN

Health Maintenance Organization (HMO)

2022 Member Handbook



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

Effective January 1, 2022

SHARP Health Plan

Amendment #1 to your Sharp Health Plan Member Handbook

Effective January 1, 2022, your Combined Evidence of Coverage and Disclosure Form is amended as follows:

1. The Member Handbook is edited so that "you" or "your" means any Member (Subscriber or the Dependent), who has enrolled in the Plan under the provisions of the Membership Agreement and for whom the applicable Premiums have been paid.

2. In the section **Choice of Plan Physicians and Plan Providers**, the following language:

   In most cases, newborns are assigned to the mother's PMG until the first day of the month following birth. You may select a different PCP or PMG for your newborn following the birth month (or discharge from the hospital, whichever is later,) by calling Customer Care.

   Is replaced with:

   In most cases, newborns are assigned to the mother's PMG until the first day of the month following birth (or discharge from the hospital, whichever is later). You may select a different PCP or PMG for your newborn following the birth month (or discharge from the hospital, whichever is later,) by calling Customer Care.

3. In the section **Call Your PCP When You Need Care**, the following language:

   You can contact your PCP's office 24 hours a day. If your PCP is not available or if it is after regular office hours, a message will be taken. Your call will be returned by a qualified health professional within 30 minutes.

   Is replaced with:

   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. Your call will be returned by a qualified health professional within 30 minutes.

4. In the section **Present Your Member ID Card and Pay Your Cost**, the following language:

   Always present your Member ID card to Plan Providers.

   If you have a new ID card because you changed PCPs, or PMGs, be sure to show your Provider your new card.

   Is replaced with:

   Always present your Member ID card when you receive health care services. If you are a new Member, you will receive your ID card within 7-10 business days of paying your initial Premium. If you are an existing Member, you will receive a new ID card within 7-10 business days of any

applicable changes in your benefits or your PCP. You can also print a temporary ID card by logging into your account online at sharphealthplan.com.

If you have a new ID card because you changed PCPs, or PMGs, or benefit plans, be sure to show your Provider your new card.

5. In the chart **Non-Urgent Appointments**, located in the section **Timely Access to Care**, the following language:

   Non-physician mental health care provider (e.g., psychologist or therapist)

   Is replaced with:

   Non-physician mental health care or substance use disorder provider (e.g. psychologist or therapist)".

6. In the section **Timely Access to Care**, the following language is added:

   Rescheduling Appointments

   If your appointment requires rescheduling, it shall be promptly rescheduled in a manner that is appropriate to your health care needs and continuity of care, consistent with good professional practice.

7. In the section **Obtain Required Authorization**, the following language:

   Except for PCP services, outpatient Mental Health or Substance Use Disorder office visits, MinuteClinic services, Emergency Services, and obstetric and gynecologic services, you are responsible for obtaining valid Authorization before you receive Covered Benefits.

   Is replaced with:

   Except for PCP services, outpatient Mental Health or Substance Use Disorder office visits, MinuteClinic services, Emergency Services, biomarker testing for enrollees with metastatic stage 3 or 4 cancer, and obstetric and gynecologic services, such as abortion, you are responsible for obtaining valid Authorization before you receive Covered Benefits.

8. In the section **Second Opinions**, the language:

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

perform, assist, or provide care including ordering tests such as laboratory studies or X-rays, as the Plan does not provide reimbursement for such care.

Is replaced with:

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

9. In the section **Copayments**, the following language:

Copayment amounts are listed on your Summary of Benefits. For your convenience, 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).

Is replaced with:

Copayment amounts are listed on your Summary of Benefits. For your convenience, 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 newborn Dependents).

10. In the section **Coinsurance**, the following language:

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, 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).

Is replaced with:

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, 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 newborn Dependents).

11. In the section **How Does the Annual Out-of-Pocket Maximum Work?**, the following language:

> 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:

Is replaced with:

> If you have Family Coverage, your benefit plan includes a Family Out-of-Pocket Maximum. Each Member, including newborn Dependents, 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:

12. In the section **How Does the Annual Out-of-Pocket Maximum Work?**, the following language:

> **How to Inform Sharp Health Plan if You Reach the Annual Out-of-Pocket Maximum**
>
> Please keep 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 for any payments over the Out-of-Pocket Maximum. 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 to be issued.

Is replaced with:

> **Annual Deductible and Out-of-Pocket Maximum Balances**
>
> We will send you your annual deductible and annual out-of-pocket maximum balances each month you use benefits by mailing you an Explanation of Benefits (EOB) until the accrual balance equals the full deductible and the full out-of-pocket maximum. Copies of your EOB and your

deductible and out-of-pocket maximum balances are also available by logging into your account at sharphealthplan.com. Additionally, you may request your balances by contacting Customer Care. The annual deductible and annual out-of-pocket maximum balances sent will be the most up-to-date information available. Sharp Health Plan defines "most up-to-date information available" to be all received and processed claims from the month in question. In instances where a provider submits a claim for services rendered during a prior month, that claim will be included on the EOB for the month in which it was processed by Sharp Health Plan.

13. In the section **What Are Your Privacy Rights?**, the following language is added:

- **You have the right to receive Sensitive Services or to submit a claim for Sensitive Services if you have the right to consent to care.**
- **You have the right, without the authorization of the Subscriber or another policyholder, to have communications containing medical information related to Sensitive Services communicated to you at an alternative mail or email address or telephone number. You can update your contact information on Sharp Connect or by contacting Customer Care at 1-858-499-8300 or toll-free at 1-800-359-2002.**
- **If you have not designated an alternative mailing address, email address, or telephone number, we will send or make all communications related to your receipt of Sensitive Services in your name at the address or telephone number on file. Such communications include written, verbal, or electronic communications, including:**
  - **Bills and attempts to collect payment.**
  - **A notice of adverse benefits determinations.**
  - **An explanation of benefits notice.**
  - **A health care service plan's request for additional information regarding a claim.**
  - **A notice of a contested claim.**
  - **The name and address of a provider, description of services provided, and other information related to a visit.**
  - **Any written, oral, or electronic communication from a health care service plan that contains protected health information.**
- **We will not disclose medical information related to your receipt of Sensitive Services to the policyholder, primary subscriber, or any plan enrollees, absent your express written authorization.**
- **You have the right to request confidential communication in a certain form and format if it is readily producible in the requested form and format, or at alternative locations. The confidential communication request shall be valid until you submit a revocation of the request or a new confidential communication request is submitted.**

14. In the section **External Review for Nonformulary Prescription Drug Exception Requests**, the following language:

External Review for Nonformulary Prescription Drug Exception Requests

If we deny a request for coverage of a Nonformulary Drug, you, your Authorized Representative or your doctor may request that the original Exception Request and subsequent denial of such request be reviewed by an independent review organization (IRO). You, your Authorized Representative or your doctor may submit a request for IRO review up to 180 calendar days following the nonformulary Exception Request denial by:

Is replaced with:

External Review for Nonformulary Prescription Drug Exception Requests, Prior Authorization Requests, and Step Therapy Exception Requests

If we deny a request for coverage of a Nonformulary Drug or a drug that requires prior Authorization or Step Therapy, you, your Authorized Representative or your provider may request that the original Exception Request and subsequent denial of such request be reviewed by an independent review organization (IRO). You, your Authorized Representative or your provider may submit a request for IRO review up to 180 calendar days following the nonformulary Exception Request denial by:

Additionally, the word "doctor" is replaced by "provider."

Finally, the following language is added:

If a request for prior authorization or a step therapy exception is incomplete or relevant information necessary to make a coverage determination is not included, we will notify the your provider within 72 hours of receipt, or within 24 hours of receipt if exigent circumstances exist, what additional or relevant information is needed to approve or deny the prior authorization or step therapy exception request, or to appeal the denial.

If we fail to notify your provider of our coverage determination within 72 hours for non-urgent requests, or within 24 hours if exigent circumstances exist, upon receipt of a completed prior authorization or step therapy exception request, the prior authorization or step therapy exception request shall be deemed approved for the duration of the prescription, including refills. If your provider does not receive a coverage determination or request for additional or clinically relevant material information within 72 hours for standard requests or 24 hours for expedited requests, the prior authorization or step therapy exception request, or appeal of a denial, shall be deemed approved for the duration of the prescription, including refills.

If your provider sends us necessary justification and supporting clinical documentation supporting your provider's determination that the drug required by step therapy is inconsistent with good professional practice for provision of medically necessary covered services, taking into consideration your needs and medical history, along with the provider's professional judgment, we will grant a request for a step therapy exception. We will review and make a determination within 72 hours (for routine requests) and 24 hours (for urgent requests) of receipt of the information reasonably necessary and requested by Sharp Health Plan to make

the determination for Step Therapy Exception requests. The process is the same as the outpatient prescription drug prior authorization request process noted on p. 46.

15. In the section **What are Your Covered Benefits?**, the following language:

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. Chemotherapy medication covered through the outpatient Prescription Drug benefit is subject to the applicable Cost Share.

Is replaced with:

Chemotherapy

Chemotherapy is covered. Outpatient chemotherapy is covered as part of a comprehensive treatment plan. If you are admitted for inpatient chemotherapy, the applicable inpatient services Cost Share applies. Chemotherapy medication covered through the outpatient Prescription Drug benefit is subject to the applicable Cost Share.

16. In the section **What are Your Covered Benefits?**, the following language:

Clinical Trials

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, unless the clinical trial is outside the state where the Member lives. 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.

Is replaced with:

Clinical Trials

If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you 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 your 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 Cost Share.

17. In the section **What are Your Covered Benefits?**, the following language:

Maternity and Pregnancy Services

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.

Is replaced by:

Maternity and Pregnancy Services

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, only if a pump previously provided by Sharp Health Plan is no longer covered under warranty.

18. In the section **What are Your Covered Benefits?**, the following language:

Outpatient Prescription Drugs

You pay the Cost Share (i.e., Copayment, Coinsurance and/or Deductible) for Covered Benefits as listed in your Summary of Benefits. If the retail price for your Prescription Drug is less than your Cost Share, you will only pay the retail price. If you pay the retail price, your payment will apply to the Deductible, if any, and the Out-of-Pocket Maximum limit in the same manner as if you had purchased the Prescription Drug by paying the Cost Share. This applies whether you purchase your Prescription Drug from a brick-and-mortar retail pharmacy or a mail order pharmacy. Your Cost Share for covered orally administered anticancer medications will not exceed $250 for an individual Prescription of up to a 30-day supply. In addition, orally administered anticancer medications, will not be subject to a Deductible, unless you are enrolled in an HSA-qualified High Deductible Health Plan. For HSA-qualified High Deductible Health Plans, your maximum Cost Share of $250 will only apply after the Deductible has been met.

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

When a Generic Drug is available, the pharmacy is required to fill your Prescription with the generic equivalent unless prior Authorization is obtained and the Brand-Name Drug is determined

to be Medically Necessary. The FDA applies rigorous standards for identity, strength, quality, purity and potency before approving a Generic Drug. Generic Drugs are required to have the same active ingredient, strength, dosage form, and route of administration as their brand name equivalents. There are a few Brand drugs that are on the Formulary but their generic is not on the Formulary. When that is the case, the Brand medication will be dispensed and you will be charged the generic cost share.

WHAT IS STEP THERAPY?

Drugs with the ST symbol next to the drug name in the Formulary are subject to Step Therapy. The Step Therapy program encourages safe and cost-effective medication use. Under this program, a "step" approach is required to receive coverage for certain drugs. This means that to receive coverage, you must first try an alternative Prescription Drug that has been determined to be clinically effective. There may be a situation when it is Medically Necessary for you to receive certain medications without first trying an alternative drug. In these instances, your doctor may request prior Authorization by calling or faxing Sharp Health Plan. The list of Prescription Drugs subject to Step Therapy is subject to change.

WHAT IS GENERIC SUBSTITUTION?

When a Generic Drug is available, the pharmacy is required to switch a Brand-Name Drug to the generic equivalent, unless the Brand-Name Drug is Authorized due to medical necessity. If the Brand-Name drug is Medically Necessary and prior Authorization is obtained, you must pay the Cost Share for the corresponding Brand-Name Drug Tier. The FDA applies rigorous standards for identity, strength, quality, purity and potency before approving a Generic Drug. Generics are required to have the same active ingredient, strength, dosage form and route of administration as their brand-name equivalents.

WHAT IF A DRUG IS NOT LISTED IN THE FORMULARY?

For Members with a four-tier benefit plan, Drugs that are not listed in the Drug List are Nonformulary Drugs and are not covered. There may be times when it is Medically Necessary for you to receive a medication that is not listed on Sharp Health Plan's Formulary. In these instances, you, your Authorized Representative or your doctor may submit a Formulary Exception Request, following the prior Authorization process. Sharp Health Plan will approve or deny the Exception Request based on medical necessity within 72 hours for standard requests, or 24 hours for urgent requests.

Nonformulary Drugs that are approved for coverage and meet the Drug Tier 4 description will be subject to the Drug Tier 4 Cost Share. Nonformulary Brand-Name Drugs approved for coverage will be subject to the Drug Tier 3 Cost Share. Nonformulary Generic Drugs approved for coverage will be subject to the Drug Tier 1 Cost Share. If your Formulary Exception Request is denied, you have the right to Appeal the decision. Information on the Appeal process can be found under the What Is the Grievance or Appeal Process? section of this Member Handbook.

Is replaced with:

Outpatient Prescription Drugs

You pay the Cost Share (i.e., Copayment, Coinsurance and/or Deductible) for Covered Benefits as listed in your Summary of Benefits. If the retail price for your Prescription Drug is less than your Cost Share, you will only pay the retail price. If you pay the retail price, your payment will apply to the Deductible, if any, and the Out-of-Pocket Maximum limit in the same manner as if you had purchased the Prescription Drug by paying the Cost Share. This applies whether you purchase your Prescription Drug from a brick-and-mortar retail pharmacy or a mail order pharmacy. Your Cost Share for covered orally administered anticancer medications will not exceed $250 for an individual Prescription of up to a 30-day supply. In addition, you are not required to meet the Deductible before the $250 maximum is applied to orally administered anticancer medications, unless you are enrolled in an HSA-qualified High Deductible Health Plan. For HSA-qualified High Deductible Health Plans, your maximum Cost Share of $250 will only apply after the Deductible has been met.

You or your provider may request a partial fill of an oral, solid dosage form of a Schedule II Prescription Drug from a pharmacy. A partial fill is when you receive less than the full quantity prescribed by your provider. A Schedule II drug is one that has a high potential for abuse, with use potentially leading to severe psychological or physical dependence. The Plan will prorate your Copayment for a partial fill; however, if the amount you are charged for multiple partial fills exceeds the Cost Share you would have paid if you did not request a partial fill, the Plan will reimburse you for the excess Copayment. Please see the section **What if You Get a Medical Bill?** for information on how to request reimbursement.

When a Generic Drug is available, the pharmacy is required to fill your Prescription with the generic equivalent unless prior Authorization is obtained and the Brand-Name Drug is determined to be Medically Necessary. The FDA applies rigorous standards for identity, strength, quality, purity and potency before approving a Generic Drug. Generic Drugs are required to have the same active ingredient, strength, dosage form, and route of administration as their brand name equivalents. In a few cases, the Brand-Name Drug is included on the Formulary, but the generic equivalent is not. When that occurs, the Brand-Name Drug will be dispensed and you will be charged the Drug Tier 1 Cost Share.

WHAT IS STEP THERAPY?

Drugs with the ST symbol next to the drug name in the Formulary are subject to Step Therapy. The Step Therapy program encourages safe and cost-effective medication use. Under this program, a "step" approach is required to receive coverage for certain drugs. This means that to receive coverage, you must first try an alternative Prescription Drug that has been determined to be clinically effective. There may be a situation when it is Medically Necessary for you to receive certain medications without first trying an alternative drug. In these instances, your provider may request prior Authorization by calling or faxing Sharp Health Plan. The list of Prescription Drugs subject to Step Therapy is subject to change. When a provider determines that the drug required under Step Therapy is inconsistent with good professional practice, the provider should submit their justification and supporting clinical documentation supporting the provider's determination at the same time as they submit a Step Therapy Exception request and the Plan will approve the Step Therapy Exception Request.

If a request for prior authorization or a step therapy exception is incomplete or relevant information necessary to make a coverage determination is not included, we will notify your provider within 72 hours of receipt, or within 24 hours of receipt if exigent circumstances exist, what additional or relevant information is needed to approve or deny the prior authorization or step therapy exception request, or to appeal the denial.

If we fail to notify your provider of our coverage determination within 72 hours for non-urgent requests, or within 24 hours if exigent circumstances exist, upon receipt of a completed prior authorization or step therapy exception request, the prior authorization or step therapy exception request shall be deemed approved for the duration of the prescription, including refills. If your provider does not receive a coverage determination or request for additional or clinically relevant material information within 72 hours for standard requests or 24 hours for expedited requests, the prior authorization or step therapy exception request, or appeal of a denial, shall be deemed approved for the duration of the prescription, including refills.

WHAT IS GENERIC SUBSTITUTION?

When a Generic Drug is available, the pharmacy is required to switch a Brand-Name Drug to the generic equivalent, unless the Brand-Name Drug is Authorized due to medical necessity. If the Brand-Name drug is Medically Necessary and prior Authorization is obtained, you must pay the Cost Share for the corresponding Brand-Name Drug Tier. The FDA applies rigorous standards for identity, strength, quality, purity and potency before approving a Generic Drug. Generics are required to have the same active ingredient, strength, dosage form and route of administration as their brand-name equivalents. In a few cases, the Brand-Name Drug is included on the Formulary, but the generic equivalent is not. When that occurs, the Brand-Name Drug will be dispensed and you will be charged the Drug Tier 1 Cost Share.

WHAT IF A DRUG IS NOT LISTED IN THE FORMULARY?

For Members with a four-tier benefit plan, Drugs that are not listed in the Drug List are Nonformulary Drugs and are not covered. There may be times when it is Medically Necessary for you to receive a medication that is not listed on Sharp Health Plan's Formulary. In these instances, you, your Authorized Representative or your provider may submit a Formulary Exception Request, following the prior Authorization process. Sharp Health Plan will approve or deny the Exception Request based on medical necessity within 72 hours for standard requests, or 24 hours for urgent requests.

Members with a four-tier benefit plan: Nonformulary Drugs that are approved for coverage and meet the Drug Tier 4 description will be subject to the Drug Tier 4 Cost Share. Nonformulary Brand-Name Drugs approved for coverage will be subject to the Drug Tier 3 Cost Share. Nonformulary Generic Drugs approved for coverage will be subject to the Drug Tier 1 Cost Share. If your Formulary Exception Request is denied, you have the right to Appeal the decision. Information on the Appeal process can be found under the **What Is the Grievance or Appeal Process?** section of this Member Handbook.

For Members with a three-tier benefit plan: Nonformulary Brand-Name Drugs approved for coverage will be subject to the Tier 3 Cost Share. Nonformulary Generic Drugs approved for coverage will be subject to the Tier 1 Cost Share. If your Formulary Exception Request is denied,

you have the right to Appeal the decision. Information on the Appeal process can be found under the **What Is the Grievance or Appeal Process?** section of this Member Handbook.

19. In the section **What are Your Covered Benefits?**, **Outpatient Prescription Drugs**, **Sharp Health Plan Formulary**, the following language is added:

    Sometimes, a Brand-Name Drug is listed on the Formulary as preferred and the Generic Drug is not on the Formulary. When that occurs, you will be charged the Drug Tier 1 Cost Share. The Generic Drug will only be covered if a prior Authorization is approved based on Medical Necessity.

20. In the section **What are Your Covered Benefits?**, the following language:

    Preventive Services

    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, BRCA screening and testing in high-risk women, human papillomavirus screening test, lung cancer screening in certain persons, and prostate cancer screening.

    Is replaced with:

    Preventive Services

    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, BRCA screening and testing in high-risk women, human papillomavirus screening test, lung cancer screening in certain persons, colorectal cancer screening, and prostate cancer screening.

21. In the section **What are Your Covered Benefits?, Preventive Services**, the following language is added:

    - Home test kits for sexually transmitted disease (including the laboratory costs for processing the kits) that are deemed Medically Necessary or appropriate and ordered directly by a provider or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.
    - Adverse Childhood Experiences (ACEs) screening.

22. In the section **What are Your Covered Benefits?**, the following language:

    Vision Services

    Pediatric Vision Services

    Medically Necessary contact lenses are covered. Necessary contact lenses, in lieu of glasses, are covered in full when verified by a Plan Provider for eye conditions that would prohibit the use of glasses. Visually necessary contact lenses are not typically covered for Members who have

received any elective cosmetic eye surgery (e.g., LASIK, PRK, or RK). However, procedures resulting with concerns such as ectasia, scarring or irregular corneas causing vision problems that require contact lenses to provide functional vision, are covered under the necessary contact lens benefit, so long as patients meet the necessary contact lens criteria. The conditions covered include aphakia, aniridia, anisometropia (must meet 3.0 diopter criteria), corneal transplant, high ametropia (must meet diopter criteria), nystagmus, keratoconus, corneal dystrophies, corneal neovascularization and other eye conditions that make contact lenses necessary and result in significantly better visual acuity. Visually Necessary contact lenses. Medically Visually Necessary contact lenses are covered. Necessary contact lenses, in lieu of glasses, are covered in full when verified by a Plan Provider for eye conditions that would hinder vision correction and regular eyeglasses and/or elective contact lenses are not the accepted standard of treatment. Visually necessary contact lenses are not typically covered for Members who have received any elective cosmetic eye surgery (e.g., LASIK, PRK, or RK). However, procedures resulting with concerns such as ectasia, scarring or irregular corneas causing vision problems that require contact lenses to provide functional vision, are covered under the necessary contact lens benefit, so long as patients meet the necessary contact lens criteria. The conditions covered include aphakia, aniridia, anisometropia (must meet 3.0 diopter criteria), corneal transplant, high ametropia (must meet diopter criteria), nystagmus, keratoconus, corneal dystrophies, corneal neovascularization and other eye conditions that make contact lenses necessary and result in significantly better visual acuity.

Is replaced with:

Vision Services

Pediatric Vision Services

Visually necessary contact lenses are covered. Necessary contact lenses, in lieu of glasses, are covered in full when verified by a Plan Provider for eye conditions that would hinder vision correction and regular eyeglasses and/or elective contact lenses are not the accepted standard of treatment. The conditions covered include aphakia, aniridia, anisometropia (must meet diopter criteria), corneal transplant, high ametropia (must meet diopter criteria), nystagmus, keratoconus, corneal dystrophies, corneal neovascularization, Pathological Myopia, Aniseikonia, Corneal Disorders, Post-traumatic Disorders, and Irregular Astigmatism and other eye conditions that make contact lenses necessary and result in significantly better visual acuity.

23. In the section **What is Not Covered**?, the language:

Non-Preventive Physical or Psychological Examinations

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

Is replaced with:

Non-Preventive Physical or Psychological Examinations

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

24. In the section **What is Not Covered?**, **Outpatient Prescription Drugs**, **Outpatient Prescription Drugs**, **Exclusions and Limitations to the Outpatient Prescription Drug Benefit** the following language is removed:

    Please refer to the Member Handbook under Disposable Medical Supplies, Durable Medical Equipment, and Family Planning for information about medical devices covered by Sharp Health Plan.

25. In the section **What is Not Covered?**, **Outpatient Prescription Drugs**, **Exclusions and Limitations to the Outpatient Prescription Drug Benefit**, the following language is added:

    Travel and/or required work-related immunizations.

26. In the section **What is Not Covered?**, the following language:

    Outpatient Prescription Drugs

    The exclusions listed above do not apply to:

    Coverage of an entire class of Prescription Drugs when one drug within that class becomes available over-the-counter.

    Drugs listed on Sharp Health Plan's Formulary.

    Over-the-counter products that are specifically covered and listed as a preventive care benefit under California State or federal law. Covered preventive drugs include FDA-approved tobacco cessation drugs and FDA-approved contraceptive drugs. Preventive drugs are provided at $0 Cost Share, subject to certain exceptions. For more information regarding coverage of certain over-the-counter drugs as preventive drugs, please see the Plan Formulary and your Family Planning Services and Preventive Care Services sections of this Member Handbook.

    Insulin, glucagon and insulin syringes. These items are covered when Medically Necessary, even if they are available without a Prescription. Please see the Diabetes Treatment benefit category in the WHAT ARE YOUR COVERED BENEFITS? section of this Member Handbook for information about equipment and supplies for the management and treatment of diabetes.

    Items that are approved by the FDA as a medical device. Please refer to the Disposable Medical Supplies, Durable Medical Equipment, and Family Planning benefit categories in the What Are

Your Covered Benefits? section of this Member Handbook for information about medical devices covered by Sharp Health Plan.

Some drugs are commercially available as both a brand-name version and a generic version. It is the policy of Sharp Health Plan that when a generic version is available, Sharp Health Plan does not cover the corresponding Brand-Name Drug. Sharp Health Plan requires the dispensing pharmacy to dispense the Generic Drug, unless prior Authorization for the Brand-Name Drug is obtained. There are a few Brand drugs that are on the Formulary but their generic is not on the Formulary. When that is the case, the Brand medication will be dispensed.

Is replaced with:

Outpatient Prescription Drugs

The exclusions listed above do not apply to:

Coverage of an entire class of Prescription Drugs when one drug within that class becomes available over-the-counter.

Drugs listed on Sharp Health Plan's Formulary.

Over-the-counter products that are specifically covered and listed as a preventive care benefit under California State or federal law. Covered preventive drugs include FDA-approved tobacco cessation drugs and FDA-approved contraceptive drugs. Preventive drugs are provided at $0 Cost Share, subject to certain exceptions. For more information regarding coverage of certain over-the-counter drugs as preventive drugs, please see the Plan Formulary and the Family Planning Services and Preventive Care Services benefit categories in the **What Are Your Covered Benefits?** of this Member Handbook.

Insulin, glucagon and insulin syringes. These items are covered when Medically Necessary, even if they are available without a Prescription. Please see the Diabetes Treatment benefit category in the **What Are Your Covered Benefits?** section of this Member Handbook for information about equipment and supplies for the management and treatment of diabetes.

Items that are approved by the FDA as a medical device. Please refer to the Disposable Medical Supplies, Durable Medical Equipment, and Family Planning Services benefit categories in the What Are Your Covered Benefits? section of this Member Handbook for information about medical devices covered by Sharp Health Plan.

Some drugs are commercially available as both a brand-name version and a generic version. It is the policy of Sharp Health Plan that when a generic version is available, Sharp Health Plan does not cover the corresponding Brand-Name Drug. Sharp Health Plan requires the dispensing pharmacy to dispense the Generic Drug, unless prior Authorization for the Brand-Name Drug is obtained. In a few cases, the Brand-Name Drug is included on the Formulary, but the generic

equivalent is not. When that occurs, the Brand-Name Drug will be dispensed and you will be charged the Drug Tier 1 Cost Share.

27. In the section **How Do You Enroll in Sharp Health Plan?**, **What If You are Eligible for Medicare?**, the following language is added:

    This plan is not intended for most Medicare beneficiaries. However, if you have Medicare coverage, we will coordinate benefits with your Medicare coverage under Medicare rules. Medicare rules determine which coverage is primary (pays first) and which coverage is secondary (pays second). You must give us any information we request to help us coordinate benefits according to Medicare rules. If you have questions about Medicare rules for coordinating coverage, please contact Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

28. In the section **Other Information**, the following language:

    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.

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

    Within 30 calendar days after entering into a surrogacy arrangement, you must send written notice of the arrangement, including:

    - Names and addresses of the other parties to the arrangement
    - A copy of any contracts or other documents explaining the surrogacy arrangement

    You must send this information, to:

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

    You must complete and send us all consents, releases, authorizations, lien forms and other documents that are reasonably necessary for us to determine the existence of any rights we

may have under this 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.

Is replaced with:

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 (or babies) to another person or persons who intend to raise the baby (or babies) as his/her/their Child (or children).

If you enter into a surrogacy arrangement and you or any other payee are entitled to receive payments or other compensation under the surrogacy arrangement (hereinafter "remuneration"), you must reimburse us for Covered Benefits you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") to the maximum extent allowed under California Civil Code Section 3040. Surrogacy arrangements are included in Subparagraphs (c)(2) and (d)(2) of Section 3040. Subparagraph (e) of Section 3040 is not applicable.

Your obligation to reimburse us for Surrogacy Health Services is limited to the remuneration you are entitled to receive under the surrogacy arrangement.

By accepting Surrogacy Health Services, you automatically assign to us your rights to receive remuneration that is payable to you or your chosen payee under the surrogacy arrangement, regardless of whether or to what extent that remuneration, or any portion of it, is characterized as being for medical expenses. To secure our rights, we will also have a lien on that remuneration, and on any escrow account, trust, or any other account that holds that remuneration (and remuneration amounts held in or paid from these accounts). That remuneration 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 paragraphs.

Within 30 calendar days after entering into a surrogacy arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses and telephone numbers of the other parties to the arrangement
- Names, addresses and telephone numbers of any escrow agents, trustees or account administrators
- Names, addresses and telephone numbers of the intended parents

- Names addresses and telephone numbers of any other parties (such as insurers or managed care plans) who may be financially responsible for Surrogacy Health Services that you, or Services the baby (or babies) may receive
- A signed copy of any contracts or other documents explaining the surrogacy arrangement

You must send this information, to:

Sharp Health Plan Customer Care
Attn: Surrogacy Arrangements
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 we request or that you believe 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. You may not agree to waive, release or reduce our rights under this "Surrogacy Arrangements" section without our prior written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third (another) 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.

If you have questions about your obligations under this provision, please contact Customer Care.

29. In the section **Glossary**, the following definition of **Sensitive Services** is added:

Sensitive services means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section

30. In the section **Glossary**, the following definition of **You** is added:
You means the Member (Subscriber), or the Dependent of a Member, who has enrolled in the Plan under the provisions of the Membership Agreement and for whom the applicable Premiums have been paid.

31. In the section **How To Use the DeltaCare USA Plan/Choice of Contract Dentist**, the following language:

Delta Dental will give written notice to the Enrollee within a reasonable time of any termination or breach of contract, or inability to perform by any Contract Dentist to perform services.

Is replaced by:

Delta Dental will give you reasonable written notice if you will be materially or adversely affected by the termination or breach of contract, or inability to perform by any Contract Dentist to perform services.

32. In the section **How To Use the DeltaCare USA Plan/Choice of Contract Dentist**, **Specialist Services**, the following language:

    If you require Specialist Services and a Contract Specialist is not within 35 miles of your home address, your assigned Contract Dentist must obtain prior Authorization from Delta Dental to refer you to an Out-of-Network specialist or Out-of-Network orthodontist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist or Out-of-Network orthodontist that are not authorized by Delta Dental will not be covered by this dental plan.

    Is replaced by:

    If you require Specialist Services and a Contract Specialist or Contract Orthodontist is not within 35 miles of your home address to provide these services, your assigned Contract Dentist must receive prior Authorization from Delta Dental to refer you to an Out-of-Network specialist or Out-of-Network orthodontist to provide these Specialist Services. Specialist Services performed by an Out-of-Network specialist or Out-of-Network orthodontist that are not authorized by Delta Dental will not be covered by this dental plan.

33. In the section **General Provisions**, **Non-Discrimination**, the following language:

    Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

    Is replaced with:

    Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex including sex stereotypes and gender identity. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CALIFORNIA*CHOICE*

SUPPLEMENT TO

EVIDENCE OF COVERAGE

WELCOME TO CALIFORNIA*CHOICE*

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

WHAT IS THE CALIFORNIA*CHOICE* PROGRAM?

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

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

IMPORTANT FEATURES OF THE CALIFORNIA*CHOICE* PROGRAM

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

1. <u>Participation Requirements</u>

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

2. <u>Eligibility Requirements</u>

   a. Employee Eligibility

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

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

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

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

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

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

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

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

b. Dependent Eligibility

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

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

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

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

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

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

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

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

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

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

New Dependents

(i) New Dependent - Spouse

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

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

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

(iii) New Dependent - Stepchild

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

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

(iv) New Dependent - Domestic Partner

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

- Have filed a Declaration of Domestic Partnership with the Secretary of State
- Agree to notify California*Choice* Benefit Administrators immediately upon termination of the domestic partnership.

The domestic partnership is established when both partners file the properly executed Declaration of Domestic Partnership with the California Secretary of State.

An individual who becomes a new Dependent by virtue of becoming a registered domestic partner of the Employee is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request form is submitted to the Employer within 45 days after such domestic partnership is established, allowing the Employer sufficient time to submit the request to the California*Choice* Benefit Administrators within 60 days after such event. If California*Choice* Benefit Administrators receives all required documentation before the 16th day of the month in which the domestic partnership was established, Premium is charged for the full month and coverage is effective as of the date of the event. If California*Choice* Benefit Administrators receives all required documentation on or after the 16th day of the month in which the domestic partnership was established, the new domestic partner will be enrolled as of the 1st of the month following the date of receipt. The Employee Enrollee requesting coverage for such new Dependent must provide a State-stamped copy of the Declaration of Domestic Partnership within 45 days after such domestic partnership is established, allowing the Employer sufficient time to submit the request and Declaration to California*Choice* Benefit Administrators within 60 days of its issuance. For purposes of this provision only, the domestic partnership is deemed established when both partners file the properly executed Declaration

of Domestic Partnership with the California Secretary of State. The Employee must agree to notify California*Choice* Benefit Administrators immediately upon termination of the domestic partnership.

3. Special and Late Enrollment

a. Special Enrollment

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

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

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

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

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

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

b. Late Enrollment

Late enrollees (as defined in California Health & Safety Code section 1357.500(f)) must wait until open enrollment to be enrolled unless covered above

under the "Special Enrollment" provisions. However, pursuant to H&S section 1357.500(f) and as further articulated in PLAN's Evidence of Coverage, if an Employee did not enroll, or enroll a Dependent, at initial enrollment or at annual open enrollment because Employee:

- or dependent loses minimum essential coverage, as described in California H&S Section 1399.849(d)(1)(A);
- gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption or arrival at status of eligible dependent child;
- is mandated to be covered as a dependent pursuant to a valid state or federal court order;
- has been released from incarceration;
- health coverage issuer substantially violated a material provision of the health coverage contract;
- gains access to new health benefit plans as a result of a permanent move;
- was receiving services from a contracting provider under another health benefit plan, for one of the conditions described in subdivision (c) of H&S Section 1373.96 and that provider is no longer participating in the health benefit plan;
- is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service; and
- demonstrates that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period because he or she was misinformed that he or she was covered under minimum essential coverage.

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

4. Waiting Period

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

5. Benefits

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

a. Cal-COBRA and COBRA

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

b. Co-payments

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

c. Plan Materials

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

6. Termination for Nonpayment of Premiums

On the first day of the month prior to the coverage month, the Premium Notice that is sent to your Employer by California*Choice* Benefit Administrators will include the mandated regulatory statement contained in Rule 1300.65(a)(2), which states: "Your Health Plan is billing you for the cost of your health coverage. You must pay all amounts

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

The Notice shall also inform your Employer that coverage will continue during a 30-day grace period that begins on the day the Notice of Start of Grace period is dated and lasts at least 30 consecutive days. For California*Choice* Program Plans, the Notice of Start of Grace Period will be dated and sent the first calendar day after the last day of paid coverage. If the Premium remains unpaid by the 14th day of the coverage month, California*Choice* Benefit Administrators on behalf of PLAN will send your Employer a "Second Notice of Grace Period" repeating the need to pay the Premium(s) and the consequences for not doing so. If Premium payment(s) is/are not received by the effective date of cancellation*, PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will cancel the membership agreement and coverage for you and all your Dependents will end on such date as is contained in the "Notice of End of Coverage" sent to your Employer . It is your Employer's responsibility to promptly send you a copy of the Notice of End of Coverage. (*The 30-day grace period begins the day the Notice of Start of Grace period is dated and lasts at least 30 consecutive days. If the affected premium(s) is(are) not paid by the last day of the Grace Period, coverage under the Agreement will be terminated prospectively, which in most cases occurs on the last day of the coverage period. Since the month of February consists of only 28/29 days, Employers who do not pay February's premium(s) by the end of the 30-day grace period will have their coverage contacts(s) terminated on the last day of March).

PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will mail a separate Notice of End of Coverage to its affected individual Members that includes similar information provided in the Notice of End of Coverage that is sent to your employer. The Notice that is sent to your Employer would provide your Employer with the following information: (1) that the agreement for coverage has been cancelled for non-payment of premiums; (2) the specific date and time when the coverage ended;

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

7. Partial Payment Protocol

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

By way of illustration only, if a Group has two separate dental coverage options, Partial Payment shall be applied to the dental contract with the highest membership count first, unless the Partial Payment amount is insufficient to cover that dental contract's due premium. Whether it is sufficient to cover the first dental contract premium or not, Choice Administrators shall then apply the Partial Payment amount or the remainder of the Partial Payment amount to the dental contract premium with the next highest membership count. If at this point of application there remains a Partial Payment amount then that amount shall be applied to any remaining dental coverage contract premiums due, ranked by membership count. If after application to dental premiums due there remains a Partial Payment amount, then it shall be applied to the vision contract with the highest membership count, and any remaining Partial Payment amount shall then be applied to the premium due for the vision contract with the next highest membership.

This progression of Partial Payment amount application shall continue down through the premiums due for additional vision coverage contracts, and then in similar fashion to premiums due for chiropractic/acupuncture coverage and then for life insurance coverage. If two contracts within the same line of coverage (*e.g*., dental) have the same membership count, Choice Administrators shall first apply available Partial Payment amounts to the coverage contract with the highest premium due.

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

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

RENEWAL

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

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

SHARP HEALTH PLAN

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

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

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

For easier reading, we have capitalized words throughout this Member Handbook. Please refer to the **GLOSSARY** section for detailed definitions.

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 1-800-359-2002
8 a.m. to 6 p.m., Monday to Friday

sharphealthplan.com

Official Partner of

COVERED CALIFORNIA

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Welcome to Sharp Health Plan

Thank you for selecting Sharp Health Plan for your health plan benefits! Your health and satisfaction with our service are very 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 1-800-359-2002. Our Customer Care team is available to assist you Monday through Friday, 8 a.m. to 6 p.m. Additionally, after hours and on weekends, you have access to speak with 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 30 years. Sharp Health Plan continues to be recognized in California and nationally for our affordable, high-quality care and service 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 Summary of Benefits, 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 whom to call if you have questions. This Member Handbook also describes your Covered Benefits and any exclusions or limitations. For easier reading, we have capitalized words throughout this Member Handbook. Please refer to the **GLOSSARY** section for detailed definitions. To access this Member Handbook online, log in to your Sharp Connect at sharphealthplan.com/login.

Summary of Benefits

Your Summary of Benefits outlines the applicable Deductible(s), Coinsurances, Copayments and Out-of-Pocket Maximum that apply to benefit plan your Employer purchased. The Summary of Benefits, also referred to as the Health Plan Benefits and Coverage Matrix, 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 at 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 WHICH GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. ALL REFERENCES TO PLAN PROVIDERS, PLAN MEDICAL GROUPS, PLAN HOSPITALS AND PLAN PHYSICIANS IN THIS MEMBER HANDBOOK REFER TO PROVIDERS AND FACILITIES IN YOUR PLAN NETWORK, AS IDENTIFIED ON YOUR MEMBER IDENTIFICATION CARD.

Please read this Member Handbook carefully to understand how to 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.

Choice of Plan Physicians and Plan Providers

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, including PCPs, hospitals and other facilities.

- The Plan has several physician groups (called Plan Medical Groups or PMGs) from which you choose your Primary Care Physician (PCP) and through which you receive specialty physician care or access to hospitals and other facilities. In some Plan Networks, you can also select a PCP who is contracted directly with the Plan. If you choose one of these PCPs, your PMG will be “Independent”.
- You select a PCP for yourself and one for each of your Dependents. Look in the Provider Directory for your Plan Network to find your current doctor or select a new one if your doctor is not listed. Family members may select different PCPs and PMGs to meet their individual needs, except as described in the next column. If you need help selecting a PCP, please call Customer Care.
- In most cases, newborns are assigned to the mother’s PMG until the first day of the month following birth (or discharge from the hospital, whichever is later). You may select a different PCP or PMG for your newborn following the birth month by calling Customer Care.
- Write your PCP selection on your enrollment form and give it to your Employer.
- If you are unable to select a doctor at the time of enrollment, we will select one for you so that you have access to care immediately. If you would like to change your PCP, just call Customer Care. We recognize that the choice of a doctor

is a personal one, and encourage you to choose a PCP who best meets your needs.

- You and your Dependents obtain Covered Benefits through your PCP and from the Plan Providers who are affiliated with your PMG. If you need to be hospitalized, your doctor will generally direct your care to the Plan Hospital or other Plan facility where your doctor has admitting privileges. Since doctors do not usually maintain privileges at all facilities, you may want to check with your doctor to see where they admit patients. If you would like assistance with this information, please call Customer Care.
- Some hospitals and other Providers do not provide one or more of the following services that may be covered under your Plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, clinic or Customer Care to ensure that you can obtain the health care services that you need.

Call your PCP when you need care

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

Present your Member ID card and pay your cost

Always present your Member ID card to Plan Providers. If you have a new ID card because you changed PCPs or PMGs, be sure to show your Provider your new card.

When you receive care, you pay the Provider any applicable Deductible, Copayment or Coinsurance specified on the Summary of

Benefits. 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 1-800-359-2002, or email us at customer.service@sharp.com.

How do you obtain medical care?

Use your Member ID card

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

Access health care services through your Primary Care Physician

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, care you receive may not be covered by the Plan and you may be responsible for paying for the care. Remember, however, that women have direct and unlimited access to OB/GYNs as well as PCPs (family practice, internal medicine, etc.) in their Primary Care Physician's PMG for obstetric and gynecologic services. You will not be required to obtain prior Authorization for sexual and reproductive health services 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. You are responsible to pay for any care not provided by Plan Providers affiliated

with your PMG, unless your PMG 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 need 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. You are responsible to pay for any care that is not provided by Plan Hospitals affiliated with your PMG, unless your PMG 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 are shown on the Member ID card that you receive when you enroll as a Sharp Health Plan Member. Remember, only Plan Providers may provide Covered Benefits to Members.

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 for services received.

Appointment wait times

Urgent appointments	Maximum wait time after request
No prior Authorization required	48 hours
Prior Authorization required	96 hours

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

Exceptions to appointment wait times

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

Your appointments for preventive and periodic follow up care services (e.g., standing referrals to specialists for chronic conditions, periodic visits to monitor and treat pregnancy, cardiac, or mental health conditions, and laboratory and radiological monitoring for recurrence of disease) may be

scheduled in advance, consistent with professionally recognized standards of practice, and exceed the listed wait times.

Telephone wait times

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

Interpreter services at scheduled appointments

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

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

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

Referrals to non-plan providers

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

Changing your PCP

It is a good idea to stay with a PCP so they 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

Except for PCP services, outpatient Mental Health or Substance Use Disorder 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, including any nonprofit professional association clinical review criteria, education program and training materials for Mental Health or Substance Use Disorders, 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.

Second opinions

When a medical or surgical procedure or course of treatment (including Mental Health or Substance Use Disorder treatment) is recommended, and either the Member or the Plan Physician requests, a second opinion may

be obtained. You may request a second opinion for any reason, including the following:

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

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

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

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.

What to do when you require Emergency Services

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

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

- If you need follow-up care after you receive Emergency Services, call your PCP to make an appointment or for a referral to a specialist. Do not go back to the hospital emergency room for follow-up care, unless you are experiencing an Emergency Medical Condition.
- You are not financially responsible for payment of Emergency Services, in any amount the Plan is obligated to pay, beyond your Copayment and/or Deductible. You are responsible only for applicable Copayments or Deductibles, as listed on the Summary of Benefits.
- Some non-Plan Providers may require that you pay for Emergency Services and seek reimbursement from the Plan. On these occasions, obtain a complete bill of all services rendered and a copy of the emergency medical report, and forward them to the Plan right away for reimbursement.

Urgent Care Services

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

What to do when you require Urgent Care Services

If you need Urgent Care Services and are in the Plan's Service Area, you must use an urgent care facility within your PMG; 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 1-800-359-2002. 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 Plan's Service Area and need Urgent Care Services, you should still call your PCP. Your PCP may want to see you when you return in order to follow up with your care.

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 1-800-359-2002. 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:

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

Access for the vision impaired

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

Case management

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

Who can you call with questions?

Customer care

From questions about your benefits, to inquiries about your doctor or filling a Prescription, we are here to ensure that you have the best health care experience possible. For questions regarding your pharmacy benefits, you may contact us toll-free at 1-855-298-4252. For questions regarding your dental benefits, you may contact Delta Dental's Customer Service Center at 1-855-370-4215. Please refer to the Pediatric Dental Addendum of this Member Handbook for more information, including Delta Dental's Customer Service Center hours of operation. For all other questions, you can call Customer Care at 1-858-499-8300 or toll-free at 1-800-359-2002, or email customer.service@sharp.com. Our dedicated Customer Care team is available to support you from 8 a.m. to 6 p.m., Monday to 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 1-800-359-2002 and select the appropriate prompt, 5 p.m. to 8 a.m., Monday to Friday and 24 hours on weekends.

Utilization Management

Our medical practitioners make Utilization Management decisions based only on

appropriateness of care and service (after confirming benefit coverage). Medical practitioners and individuals who conduct utilization reviews are not rewarded for denials of coverage for care and service. There are no incentives for Utilization Management decision-makers that encourage decisions resulting in underutilization of health care services. Appropriate staff is available from 8 a.m. to 5 p.m., Monday to Friday to answer questions from providers and Members regarding Utilization Management. After business hours Members have the option of leaving a voicemail for a return call by the next business day. When returning calls our staff 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, or pharmacy in the case of outpatient Prescription Drugs, is responsible for the collection of Copayments. Copayment amounts may vary depending on the type of care you receive.

Copayment amounts are listed on your Summary of Benefits. For your convenience, 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 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, or pharmacy in the case of outpatient Prescription Drugs, 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, 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, but not all, benefit plans include one or more Deductibles. If you have a Deductible, it will be listed on your Summary of Benefits. You may have one Deductible for medical services and a separate Deductible for Prescription Drugs, or you may have a combined Deductible for medical services and Prescription Drugs.

A Deductible is the amount you must pay each Calendar Year for certain Covered Benefits before we will start to pay for those Covered Benefits. 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. The Deductible starts over each Calendar 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 Evidence of Coverage 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. Premium contributions and any applicable Copayments and Coinsurance are still required.

If you have Family Coverage, your benefit plan includes a Family Deductible. In that case, each Member, including a newborn Dependent, also has an Individual Deductible. Each individual in the family can satisfy the applicable Deductibles 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. 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 their 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.

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.

Annual Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the total amount of Copayments, Deductibles, and Coinsurance you pay each Calendar Year for Covered Benefits, excluding supplemental benefits. The annual Out-of-Pocket Maximum amount is listed on your Summary of Benefits and is renewed at the beginning of each Calendar Year.

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 Evidence of Coverage or noted in the Summary of Benefits, and
- Copayments, Deductibles, and Coinsurance for supplemental benefits (e.g., 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 are still 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. 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 their 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.

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 Benefits (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.

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 for any payments over the Out-of-Pocket Maximum. 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 Plan, subject to any applicable Coinsurance or Copayment, for the remainder of the Calendar 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.

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, including covered Prescription Drugs, 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.
- If any number of covered family members collectively meet the Family Deductible, then Covered Benefits, including covered Prescription Drugs, 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.

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

Deductible credits

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

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 1-800-359-2002 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 Deductibles, 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 showing why it was not reasonably possible to submit the information within 180 days.

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

In some cases, a non-Plan 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.

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 (Grievances) or Appeals about Sharp Health Plan or the services you receive as a Sharp Health Plan Member.
- Receive information about Sharp Health Plan, our services and providers, and Member rights and responsibilities.
- Make recommendations about these rights and responsibilities.
- 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, include no

longer working or residing in the Plan's Service Area.

Security of your confidential information (Notice of privacy practices)

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

PLEASE REVIEW IT CAREFULLY.

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

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

A. HOW WE MAY USE AND SHARE INFORMATION ABOUT YOU

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

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

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

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

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

B. OTHER USES FOR YOUR HEALTH INFORMATION

1. Sometimes a court will order us to give out your health information. We also will give information to a court, investigator, or lawyer under certain circumstances. This may involve fraud or actions to recover money from others.
2. You or your doctor, hospital and other health care providers may Appeal decisions made about claims for your health care. Your health information may be used to make these Appeal decisions.

3. We also may share your health information with agencies and organizations that check how our health plan is providing services.
4. We must share your health information with the federal government when it is checking on how we are meeting privacy rules.
5. We may share your information with researchers when an Institutional Review Board (IRB) has reviewed and approved the reason for the research, and has established appropriate protocols to ensure the privacy of the information.
6. We may disclose health information, when necessary, to prevent a serious threat to your health or safety or the health and safety of another person or the public. Such disclosures would be made only to someone able to help prevent the threat.
7. We provide Employers only with the information allowed under the federal law. This information includes summary data about their group and information concerning Premium and enrollment data. The only other way that we would disclose your Protected Health Information to your Employer is if you Authorized us to do so.

C. WHEN WRITTEN PERMISSION IS NEEDED

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

D. WHAT ARE YOUR PRIVACY RIGHTS?

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

notification if we discover a breach of your unsecured PHI, and determine through a risk assessment that notification is required.

- You have a right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing, for most uses or disclosures of psychotherapy 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
Toll-free at 1-800-359-2002

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

F. COMPLAINTS

If you believe that 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 1-800-359-2002
- 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 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:

For Appeals involving outpatient prescription drug benefits (e.g., requests to re-evaluate Plan's coverage decision for a Prescription Drug):

Attn: Prescription Claim Appeals MC 109 – CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072-2084
Toll-free: 1-855-298-4252
Fax: 1-866-443-1172

For Appeals or Grievances involving your dental benefits:

Delta Dental of California
Attn: Quality Management Department
P.O. Box 6050
Artesia, CA 90702
Toll-free: 1-855-370-4215

Please see the Pediatric Dental Addendum included with this Member Handbook for more information.

For all other Appeals or Grievances:

Sharp Health Plan
Attn: Appeal/Grievance Department
8520 Tech Way, Suite 200
San Diego, CA 92123-1450
Toll-free: 1-800-359-2002
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.

Except for an Appeal of a denial of coverage for a Nonformulary Drug, which follows the timeframes described below, 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.

If your Appeal involves a request for coverage of a Nonformulary Drug (referred to as a non-formulary Exception Request), we will provide you with a decision within 72 hours. A request may be expedited if urgent, in which case we will provide you with a decision within 24 hours. A non-formulary Exception Request is considered urgent when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when the Member is undergoing a current course of treatment using the Nonformulary Drug.

External review for Nonformulary Prescription Drug exception requests

If we deny a request for coverage of a Nonformulary Drug, you, your Authorized Representative or your doctor may request that the original Exception Request and subsequent denial of such request be reviewed by an independent review organization (IRO). You, your Authorized Representative or your doctor may submit a request for IRO review up to 180 calendar days following the Nonformulary Drug Exception Request denial by:

- Calling toll free at 1-855-298-4252
- Mailing a written request to:
  Attn: Prescription Claim Appeals MC 109 – CVS Caremark
  P.O. Box 52084
  Phoenix, AZ 85072-2084
- Faxing a written request to:
  1-866-443-1172
- Completing the Member Grievance and Appeal form on our website at:
  sharphealthplan.com

You will be notified of the IRO's decision within 72 hours for standard requests or 24 hours for expedited requests.

The IRO review process described above is in addition to your rights to file a Grievance or Appeal with Sharp Health Plan and to file a Grievance or request an Independent Medical Review (IMR) with the California Department of Managed Health Care.

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 at **1-800-359-2002** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **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 calendar 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 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 calendar days of receipt of your application and supporting documents. For urgent cases involving an imminent and serious threat to your health, including but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization will provide its determination within three business days. At the request of the experts, the deadline can be extended by up to three days if there is a delay in obtaining all necessary documentation. IMR is available in the 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 the doctor certifies in writing is likely to be more beneficial to you than any available standard therapies or (b) you or your specialist Plan Physician (board eligible or board certified) has requested a therapy that, based on documentation from the medical and scientific evidence, is likely to be more beneficial than any available standard therapy.
4. You have been denied coverage by the Plan for a drug, device, procedure or other therapy recommended or requested as described in paragraph (3) above.
5. The specific drug, device, procedure or other therapy recommended would be a Covered Benefit, except for the Plan's determination that 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).

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

Denial of a health care service as not Medically Necessary

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

The Plan will provide you with an IMR application form with any Appeal findings letter that denies, modifies or delays health care services because the service is not Medically Necessary. If you would like to request an IMR, return your application to the DMHC. Your application for IMR must be submitted to the DMHC within six months and meet all of the following conditions:

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

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

What are your Covered Benefits?

Covered Benefits

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

1. Medically Necessary;
2. Described in this Member Handbook or otherwise required by law;
3. Provided by Plan Providers, unless services are for Emergency or Out-of-Area Urgent Care or services have been prior Authorized by the Plan to be received by non-Plan Providers;
4. Prescribed by a Plan Physician, except when coverage is required for treatment of an Emergency Medical Condition or services are prescribed as part of a treatment plan prior Authorized by the Plan with a non-Plan provider;
5. If required, Authorized in advance by your PCP, your PMG or Sharp Health Plan; and
6. 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 for Members 19 years of age and older (except as specifically described under the **Dental services/oral surgical services** benefit category of this section), chiropractic services or assisted reproductive technologies. 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 Summary of Benefits details applicable Deductibles, Copayments, Coinsurance and the annual Out-of-Pocket Maximum.

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

Acupuncture services

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

Acute inpatient rehabilitation facility services

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

Ambulance and medical transportation services

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

- Emergency Services.
- An Authorized transfer of a Member to a Plan Hospital or Plan Skilled Nursing Facility or other interfacility transport.
- Emergency Services rendered by a paramedic without emergency transport.
- Nonemergency ambulance and psychiatric transport van services in the Service Area if the Plan or a Plan Provider determines that your condition requires the use of services 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.

The covered medical transportation services described above include services received from an air ambulance provider, whether contracted or not contracted with Sharp Health Plan. If the Member receives covered services from a non-contracting air ambulance provider, the Member's Cost Share will be the same as the Cost Share he or she would pay for covered services received from a contracting air ambulance provider. The Cost Share paid by the Member will count toward the Out-of-Pocket Maximum and Deductible (if applicable) set forth in the Summary of Benefits. The Member will not be responsible for any additional costs above the amount of their Cost Share.

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.

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. Chemotherapy medication covered through the outpatient Prescription Drug benefit is subject to the applicable Cost Share.

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 criteria:

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 an investigational new drug application reviewed by the United States Food and Drug Administration.

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 Cost Sharing applied to the same services not delivered in a clinical trial.

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

Dental services/oral surgical services

Your benefit plan includes pediatric dental benefits for Members under the age of 19. Sharp Health Plan's pediatric dental benefits are provided through the Plan's dental provider, Delta Dental. Enclosed with this Member Handbook is your DeltaCare® USA Plan schedule of benefits that sets forth the applicable benefits and Cost Sharing information for the pediatric dental benefits included with this plan. In addition to the pediatric dental benefits described in the DeltaCare® USA Plan schedule of benefits, dental services for all Members are covered only as described below:

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

Oral surgical services are covered only as described below:

- Reduction or manipulation of fractures of facial bones.
- Excision of lesions of the mandible, mouth, lip or tongue.
- Incision of accessory sinuses, mouth, salivary glands, or ducts.
- Reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect or accidental injury.
- Oral or dental examinations performed on an inpatient or outpatient basis as part

of a comprehensive workup prior to transplantation surgery.

- Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol.
- Biopsy of gums or soft palate.
- Fluoride trays and/or bite guards used to protect the teeth from caries and possible infection during radiation therapy.
- Reconstruction of a ridge that is performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes).
- Reconstruction of the jaw (e.g., radical neck or removal of mandibular bone for cancer or tumor).
- Ridge augmentation or alveoplasty when consistent with medical policies for reconstructive surgery or cleft palate policies.
- Tooth extraction prior to a major organ transplant or radiation therapy of neoplastic disease to the head or neck.
- Treatment of maxillofacial cysts, including extraction and biopsy.
- Custom-fitted and prefabricated oral appliances for obstructive sleep apnea patients who have mild sleep apnea and meet the criteria for coverage of continuous positive airway pressure (CPAP), but who are intolerant to CPAP.

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

1. Under seven years of age,
2. Developmentally disabled, regardless of age, or
3. Whose health is compromised and for whom general anesthesia is Medically Necessary, regardless of age.

Diabetes treatment

The following supplies, equipment and services for the treatment and/or control of diabetes are covered. Some items may require a Prescription from the Plan Provider.

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

Insulin, glucagon and other Prescription medications for the treatment of diabetes

are covered under the outpatient Prescription Drug benefit.

Diabetic supplies used with diabetic durable medical equipment (DME) are subject to the DME Cost Share (e.g., Omnipods).

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. For information about coverage for ostomy and urological supplies please see the section titled **Ostomy and urological services.**

Single-use supplies used with Durable Medical Equipment (DME) are subject to the applicable DME Cost Share (e.g., Omnipods).

Durable Medical Equipment

Durable Medical Equipment (DME) is covered. Coverage is limited to the standard item of equipment that adequately meets your medical needs.

DME is limited to equipment and devices that are:

1. Intended for repeated use over a prolonged period;
2. Ordered by a licensed health care provider acting within the scope of their license;
3. Intended for the exclusive use of the Member;
4. Not duplicative of the function of another piece of equipment or device already covered for the Member;
5. Generally not useful to a person in the absence of illness or injury;
6. Primarily serving a medical purpose;
7. Appropriate for use in the home; and
8. 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 their license, and when not caused by misuse or loss. Applicable Copayments apply for Authorized DME replacement. No additional Copayments are required for repair of DME.

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

- For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets and lancet devices).
- Infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other drugs).
- Standard curved handle or quad cane and replacement supplies.
- Standard or forearm crutches and replacement supplies.
- Dry pressure pad for a mattress.
- Nebulizer and supplies.
- Peak flow meters.
- IV pole.

- Tracheostomy tube and supplies.
- Enteral pump and supplies.
- Bone stimulator.
- Cervical traction (over door).
- Phototherapy blankets for treatment of jaundice in newborns.

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

Supplies used with Durable Medical Equipment (DME) are subject to the DME Cost Share (e.g., Omnipods).

Emergency services

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

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

Emergency services and care include both physical and psychiatric emergency conditions, and Active Labor.

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

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 Plan Hospital or not. The Copayment is waived if the Member is admitted to the hospital from its emergency room.

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 the Member 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 and location of the service. For example, a service that takes place at an outpatient facility will result in an outpatient facility Cost Share. Please see the Summary of Benefits.

The Plan covers all FDA-approved contraceptive methods, sterilization procedures and patient education and counseling for women, as recommended by the Health Resources and Services Administration (HRSA) guidelines, These services are covered without any Cost Sharing on the Member's part.

Habilitative Services

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

Health education services

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

Home health services

Home health services are services provided at the home of the Member and provided by a Plan Provider or other Authorized health care professional operating within the scope of their 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 their licensure.

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

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

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

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

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

Hospice services

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

Covered Benefits include:

- Nursing care.
- Medical social services.

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

Special coverage is also provided for:

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

Hospital facility inpatient services

Hospital facility inpatient services are covered. After the Deductible (if any) has been paid, the Member pays an applicable Copayment or Coinsurance to the hospital for each hospitalization. The Member Cost Share for the entire inpatient stay is determined by the benefit plan in effect on the day you were 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.

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, in a hospital, 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 and location of the service. For example, if this service is provided during an office visit, then the applicable office visit Cost Share will be charged. If the service is provided in an outpatient hospital facility, the Outpatient Services Cost Share will apply. Please see the Summary of Benefits.

Injectable drugs

Outpatient injectable medications and self-injectable medications are covered. Outpatient injectable medications include those drugs or preparations which are not usually self-administered and which are given by the intramuscular or subcutaneous route. Outpatient injectable medications 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. Customary components of an office visit include, but are not limited to, certain immunizations, infertility drugs, or off-label use of covered injectable medications.

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 injection devices along with instructions on how to administer. Epi-pens, self-injectable insulin, and GLP1 agents for diabetes are covered under the outpatient Prescription Drug benefit. Most other self-administered injectable drugs are covered as part of the medical benefit.

Maternity and pregnancy services

The following maternity and pregnancy services are covered:

- Prenatal and postnatal services, including, but not limited to, Plan Physician visits.
- Laboratory services (including the California Department of Health Services' Expanded Alpha Fetoprotein (AFP) Program).
- Radiology services.
- Prenatal diagnosis of genetic disorders of a fetus in high-risk pregnancy cases.
- 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.

- Screening and treatment for a Maternal Mental 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. 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.
- Depression screening and appropriate follow up.
- Tobacco use cessation counseling.
- Unhealthy alcohol use screening and behavioral counseling.
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP).
- Gestational diabetes mellitus screening.
- Hepatitis B and 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 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 Medically Necessary services for the diagnosis or treatment of mental health conditions that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that are listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, which include but are not limited to the following services:

Outpatient Mental Health Services

- Physician services, including consultation and referral
- Individual office visits and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Health 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 autism spectrum disorder
- 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
- Diagnostic laboratory and diagnostic and therapeutic radiologic services
- Home health services
- Preventive health services, as described under **Preventive care services**

Intensive Psychiatric Treatment Programs

- Hospital-based intensive outpatient care (partial hospitalization)
- Multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Residential treatment

Inpatient Mental Health Services

- Inpatient psychiatric hospitalization, including room and board, drugs, supplies and services of health care professionals.
- 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.

Emergency Health Care Services, including ambulance and ambulance transport services and Out-of-Area coverage, as described under **Emergency Services and Care**.

Prescription Drugs, as described under **Outpatient Prescription Drugs.**

Other services are also covered if Medically Necessary for treatment of a Mental Health Disorder.

Members have direct access to health care providers of mental health services without

obtaining a PCP referral. Services must be provided by Plan Providers. If services for the Medically Necessary treatment of a Mental Health Disorder are not available in network within the geographic and timely access standards set by law or regulation, Sharp Health Plan will Authorize Medically Necessary out-of-network services and any Medically Necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. The Member will pay in-network cost sharing for out-of-network services Authorized by the Plan.

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 MinuteClinic, your cost is equal to the PCP 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 Prescription Drugs

Outpatient Prescription Drugs are covered. You may obtain covered outpatient Prescription Drug benefits from any retail, specialty or mail order Plan Pharmacy in the Plan network. Some Prescription Drugs are subject to restricted distribution by the United States Food and Drug Administration (FDA) or require special handling, provider coordination, or patient education that can only be provided by a specific pharmacy.

Except for Emergency Services and Out-of-Area Urgent Care Services, outpatient Prescription Drugs that are not obtained from a Plan Pharmacy are not covered, and you will be responsible for payment. The amount paid will not count toward your Deductible, if any, or Out-of-Pocket Maximum. In addition, you will be responsible for payment of outpatient Prescription Drugs not obtained through your pharmacy benefits with your Sharp Health Plan Member ID card (for example, paid for by cash, with a coupon or discount card), and such payment will not count toward your Deductible, if any, or Out-of-Pocket Maximum. If you pay for outpatient Prescription Drugs not obtained through your pharmacy benefits, you are eligible to receive reimbursement from the Plan, and credit towards your Deductible, if any, and Out-of-Pocket Maximum, subject to the terms and conditions of this Member Handbook, in the following circumstances:

- The Prescription Drug obtained was Medically Necessary for the treatment of an Emergency Medical Condition or urgent care condition.
- You received prior Authorization from the Plan for the Prescription Drug, and the drug was obtained from a Plan Pharmacy.
- The Prescription Drug obtained is listed as covered on the Formulary, was obtained from a Plan Pharmacy, and all applicable Utilization Management criteria (e.g., Step Therapy, quantity limits, etc.) were satisfied.

You will be reimbursed for your share of the cost (excluding any portion of the charges covered by a coupon or discount card for which you did not incur an out-of-pocket expense), minus your applicable Cost Share and up to the contracted rate with

the Plan Pharmacy, if applicable. Please see the section **What if you get a medical bill?** for information on how to request reimbursement.

Look in your Provider Directory to find a Plan Pharmacy near you or search for "Find a Pharmacy" on our website at sharphealthplan.com. The "Find a Pharmacy" function provides the names and locations of contracted pharmacies. Always present your Sharp Health Plan Member ID card to the Plan Pharmacy. Ask them to inform you if something is not going to be covered.

You pay the Cost Share (i.e., Copayment, Coinsurance and/or Deductible) for Covered Benefits as listed in your Summary of Benefits. If the retail price for your Prescription Drug is less than your Cost Share, you will only pay the retail price. If you pay the retail price, your payment will apply to the Deductible, if any, and the Out-of-Pocket Maximum limit in the same manner as if you had purchased the Prescription Drug by paying the Cost Share. This applies whether you purchase your Prescription Drug from a brick-and-mortar retail pharmacy or a mail order pharmacy. Your Cost Share for covered orally administered anticancer medications will not exceed $250 for an individual prescription of up to a 30-day supply. In addition, orally administered anticancer medications will not be subject to a Deductible, unless you are enrolled in a HSA-qualified High Deductible Health Plan. For HSA-qualified High Deductible Health Plans, your maximum Cost Share of $250 will only apply after the Deductible has been met.

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

The Formulary is categorized into Drug Tiers as described below. Your Summary of Benefits identifies the number of Drug Tiers for your benefit plan. The Sharp Health Plan Formulary identifies the drugs included on each tier. Your Cost Share may vary based on the Drug Tier.

For Members with a four-tier benefit plan, covered outpatient prescription medications include:

Category	Formulary symbol	Description
Drug Tier 1	1	Most Generic Drugs and low-cost preferred Brand-Name Drugs.
Drug Tier 2	2	Non-preferred Generic Drugs, preferred Brand-Name Drugs, and any other drugs recommended by the Pharmacy and Therapeutics (P&T) Committee based on safety, efficacy and cost.

Category	Formulary symbol	Description
Drug Tier 3	3	Non-preferred Brand-Name Drugs or drugs that are recommended by the P&T Committee based on drug safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.
Drug Tier 4	4	Drugs that are biologics, drugs that the Food and Drug Administration (FDA) or manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) for a one-month (30-day) supply.
Preventive	PV	Select drugs covered with no Copayment when recommended for preventive use as indicated under **Preventive care services**, including certain generic and over-the-counter contraceptives for women.
Medical Benefit Drugs	MB	Drugs covered under the medical benefit. Please refer to your Medical Benefit coverage information.

For Members with a three-tier benefit plan, covered outpatient prescription medications include:

Category	Formulary symbol	Description
Drug Tier 1	1	Preferred Generic Drugs.
Drug Tier 2	2	Preferred Brand-Name Drugs and inhaler spacers listed on the Sharp Health Plan Drug Formulary.
Drug Tier 3	3	Non-preferred Generic and Brand-Name Drugs.
Preventive	PV	Select drugs covered with no Copayment when recommended for preventive use as indicated under **Preventive care services,** including certain generic and over-the-counter contraceptives for women.
Medical Benefit Drugs	Not applicable (not listed on Formulary)	Drugs covered under the medical benefit. Please refer to your Medical Benefit coverage information.

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

When a Generic Drug is available, the pharmacy is required to fill your Prescription with the generic equivalent unless prior Authorization is obtained and the Brand-Name Drug is determined to be Medically Necessary. The FDA applies rigorous standards for identity, strength, quality, purity and potency before approving a Generic Drug. Generic Drugs are required to have the same active ingredient, strength, dosage form, and route of administration as their brand name equivalents.

The amount of drug you may receive at any one time is limited to a 30-day supply or, if the treatment is for less than 30 days, for the Medically Necessary amount of the drug, unless the Prescription is for a maintenance drug. This limitation does not apply to FDA-approved, covered self-administered hormonal contraceptives, which are available in a 12-month supply. For more information about maintenance drugs, see the **HOW DO I OBTAIN MAINTENANCE DRUGS BY MAIL ORDER?** section below.

SHARP HEALTH PLAN FORMULARY

The Sharp Health Plan Formulary (also known as the Drug List) was developed to identify safe and effective drugs for Members while maintaining affordable pharmacy benefits. The Formulary is updated regularly, based on input from the Pharmacy & Therapeutics (P&T) Committee, which meets quarterly. The P&T Committee members are clinical pharmacists and actively practicing physicians of various medical specialties. In addition, the P&T Committee frequently consults with other medical experts to provide input to the Committee.

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

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

Some drugs are commercially available as both a brand name version and a generic version. It is the policy of Sharp Health Plan that when a Generic Drug is available, Sharp Health Plan does not cover the corresponding Brand-Name Drug. Sharp Health Plan requires the dispensing pharmacy to dispense the Generic Drug, unless prior Authorization for the brand is obtained. If the Brand-Name Drug is Medically Necessary and prior Authorization is obtained, the Member must pay the Cost Share for the corresponding Drug Tier.

To obtain a copy of Sharp Health Plan's current Formulary, please visit our website at sharphealthplan.com, or call the dedicated pharmacy customer service line at 1-855-298-4252.

WHAT IS THE OUTPATIENT PRESCRIPTION DRUG PRIOR AUTHORIZATION PROCESS?

Drugs with the PA symbol next to the drug name in the Formulary are subject to prior Authorization. This means that your doctor must contact Sharp Health Plan to obtain advance approval for coverage of the drug. To request prior Authorization, your doctor

must fill out a Prescription Drug Prior Authorization Form, include information to demonstrate medical necessity and submit it to Sharp Health Plan. Sharp Health Plan processes routine and urgent requests from doctors in a timely fashion. Routine requests are processed within 72 hours and urgent requests are processed within 24 hours of receipt of the information reasonably necessary and requested by Sharp Health Plan to make the determination. Information reasonably necessary to make a determination includes information the Plan has requested to make a determination, as appropriate and Medically Necessary for the nature of your condition. Urgent circumstances exist when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function. Upon receiving your physician's request for prior Authorization, Sharp Health Plan will evaluate the information submitted and make a determination based on established clinical criteria for the particular drug.

If your doctor's request for prior Authorization is denied, you will receive a letter that explains the specific reason(s) for the denial and your right to Appeal or file a Grievance, as set forth in the section **WHAT IS THE GRIEVANCE OR APPEAL PROCESS?**

WHAT ARE OPIATE DOSAGE THRESHOLDS?

Certain classes, categories, doses or combinations of opiate drugs may require prior Authorization when the dosage is at or above a threshold considered unsafe, as determined by the P&T Committee or in the professional clinical judgment of your pharmacist. If your doctor deems that an opiate dosage above the threshold is Medically Necessary for you, he or she may need to submit a request for Authorization to support the medical necessity for coverage.

WHAT IS STEP THERAPY?

Drugs with the ST symbol next to the drug name in the Formulary are subject to Step Therapy. The Step Therapy program encourages safe and cost-effective medication use. Under this program, a "step" approach is required to receive coverage for certain drugs. This means that to receive coverage, you must first try an alternative Prescription Drug that has been determined to be clinically effective. There may be a situation when it is Medically Necessary for you to receive certain medications without first trying an alternative drug. In these instances, your doctor may request prior Authorization by calling or faxing Sharp Health Plan. The list of Prescription Drugs subject to Step Therapy is subject to change.

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

If you have moved from another insurance plan to Sharp Health Plan and are taking a drug that your previous insurer covered, Sharp Health Plan will not require you to follow Step Therapy in order to obtain that drug. Your doctor may need to submit a request to Sharp Health Plan in order to provide you with continuity of coverage.

WHAT IS QUANTITY LIMIT?

Drugs with the QL symbol next to the drug name in the Formulary are subject to quantity limits. It is the policy of Sharp Health Plan to maintain effective drug Utilization Management procedures. Such procedures include quantity limits on Prescription Drugs.

The Plan ensures appropriate review when determining whether or not to authorize a quantity of drug that exceeds the quantity limit. Quantity limits exist when drugs are limited to a determined number of doses based on criteria including, but not limited to, safety, potential overdose hazard, abuse potential, or approximation of usual doses per month, not to exceed the FDA maximum approved dose. Your doctor may follow the prior Authorization process when requesting an exception to the quantity limit for a drug.

WHAT IS THERAPEUTIC INTERCHANGE?

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

WHAT IS GENERIC SUBSTITUTION?

When a Generic Drug is available, the pharmacy is required to switch a Brand-Name Drug to the generic equivalent, unless the Brand-Name Drug is Authorized due to medical necessity. If the Brand-Name Drug is Medically Necessary and prior Authorization is obtained, you must pay the Cost Share for the corresponding Brand-Name Drug Tier. The FDA applies rigorous standards for identity, strength, quality, purity and potency before approving a Generic Drug. Generics are required to have the same active ingredient, strength, dosage form, and route of administration as their brand-name equivalents.

WHAT IF A DRUG IS NOT LISTED IN THE FORMULARY?

Drugs that are not listed in the Drug List are Nonformulary Drugs and are not covered. There may be times when it is Medically Necessary for you to receive a medication that is not listed on Sharp Health Plan's Formulary. In these instances, you, your Authorized Representative or your doctor may submit a Formulary Exception Request, following the prior Authorization process. Sharp Health Plan will approve or deny the Exception Request based on medical necessity within 72 hours for standard requests, or 24 hours for urgent requests. Nonformulary Drugs that are approved for coverage and meet the Drug Tier 4 description will be subject to the Drug Tier 4 Cost Share. Nonformulary Brand-Name Drugs approved for coverage will be subject to the Drug Tier 3 Cost Share. Nonformulary Generic Drugs approved for coverage will be subject to the Drug Tier 1 Cost Share. If your Formulary Exception Request is denied, you have the right to Appeal the decision. Information on the Appeal process can be found under the **WHAT IS THE GRIEVANCE OR APPEAL PROCESS?** section of this Member Handbook.

Additional information about specific Prescription Drug benefits can be found in your Summary of Benefits. Information about Prescription Drug benefit exclusions and limitations can be found under **Outpatient**

Prescription Drugs in the **WHAT IS NOT COVERED?** section of this Member Handbook.

HOW DO I OBTAIN MAINTENANCE DRUGS BY MAIL ORDER?

Maintenance drugs are identified by the Mail Order (MO) symbol in the Formulary. Maintenance drugs are those prescribed on a regular, ongoing basis to maintain health. Most maintenance drugs can be obtained for a 90-day supply through mail order or retail. Mail order is a convenient, cost-effective way to obtain maintenance drugs. To use this service:

1. Have your doctor write a Prescription for up to a 90-day supply of your maintenance drug.
2. Complete the mail service order form brochure. You can call Customer Care at 1-855-298-4252 to have one mailed to you.
3. Mail your original Prescription, along with your Cost Share payment or payment information, using the pre-addressed, postage-paid envelope attached to the order form. Your Prescription will arrive at your home in two to three weeks.
4. If your Prescription includes refills, you can re-order by phone. Simply call the toll-free number on your prescription bottle to order a refill. If you have any questions or do not have a brochure, contact Customer Care at 1-855-298-4252.

Please check your Formulary, or use the searchable Formulary tool at sharphealthplan.com to determine if your drug is available through mail order. You may also call Customer Care.

HOW DO I OBTAIN SPECIALTY DRUGS?

A specialty drug is a drug that the FDA or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require special training or clinical monitoring for self-administration, or drugs that the P&T Committee determines to be a specialty medication. They are often for chronic conditions and involve complex care issues that need clinical management. Examples include Harvoni, Sovaldi, Xeloda, Temodar, Sensipar, and Zortress.

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

Most specialty medications require prior Authorization.

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

The following Cost Shares apply to Prescription Drugs prescribed by a Plan Provider and dispensed by a Plan Network Pharmacy and to Prescription Drugs prescribed and dispensed for Emergency Services or Out-of-Area Urgent Care Services. Please see your Summary of Benefits for the Cost Share amount for each tier.

For Members with a four-tier benefit plan, you pay:

A. Retail Pharmacy

1. For up to a 30-day supply of a Tier 1 drug on the Formulary, you pay **one Drug Tier 1 Copayment or Coinsurance.**
2. For up to a 30-day supply of a Tier 2 drug on the Formulary, you pay **one Drug Tier 2 Copayment or Coinsurance.**
3. For up to a 30-day supply of a Tier 3

drug on the Formulary, you pay **one Drug Tier 3 Copayment or Coinsurance.**

4. For up to a 30-day supply of a Tier 4 drug on the Formulary, you pay **one Drug Tier 4 Coinsurance** amount.
5. Medications identified as PV are available with $0 Cost Share and are not subject to a Deductible.
6. Medications identified as MB are obtained through your medical benefit and are subject to the charges applicable under your medical benefit.

B. Mail Order Pharmacy

1. For up to a 90-day supply of a Tier 1 maintenance drug that is obtained through the Prescription Home Delivery Service, you pay **two Drug Tier 1 Copayments.**
2. For up to a 90-day supply of a Tier 2 maintenance drug that is obtained through the Prescription Home Delivery Service, you pay **two Drug Tier 2 Copayments.**
3. For up to a 90-day supply of a Tier 3 maintenance drug that is obtained through the Prescription Home Delivery Service, you pay **two Drug Tier 3 Copayments.**
4. Medications on Tier 4 are only available for a 30-day supply per fill. You pay **one Drug Tier 4 Coinsurance amount.** Tier 4 medications must be filled by CVS Specialty Pharmacy; however, Prescriptions may be dropped off and picked up at a CVS retail pharmacy. The CVS retail pharmacy will coordinate with CVS Specialty Pharmacy to fill the Prescription.
5. For up to a 90-day supply of a PV maintenance drug that is obtained through the Prescription Home Delivery Service (if covered), you pay no Cost Share.

For Members with a three-tier benefit plan, you pay:

A. Retail Pharmacy

1. For up to a 30-day supply of a Tier 1 drug listed on the Formulary, you pay **one Drug Tier 1 Copayment or Coinsurance.**
2. For up to a 30-day supply of a Tier 2 drug listed on the Formulary, you pay **one Drug Tier 2 Copayment or Coinsurance.**
3. For up to a 30-day supply of a Tier 3 drug (if covered), you pay **one Drug Tier 3 Copayment or Coinsurance.**
4. Medications identified as PV are available with $0 Cost Share and are not subject to a Deductible.
5. Medical benefit drugs are subject to the charges applicable under your medical benefit.

B. Mail Order Pharmacy

1. For up to a 90-day supply of a Tier 1 maintenance drug that is obtained through the Prescription Home Delivery Service, you pay **two Drug Tier 1 Copayments.**
2. For up to a 90-day supply of a Tier 2 maintenance drug that is obtained through the Prescription Home Delivery Service, you pay **two Drug Tier 2 Copayments.**
3. For up to a 90-day supply of a Tier 3 maintenance drug that is obtained through the Prescription Home Delivery Service (if covered), you pay

two Drug Tier 3 Copayments.

4. For up to a 90-day supply of a PV maintenance drug that is obtained through the Prescription Home Delivery Service (if covered), you pay no Cost Share.

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

WHEN CAN I REFILL MY PRESCRIPTION?

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

Exceptions to filling a drug before the approved refill date may be made in certain circumstances. If your doctor increases your daily dose, the pharmacy or prescribing physician can submit a Prescription Drug Prior Authorization Form to Sharp Health Plan, requesting an override of the "refill too soon" block. If you need to refill a medication early because you are going on an extended vacation, you can call 1-855-298-4252 to request a "vacation override." Please allow 72 hours for Plan representatives to review your request and make a decision.

If you have any questions regarding when your Prescription is eligible to be refilled, please call Customer Care at 1-855-298-4252.

DRUGS, SERVICES AND SUPPLIES COVERED UNDER YOUR MEDICAL BENEFIT

The following services and supplies are covered as described elsewhere in this Member Handbook. These Covered Benefits are not subject to the same Cost Shares, exclusions, or limitations that apply to your outpatient Prescription Drug benefits. Please refer to the applicable sections of your Member Handbook for specific information about the Deductibles, Copayments, Coinsurance, exclusions, and limitations that apply to these Covered Benefits.

1. Medically Necessary formulas and special food products prescribed by a Plan Physician to treat phenylketonuria (PKU), provided that these formulas and special foods exceed the cost of a normal diet.

2. Medically Necessary injectable and non-injectable drugs and supplies that are administered in a physician's office and self-injectable drugs covered under the medical benefit.

3. FDA-approved medications used to induce spontaneous and non-spontaneous abortions that may only be dispensed by or under direct supervision of a physician.

4. Immunization or immunological agents, including, but not limited to: biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
5. Equipment and supplies for the management and treatment of diabetes, including insulin pumps and all related necessary supplies, blood glucose monitors, testing strips, lancets and lancet puncture devices. Insulin, glucagon and insulin syringes are covered under the outpatient Prescription Drug benefit.
6. Items that are approved by the FDA as a medical device. Please refer to the Disposable Medical Supplies, Durable Medical Equipment, and Family Planning benefit categories under the **WHAT ARE YOUR COVERED BENEFITS?** section of this Member Handbook for information about medical devices covered by Sharp Health Plan.

Outpatient rehabilitation therapy services

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

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

Phenylketonuria (PKU)

The diagnosis and treatment of phenylketonuria are covered as follows:

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

Preventive care services

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, 2020, the benefit changes required would take effect January 1, 2022 (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, BRCA screening and testing in high-risk women, human papillomavirus screening test, lung cancer screening in certain persons and prostate cancer screening.
- Other preventive diagnostic tests that may be delivered in an outpatient surgical facility, including but not limited to colonoscopy and endoscopy.
- HIV testing regardless of whether the testing is related to a primary diagnosis.
- Hepatitis B and Hepatitis C screenings
- Depression screening
- Screening for tobacco use.
- For those who use tobacco products, All FDA-approved tobacco cessation medications (including over-the-counter medications) when prescribed by a health care provider, without prior Authorization.

Any item, service or immunization not specifically listed here but that is recommended by the USPSTF with an "A" or "B" rating, recommended by ACIP or supported by HRSA, as described above, will

also be covered as preventive. All preventive care services are provided at no Cost Share to Members; however, reasonable medical management techniques may be used to determine the frequency, method, treatment or clinical setting for a recommended preventive service, to the extent not specified in the recommendation or guideline regarding that preventive service.

Professional Services

The following Professional Services (provided by a Plan Physician or other licensed health professional) are covered. The Cost Share for Professional Services is determined based on the type and location of the service. Please see the Summary of Benefits.

- Doctor office visits for consultation, treatment, diagnostic testing, etc.
- Surgery and assistant surgery.
- Inpatient hospital and Skilled Nursing Facility visits.
- Professional office visits.
- Doctor visits in the Member's home when the Member is too ill or disabled to be seen during regular office hours.
- Anesthesia administered by an anesthetist or anesthesiologist.
- Diagnostic radiology testing.
- Diagnostic laboratory testing.
- Radiation therapy and chemotherapy.
- Dialysis treatment.
- Supplies and drugs approved by the 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 including disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes and foot disfigurement caused by accident or developmental disability.

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

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

Repair or replacement of prosthetics and orthotics are covered when prescribed by a Plan Physician or ordered by a licensed health care provider acting within the scope of their license and when not caused by misuse or loss. The applicable Cost Share, per the Summary of Benefits, applies for both repair and replacement.

Radiation therapy

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

Radiology services

Radiology services provided in the doctor's office, outpatient facility, or inpatient hospital facility are covered. Advanced radiology services are covered for the diagnosis and

ongoing medical management of an illness or injury. Examples of advanced radiology procedures include, but are not limited to, CT scan, PET scan, magnetic resonance imaging (MRI), magnetic resonance angiography (MRA) and nuclear scans.

Reconstructive surgical services

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

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

The Cost Share for reconstructive surgical services is determined based on the type and location of the service. Please see the Summary of Benefits.

Skilled Nursing Facility services

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

Covered Benefits include:

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

their administration.

- Medical social services.

Sterilization services

Voluntary sterilization services are covered.

Substance Use Disorder treatment

Sharp Health Plan covers Medically Necessary services for the diagnosis or treatment of Substance Use Disorders that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that are listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, which include but are not limited to the following services:

- Physician services, including consultation and referral
- Diagnostic laboratory and diagnostic and therapeutic radiologic services
- Home health services
- Preventive health services, as described under **Preventive Care Services**
- Emergency health care services, including ambulance and ambulance transport services and Out-of-Area coverage, as described under **Emergency Services and Care**
- Inpatient detoxification: 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: Substance Use Disorder 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 Substance Use Disorder treatment: Day-treatment programs, intensive outpatient programs (programs usually less than five hours per day), individual and group Substance Use Disorder counseling, medical treatment for withdrawal symptoms, partial hospitalization (programs usually more than five hours per day), and case management services.
- Prescription drugs, as described under **Outpatient Prescription Drugs.**

Other services are also covered if Medically Necessary for treatment of a Substance Use Disorder.

Prior Authorization is not required for outpatient Substance Use Disorder office visits. Services must be provided by Plan Providers. If services for the Medically Necessary treatment of a Substance Use Disorder are not available in network within the geographic and timely access standards set by law or regulation, Sharp Health Plan will Authorize Medically Necessary out-of-network services and any Medically Necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. The Member will in-network cost sharing for out-of-network services Authorized by the Plan.

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 Plan centers having documented skills, resources, commitment and record of favorable outcomes to qualify the centers to provide such care.
2. Patients are selected by the patient-selection committee of the Plan facilities.
3. Only anti-rejection drugs, biological products and procedures that have been established as safe and effective, and no longer determined to be Experimental or Investigational Treatment, are covered.

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

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

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

Urgent Care Services

Urgent Care Services are covered inside and

outside the Service Area. Urgent Care Services means those services that are medically required within a short timeframe, usually within 24 hours, in order to prevent a serious deterioration of a Member's health due to an illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgently needed services include maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the Member's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until she 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 should contact your PCP prior to accessing Urgent Care Services.

Vision services

The following special contact lenses are covered:

- Up to two (2) contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris).
- Up to six (6) aphakic contact lenses per eye (including fitting and dispensing), per Calendar Year to treat aphakia (absence of the crystalline lens of the eye).

Pediatric Vision Services

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

- Routine vision exam (with refraction). One (1) exam every Calendar Year (including dilation, if professionally indicated) at no cost to the Member.
- Lenses for glasses. One (1) pair of lenses covered in full (no cost to the Member) every Calendar Year, including single vision, bifocal, trifocal and lenticular; choice of glass, plastic, or polycarbonate.
- Frames for glasses. Standard frames within the Otis & Piper™ eyewear collection are covered in full (no cost to the Member) once each Calendar Year.
- Contact lenses. Contact lenses are covered once every Calendar Year, in lieu of eyeglasses (unless Medically Necessary) as follows:
  - Standard (one pair annually)
  - Monthly (six-month supply)
  - Bi-weekly (three-month supply)
  - Dailies (three-month supply)
- Medically Necessary contact lenses. Medically Necessary contact lenses are covered. Necessary contact lenses, in lieu of glasses, are covered in full when verified by a Plan Provider for eye conditions that would prohibit the use of glasses. Visually necessary contact lenses are not typically covered for Members who have received any elective cosmetic eye surgery (e.g., LASIK, PRK, or RK). However, procedures resulting with concerns such as ectasia, scarring or irregular corneas causing vision problems that require contact lenses to provide functional vision, are covered under the necessary contact lens benefit, so long as patients meet the necessary contact lens criteria. The conditions covered include aphakia, aniridia, anisometropia (must meet 3.0 diopter criteria), corneal transplant, high ametropia (must meet diopter criteria), nystagmus, keratoconus, corneal dystrophies, corneal neovascularization and other eye

conditions that make contact lenses necessary and result in significantly better visual acuity.

- Low vision services. Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for Members with low vision. Covered low vision services will include one comprehensive low vision evaluation every year, approved low vision aids, such as high-power spectacles, magnifiers and telescopes are covered in full.

Wigs or hairpieces

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

What is not covered?

Exclusions and limitations

The services and supplies listed in this section are exclusions (not Covered Benefits) or are covered with limitations (Covered Benefits only in specific instances) in addition to those already described in this Member Handbook. Additional limitations may be specified in the Summary of Benefits.

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 Summary of Benefits;
3. Specified as excluded in this Member Handbook;
4. Not provided by Plan Providers, unless services are for Emergency or Out-of-Area Urgent Care; or services have been prior Authorized by the Plan to be received from non-Plan Providers;
5. Not prescribed by a Plan Physician, unless coverage is required for treatment of an Emergency Medical Condition or services are prescribed as part of a treatment plan prior Authorized by the Plan with a non-Plan provider;
6. Not Authorized in advance by your PCP, your PMG or Sharp Health Plan, if required (exception Emergency Services do not require Authorization);
7. Part of a treatment plan for non-Covered Benefits; or
8. Received prior to the Member's effective date of coverage or after the Member's termination from coverage under this Member Handbook.

Ambulance and medical transportation services

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

Chiropractic services

Chiropractic services are not covered, unless provided as a supplemental benefit. Sharp Health Plan offers supplemental benefits for chiropractic services only for benefit plans offered outside the Covered California for Small Business exchange.

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, except for the fact that they are being provided in a clinical trial, are otherwise excluded from coverage under this Member Handbook.
- 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. (Medically Necessary treatment of Mental Health or Substance Use Disorders resulting in hair loss is not excluded from coverage.)
- Treatment of obesity by medical and surgical means, except for services determined by Sharp Health Plan to be Medically Necessary for the treatment of morbid obesity. In no instance shall treatment for obesity be covered when 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 unless covered under the pediatric

dental benefit for Members under the age of 19. Dental services are defined as all services required for treatment of the teeth or gums.

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

Disposable Medical Supplies

Disposable Medical Supplies that are not provided in a hospital or physician office or by a home health professional are not covered. An exception to this is certain ostomy and urological supplies. See **Ostomy and urological Services** for more information.

Durable Medical Equipment (DME)

The following items are not covered:

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

Emergency Services

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

Experimental or Investigational Services

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 were provided or Authorized by the Member's Primary Care Physician or Plan Medical Group in accordance with the terms of the Plan or were Emergency Services or Urgent Care Services. This exclusion does not restrict the Plan's liability with respect to expenses for Covered Services solely because the expenses were incurred in a state hospital; however, the Plan's liability with respect to expenses for Covered Services provided in a state or county hospital is limited to the reimbursement that the Plan would pay for those Covered Services if provided by a Plan Hospital.

Hearing services

Hearing aids and routine hearing examinations are not covered, except as specifically listed as covered in this Member Handbook or unless provided as a supplemental benefit. Sharp Health Plan offers supplemental benefits for hearing aids only for benefit plans offered outside the Covered California for Small Business exchange.

Hospital facility inpatient and outpatient services

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

Immunizations and vaccines

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

Infertility services

The following services are not Covered Benefits:

- Infertility services, including treatment of the Member's underlying infertility condition. Infertility is defined as (1) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual intercourse without contraception, or (2) the presence

of a demonstrated condition recognized by a physician as a cause of infertility. A woman without a male partner who is unable to conceive may be considered infertile if she is unable to conceive or produce conception after at least twelve (12) cycles of donor insemination; these 12 cycles are not covered by the Plan.

- Assisted Reproductive Technologies (ART) procedures, otherwise known as conception by artificial means, including but not limited to artificial insemination, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), multi-cell embryo transfer (TET), intracytoplasmic sperm injections (ICSI), blastocyst transfer, assisted hatching and any other procedures that may be employed to bring about conception without sexual intercourse, unless provided as a supplemental benefit. Copayments made for supplemental benefits do not apply toward the annual Out-of-Pocket Maximum.
- Any service, procedure, or process 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 medical 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 unless determined to be Medically Necessary* for diagnosis or treatment of a Mental Health Disorder:

- 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 that is not identified as a "mental disorder" in the most recent edition of the DSM.**
- Diagnosis and treatment for learning disorders or those services primarily

oriented toward treatment of social or learning disorders.**

- Counseling for 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.**

Services for conditions that the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) identifies as something other than a Mental Disorder are not covered.

Changes in terminology, organization, or classification of Mental Health and Substance Use Disorders in future versions of the DSM or ICD shall not affect the conditions covered by the Plan as long as a condition is commonly understood to be a Mental Health or Substance Use Disorder by health care providers practicing in relevant clinical specialties.

Any services provided to the Member by an Employee Assistance Program (EAP) offered by an employer are not Covered Benefits. Sharp Health Plan does not provide EAP services.

* Benefits or coverage for Medically Necessary services shall not be limited or excluded on the basis that those services should be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance.

** These non-Covered Benefits do not include Behavioral Health Treatment for autism spectrum disorder, which is a Covered Benefit.

Non-preventive physical or psychological examinations

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

Ostomy and urological supplies

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

Outpatient Prescription Drugs

EXCLUSIONS AND LIMITATIONS TO THE OUTPATIENT PRESCRIPTION DRUG BENEFIT

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

1. Drugs dispensed by a person or entity other than a Plan Pharmacy, except as Medically Necessary for treatment of an Emergency Medical Condition or urgent care condition.
2. Drugs prescribed by non-Plan Providers and not Authorized by Sharp Health Plan, except when coverage is otherwise required for treatment of an Emergency Medical Condition.
3. Over-the-counter medications or supplies, even if written on Prescription,

except as specifically identified as covered in the Sharp Health Plan Formulary. This exclusion does not apply to over-the-counter products that we must cover as a "preventive care" benefit under federal law with a Prescription or if the prescription legend drug is Medically Necessary due to a documented treatment failure or intolerance to the over-the-counter equivalent or therapeutically comparable drug.

4. Drugs dispensed in institutional packaging (such as unit dose) and drugs that are repackaged.Drugs that are packaged with over-the-counter drugs or other non-prescription items/supplies.

5. Vitamins (other than pediatric or prenatal vitamins listed on the Formulary).

6. Drugs and supplies prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. (Drugs for mental performance are covered when they are Medically Necessary to treat Mental Health or Substance Use Disorders or medical conditions affecting memory, including but not limited to treatment of the conditions or symptoms of dementia or Alzheimer's disease. Drugs for treatment of hair loss or sexual dysfunction are covered when they are Medically Necessary to treat Mental Health or Substance Use Disorders.)

7. Herbal, nutritional and dietary supplements.

8. Drugs prescribed solely for the purpose of shortening the duration of the common cold.

9. Dental products and medications prescribed for a dental treatment (such as mouthwash to prevent gum disease) are not covered. Drugs prescribed by a dentist to treat a medical condition (such as antibiotics to treat an infection) are covered.

10. Drugs and supplies prescribed in connection with a service or supply that is not a covered benefit unless required to treat a complication that arises as a result of the service or supply.

11. Please refer to the Member Handbook under **Disposable Medical Supplies, Durable Medical Equipment**, and **Family planning** for information about medical devices covered by Sharp Health Plan.

12. Infertility drugs are excluded, unless added by the employer as a supplemental benefit.

13. Drugs obtained outside of the United States, unless furnished in connection with Urgent Care Services or Emergency Services.

14. Drugs that are prescribed solely for the purposes of losing weight, except when Medically Necessary for the treatment of morbid obesity or Mental Health and Substance Use Disorders. Members must be enrolled in a Sharp Health Plan-approved comprehensive weight loss program prior to or concurrent with receiving the weight loss drug and meet Plan criteria for coverage when prescribed for treatment of morbid obesity.

15. Off-label use of FDA-approved Prescription Drugs, unless the drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or the safety and effectiveness of use for this indication has been adequately demonstrated by at least two studies

published in a nationally recognized, major peer reviewed journal.

16. Replacement of lost, stolen, or destroyed medications.
17. Compounded medications, unless determined to be Medically Necessary and prior Authorization is obtained.
18. Brand-Name Drugs when a generic equivalent is available.
19. Any Prescription Drug for which there is an over-the-counter product that has the identical active ingredient and dosage as the Prescription Drug.

The exclusions listed above do not apply to:

1. Coverage of an entire class of Prescription Drugs when one drug within that class becomes available over-the-counter.
2. Drugs listed on Sharp Health Plan's Formulary.
3. Over-the-counter products that are specifically covered and listed as a Preventive Care benefit under California State or federal law. Covered preventive drugs include FDA-approved tobacco cessation drugs and FDA-approved contraceptive drugs. Preventive drugs are provided at $0 Cost Sharing subject to certain exceptions. For more information regarding coverage of certain over-the-counter drugs as preventive drugs, please see the Plan Formulary and your **Family planning** and **Preventive care services** sections of this Member Handbook.
4. Insulin, glucagon and insulin syringes. These items are covered when Medically Necessary, even if they are available without a Prescription. Please see the **Diabetes treatment** benefit category in the **WHAT ARE YOUR COVERED BENEFITS?** section of this Member Handbook for information about equipment and supplies for the management and treatment of diabetes.
5. Items that are approved by the FDA as a medical device. Please refer to the **Disposable Medical Supplies, Durable Medical Equipment**, and **Family planning** benefit categories in the **WHAT ARE YOUR COVERED BENEFITS?** section of this Member Handbook for information about medical devices covered by Sharp Health Plan.

Some drugs are commercially available as both a brand-name version and a generic version. It is the policy of Sharp Health Plan that when a generic version is available, Sharp Health Plan does not cover the corresponding Brand-Name Drug. Sharp Health Plan requires the dispensing pharmacy to dispense the Generic Drug, unless prior Authorization for the Brand-Name Drug is obtained.

Private-duty nursing services

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

Prosthetic and orthotic services

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

- A shoe that is an integral part of a leg brace and is included as part of the cost of the brace.
- Therapeutic shoes furnished to select diabetic Members.

- Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care.
- A prosthetic shoe that is an integral part of a prosthesis.
- Special footwear needed by persons who suffer from foot disfigurement including disfigurement from cerebral palsy, arthritis, polio, spina bifida, 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 unless Medically Necessary for treatment of a Mental Health or Substance Use Disorder.

Sterilization services

Reversal of sterilization services is not covered.

Substance Use Disorder treatment

Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation, custody, or visitation is not covered unless determined to be Medically Necessary for diagnosis or treatment of a Substance Use Disorder.

Any services provided to the Member by an Employee Assistance Program (EAP) offered by an employer are not Covered Benefits. Sharp Health Plan does not provide EAP services.

Services for conditions that the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Diseases (ICD) identifies as something other than a Mental Disorder are not covered. Changes in terminology, organization, or classification of Mental Health and Substance Use Disorders in future versions of the DSM or ICD shall not affect the conditions covered by the Plan as long as a condition is commonly understood to be a Mental Health or Substance Use Disorder by health care providers practicing in relevant clinical specialties.

Benefits or coverage for Medically Necessary services shall not be limited or excluded on the basis that those services should be covered by a public entitlement program, including, but not limited to, special education or an individualized education program, Medicaid, Medicare, Supplemental Security Income, or Social Security Disability Insurance.

Vision services

Vision services are not covered unless

specifically listed as covered in this Member Handbook or provided as a supplemental benefit. Sharp Health Plan offers supplemental benefits for vision services only for benefit plans offered outside the Covered California for Small Business exchange. Vision services that are specifically not covered for Members age 19 and older without a supplemental benefit include, but are not limited to:

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

Other

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

- Benefits for services or expenses directly related to any condition that caused a Member's Total Disability are excluded when such Member is Totally Disabled on the date of discontinuance of a prior carrier's policy and the Member is entitled to an extension of benefits for Total Disability from that prior carrier.

How do you enroll in Sharp Health Plan?

When is an employee eligible to enroll in Sharp Health Plan?

If you are an employee, you may enroll during your initial enrollment period or during your Employer's Open Enrollment Period, provided you live or work within the Service Area, meet certain eligibility requirements and complete the required enrollment process. Your initial enrollment period begins the day you become an Eligible Employee and ends 31 days 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 must obtain all Covered Benefits from Plan Providers inside the Service Area, except for Out-of-Area Emergency Services or Urgent Care Services.

When is a Dependent eligible to enroll in Sharp Health Plan?

Dependents (Spouse, Domestic Partner and Children) become eligible when the Eligible Employee is determined by the Employer to

be eligible. Dependents may enroll during the Eligible Employee's initial enrollment period or during the Employer's Open Enrollment Period. Enrollment begins at 12:01 a.m. on the date established by your Employer and the Plan.

For purposes of eligibility, Children of the Enrolled Employee include:

- The naturally born Children, legally adopted Children, or stepchildren of the Enrolled Employee;
- Children for whom the Enrolled Employee has been appointed a legal guardian by a court;
- Children for whom the Enrolled Employee is required to provide health coverage pursuant to a qualified medical support order;
- 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 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, marital, or financial status. An enrolled Dependent Child who reaches age 26 during a Benefit Year may remain enrolled as a Dependent until the end of that Benefit Year. The Dependent Child's coverage shall end on the last day of the Benefit Year during which the Dependent Child becomes ineligible.

A Dependent Child who is Totally Disabled at the time of attaining the maximum age of 26 may remain enrolled as a Dependent until the disability ends. For 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 request must include a written statement and supporting clinical documentation from the 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 must obtain all Covered Benefits from Plan Providers inside the Service Area, except for Out-of-Area Emergency Services or 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 days from the date of the newborn's birth, and the adopted Child of an Enrolled Employee or 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 Application for the Child to your Employer within the initial 31-day period following birth or adoption. A birth or adoption certificate may be required as proof of Dependent status. If applicable, Sharp Health Plan may coordinate the cost of care if another health insurance carrier also covers the Child.

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 60 days after your other coverage ends.

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

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

Your Employer is responsible for notifying the Plan to enroll or disenroll your eligible Dependents. If notification of the status change is not received by your Employer within the 60-day period, your Dependent(s) will not be covered and you will be responsible for payment of any services received. To add a new Spouse to your coverage, you must complete and submit an Enrollment Change Form to your Employer within the 60-day

period following your marriage.

How do you update your enrollment information?

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

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

What if you have other health insurance coverage?

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

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

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

If you have purchased a supplemental pediatric dental benefit plan on the Covered California for Small Business exchange, pediatric dental benefits covered under this plan will be paid first, with the supplemental pediatric plan covering non-covered services and or Cost Sharing as described in your pediatric dental plan.

What if you are eligible for Medicare?

It is 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; however, you may be able to purchase individual coverage. Please call Customer Care for assistance.

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

When will your coverage end?

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, 2022, your last moment of coverage was at 11:59 p.m. on December 31, 2021). 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. If your Employer is providing your health coverage through Covered California for Small Business (CCSB), please contact Covered California for information about how to apply for reinstatement.

- When your Employer 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 of the Service Area or termination of Total Disability status. Coverage will end on the last day of the month in which eligibility ends. The Dependent may be eligible to elect COBRA or Cal-COBRA coverage.

Fraud or intentional misrepresentation of material fact

Coverage for you or your Dependent(s) will also end if either you or that Dependent(s) commit(s) an act of fraud or intentional misrepresentation of a material fact to circumvent state or federal laws or the policies of the Plan, such as allowing someone else to use your Member ID card, providing materially incomplete or incorrect enrollment or required updated information deliberately, including but not limited to incomplete or incorrect information regarding date of hire, date of birth, relationship to Enrolled Employee or Dependent, place of residence, other group health insurance or workers' compensation benefits, or disability status.

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

Cancellation of the Group Agreement for nonpayment of Premiums

If the Group Agreement is cancelled because the 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 Nonpayment 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 the Plan mails you 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 calendar days of termination of the Group Agreement; however, you or your Dependent, as applicable, is covered during this 90-day period.

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

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

COBRA continuation coverage

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

COBRA continuation coverage consists of the coverage under the company health plan that you and other qualified beneficiaries had immediately before your coverage terminated. If your Employer or Sharp Health Plan changes benefits, Premiums, etc., your continuation

coverage will change accordingly. If the contract between the Employer and Sharp Health Plan terminates while you are still eligible for COBRA, you may elect to continue COBRA coverage under the Employer's subsequent group health plan.

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

Cal-COBRA continuation coverage

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

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

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

Qualifying events

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

- As an Enrolled Employee, you may be eligible for Cal-COBRA continuation coverage if you would lose group health plan coverage due to the termination of your employment (for reasons other than gross misconduct) or due to a reduction in your work hours.
- As a Member who is the Dependent of an Enrolled Employee, you may be eligible for Cal-COBRA continuation coverage if you would lose group health plan coverage under Sharp Health Plan for any of the following reasons:
    1. Death of the Enrolled Employee.
    2. Termination of the Enrolled Employee's employment (for reasons other than gross misconduct) or a reduction in the Enrolled Employee's work hours.
    3. Divorce or legal separation from the Enrolled Employee.

4. Enrolled Employee's Medicare entitlement.
5. Your loss of Dependent status.

- A Member who has exhausted COBRA continuation coverage may be eligible for Cal-COBRA continuation coverage if your COBRA coverage was less than 36 months. COBRA and Cal-COBRA continuation coverage is limited to a combined maximum of 36 months.

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

How to elect Cal-COBRA coverage

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

Adding Dependents to Cal-COBRA

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

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

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

Premiums for Cal-COBRA coverage

The Member is responsible for payment to Sharp Health Plan of the entire monthly Premium for continuation coverage under Cal-COBRA. The initial Premium payment must be made on or before the 45th calendar day after election of Cal-COBRA coverage and must be delivered by first-class mail, certified mail, or other reliable means of delivery to the Plan. The Premium rate you pay will not be more than 110% 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 by the Premium due date listed on your monthly invoice. If any Premium payment is not made within 30 calendar days of the date it is due, Cal-COBRA coverage will be cancelled. No claims for medical services received under continuation coverage are paid until the Premium for the month of coverage is paid. If, for any reason, a Member receives medical benefits under the Plan during a month for which the Premium was not paid, the benefits received are not covered by the Plan and the Member will be required to pay the provider of service directly.

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

What can you do if you believe your coverage was terminated unfairly?

Sharp Health Plan will never terminate your coverage because of your health status or your need for health services. If you believe that your coverage or your Dependent's coverage was or will be, cancelled, Rescinded or not renewed due to health status or requirements for health care services, you have the 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 or 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 medical group, and may also cover certain referral services.
- Some doctors receive a different agreed-upon payment from us to provide services to you. Each time you receive health care services from one of these providers, the doctor receives payment for that service.
- Some hospitals in our network receive an agreed-upon monthly payment in return for providing hospital services for Members. Other hospitals are paid on a fee-for-service basis or receive a fixed payment per day of hospitalization.
- On a regular basis, we agree with each Plan Medical Group and some of our contracted hospitals on the monthly payment from Sharp Health Plan for services, including referral services, under the program for any Plan Members treated by the PMG/Hospital.
- 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 Providers that provide health care services to you and your family. At least annually, Sharp Health Plan provides Members, through the Member Resource Guide, 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 calendar days after entering into a surrogacy arrangement, you must send written notice of the arrangement, including the names and addresses of the other parties to the arrangement, and a copy of any contracts or other documents explaining the arrangement, to:

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

You must complete and send us all consents, releases, authorizations, lien forms and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this 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 autism spectrum disorder 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 the twelve-month period that begins at 12:01 a.m. on the first day of the month of each year established by the Employer and Sharp Health Plan.

Brand-Name Drug means a drug that is marketed under a proprietary, trademark-protected name.

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 Enrolled Employee including:

- The naturally born Children, legally adopted Children, or stepchildren of the Enrolled Employee;
- Children for whom the Enrolled Employee has been appointed a legal guardian by a court;
- Children for whom the Enrolled Employee is required to provide health coverage pursuant to a qualified medical support order; and
- Children for whom the Enrolled Employee has assumed a parent-child relationship, as indicated by intentional 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 Child remains eligible for coverage through the end of the Benefit Year in which they turn 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:

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.

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 Summary of Benefits and any supplemental benefit rider, if applicable, 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, Prescription Drugs and supplies that Members are entitled to receive under a Group Agreement and which are described in this Member Handbook.

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

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

Deductible means the amount a Member pays for certain Covered Benefits before Sharp Health Plan begins payment for all or part of the cost of those Covered Benefits.

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. All Employers who offer coverage to the Spouses of employees must also offer coverage to Registered Domestic Partners.

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.

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

Drug Tier means a group of Prescription Drugs that corresponds to a specified Cost Sharing tier in Sharp Health Plan's Prescription Drug coverage. The tier in which a Prescription Drug is placed determines the Member's portion of the cost for the drug.

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, 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.

Exception Request means a request for coverage of a Prescription Drug. If a Member, his or her designee, or prescribing health care provider submits an Exception Request for coverage of a Prescription Drug, Sharp Health Plan must cover the Prescription Drug when the drug is determined to be Medically Necessary to treat the Member's condition. Drugs and supplies that fall within one of the outpatient Prescription Drug benefit exclusions described in this Member Handbook are not eligible for an Exception Request.

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 published in, 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 an Enrolled Employee and one or more Dependents.

Family Deductible means the Deductible amount, if any, that applies each Calendar Year to an Enrolled Employee and that Enrolled Employee'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 an Enrolled Employee and that Enrolled Employee's Dependent(s) enrolled in Sharp Health Plan.

Formulary means the complete list of drugs preferred for use and eligible for coverage under a Sharp Health Plan product and includes all drugs covered under the outpatient Prescription Drug benefit of the Sharp Health Plan product. Formulary is also known as a Prescription Drug list.

Generic Drug means the same drug as its brand name equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use.

Grace Period means 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 an Employer to pay an unpaid Premium amount without losing healthcare coverage. To qualify for the Grace Period, the Employer must have paid at least one full month's Premium for the 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 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.

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 Enrolled Employee 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 Enrolled Employee 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, or 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:

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

For purposes of Mental Health or Substance Use Disorders, Medically Necessary means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition or its symptoms in a manner that is all of the following:

- In accordance with the generally accepted standards of Mental Health and Substance Use Disorder care
- Clinically appropriate in terms of type, frequency, extent, site and duration
- Not primarily for the economic benefit of the Plan or Members, or for the

convenience of the patient, treating physician or other health care provider.

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

Mental Health Disorder means a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Nonformulary Drug means a Prescription Drug that is not listed on Sharp Health Plan's Formulary.

Nonpayment of Premium means failure of the Employer, having been duly notified and billed for the charge, to pay any Premium, or portion of Premium, when due to Plan. An Employer shall be considered duly notified and billed for the charge when billing information has been sent to the Employer 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, established between the Employer and Sharp Health Plan, during which Eligible Employees 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 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-Pocket Maximum means the maximum total amount of expenses that a Member will pay for Covered Benefits in a Calendar Year before Plan pays Covered Benefits at 100%. All Member Cost Sharing (including Copayments, Deductibles and Coinsurance) for Covered Benefits, excluding supplemental benefits, contributes to the Out-of-Pocket Maximum.

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 Employer or the Member, as indicated on the Member Identification Card.

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

Plan Physician means any doctor of medicine, osteopathy, or podiatry licensed by the State of California who has agreed to provide Professional Services to Members, either through an agreement with 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 Provider 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.

For purposes of Mental Health and Substance Use Disorders, Providers include:

a. A person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

b. An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code.

c. A Qualified Autism Service Provider or Qualified Autism Service Professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73.

d. An associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code.

e. An associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code.

f. A registered psychologist, as described in Section 2909.5 of the Business and Professions Code.

g. A registered psychological assistant, as described in Section 2913 of the Business and Professions Code.

h. A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code

Prescription means an oral, written, or electronic order by a prescribing provider for a specific Member that contains the name of the Prescription Drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the Prescription is in writing, and if requested by the Member, the medical condition or purpose for which the drug is being prescribed.

Prescription Drug means a drug that is approved by the federal Food and Drug Administration (FDA), is prescribed by the Member's prescribing provider and requires a Prescription under applicable law.

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 autism spectrum disorder 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 autism spectrum disorder, 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 autism spectrum disorder, provided the services are within the experience and competence of the licensee.

Qualified Health Plan or **QHP** means a health plan that is certified by the Covered California Health Benefits Exchange, provides essential health benefits, is licensed by the State of California, and meets other requirements under the Affordable Care Act.

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

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.

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

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 includes certain ZIP codes in San Diego County, California, and southern Riverside County, California. The Service Area varies based on Plan Network. Plan offers southern Riverside County only in connection with benefit plans offered outside the Covered California Health Benefits Exchange. For more information about your Plan Network Service Area, please visit our website at sharphealthplan.com, or call Customer Care.

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.

Step Therapy means a process specifying the sequence in which different Prescription Drugs for a given medical condition and medically appropriate for a particular patient are prescribed. Sharp Health Plan may require a Member to try one or more drugs to treat the Member's medical condition before Sharp Health Plan will cover a particular drug for the condition pursuant

to a Step Therapy request. If the Member's prescribing provider submits a request for Step Therapy exception, Sharp Health Plan shall make exceptions to Step Therapy when the criteria is met.

Subscriber means the person who is responsible for payment to Sharp Health Plan and whose status, except for family dependency, is the basis for eligibility for membership in the Plan.

Substance Use Disorder means a Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

Summary of Benefits is a list of the most commonly used Covered Benefits and applicable Cost Shares for the specific benefit plan purchased by the Employer. Members receive a copy of the Summary of Benefits along with the Member Handbook.

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. Telehealth 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 Enrolled Employee for support and maintenance. The determination as to whether a Member is Totally Disabled will be made based upon an objective review consistent with professionally recognized medical standards.

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

Utilization Management 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.

Pediatric dental addendum to Evidence of Coverage

Introduction

This document is an addendum to your Sharp Health Plan Evidence of Coverage ("Sharp EOC") to add coverage for pediatric dental Essential Health Benefits as described in this dental Evidence of Coverage ("Dental EOC").

Sharp contracts with Delta Dental of California ("Delta Dental") to make the DeltaCare® USA Network of Contract Dentists available to you. You can obtain covered Benefits from your assigned Contract Dentist without a referral from a Plan Physician. When you visit your assigned Contract Dentist, your Copayment is due and you pay only the applicable Copayment of Benefits up to the Plan Out-of-Pocket Maximum. These pediatric dental Benefits are for Children from birth to age 19 who meet the eligibility requirements specified in your Sharp EOC. See your Sharp EOC and medical copayment summary for further information about your Plan Out-of-Pocket Maximum.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a Contract Dentist may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. To fully understand your coverage, you may wish to carefully review this addendum.

Additional information about your pediatric dental Benefits is available by calling Delta Dental's Customer Service Center at 1-855-370-4215, from 5 a.m. – 6 p.m. Pacific Time, Monday through Friday.

Eligibility under this Dental EOC is determined by Sharp.

Using this Dental Evidence of Coverage

This Addendum discloses the terms and conditions of your pediatric dental coverage and is designed to help you make the most of your dental plan. It will help you understand how this dental plan works and how to obtain dental care. Please read this Dental EOC completely and carefully. Persons with Special Health Care Needs should read the section entitled "Special Health Care Needs." A matrix describing this plan's major Benefits and coverage can be found on the last page of this Dental EOC ("Schedule C").

Definitions

In addition to the terms defined in the "Definitions" section of your Sharp EOC, the following terms, when capitalized and used in any part of this Dental EOC, have the following meanings:

Administrator: Delta Dental Insurance Company or other entity designated by Delta Dental operating as an Administrator in the state of California. Certain functions described

throughout this Addendum may be performed by the Administrator as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 1-855-370-4215.

Authorization: the process by which Delta Dental determines if a procedure or treatment is a referable Benefit to Enrollees under this Plan.

Benefits: covered dental services provided to Enrollees under the terms of this Addendum.

Calendar Year: the 12 months of the year from January 1 through December 31.

Contract Dentist: a DeltaCare USA Dentist who provides services in general dentistry and who has agreed to provide Benefits under this dental plan. Enrollees must obtain a referral from their Contract Dentist to obtain Specialist Services.

Contract Orthodontist: a DeltaCare USA Dentist who specializes in orthodontics and who has agreed to provide Benefits under this dental plan which covers Meddically Necessary orthodontics. Enrollees must obtain a referral from their Contract Dentist to obtain services from a Contract Orthodontist.

Contract Specialist: a DeltaCare USA Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under this dental plan. Enrollees must obtain a referral from their Contract Dentist to obtain services from a Contract Specialist.

Copayment/Cost Share: the amount listed in the Schedules attached to this Addendum and charged to an Enrollee by a Contract Dentist, Contract Specialist or Contract Orthodontist for the Benefits provided under this Plan. Copayments amounts must be paid at the time treatment is received.

Delta Dental Service Area: all geographic areas in the state of California in which Delta Dental is licensed as a specialized health care service plan.

Dentist: a duly licensed dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Department of Managed Health Care: a department of the California Health and Human Services Agency who has charge of regulating specialized health care service plans. Also referred to as the “Department” or “DMHC.”

Emergency Dental Condition: dental symptoms and/or pain that are so severe that a reasonable person would believe that, without immediate attention by a Dentist, it could reasonably be expected to result in any of the following:

- placing the patient’s health in serious jeopardy,
- serious impairment to bodily functions,
- serious dysfunction of any bodily organ or part, or
- death

Emergency Dental Service: a dental screening, examination and evaluation by a Dentist or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Dentist, to determine if an Emergency Dental Condition 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 Dental Condition, within the capability of the facility.

Optional: any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered

procedure but is chosen by the Enrollee and is subject to the limitations and exclusions described in the Schedules attached to this Addendum.

Out-of-Network: treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits to Enrollees under the terms of this Addendum.

Pediatric Enrollee: an eligible pediatric individual enrolled under this dental plan to receive Benefits.

Procedure Code: the Current Dental Terminology® ("CDT") number assigned to a Single Procedure by the American Dental Association.

Single Procedure: a dental procedure that is assigned a separate Procedure Code.

Special Health Care Need: a physical or mental impairment, limitation or condition that substantially interferes with an Enrollee's ability to obtain Benefits. Examples of such a Special Health Care Need are: 1) the Enrollee's inability to obtain access to their assigned Contract Dentist facility because of a physical disability, and 2) the Enrollee's inability to comply with their Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

Specialist Services: services performed by a Contract Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics (if Medically Necessary) or pediatric dentistry. Specialist Services must be authorized by Delta Dental.

Treatment in Progress: any Single Procedure, as defined by the CDT Code that has been started while the Enrollee was eligible to receive Benefits and for which multiple appointments are necessary to complete the Single Procedure(s), whether or not the Enrollee continues to be eligible for Benefits under this Plan. Examples include: 1) teeth that have been prepared for crowns, 2) root canals where a working length has been established, 3) full or partial dentures for which an impression has been taken and 4) orthodontics when bands have been placed and tooth movement has begun.

Urgent Dental Services: Medically Necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

Overview of dental benefits

This section provides information that will give you a better understanding of how this dental plan works and how to make it work best for you.

What is the DeltaCare USA Plan?

The DeltaCare USA Plan provides Pediatric Benefits through a convenient network of Contract Dentists in the state of California. These Contract Dentists are screened to ensure that our standards of quality, access and safety are maintained. The network is composed of established dental professionals. When you visit your assigned Contract Dentist, you pay only the applicable Copayment for Benefits. There are no deductibles, lifetime maximums or claim forms.

Benefits, limitations and exclusions

This plan provides the Benefits described in the Schedules that are a part of this Dental EOC. Benefits are only available in the state of California. Services are performed as deemed appropriate by your assigned Contract Dentist.

Cost Share and other charges

You are required to pay any Copayments listed in the Schedules attached to this Dental

EOC. Copayments are paid directly to the Contract Dentist who provides treatment. Charges for broken appointments and visits after normal visiting hours are listed in the Schedules attached to this Dental EOC.

In the event that we fail to pay a Contract Dentist, you will not be liable to that Contract Dentist for any sums owed by us. By statute, the DeltaCare USA dentist contract contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental. Except for the provisions in the "Emergency Dental Services" Section, if you have not received Authorization for treatment from an Out-of-Network Dentist and we fail to pay that Out-of-Network Dentist, you may be liable to that Out-of-Network Dentist for the cost of services received. For further clarification, see the "Emergency Dental Services" and "Specialist Services" provisions in this Dental EOC.

How to use the DeltaCare USA Plan/choice of Contract Dentist

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW HOW TO OBTAIN DENTAL SERVICES. YOU MUST OBTAIN DENTAL BENEFITS FROM, OR BE REFERRED FOR SPECIALIST SERVICES BY YOUR ASSIGNED CONTRACT DENTIST.

Delta Dental will provide Contract Dentists to Enrollees at convenient locations during the term of this Dental EOC. Upon enrollment, Delta Dental will assign Enrollees covered under this Dental EOC to one Contract Dentist facility. The Enrollee may request changes to the assigned Contract Dentist facility by contacting our Customer Service Center at 1-855-370-4215. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. The change must be requested prior to the 15th of the month to become effective on the first day of the following month.

You will be provided with written notice of assignment to another Contract Dentist facility near the Enrollee's home if:
1) a requested facility is closed to further enrollment; 2) a chosen Contract Dentist facility withdraws from the plan; or
3) an assigned facility requests, for good cause, that the Enrollee be re-assigned to another Contract Dentist facility.

All Treatment in Progress must be completed before you change to another Contract Dentist facility. For example, this would include:
1) partial or full dentures for which final impressions have been taken; 2) completion of root canals in progress; or 3) delivery of crowns when teeth have been prepared.

All services which are Benefits will be rendered at the Contract Dentist facility assigned to the Enrollee. Specialist Services obtained from a Contract Orthodontist or Contract Specialist must be referred by the Enrollee's Contract Dentist. Delta Dental shall have no obligation or liability with respect to services rendered by Out-of-Network Dentists with the exception of Emergency Dental Services or Specialist Services referred by a Contract Dentist and authorized by Delta Dental. All authorized Specialist Services claims will be paid by Delta Dental, less any applicable Cost Share amounts. A Contract Dentist may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services.

If your assigned Contract Dentist facility terminates participation in this dental plan, that Contract Dentist facility will complete all Treatment in Progress, as described above. If, for any reason, your Contract Dentist is unable to complete treatment, Delta Dental will make

reasonable and appropriate provisions for the completion of such treatment by another Contract Dentist.

Delta Dental will give written notice to the Enrollee within a reasonable time of any termination or , breach of contract, or inability to perform by any Contract Dentist if the Enrollee will be materially or adversely affected.

Emergency Dental Services

Emergency Dental Services are used for palliative relief, controlling of dental pain, and/or stabilizing the Enrollee's condition. The Enrollee's assigned Contract Dentist facility maintains a 24-hour emergency dental services system, 7 days a week. If the Enrollee is experiencing an Emergency Dental Condition, the Enrollee can call 911 (where available) or obtain Emergency Dental Services from any Dentist without a referral.

After Emergency Dental Services are provided, further non-emergency treatment is usually needed. Non-emergency treatment must be obtained at the Enrollee's assigned Contract Dentist facility.

The Enrollee is responsible for any Copayment(s) for Emergency Dental Services received. Non-covered procedures will be the Enrollee's financial responsibility and will not be paid by this dental plan.

Benefits for Emergency Dental Services not provided by the Enrollee's assigned Contract Dentist are limited to a maximum of $100.00 per emergency, per Enrollee, less the applicable Cost Share. If the maximum is exceeded or if the conditions in the "Timely Access to Care" section are not met, the Enrollee is responsible for any charges for services received by a Dentist other than from their assigned Contract Dentist.

Urgent Dental Services

Inside the Delta Dental Service Area

An Urgent Dental Service requires prompt dental attention but is not an Emergency Dental Condition. If an Enrollee thinks that they may need Urgent Dental Services, the Enrollee can call their Contract Dentist.

Outside the Delta Dental Service Area

If an Enrollee needs Urgent Dental Services due to an unforeseen dental condition or injury, this dental plan covers Medically Necessary dental services when prompt attention is required from an Out-of-Network Dentist if all of the following are true:

- The Enrollee receives Urgent Dental Services from an Out-of-Network Dentist while temporarily outside of the Delta Dental Service Area.
- A reasonable person would have believed that the Enrollee's health would seriously deteriorate if they delayed treatment until they returned to the Delta Dental Service Area.

Enrollees do not need prior Authorization from Delta Dental to receive Urgent Dental Services outside the Delta Dental Service Area. Any Urgent Dental Services an Enrollee receives from Out-of-Network Dentists outside the Delta Dental Service Area are covered by this dental plan if the Benefits would have been covered if the Enrollee had received them from Contract Dentists.

We do not cover follow-up care from Out-of-Network Dentists after the Enrollee no longer needs Urgent Dental Services. To obtain follow-up care from a Dentist, the Enrollee can call their assigned Contract Dentist. The Enrollee is responsible for any Cost Share for Urgent Dental Services received.

Timely access to care

Contract Dentists, Contract Orthodontists and Contract Specialists have agreed waiting times to Enrollees for appointments for care which will never be greater than the following timeframes:

- for emergency care, 24 hours a day, 7 day days a week;
- for any urgent care, 72 hours for appointments consistent with the Enrollee's individual needs;
- for any non-urgent care, 36 business days; and
- for any preventive services, 40 business days.

During non-business hours, the Enrollee will have access to their Contract Dentist's answering machine, answering service, cell phone or pager for guidance on what to do and whom to contact if the Enrollee is calling due to an Emergency Dental Condition.

If the Enrollee calls Delta Dental's Customer Service Center, a representative will answer the phone within 10 minutes during normal business hours.

Should the Enrollee need interpretation services when scheduling an appointment with any of our Contract Dentists, Contract Orthodontists or Contract Specialists' facilities, they may call our Customer Service Center at 1-855-370-4215 for assistance.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics, orthodontics (if Medically Necessary) or pediatric dentistry must be: 1) referred by your assigned Contract Dentist, and 2) authorized by Delta Dental. You pay the specified Copayment(s). (Refer to the Schedules attached to this Dental EOC.)

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the Schedules attached to this Dental EOC to determine Benefits.

If you require Specialist Services and a Contract Specialist is not within 35 miles of your home address, your assigned Contract Dentist must obtain prior Authorization from Delta Dental to refer you to an Out-of-Network specialist or Out-of-Network orthodontist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist or Out-of-Network orthodontist that are not authorized by Delta Dental will not be covered by this dental plan.

If an Enrollee is assigned to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

Claims for reimbursement

Claims for covered Emergency Dental Services and authorized Specialist Services should be sent to us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All dental claims must be received within (1) year of the treatment date. The address for claims submission is: Delta Dental, Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Dentist compensation

A Contract Dentist is compensated by Delta Dental through monthly capitation (an amount based on the number of Enrollees assigned to the Dentist) and by Enrollees through required Cost Share amounts for treatment received. A Contract Specialist is compensated by Delta Dental

through an agreed-upon amount for each covered procedure, less the applicable Cost Share paid by the Enrollee. In no event does Delta Dental pay a Contract Dentist or a Contract Specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

You may obtain further information concerning Dentist compensation by calling Delta Dental at the toll-free telephone number shown in this Dental EOC.

Processing policies

The dental care guidelines for this dental plan explain to Contract Dentists what services are covered under this Dental EOC. Contract Dentists, Contract Orthodontists and Contract Specialists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist, Contract Orthodontists and Contract Specialists that fall under the scope of Benefits of this dental plan are provided subject to any Copayment(s). If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered Benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a Contract Specialist. An Enrollee may contact Delta Dental's Customer Service Center at 1-855-370-4215 for information regarding the dental care guidelines for this dental plan.

A covered Benefit appropriately provided through teledentistry is covered on the same basis and to the same extent that the covered Benefit is provided through in-person diagnosis, consultation or treatment.

Renewal and termination of coverage

Please refer to your Sharp EOC for further information regarding renewal and termination of this dental plan.

Second opinion

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your Contract Dentist. You may also be requested to obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner appropriate to the nature of the Enrollee's condition. Requests involving an Emergency Dental Condition will be authorized or denied in a timely fashion appropriate for the nature of your condition, not to exceed 72 hours after receipt of the request, whenever possible. For assistance or additional information regarding the procedures and timeframes for second opinion Authorizations, contact Delta Dental's Customer Service Center at 1-855-370-4215 or write to Delta Dental.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Delta Dental. A second opinion by an Out-of-Network Dentist will be authorized if an appropriately qualified Contract Dentist is not available. Only second opinion which have been approved or authorized will be paid. You will be sent written notification if your request for a second opinion is not authorized. If you disagree with this determination, you may file a grievance. Refer to the "Enrollee Complaint Procedure" section in this Dental EOC for more information.

Special Health Care Needs

If you believe you have a Special Health Care Need, you should contact Delta Dental's Customer Service Center at 1-855-370-4215. Delta Dental will confirm whether such a Special Health Care Need exists and what arrangements can be made to assist you in obtaining Benefits. Delta Dental will not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Contract Dentist treating Enrollees with Special Health Care Needs.

Facility accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service Center at 1-855-370-4215.

Enrollee complaint procedure

If you have any complaint regarding, eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the quality of dental services performed by a Contract Dentist, you may call the Customer Service Center at 1-855-370-4215, or the complaint may be addressed in writing to:

Delta Dental of California
Quality Management Department
P.O. Box 6050
Artesia, CA 90702

Written communication must include: 1) the name of the patient; 2) the name, address, telephone number and ID number of the Pediatric Enrollee; and 3) the Dentist's name and facility location.

"Grievance" means a written or oral expression of dissatisfaction regarding this plan and/or Dentist including quality of care concerns and shall include a complaint, dispute, request for reconsideration or appeal made by Pediatric Enrollee or the Enrollee's representative. Where this plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

"Complaint" is the same as "grievance."

"Complainant" is the same as "grievant" and means the person who filed the grievance including the Enrollee, a representative designated by the Enrollee, or other individual with authority to act on behalf of the Enrollee.

Within five calendar days of the receipt of any complaint, a quality management coordinator will forward to you a written acknowledgment of the complaint, which will include the date of the receipt and contact information. Certain complaints may require that you be referred to a Dentist for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves an Emergency Dental Condition, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the grievance within three (3) days.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a complaint with the Department. You may file a complaint with the Department immediately if you are experiencing an Emergency Dental Condition.

The Department is responsible for regulating health care service plans. If you have a grievance against Delta Dental, you should

first telephone Delta Dental at **1-855-370-4215** and use our grievance process above 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 Dental Condition, a grievance that has not been satisfactorily resolved by us, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

Independent Medical Review ("IMR")

You may also be eligible for IMR. If you are eligible for IMR, the 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 for disputes for your Emergency Dental Condition 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. DMHC's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

Complaints involving an adverse benefit determination

For complaints involving an adverse benefit determination (e.g., a denial, modification or termination of a requested benefit or claim), an Enrollee must file a request for review (a complaint) with Delta Dental within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide the Enrollee with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination.

If the review of a denial is based, in whole or in part, on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of this Plan, Delta Dental will consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

General provisions

Third Party Administrator ("TPA")

Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under this Dental EOC. Any TPA providing such services or receiving such information shall enter into a separate business associate agreement with Delta Dental providing that the TPA shall meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

Non-discrimination

Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- 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 Delta Dental's Customer Service Center at 1-855-370-4215.

If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance electronically online, over the phone with a Customer Service representative or by mail.

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
Telephone Number: 1-855-370-4215
Website Address: deltadentalins.com

You can also file a civil rights complaint 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, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)

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

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: 711) Fax: (619) 740-8572

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

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

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

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

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

Sharp Health Plan cumple con las leyes de derechos civiles federales correspondientes y no discrimina por motivos de raza, color,

nacionalidad, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad ni discapacidad. Tampoco excluye a las personas ni las trata de forma diferente por motivos de raza, color, nacionalidad, ascendencia, religión, sexo, estado civil, género, identidad de género, orientación sexual, edad ni discapacidad.

Sharp Health Plan:

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

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

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

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

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

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

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

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

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

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

Language Assistance Services

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

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

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

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

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

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

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

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

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

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

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

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁ ਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁ ਹਾਡੇ ਲਈ ਮੁ ਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY:711) 'ਤੇ ਕਾਲ ਕਰੋ।

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

Language assistance services

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 मुफ़्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY:711) पर कॉल करें।

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

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1-800-359-2002

PEDIATRIC DENTAL ADDENDUM TO EVIDENCE OF COVERAGE

INTRODUCTION

This document is an addendum to your Sharp Health Plan *Evidence of Coverage* ("Sharp EOC") to add coverage for pediatric dental Essential Health Benefits as described in this dental *Evidence of Coverage* ("Dental EOC").

Sharp contracts with Delta Dental of California ("Delta Dental") to make the DeltaCare® USA Network of Contract Dentists available to you. You can obtain covered Benefits from your assigned Contract Dentist without a referral from a Plan Physician. When you visit your assigned Contract Dentist your Copayment is due and you pay only the applicable Copayment of Benefits up to the Plan Out-of-Pocket Maximum . These pediatric dental Benefits are for children from birth to age 19 who meet the eligibility requirements specified in your Sharp EOC. See your Sharp EOC and medical copayment summary for further information about your Plan Out-of-Pocket Maximum.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a Contract Dentist may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. To fully understand your coverage, you may wish to carefully review this addendum.

Additional information about your pediatric dental Benefits is available by calling Delta Dental's Customer Service Center at 855-370-4215, from 5 a.m. – 6 p.m. Pacific Time, Monday through Friday.

Eligibility under this Dental EOC is determined by Sharp.

Using This Dental Evidence of Coverage

This Addendum discloses the terms and conditions of your pediatric dental coverage and is designed to help you make the most of your dental plan. It will help you understand how this dental plan works and how to obtain dental care. Please read this Dental EOC completely and carefully. Persons with Special Health Care Needs should read the section entitled "Special Health Care Needs." A matrix describing this plan's major Benefits and coverage can be found on the last page of this Dental EOC ("Schedule C").

DEFINITIONS

In addition to the terms defined in the "Definitions" section of your Sharp EOC, the following terms, when capitalized and used in any part of this Dental EOC, have the following meanings:

Administrator: Delta Dental Insurance Company or other entity designated by Delta Dental operating as an Administrator in the state of California. Certain functions described throughout this Addendum may be performed by the Administrator as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 855-370-4215.

Authorization: the process by which Delta Dental determines if a procedure or treatment is a referable Benefit to Enrollees under this Plan.

Benefits: covered dental services provided to Enrollees under the terms of this Addendum.

Calendar Year: the 12 months of the year from January 1 through December 31.

Contract Dentist: a DeltaCare USA Dentist who provides services in general dentistry and who has agreed to provide Benefits under this dental plan. Enrollees must obtain a referral from their Contract Dentist to obtain Specialist Services.

Contract Orthodontist: a DeltaCare USA Dentist who specializes in orthodontics and who has agreed to provide Benefits under this dental plan which covers medically necessary orthodontics. Enrollees must obtain a referral from their Contract Dentist to obtain services from a Contract Orthodontist.

Contract Specialist: a DeltaCare USA Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under this dental plan. Enrollees must obtain a referral from their Contract Dentist to obtain services from a Contract Specialist.

Copayment/:Cost Share: the amount listed in the Schedules attached to this Addendum and charged to an Enrollee by a Contract Dentist, Contract Specialist or Contract Orthodontist for the Benefits provided under this Plan. Copayments amounts must be paid at the time treatment is received.

Delta Dental Service Area: all geographic areas in the state of California in which Delta Dental is licensed as a specialized health care service plan.

Dentist: a duly licensed dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Department of Managed Health Care: a department of the California Health and Human Services Agency who has charge of regulating specialized health care service plans. Also referred to as the “Department” or “DMHC.”

Emergency Dental Condition: dental symptoms and/or pain that are so severe that a reasonable person would believe that, without immediate attention by a Dentist, it could reasonably be expected to result in any of the following:

- placing the patient's health in serious jeopardy,
- serious impairment to bodily functions,
- serious dysfunction of any bodily organ or part, or
- death

Emergency Dental Service: a dental screening, examination and evaluation by a Dentist or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Dentist, to determine if an Emergency Dental Condition 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 Dental Condition, within the capability of the facility.

Optional: any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure but is chosen by the Enrollee and is subject to the limitations and exclusions described in the Schedules attached to this Addendum.

Out-of-Network: treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits to Enrollees under the terms of this Addendum.

Pediatric Enrollee: an eligible pediatric individual enrolled under this dental plan to receive Benefits.

Procedure Code: the Current Dental Terminology® ("CDT") number assigned to a Single Procedure by the American Dental Association.

Single Procedure: a dental procedure that is assigned a separate Procedure Code.

Special Health Care Need: a physical or mental impairment, limitation or condition that substantially interferes with an Enrollee's ability to obtain Benefits. Examples of such a Special Health Care Need are: 1) the Enrollee's inability to obtain access to their assigned Contract Dentist facility because of a physical disability, and 2) the Enrollee's inability to comply with their Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

Specialist Services: services performed by a Contract Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics (if medically necessary) or pediatric dentistry. Specialist Services must be authorized by Delta Dental.

Treatment in Progress: any Single Procedure, as defined by the CDT Code that has been started while the Enrollee was eligible to receive Benefits and for which multiple appointments are necessary to complete the Single Procedure(s), whether or not the Enrollee continues to be eligible for Benefits under this Plan. Examples include: 1) teeth that have been prepared for crowns, 2) root canals where a working length has been established, 3) full or partial dentures for which an impression has been taken and 4) orthodontics when bands have been placed and tooth movement has begun.

Urgent Dental Services: medically necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

OVERVIEW OF DENTAL BENEFITS

This section provides information that will give you a better understanding of how this dental plan works and how to make it work best for you.

What is the DeltaCare USA Plan?

The DeltaCare USA Plan provides Pediatric Benefits through a convenient network of Contract Dentists in the state of California. These Contract Dentists are screened to ensure that our standards of quality, access and safety are maintained. The network is composed of established dental professionals. When you visit your assigned Contract Dentist, you pay only the applicable Copayment for Benefits. There are no deductibles, lifetime maximums or claim forms.

Benefits, Limitations and Exclusions

This plan provides the Benefits described in the Schedules that are a part of this Dental EOC. Benefits are only available in the state of California. Services are performed as deemed appropriate by your assigned Contract Dentist.

Cost Share and Other Charges

You are required to pay any Copayments listed in the Schedules attached to this Dental EOC. Copayments are paid directly to the Contract Dentist who provides treatment. Charges for broken appointments and visits after normal visiting hours are listed in the Schedules attached to this Dental EOC.

In the event that we fail to pay a Contract Dentist, you will not be liable to that Contract Dentist for any sums owed by us. By statute, the DeltaCare USA dentist contract contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental. Except for the provisions in the "Emergency Dental Services" Section, if you have not received Authorization for treatment from an Out-of-Network Dentist and we fail to pay that Out-of-Network Dentist, you may be liable to that Out-of-Network Dentist for the cost of services received. For further clarification, see the "Emergency Dental Services" and "Specialist Services" provisions in this Dental EOC.

HOW TO USE THE DELTACARE USA PLAN / CHOICE OF CONTRACT DENTIST

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW HOW TO OBTAIN DENTAL SERVICES. YOU MUST OBTAIN DENTAL BENEFITS FROM, OR BE REFERRED FOR SPECIALIST SERVICES BY YOUR ASSIGNED CONTRACT DENTIST.

Delta Dental will provide Contract Dentists to Enrollees at convenient locations during the term of this Dental EOC. Upon enrollment, Delta Dental will assign Enrollees covered under this Dental EOC to one Contract Dentist facility. The Enrollee may request changes to the assigned Contract Dentist facility by contacting our Customer Service Center at 855-370-4215. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. The change must be requested prior to the 15th of the month to become effective on the first day of the following month.

You will be provided with written notice of assignment to another Contract Dentist facility near the Enrollee's home if: 1) a requested facility is closed to further enrollment; 2) a chosen Contract Dentist facility withdraws from the plan; or 3) an assigned facility requests, for good cause, that the Enrollee be re-assigned to another Contract Dentist facility.

All Treatment in Progress must be completed before you change to another Contract Dentist facility. For example, this would include: 1) partial or full dentures for which final impressions have been taken; 2) completion of root canals in progress; or 3) delivery of crowns when teeth have been prepared.

All services which are Benefits will be rendered at the Contract Dentist facility assigned to the Enrollee. Specialist Services obtained from a Contract Orthodontist or Contract Specialist must be referred by the Enrollee's Contract Dentist. Delta Dental shall have no obligation or liability with respect to services rendered by Out-of-Network Dentists with the exception of Emergency Dental Services or Specialist Services referred by a Contract Dentist and authorized by Delta Dental. All authorized Specialist Services claims will be paid by Delta Dental, less any applicable Cost Share amounts. A Contract Dentist may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services.

If your assigned Contract Dentist facility terminates participation in this dental plan, that Contract Dentist facility will complete all Treatment in Progress, as described above. If, for any reason, your Contract Dentist is unable to complete treatment, Delta Dental will make reasonable and appropriate provisions for the completion of such treatment by another Contract Dentist.

Delta Dental will give written notice to the Enrollee within a reasonable time of any termination or , breach of contract, or inability to perform by any Contract Dentist if the Enrollee will be materially or adversely affected.

Emergency Dental Services

Emergency Dental Services are used for palliative relief, controlling of dental pain, and/or stabilizing the Enrollee's condition. The Enrollee's assigned Contract Dentist facility maintains a 24-hour emergency dental services system, 7 days a week. If the Enrollee is experiencing an Emergency Dental Condition, the Enrollee can call 911 (where available) or obtain Emergency Dental Services from any Dentist without a referral.

After Emergency Dental Services are provided, further non-emergency treatment is usually needed. Non-emergency treatment must be obtained at the Enrollee's assigned Contract Dentist facility.

The Enrollee is responsible for any Copayment(s) for Emergency Dental Services received. Non-covered procedures will be the Enrollee's financial responsibility and will not be paid by this dental plan.

Benefits for Emergency Dental Services not provided by the Enrollee's assigned Contract Dentist are limited to a maximum of $100.00 per emergency, per Enrollee, less the applicable Cost Share. If the maximum is exceeded or if the conditions in the "Timely Access to Care" section are not met, the Enrollee is responsible for any charges for services received by a Dentist other than from their assigned Contract Dentist.

Urgent Dental Services

Inside the Delta Dental Service Area

An Urgent Dental Service requires prompt dental attention but is not an Emergency Dental Condition. If an Enrollee thinks that they may need Urgent Dental Services, the Enrollee can call their Contract Dentist.

Outside the Delta Dental Service Area

If an Enrollee needs Urgent Dental Services due to an unforeseen dental condition or injury, this dental plan covers medically necessary dental services when prompt attention is required from an Out-of-Network Dentist if all of the following are true:

- The Enrollee receives Urgent Dental Services from an Out-of-Network Dentist while temporarily outside of the Delta Dental Service Area.
- A reasonable person would have believed that the Enrollee's health would seriously deteriorate if they delayed treatment until they returned to the Delta Dental Service Area.

Enrollees do not need prior Authorization from Delta Dental to receive Urgent Dental Services outside the Delta Dental Service Area. Any Urgent Dental Services an Enrollee receives from Out-of-Network Dentists outside the Delta Dental Service Area are covered by this dental plan if the Benefits would have been covered if the Enrollee had received them from Contract Dentists.

We do not cover follow-up care from Out-of-Network Dentists after the Enrollee no longer needs Urgent Dental Services. To obtain follow-up care from a Dentist, the Enrollee can call their assigned Contract Dentist. The Enrollee is responsible for any Cost Share for Urgent Dental Services received.

Timely Access to Care

Contract Dentists, Contract Orthodontists and Contract Specialists have agreed waiting times to Enrollees for appointments for care which will never be greater than the following timeframes:

- for emergency care, 24 hours a day, 7 day days a week;
- for any urgent care, 72 hours for appointments consistent with the Enrollee's individual needs;
- for any non-urgent care, 36 business days; and
- for any preventive services, 40 business days.

During non-business hours, the Enrollee will have access to their Contract Dentist's answering machine, answering service, cell phone or pager for guidance on what to do and whom to contact if the Enrollee is calling due to an Emergency Dental Condition.

If the Enrollee calls Delta Dental's Customer Service Center, a representative will answer the phone within 10 minutes during normal business hours.

Should the Enrollee need interpretation services when scheduling an appointment with any of our Contract Dentists, Contract Orthodontists or Contract Specialists' facilities, they may call our Customer Service Center at 855-370-4215 for assistance.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics, orthodontics (if medically necessary) or pediatric dentistry must be: 1) referred by your assigned Contract Dentist, and 2) authorized by Delta Dental. You pay the specified Copayment(s). (Refer to the Schedules attached to this Dental EOC.)

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the Schedules attached to this Dental EOC to determine Benefits.

If you require Specialist Services and a Contract Specialist is not within 35 miles of your home address, your assigned Contract Dentist must obtain prior Authorization from Delta Dental to refer you to an Out-of-Network specialist or Out-of-Network orthodontist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist or Out-of-Network orthodontist that are not authorized by Delta Dental will not be covered by this dental plan.

If an Enrollee is assigned to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

Claims for Reimbursement

Claims for covered Emergency Dental Services and authorized Specialist Services should be sent to us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All dental claims must be received within (1) year of the treatment date. The address for claims submission is: Delta Dental, Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Dentist Compensation

A Contract Dentist is compensated by Delta Dental through monthly capitation (an amount based on the number of Enrollees assigned to the Dentist) and by Enrollees through required Cost Share amounts for treatment received. A Contract Specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Cost Share paid by the Enrollee. In no event does Delta Dental pay a Contract Dentist or a Contract Specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

You may obtain further information concerning Dentist compensation by calling Delta Dental at the toll-free telephone number shown in this Dental EOC.

Processing Policies

The dental care guidelines for this dental plan explain to Contract Dentists what services are covered under this Dental EOC. Contract Dentists, Contract Orthodontists and Contract Specialists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist, Contract Orthodontist and Contract Specialist that fall under the scope of Benefits of this dental plan are provided subject to any Copayment(s). If a Contract Dentist believes that an Enrollee should seek treatment

from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered Benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a Contract Specialist. An Enrollee may contact Delta Dental's Customer Service Center at 855-370-4215 for information regarding the dental care guidelines for this dental plan.

A covered Benefit appropriately provided through teledentistry is covered on the same basis and to the same extent that the covered Benefit is provided through in-person diagnosis, consultation or treatment.

Renewal and Termination of Coverage

Please refer to your Sharp EOC for further information regarding renewal and termination of this dental plan.

Second Opinion

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your Contract Dentist. You may also be requested to obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner appropriate to the nature of the Enrollee's condition. Requests involving an Emergency Dental Condition will be authorized or denied in a timely fashion appropriate for the nature of your condition, not to exceed 72 hours after receipt of the request, whenever possible. For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service Center at 855-370-4215 or write to Delta Dental.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Delta Dental. A second opinion by an Out-of-Network Dentist will be authorized if an appropriately qualified Contract Dentist is not available. Only second opinion which have been approved or authorized will be paid. You will be sent written notification if your request for a second opinion is not authorized. If you disagree with this determination, you may file a grievance. Refer to the "Enrollee Complaint Procedure" section in this Dental EOC for more information.

Special Health Care Needs

If you believe you have a Special Health Care Need, you should contact Delta Dental's Customer Service Center at 855-370-4215. Delta Dental will confirm whether such a Special Health Care Need exists and what arrangements can be made to assist you in obtaining Benefits. Delta Dental will not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Contract Dentist treating Enrollees with Special Health Care Needs.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service Center at 855-370-4215.

Enrollee Complaint Procedure

If you have any complaint regarding, eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the quality of dental services performed by a Contract Dentist, you may call the Customer Service Center at 855-370-4215, or the complaint may be addressed in writing to:

Delta Dental of California
Quality Management Department
P.O. Box 6050
Artesia, CA 90702

Written communication must include: 1) the name of the patient; 2) the name, address, telephone number and ID number of the Pediatric Enrollee; and 3) the Dentist's name and facility location.

"Grievance" means a written or oral expression of dissatisfaction regarding this plan and/or Dentist including quality of care concerns and shall include a complaint, dispute, request for reconsideration or appeal made by Pediatric Enrollee or the Enrollee's representative. Where this plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

"Complaint" is the same as "grievance."

"Complainant" is the same as "grievant" and means the person who filed the grievance including the Enrollee, a representative designated by the Enrollee, or other individual with authority to act on behalf of the Enrollee.

Within five calendar days of the receipt of any complaint, a quality management coordinator will forward to you a written acknowledgment of the complaint which will include the date of the receipt and contact information. Certain complaints may require that you be referred to a Dentist for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint. If the complaint involves an Emergency Dental Condition, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the grievance within three (3) days.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a complaint with the Department. You may file a complaint with the Department immediately if you are experiencing an Emergency Dental Condition.

The Department is responsible for regulating health care service plans. If you have a grievance against Delta Dental, you should first telephone Delta Dental at **855-370-4215** and use our grievance process above 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 Dental Condition, a grievance that has not been satisfactorily resolved by us, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

Independent Medical Review ("IMR")

You may also be eligible for IMR. If you are eligible for IMR, the 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 for disputes for your Emergency Dental Condition 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. DMHC's internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

Complaints Involving an Adverse Benefit Determination

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim), an Enrollee must file a request for review (a complaint) with Delta Dental within 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide the Enrollee with copies of any pertinent documents

that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination.

If the review of a denial is based, in whole or in part, on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of this Plan, Delta Dental will consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

GENERAL PROVISIONS

Third Party Administrator ("TPA")

Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under this Dental EOC. Any TPA providing such services or receiving such information shall enter into a separate business associate agreement with Delta Dental providing that the TPA shall meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

Non-Discrimination

Delta Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Delta Dental:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- 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 Delta Dental's Customer Service Center at 855-370-4215.

If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance electronically online, over the phone with a Customer Service representative or by mail.

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
Telephone Number: 888-282-8528
Website Address: deltadentalins.com

You can also file a civil rights complaint 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, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)

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

SCHEDULE A

Description of Benefits and Cost Shares for Pediatric Enrollees (Under Age 19)

The Benefits shown below are performed as needed and deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the DeltaCare® USA Plan ("Plan"). Please refer to Schedule B for further clarification of Benefits. Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under this Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2021 Procedure Codes, descriptors or nomenclature which is under copyright by the American Dental Association® ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D0100–D0999 I. DIAGNOSTIC			
D0999	Unspecified diagnostic procedure, by report	No charge	*Includes office visit, per visit (in addition to other services); In addition, shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D0120	Periodic oral evaluation - established patient	No charge	*1 per 6 months per Contract Dentist*
D0140	Limited oral evaluation - problem focused	No charge	*1 per Enrollee per Contract Dentist*
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge	*1 per 6 months per Contract Dentist, included with D0120, D0150*
D0150	Comprehensive oral evaluation - new or established patient	No charge	*Initial evaluation, 1 per Contract Dentist*
D0160	Detailed and extensive oral evaluation - problem focused, by report	No charge	*1 per Enrollee per Contract Dentist*
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No charge	*6 per 3 months, not to exceed 12 per 12 month period*
D0171	Re-evaluation - post-operative office visit	No charge	
D0180	Comprehensive periodontal evaluation - new or established patient	No charge	*Included with D0150*
D0210	Intraoral - complete series of radiographic images	No charge	*1 series per 36 months per Contract Dentist*
D0220	Intraoral - periapical first radiographic image	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*
D0230	Intraoral - periapical each additional radiographic image	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*
D0240	Intraoral - occlusal radiographic image	No charge	*2 per 6 months per Contract Dentist*
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	No charge	*1 per date of service*
D0251	Extra-oral posterior dental radiographic image	No charge	*4 per date of service*
D0270	Bitewing - single radiographic image	No charge	*1 of (D0270, D0273) per date of service*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D0272	Bitewings - two radiographic images	No charge	*1 of (D0272, D0273) per 6 months per Contract Dentist*
D0273	Bitewings - three radiographic images	No charge	*1 of (D0270, D0273) per date of service; 1 of (D0272, D0273) per 6 months per Contract Dentist*
D0274	Bitewings - four radiographic images	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*
D0277	Vertical bitewings - 7 to 8 radiographic images	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*
D0310	Sialography	No charge	
D0320	Temporomandibular joint arthrogram, including injection	No charge	*Limited to trauma or pathology; 3 per date of service*
D0322	Tomographic survey	No charge	*2 per 12 months per Contract Dentist*
D0330	Panoramic radiographic image	No charge	*1 per 36 months per Contract Dentist*
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	No charge	*2 per 12 months per Contract Dentist*
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No charge	*For the diagnosis and treatment of the specific clinical condition not apparent on radiographs; 4 per date of service*
D0351	3D photographic image	No charge	*1 per date of service*
D0460	Pulp vitality tests	No charge	
D0470	Diagnostic casts	No charge	*For the evaluation of orthodontic Benefits only; 1 per Contract Dentist unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment)*
D0502	Other oral pathology procedures, by report	No charge	*Performed by an oral pathologist*
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0701	Panoramic radiographic image - image capture only	No charge	
D0702	2D cephalometric radiographic image - image capture only	No charge	
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No charge	
D0704	3D photographic image - image capture only	No charge	
D0705	Extra-oral posterior dental radiographic image - image capture only	No charge	
D0706	Intraoral - occlusal radiographic image - image capture only	No charge	
D0707	Intraoral - periapical radiographic image - image capture only	No charge	
D0708	Intraoral - bitewing radiographic image - image capture only	No charge	
D0709	Intraoral - complete series of radiographic images - image capture only	No charge	
D1000-D1999 II. PREVENTIVE			
D1110	Prophylaxis - adult	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1120	Prophylaxis - child	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1206	Topical application of fluoride varnish	No charge	*1 of (D1206, D1208) per 6 months*
D1208	Topical application of fluoride - excluding varnish	No charge	*1 of (D1206, D1208) per 6 months*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D1310	Nutritional counseling for control of dental disease	No charge	
D1320	Tobacco counseling for the control and prevention of oral disease	No charge	
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	No charge	
D1330	Oral hygiene instructions	No charge	
D1351	Sealant - per tooth	No charge	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No charge	*1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1353	Sealant repair - per tooth	No charge	*The original Contract Dentist or dental office is responsible for any repair or replacement during the 36-month period*
D1354	Interim caries arresting medicament application - per tooth	No charge	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*
D1355	Caries preventive medicament application - per tooth	No charge	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*
D1510	Space maintainer - fixed, unilateral - per quadrant	No charge	*1 per quadrant; posterior teeth*
D1516	Space maintainer - fixed - bilateral, maxillary	No charge	*1 per arch; posterior teeth*
D1517	Space maintainer - fixed - bilateral, mandibular	No charge	*1 per arch; posterior teeth*
D1520	Space maintainer - removable, unilateral - per quadrant	No charge	*1 per quadrant; posterior teeth*
D1526	Space maintainer - removable - bilateral, maxillary	No charge	*1 per arch, through age 17; posterior teeth*
D1527	Space maintainer - removable - bilateral, mandibular	No charge	*1 per arch, through age 17; posterior teeth*
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1556	Removal of fixed unilateral space maintainer - per quadrant	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1557	Removal of fixed bilateral space maintainer - maxillary	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1558	Removal of fixed bilateral space maintainer - mandibular	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	No charge	*1 per quadrant, age 8 and under; posterior teeth*
D2000-D2999 III. RESTORATIVE			
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.			
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years (60+ months) old.			

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D2140	Amalgam - one surface, primary or permanent	$25	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2150	Amalgam - two surfaces, primary or permanent	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2160	Amalgam - three surfaces, primary or permanent	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2161	Amalgam - four or more surfaces, primary or permanent	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2330	Resin-based composite - one surface, anterior	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2331	Resin-based composite - two surfaces, anterior	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2332	Resin-based composite - three surfaces, anterior	$55	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$60	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2390	Resin-based composite crown, anterior	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2391	Resin-based composite - one surface, posterior	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2392	Resin-based composite - two surfaces, posterior	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2393	Resin-based composite - three surfaces, posterior	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2394	Resin-based composite - four or more surfaces, posterior	$70	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2710	Crown - resin-based composite (indirect)	$140	*1 per 60 months, permanent teeth; age 13 through 18*
D2712	Crown - 3/4 resin-based composite (indirect)	$190	*1 per 60 months, permanent teeth; age 13 through 18*
D2721	Crown - resin with predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2740	Crown - porcelain/ceramic	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2751	Crown - porcelain fused to predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2781	Crown - 3/4 cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2783	Crown - 3/4 porcelain/ceramic	$310	*1 per 60 months, permanent teeth; age 13 through 18*
D2791	Crown - full cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$25	*1 per 12 months per Contract Dentist*
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$25	
D2920	Re-cement or re-bond crown	$25	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45	*1 per 12 months*
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$120	*1 per 36 months*
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95	*1 per 12 months*
D2930	Prefabricated stainless steel crown - primary tooth	$65	*1 per 12 months*
D2931	Prefabricated stainless steel crown - permanent tooth	$75	*1 per 36 months*
D2932	Prefabricated resin crown	$75	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2933	Prefabricated stainless steel crown with resin window	$80	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2940	Protective restoration	$25	*1 per 6 months per Contract Dentist*
D2941	Interim therapeutic restoration - primary dentition	$30	*1 per tooth per 6 months per Contract Dentist*
D2949	Restorative foundation for an indirect restoration	$45	
D2950	Core buildup, including any pins when required	$20	
D2951	Pin retention - per tooth, in addition to restoration	$25	*1 per tooth regardless of the number of pins placed; permanent teeth*
D2952	Post and core in addition to crown, indirectly fabricated	$100	*Base metal post; 1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2953	Each additional indirectly fabricated post - same tooth	$30	*Performed in conjunction with D2952*
D2954	Prefabricated post and core in addition to crown	$90	*1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2955	Post removal	$60	*Included in case fee by Contract Dentist or dental office who performed endodontic and restorative procedures. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2957	Each additional prefabricated post - same tooth	$35	*Performed in conjunction with D2954*
D2971	Additional procedures to construct new crown under existing partial denture framework	$35	*Included in the fee for laboratory processed crowns. The listed fee applies for service provided by a Contract Dentist other than the original treating Dentist/dental office.*
D2980	Crown repair necessitated by restorative material failure	$50	*Repair during the 12 months following initial placement or previous repair is included, no additional charge to the Enrollee or plan is permitted by the original treating Contract Dentist/dental office.*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D2999	Unspecified restorative procedure, by report	$40	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D3000-D3999 IV. ENDODONTICS			
D3110	Pulp cap - direct (excluding final restoration)	$20	
D3120	Pulp cap - indirect (excluding final restoration)	$25	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$40	*1 per primary tooth*
D3221	Pulpal debridement, primary and permanent teeth	$40	*1 per tooth*
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60	*1 per permanent tooth*
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$55	*1 per tooth*
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$55	*1 per tooth*
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$195	*Root canal*
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	$235	*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$300	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$50	
D3333	Internal root repair of perforation defects	$80	
D3346	Retreatment of previous root canal therapy - anterior	$240	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3347	Retreatment of previous root canal therapy - premolar	$295	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3348	Retreatment of previous root canal therapy - molar	$365	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$85	*1 per permanent tooth*
D3352	Apexification/recalcification - interim medication replacement	$45	*1 per permanent tooth*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D3410	Apicoectomy - anterior	$240	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3421	Apicoectomy - premolar (first root)	$250	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3425	Apicoectomy - molar (first root)	$275	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3426	Apicoectomy (each additional root)	$110	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only; a benefit for 3rd molar if it occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.*
D3430	Retrograde filling - per root	$90	
D3471	Surgical repair of root resorption - anterior	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3472	Surgical repair of root resorption - premolar	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3473	Surgical repair of root resorption - molar	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	
D3999	Unspecified endodontic procedure, by report	$100	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D4000-D4999 V. PERIODONTICS			
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$150	*1 per quadrant per 36 months, age 13+*
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50	*1 per quadrant per 36 months, age 13+*
D4249	Clinical crown lengthening - hard tissue	$165	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$265	*1 per quadrant per 36 months, age 13+*
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$140	*1 per quadrant per 36 months, age 13+*
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$55	*1 per quadrant per 24 months; age 13+*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30	*1 per quadrant per 24 months; age 13+*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$40	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	$40	*1 treatment per 12 consecutive months*
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10	
D4910	Periodontal maintenance	$30	*1 per 3 months; service must be within the 24 months following the last scaling and root planing*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$15	*1 per Contract Dentist; age 13+*
D4999	Unspecified periodontal procedure, by report	$350	*Enrollees age 13+. Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5000-D5899 VI. PROSTHODONTICS (removable)			
- For all listed dentures and partial dentures, Cost Share includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.			
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.			
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years (60+ months) old.			
D5110	Complete denture - maxillary	$300	*1 per 60 months*
D5120	Complete denture - mandibular	$300	*1 per 60 months*
D5130	Immediate denture - maxillary	$300	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*
D5140	Immediate denture - mandibular	$300	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$300	*1 per 60 months*
D5212	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	$300	*1 per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$335	*1 per 60 months*
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	$335	*1 per 60 months*
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$275	*1 per 60 months*
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	$275	*1 per 60 months*
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330	*1 per 60 months*
D5410	Adjust complete denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5411	Adjust complete denture - mandibular	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5421	Adjust partial denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5422	Adjust partial denture - mandibular	$20	*1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months*
D5511	Repair broken complete denture base, mandibular	$40	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5512	Repair broken complete denture base, maxillary	$40	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5520	Replace missing or broken teeth - complete denture (each tooth)	$40	*Up to 4 per arch per date of service after the initial 6 months; up to 2 per arch per 12 months per Contract Dentist*
D5611	Repair resin partial denture base, mandibular	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5612	Repair resin partial denture base, maxillary	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5621	Repair cast partial framework, mandibular	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5622	Repair cast partial framework, maxillary	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5630	Repair or replace broken retentive clasping materials - per tooth	$50	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5640	Replace broken teeth - per tooth	$35	*4 per arch per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5650	Add tooth to existing partial denture	$35	*Up to 3 per date of service per Contract Dentist; 1 per tooth after the initial 6 months*
D5660	Add clasp to existing partial denture - per tooth	$60	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5730	Reline complete maxillary denture (direct)	$60	*Included for the first 6 months after placement by the Contract Dentist or dental office where the appliance was originally delivered; 1 per 12 month period after the initial 6 months*
D5731	Reline complete mandibular denture (direct)	$60	*1 per 12 month period after the initial 6 months*
D5740	Reline maxillary partial denture (direct)	$60	*1 per 12 month period after the initial 6 months*
D5741	Reline mandibular partial denture (direct)	$60	*1 per 12 month period after the initial 6 months*
D5750	Reline complete maxillary denture (indirect)	$90	*1 per 12 month period after the initial 6 months*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D5751	Reline complete mandibular denture (indirect)	$90	*1 per 12 month period after the initial 6 months*
D5760	Reline maxillary partial denture (indirect)	$80	*1 per 12 month period after the initial 6 months*
D5761	Reline mandibular partial denture (indirect)	$80	*1 per 12 month period after the initial 6 months*
D5850	Tissue conditioning, maxillary	$30	*2 per prosthesis per 36 months after the initial 6 months*
D5851	Tissue conditioning, mandibular	$30	*2 per prosthesis per 36 months after the initial 6 months*
D5862	Precision attachment, by report	$90	*Included in the fee for prosthetic and restorative procedures by the Contract Dentist or dental office where the service was originally delivered. The listed fee applies for service provided by a dentist other than the original treating Contract Dentist or dental office.*
D5863	Overdenture - complete maxillary	$300	*1 per 60 months*
D5864	Overdenture - partial maxillary	$300	*1 per 60 months*
D5865	Overdenture - complete mandibular	$300	*1 per 60 months*
D5866	Overdenture - partial mandibular	$300	*1 per 60 months*
D5899	Unspecified removable prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS			
- All maxillofacial prosthetic procedures require prior Authorization.			
D5911	Facial moulage (sectional)	$285	
D5912	Facial moulage (complete)	$350	
D5913	Nasal prosthesis	$350	
D5914	Auricular prosthesis	$350	
D5915	Orbital prosthesis	$350	
D5916	Ocular prosthesis	$350	
D5919	Facial prosthesis	$350	
D5922	Nasal septal prosthesis	$350	
D5923	Ocular prosthesis, interim	$350	
D5924	Cranial prosthesis	$350	
D5925	Facial augmentation implant prosthesis	$200	
D5926	Nasal prosthesis, replacement	$200	
D5927	Auricular prosthesis, replacement	$200	
D5928	Orbital prosthesis, replacement	$200	
D5929	Facial prosthesis, replacement	$200	
D5931	Obturator prosthesis, surgical	$350	
D5932	Obturator prosthesis, definitive	$350	
D5933	Obturator prosthesis, modification	$150	*2 per 12 months*
D5934	Mandibular resection prosthesis with guide flange	$350	
D5935	Mandibular resection prosthesis without guide flange	$350	
D5936	Obturator prosthesis, interim	$350	
D5937	Trismus appliance (not for TMD treatment)	$85	
D5951	Feeding aid	$135	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D5952	Speech aid prosthesis, pediatric	$350	
D5953	Speech aid prosthesis, adult	$350	
D5954	Palatal augmentation prosthesis	$135	
D5955	Palatal lift prosthesis, definitive	$350	
D5958	Palatal lift prosthesis, interim	$350	
D5959	Palatal lift prosthesis, modification	$145	*2 per 12 months*
D5960	Speech aid prosthesis, modification	$145	*2 per 12 months*
D5982	Surgical stent	$70	
D5983	Radiation carrier	$55	
D5984	Radiation shield	$85	
D5985	Radiation cone locator	$135	
D5986	Fluoride gel carrier	$35	
D5987	Commissure splint	$85	
D5988	Surgical splint	$95	
D5991	Vesiculobullous disease medicament carrier	$70	
D5999	Unspecified maxillofacial prosthesis, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D6000-D6199 VIII. IMPLANT SERVICES			
- A Benefit only under exceptional medical conditions. Prior Authorization is required. Refer also to Schedule B.			
D6010	Surgical placement of implant body: endosteal implant	$350	*A Benefit only under exceptional medical conditions*
D6011	Surgical access to an implant body (second stage implant surgery)	$350	*A Benefit only under exceptional medical conditions*
D6013	Surgical placement of mini implant	$350	*A Benefit only under exceptional medical conditions*
D6040	Surgical placement: eposteal implant	$350	*A Benefit only under exceptional medical conditions*
D6050	Surgical placement: transosteal implant	$350	*A Benefit only under exceptional medical conditions*
D6055	Connecting bar - implant supported or abutment supported	$350	*A Benefit only under exceptional medical conditions*
D6056	Prefabricated abutment - includes modification and placement	$135	*A Benefit only under exceptional medical conditions*
D6057	Custom fabricated abutment - includes placement	$180	*A Benefit only under exceptional medical conditions*
D6058	Abutment supported porcelain/ceramic crown	$320	*A Benefit only under exceptional medical conditions*
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295	*A Benefit only under exceptional medical conditions*
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300	*A Benefit only under exceptional medical conditions*
D6062	Abutment supported cast metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6063	Abutment supported cast metal crown (predominantly base metal)	$300	*A Benefit only under exceptional medical conditions*
D6064	Abutment supported cast metal crown (noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6065	Implant supported porcelain/ceramic crown	$340	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D6066	Implant supported crown - porcelain fused to high noble alloys	$335	*A Benefit only under exceptional medical conditions*
D6067	Implant supported crown - high noble alloys	$340	*A Benefit only under exceptional medical conditions*
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320	*A Benefit only under exceptional medical conditions*
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions*
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300	*A Benefit only under exceptional medical conditions*
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315	*A Benefit only under exceptional medical conditions*
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions*
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320	*A Benefit only under exceptional medical conditions*
D6075	Implant supported retainer for ceramic FPD	$335	*A Benefit only under exceptional medical conditions*
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	$330	*A Benefit only under exceptional medical conditions*
D6077	Implant supported retainer for metal FPD - high noble alloys	$350	*A Benefit only under exceptional medical conditions*
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$30	*A Benefit only under exceptional medical conditions*
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	$30	*A Benefit only under exceptional medical conditions*
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$335	*A Benefit only under exceptional medical conditions.*
D6083	Implant supported crown - porcelain fused to noble alloys	$335	*A Benefit only under exceptional medical conditions*
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$335	*A Benefit only under exceptional medical conditions*
D6085	Provisional implant crown	$300	*A Benefit only under exceptional medical conditions*
D6086	Implant supported crown - predominantly base alloys	$340	*A Benefit only under exceptional medical conditions*
D6087	Implant supported crown - noble alloys	$340	*A Benefit only under exceptional medical conditions*
D6088	Implant supported crown - titanium and titanium alloys	$340	*A Benefit only under exceptional medical conditions*
D6090	Repair implant supported prosthesis, by report	$65	*A Benefit only under exceptional medical conditions*
D6091	Replacement of replaceable part of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40	*A Benefit only under exceptional medical conditions*
D6092	Re-cement or re-bond implant/abutment supported crown	$25	*A Benefit only under exceptional medical conditions*
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$35	*A Benefit only under exceptional medical conditions*
D6094	Abutment supported crown - titanium and titanium alloys	$295	*A Benefit only under exceptional medical conditions*
D6095	Repair implant abutment, by report	$65	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D6096	Remove broken implant retaining screw	$60	*A Benefit only under exceptional medical conditions*
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$315	*A Benefit only under exceptional medical conditions*
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330	*A Benefit only under exceptional medical conditions*
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$330	*A Benefit only under exceptional medical conditions*
D6100	Implant removal, by report	$110	*A Benefit only under exceptional medical conditions*
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions*
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions*
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$330	*A Benefit only under exceptional medical conditions*
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350	*A Benefit only under exceptional medical conditions*
D6122	Implant supported retainer for metal FPD - noble alloys	$350	*A Benefit only under exceptional medical conditions*
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350	*A Benefit only under exceptional medical conditions*
D6190	Radiographic/surgical implant index, by report	$75	*A Benefit only under exceptional medical conditions*
D6191	Semi-precision abutment - placement	$350	*A Benefit only under exceptional medical conditions*
D6192	Semi-precision attachment - placement	$350	*A Benefit only under exceptional medical conditions*
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	$265	*A Benefit only under exceptional medical conditions*
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315	*A Benefit only under exceptional medical conditions*
D6199	Unspecified implant procedure, by report	$350	*Implant services are a Benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Written documentation shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.*
D6200-D6999 IX. PROSTHODONTICS, fixed			
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge).			
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years (60+ months) old.			
D6211	Pontic - cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6241	Pontic - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6245	Pontic - porcelain/ceramic	$300	*1 per 60 months; age 13+*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D6251	Pontic - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6721	Retainer crown - resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6740	Retainer crown - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6751	Retainer crown - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6781	Retainer crown - 3/4 cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6783	Retainer crown - 3/4 porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6784	Retainer crown - 3/4 titanium and titanium alloys	$300	*1 per 60 months; age 13+*
D6791	Retainer crown - full cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6930	Re-cement or re-bond fixed partial denture	$40	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D6980	Fixed partial denture repair necessitated by restorative material failure	$95	
D6999	Unspecified fixed prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment. Not a Benefit within 12 months of initial placement of a fixed partial denture by the same Contract Dentist/office.*
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY			
- Prior Authorization required for procedures performed by a Contract Specialist. medical necessity must be demonstrated for procedures D7340 - D7997. Refer also to Schedule B.			
- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic. Post-operative services include exams, suture removal and treatment of complications.			
D7111	Extraction, coronal remnants - primary tooth	$40	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$120	
D7220	Removal of impacted tooth - soft tissue	$95	
D7230	Removal of impacted tooth - partially bony	$145	
D7240	Removal of impacted tooth - completely bony	$160	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175	
D7250	Removal of residual tooth roots (cutting procedure)	$80	
D7260	Oroantral fistula closure	$280	
D7261	Primary closure of a sinus perforation	$285	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$185	*1 per arch regardless of number of teeth involved; permanent anterior teeth*
D7280	Exposure of an unerupted tooth	$220	
D7283	Placement of device to facilitate eruption of impacted tooth	$85	*For active orthodontic treatment only*
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	$180	*1 per arch per date of service; regardless of number of areas involved*
D7286	Incisional biopsy of oral tissue-soft	$110	*3 per date of service*
D7290	Surgical repositioning of teeth	$185	*1 per arch, for permanent teeth only; applies to active orthodontic treatment*
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	*1 per arch; applies to active orthodontic treatment*
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$85	
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$120	
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65	
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$350	*1 per arch per 60 months*
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350	*1 per arch*
D7410	Excision of benign lesion up to 1.25 cm	$75	
D7411	Excision of benign lesion greater than 1.25 cm	$115	
D7412	Excision of benign lesion, complicated	$175	
D7413	Excision of malignant lesion up to 1.25 cm	$95	
D7414	Excision of malignant lesion greater than 1.25 cm	$120	
D7415	Excision of malignant lesion, complicated	$255	
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$105	
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$185	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180	
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330	
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155	
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250	
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D7471	Removal of lateral exostosis (maxilla or mandible)	$140	*1 per quadrant*
D7472	Removal of torus palatinus	$145	*1 per lifetime*
D7473	Removal of torus mandibularis	$140	*1 per quadrant*
D7485	Reduction of osseous tuberosity	$105	*1 per quadrant*
D7490	Radical resection of maxilla or mandible	$350	
D7510	Incision and drainage of abscess - intraoral soft tissue	$70	*1 per quadrant per date of service*
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$70	*1 per quadrant per date of service*
D7520	Incision and drainage of abscess - extraoral soft tissue	$70	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80	
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45	*1 per date of service*
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	*1 per date of service*
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	*1 per quadrant per date of service*
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	
D7610	Maxilla - open reduction (teeth immobilized, if present)	$140	
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$250	
D7630	Mandible - open reduction (teeth immobilized, if present)	$350	
D7640	Mandible - closed reduction (teeth immobilized, if present)	$350	
D7650	Malar and/or zygomatic arch - open reduction	$350	
D7660	Malar and/or zygomatic arch - closed reduction	$350	
D7670	Alveolus - closed reduction, may include stabilization of teeth	$170	
D7671	Alveolus - open reduction, may include stabilization of teeth	$230	
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350	
D7710	Maxilla - open reduction	$110	
D7720	Maxilla - closed reduction	$180	
D7730	Mandible - open reduction	$350	
D7740	Mandible - closed reduction	$290	
D7750	Malar and/or zygomatic arch - open reduction	$220	
D7760	Malar and/or zygomatic arch - closed reduction	$350	
D7770	Alveolus - open reduction stabilization of teeth	$135	
D7771	Alveolus, closed reduction stabilization of teeth	$160	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D7780	Facial bones - complicated reduction with fixation and multiple approaches	$350	
D7810	Open reduction of dislocation	$350	
D7820	Closed reduction of dislocation	$80	
D7830	Manipulation under anesthesia	$85	
D7840	Condylectomy	$350	
D7850	Surgical discectomy, with/without implant	$350	
D7852	Disc repair	$350	
D7854	Synovectomy	$350	
D7856	Myotomy	$350	
D7858	Joint reconstruction	$350	
D7860	Arthrotomy	$350	
D7865	Arthroplasty	$350	
D7870	Arthrocentesis	$90	
D7871	Non-arthroscopic lysis and lavage	$150	
D7872	Arthroscopy - diagnosis, with or without biopsy	$350	
D7873	Arthroscopy: lavage and lysis of adhesions	$350	
D7874	Arthroscopy: disc repositioning and stabilization	$350	
D7875	Arthroscopy: synovectomy	$350	
D7876	Arthroscopy: discectomy	$350	
D7877	Arthroscopy: debridement	$350	
D7880	Occlusal orthotic device, by report	$120	
D7881	Occlusal orthotic device adjustment	$30	*1 per date of service per Contract Dentist; 2 per 12 months per Contract Dentist*
D7899	Unspecified TMD therapy, by report	$350	
D7910	Suture of recent small wounds up to 5 cm	$35	
D7911	Complicated suture - up to 5 cm	$55	
D7912	Complicated suture - greater than 5 cm	$130	
D7920	Skin graft (identify defect covered, location and type of graft)	$120	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80	
D7940	Osteoplasty - for orthognathic deformities	$160	
D7941	Osteotomy - mandibular rami	$350	
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350	
D7944	Osteotomy - segmented or subapical	$275	
D7945	Osteotomy - body of mandible	$350	
D7946	LeFort I (maxilla - total)	$350	
D7947	LeFort I (maxilla - segmented)	$350	
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350	
D7949	LeFort II or LeFort III - with bone graft	$350	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	$190	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	
D7952	Sinus augmentation via a vertical approach	$175	

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	
D7961	Buccal/labial frenectomy (frenulectomy)	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7962	Lingual frenectomy (frenulectomy)	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7963	Frenuloplasty	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7970	Excision of hyperplastic tissue - per arch	$175	*1 per arch per date of service*
D7971	Excision of pericoronal gingiva	$80	
D7972	Surgical reduction of fibrous tuberosity	$100	*1 per quadrant per date of service*
D7979	Non-surgical sialolithotomy	$155	
D7980	Surgical sialolithotomy	$155	
D7981	Excision of salivary gland, by report	$120	
D7982	Sialodochoplasty	$215	
D7983	Closure of salivary fistula	$140	
D7990	Emergency tracheotomy	$350	
D7991	Coronoidectomy	$345	
D7995	Synthetic graft - mandible or facial bones, by report	$150	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	*Removal of appliances related to surgical procedures only; 1 per arch per date of service; the listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D7999	Unspecified oral surgery procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees ONLY			
- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.			
- Pediatric Enrollee must continue to be eligible, Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.			
- Comprehensive orthodontic treatment procedure (D8080) includes all appliances, adjustments, insertion, removal and post treatment stabilization (retention). The Enrollee must continue to be eligible during active treatment. No additional charge to the Enrollee is permitted from the original treating Contract Orthodontist or dental office who received the comprehensive case fee. A separate fee applies for services provided by a Contract Orthodontist other than the original treating Contract Orthodontist or dental office.			
- Cost Share payment for medically necessary orthodontics applies to course of treatment, not individual benefit years within a multi-year course of treatment. This Cost Share applies to the course of treatment as long as the Pediatric Enrollee remains enrolled in this Plan.			
- Refer to Schedule B for additional information on medically necessary orthodontics.			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,000	*1 per Enrollee per phase of treatment; included in comprehensive case fee*
D8210	Removable appliance therapy		*1 per lifetime; age 6 through 12; included in comprehensive case fee*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D8220	Fixed appliance therapy		*1 per lifetime; age 6 through 12; included in comprehensive case fee*
D8660	Pre-orthodontic treatment examination to monitor growth and development		*1 per 3 months when performed by the same Contract Dentist or dental office; up to 6 visits per lifetime; included in comprehensive case fee*
D8670	Periodic orthodontic treatment visit		*Included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		*1 per arch for each authorized phase of orthodontic treatment; included in comprehensive case fee*
D8681	Removable orthodontic retainer adjustment		*Included in comprehensive case fee*
D8696	Repair of orthodontic appliance - maxillary		*1 per appliance; included in comprehensive case fee*
D8697	Repair of orthodontic appliance - mandibular		*1 per appliance; included in comprehensive case fee*
D8698	Re-cement or re-bond fixed retainer - maxillary		*1 per Contract Dentist; included in comprehensive case fee*
D8699	Re-cement or re-bond fixed retainer - mandibular		*1 per Contract Dentist; included in comprehensive case fee*
D8701	Repair of fixed retainer, includes reattachment - maxillary		*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*
D8702	Repair of fixed retainer, includes reattachment - mandibular		*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*
D8703	Replacement of lost or broken retainer - maxillary		*1 per arch; within 24 months following the date of service for orthodontic retention (D8680); included in comprehensive case fee*
D8704	Replacement of lost or broken retainer - mandibular		*1 per arch; within 24 months following the date of service for orthodontic retention (D8680); included in comprehensive case fee*
D8999	Unspecified orthodontic procedure, by report		*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment; included in comprehensive case fee.*
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES			
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$30	*1 per date of service per Contract Dentist; regardless of the number of teeth and/or areas treated*
D9120	Fixed partial denture sectioning	$95	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$10	*1 per date of service per Contract Dentist; for use to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state*
D9211	Regional block anesthesia	$20	
D9212	Trigeminal division block anesthesia	$60	
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	
D9222	Deep sedation/general anesthesia - first 15 minutes	$45	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*

Code	Description	Pediatric Enrollee Pays	Clarification/ Limitations for Pediatric Enrollees
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	$45	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service*
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$15	*(Where available)*
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	$60	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	$60	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9248	Non-intravenous conscious sedation	$65	*Where available; 1 per date of service per Contract Dentist*
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50	
D9311	Consultation with a medical health care professional	No charge	
D9410	House/extended care facility call	$50	*1 per Enrollee per date of service*
D9420	Hospital or ambulatory surgical center call	$135	
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$20	*1 per date of service per Contract Dentist*
D9440	Office visit - after regularly scheduled hours	$45	*1 per date of service per Contract Dentist*
D9610	Therapeutic parenteral drug, single administration	$30	*4 of (D9610, D9612) injections per date of service*
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$40	*4 of (D9610, D9612) injections per date of service*
D9910	Application of desensitizing medicament	$20	*1 per 12 months per Contract Dentist; permanent teeth*
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$35	*1 per date of service per Contract Dentist within 30 days of an extraction*
D9950	Occlusion analysis - mounted case	$120	*Prior Authorization is required; 1 per 12 months for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9951	Occlusal adjustment - limited	$45	*1 per 12 months for quadrant per Contract Dentist; age 13+*
D9952	Occlusal adjustment - complete	$210	*1 per 12 months following occlusion analysis - mounted case (D9950) for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9997	Dental case management - patients with special health care needs	No charge	
D9999	Unspecified adjunctive procedure, by report	No charge	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

Endnotes:

Unless clarified elsewhere, base metal is the Benefit. If noble (D6061, D6064, D6071, D6074, D6083, D6087, D6099, D6122) or

high noble metal (precious) (D6059, D6062, D6066, D6067, D6069, D6072, D6076, D6077) is used for an implant/abutment supported crown or fixed bridge retainer, the Enrollee will be charged the additional laboratory cost of the noble or high noble metal. If covered, an additional laboratory charge also applies to a titanium crown (D6084, D6088, D6094, D6097, D6194, D6195, D6784).

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Cost Share. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Cost Share specified for such services.

Optional or upgraded procedure(s) are defined as any alternative procedure(s) presented by the Contract Dentist and formally agreed upon by financial consent that satisfies the same dental need as a covered procedure. Enrollee may elect an Optional or upgraded procedure, subject to the limitations and exclusions of this Plan. The applicable charge to the Enrollee is the difference between the Contract Dentist's regularly charged fee (or contracted fee, when applicable) for the Optional or upgraded procedure and the covered procedure, plus any applicable Cost Share for the covered procedure.

Additional Endnotes to Covered California's 2022 Dental Standard Benefit Plan Designs

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan or Family Dental Plan)

Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment ("EPSDT") benefit.

SCHEDULE B

Limitations and Exclusions of Benefits for Pediatric Enrollees (Under age 19)

Limitations of Benefits for Pediatric Enrollees

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments.* Additional requests, beyond the stated frequency limitations, for prophylaxis, fluoride and scaling procedures (D1110, D1120, D1206, D1208 and D4346) shall be considered for prior Authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.

2. A filling [D2140-D2161, D2330-D2335, D2391-D2394] is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.

3. A crown [D2390 and covered codes only between D2710-D2791] is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five+ year (60+ months) limitation.

4. The replacement of an existing crown [D2390 and covered codes only between D2710-D2791], fixed partial denture (bridge) [covered codes only between D6211-D6245, D6251, D6721-D6791] or a removable full [D5110, D5120] or partial denture [covered codes only between D5211-D5214, D5221-D5224] is covered when:

   a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, and
   b. Either of the following:
      - The existing non-functional restoration/bridge/denture was placed five or more years (60+ months) prior to its replacement, or
      - If an existing partial denture is less than five years old (60 months), but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.

5. Coverage for the placement of a fixed partial denture (bridge) [covered codes only between D6211-D6245, D6251, D6721-D6791] or removable partial denture [covered codes only between D5211-D5214, D5221-D5224]:

   a. Fixed partial denture (bridge):
      - A fixed partial denture is a Benefit only when medical conditions or employment preclude the use of a removable partial denture.
      - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, or
      - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics, or
      - Each abutment tooth to be crowned meets Limitation #3.
   b. Removable partial denture:
      - Cast metal (D5213, D5214, D5223, D5224), one or more teeth are missing in an arch.
      - Resin based (D5211, D5212, D5221, D5222), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease.

6. Immediate dentures [D5130, D5140, D5221–D5224] are covered when one or more of the following conditions are present:
   a. Extensive or rampant caries are exhibited in the radiographs, or
   b. Severe periodontal involvement indicated, or
   c. Numerous teeth are missing resulting in diminished chewing ability adversely affecting the Enrollee's health.

7. Maxillofacial prosthetic services [covered codes only between D5911-D5999] for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.

8. All maxillofacial prosthetic procedures [covered codes only between D5911-D5999] require prior Authorization for medically necessary procedures.

9. Implant services [covered codes only between D6010-D6199] are a Benefit only under exceptional medical conditions. Exceptional medical conditions include, but are not limited to:

    a. Cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prosthesis.
    b. Severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures [D7340, D7350] or osseous augmentation procedures [D7950], and the Enrollee is unable to function with conventional prosthesis.
    c. Skeletal deformities that preclude the use of conventional prosthesis (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).

10. Temporomandibular joint ("TMJ") dysfunction procedure codes [covered codes only between D7810-D7880] are limited to differential diagnosis and symptomatic care and require prior Authorization.

11. Certain listed procedures performed by a Contract Specialist may be considered to be primary under the Enrollee's medical coverage. Dental Benefits will be coordinated accordingly.

12. Deep sedation/general anesthesia [D9222, D9223] or intravenous conscious sedation/analgesia [D9239, D9243] for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.

Exclusions of Benefits for Pediatric Enrollees

1. Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Copayments, except as required by state or federal law*.

2. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

3. Lost or theft of full or partial dentures [covered codes only between D5110-D5140, D5211-D5214, D5221-D5224], space maintainers [D1510–D1575], crowns [D2390 and covered codes only between D2710–D2791], fixed partial dentures (bridges) [covered codes only between D6211-D6245, D6251, D6721-D6791] or other appliances.

4. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.

5. Dental expenses incurred in connection with any dental procedure before the Enrollee's eligibility in this Plan. Examples include: teeth prepared for crowns, partials and dentures, root canals in progress.

6. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.) unless included in *Schedule A*.

7. Dispensing of drugs not normally supplied in a dental facility unless included in *Schedule A*.

8. Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:
    a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
    b. is inconsistent with generally accepted standards for dentistry.

9. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized or as cited under the "Emergency Dental Services" and "Urgent Dental Services" sections of the EOC. To obtain written Authorization, the Enrollee should call Delta Dental's Customer Care at 800-471-9925.

10. Consultations [D9310, D9311] or other diagnostic services [covered codes only between D0120–D0999], for non-covered Benefits.

11. Single tooth implants [covered codes only between D6000–D6199].

12. Restorations [covered codes only between D2330-D2335, D2391-D2394, D2710-D2791, D6211-D6245, D6251, D6721-D6791] placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.

13. Preventive [covered codes only between D1110-D1575], endodontic [covered codes only between D3110-D3999] or restorative [covered codes only between D2140-D2999] procedures are not a Benefit for teeth to be retained for overdentures.

14. Partial dentures [covered codes only between D5211-5214, D5221-D5224] are not a Benefit to replace missing 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for a partial denture with cast clasps or rests.

15. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth [covered codes only between D8000-D8999], periodontal splinting [D4320-D4321], gnathologic recordings, equilibration [D9952] or treatment of disturbances of the TMJ [covered codes only between D0310-D0322, D7810-D7899], unless included in *Schedule A*.

16. Porcelain denture teeth, precision abutments for removable partials [D5862] or fixed partial dentures (overlays, implants, and appliances associated therewith) [D6940, D6950] and personalization and characterization of complete and partial dentures.

17. Extraction of teeth [D7111, D7140, D7210, D7220-D7240], when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars.

18. TMJ dysfunction treatment modalities that involve prosthodontia [D5110-D5224, D6211-D6245, D6251, D6721-D6791], orthodontia [covered codes only between D8000–D8999], and full or partial occlusal rehabilitation or TMJ dysfunction procedures [covered codes only between D0310-D0322, D7810-D7899] solely for the treatment of bruxism.

19. Vestibuloplasty / ridge extension procedures [D7340, D7350] performed on the same date of service as extractions [D7111-D7250] on the same arch.

20. Deep sedation/general anesthesia [D9222, D9223] for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for intravenous conscious sedation/analgesia [D9239, D9243].

21. Intravenous conscious sedation/analgesia [D9239, D9243] for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for deep sedation/general anesthesia [D9222, D9223].

22. Inhalation of nitrous oxide [D9230] when administered with other covered sedation procedures.

23. Cosmetic dental care [exclude covered codes in this list if done for purely cosmetic reasons: D2330-D2394, D2710–D2751, D2940, D6211-D6245, D6251, D6721-D6791, D8000-D8999].

Medically Necessary Orthodontic for Pediatric Enrollees

1. Coverage for comprehensive orthodontic treatment [D8080] requires acceptable documentation of a handicapping malocclusion as evidence by a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form and pre-treatment diagnostic casts [D0470]. Comprehensive orthodontic treatment [D8080]:

   a) is limited to Enrollees who are between 13 through 18 years of age with a permanent dentition without a cleft palate or craniofacial anomaly; but
   b) may start at birth for patients with a cleft palate or craniofacial anomaly.

2. Removable appliance therapy [D8210] or fixed appliance therapy [D8220] is limited to Enrollee between 6 to 12 years of age, once in a lifetime, to treat thumb sucking and/or tongue thrust.

3. The Benefit for a pre-orthodontic treatment examination [D8660] includes needed oral/facial photographic images [D0350, D0351, D0703, D0704]. Neither the Enrollee nor the plan may be charged for D0350, D0351, D0703 or D0704 in conjunction with a pre-orthodontic treatment examination.

4. The number of covered periodic orthodontic treatment [D8670] visits and length of covered active orthodontics is limited to a maximum of up to:

   a. Handicapping malocclusion - Eight (8) quarterly visits;
   b. Cleft palate or craniofacial anomaly - Six (6) quarterly visits for treatment of primary dentition;
   c. Cleft palate or craniofacial anomaly - Eight (8) quarterly visits for treatment of mixed dentition; or
   d. Cleft palate or craniofacial anomaly - Ten (10) quarterly visits for treatment of permanent dentition.
   e. Facial growth management – Four (4) quarterly visits for treatment of primary dentition;
   f. Facial growth management – Five (5) quarterly visits for treatment of mixed dentition;
   g. Facial growth management - Eight (8) quarterly visits for treatment permanent dentition.

5. Orthodontic retention [D8680] is a separate Benefit after the completion of covered comprehensive orthodontic treatment [D8080] which:

   a. Includes removal of appliances and the construction and place of retainer(s) [D8680]; and
   b. Is limited to Enrollees under age 19 and to one per arch after the completion of each phase of active treatment for retention of permanent dentition unless treatment was for a cleft palate or a craniofacial anomaly.

   An adjustment of an orthodontic retainer is included in the fee for the retainer for the first six months after delivery.

6. Copayment is payable to the Contract Orthodontist who initiates banding in a course of prior authorized orthodontic treatment [covered codes only between D8000–D8999]. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:

   a. will not be entitled to a refund of any amounts previously paid, and
   b. will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.

7. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment [covered codes only between D8000–D8999], the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

   If an Enrollee is receiving ongoing orthodontic treatment at the time of termination, Delta Dental will continue to provide orthodontic Benefits for:

   a. 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or
   b. until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

At the end of 60 days (or at the end of the quarter), the Enrollee's obligation shall be based on the Contract Orthodontist's submitted fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

8. Orthodontics, including oral evaluations and all treatment, [covered codes only between D8000-D8999] must be performed by a licensed dentist or his or her supervised staff, acting within the scope of applicable law.

9. The removal of fixed orthodontic appliances [D8680] for reasons other than completion of treatment is not a covered Benefit.

SCHEDULE C

Information Concerning Benefits Under The DeltaCare® USA Program

THIS MATRIX IS INTENDED TO BE USED TO COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THIS AMENDMENT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PROGRAM BENEFITS AND LIMITATIONS.

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Out-of-Pocket Maximum	Covered pediatric dental services apply to the out-of-pocket maximum in your Sharp EOC. See your Sharp EOC for information about your out-of-pocket maximum.
(D) Professional Services	An Enrollee may be required to pay a Cost Share amount for each procedure as shown in the Description of Benefits and Cost Share, subject to the limitations and exclusions of the program. Cost Share ranges by category of service. Examples are as follows: Diagnostic Services No Charge Preventive Services No Charge Restorative Services $ 20.00 - $ 310.00 Endodontic Services $ 20.00 - $ 365.00 Periodontic Services $ 10.00 - $ 350.00 Prosthodontic Services, (removable) $ 20.00 - $ 350.00 Maxillofacial Prosthetics $ 35.00 - $ 350.00 Implant Services (medically necessary only) $ 25.00 - $ 350.00 Prosthodontic Services, (fixed) $ 40.00 - $ 350.00 Oral and Maxillofacial Surgery $ 30.00 - $ 350.00 Orthodontic Services (medically necessary only) $1,000.00 - $ 1,000.00 Adjunctive General Services No Charge - $ 210.00 NOTE: Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to one in a 6-month period.
(E) Outpatient Services	Not Covered
(F) Hospitalization Services	Not Covered
(G) Emergency Dental Coverage	Benefits for Emergency Pediatric Dental Services by an Out-of-Network Dentist are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.
(H) Ambulance Services	Not Covered
(I) Prescription Drug Services	Not Covered
(J) Durable Medical Equipment	Not Covered
(K) Mental Health Services	Not Covered
(L) Chemical Dependency Services	Not Covered
(M) Home Health Services	Not Covered
(N) Other	Not Covered

Each individual procedure within each category listed above, and that is covered under the plan, has a specific Cost Share that is shown in the *Description of Benefits and Cost Share for Pediatric Benefits* in this Amendment.

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 711)
- Fax: 1-619-740-8572

You can file a grievance in person or by mail or 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 **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, 1-800-537-7697 (TDD).

Complaint forms are available at **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 Health Care for assistance:

- 1-888-466-2219 Voice
- 1-877-688-9891 TDD

The Department of Managed Health Care's website has complaint forms and instructions online: **www.dmhc.ca.gov**.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.

Language Assistance Services

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

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

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

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

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

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

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

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می‌کنید تسهیلات زبانی رایگان برای شما مهیا می‌باشد. با 1-800-359-2002 (TTY:711) تماس بگیرید.

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

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

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

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

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

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

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

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