SHARP Health Plan

2027 Provider Operations Manual

Commercial Plans

Effective January 2027



HELLO

As our trusted providers, we want to acknowledge and thank you for caring for our members. We greatly appreciate your hard work, dedication, and compassion.



Table of Contents

SECTION I 9

Introduction and Overview 9
About Us 10
Resource Guide 11
Sharp Health Plan's Responsibilities 16
Service Area 16
Compliance Program 17
Health Care Fraud, Waste, and Abuse Prevention 17
Provider Responsibilities 18
Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule 19
California Mental Health Parity Law 20

SECTION II 21

Sharp Health Plan Benefits 21
Product Overview 22
Benefit Coverage Options 22
Health Maintenance Organization (HMO) 22
Point of Service (POS) 22
Covered California 23
Dental Services – Pediatric 24
Vision Services – Pediatric 24
Preferred Provider Organization (PPO) 24
High-Deductible Health Plans (HDHP) 25
Health Savings Accounts (HSA) – Compatible Health Plan 25
Behavioral Health Services 26
Ancillary Benefits 26
Acupuncture/Chiropractic — American Specialty Health Plans of California, Inc. (ASH) 26
Vision Services Plan – VSP 26
Delta Dental 26
Value-Added Services 27
Best Health 27
Global Travel Assistance Services 28
The ChooseHealthy® Program 28
MinuteClinic at CVS® 29
Sharp Nurse Connection® 29
Enhanced Provider Services 30
Sharp Health Plan Web-Based App for Providers 30
Smart Partnership 30

SECTION III 31

Member Enrollment and Eligibility 31
Member Enrollment Overview 32
Eligibility Verification 32
Eligibility List 35
Member ID Cards 35
HMO Member ID Cards 35
CalPERS HMO Member ID Cards 38
Covered California Member ID Cards 38
City of San Diego / SDPEBA Member ID Cards 39
Point of Service (POS) Member ID Cards (3-Tier) 39
San Diego County Teamsters & Tri-City Medical Center Member ID Cards 41
PPO Member ID Cards 41

SECTION IV 43

Member Services 43
Customer Care 44
Interpreter Services 45
Member Rights and Responsibilities 45
Member Rights 45
Member Responsibilities 48
Primary Care Provider (PCP) Assignment and Selection 49
Member Grievances and Appeals 50
Independent Medical Review (IMR) 55
Independent Medical Review is available in the following situations: 55
Denial of a Health Care Service as Not Medically Necessary 56
Additional Resources for Members 57
DMHC Help Center 57

SECTION V 58

Provision of Professional Services 58
Plan Provider Responsibilities 59
Conflicts of Interest 60
Role of the Primary Care Physician (PCP) 61
On-Call Providers Coverage 62
Role of the Specialty and Ancillary Provider 62
Contract Terminations 63
Provider Terminations 63
Block Transfers 63
Contract Suspensions 64
Disabled Member Services 64
Emergency Services 64
Telehealth Services 65
Confidentiality and Disclosure of Medical Information 65

Medical Record Standards....65
Amendment to Member Medical Record....67
Confidentiality and Availability of Medical Records....67
Confidentiality of Medical Information Act....67
Legally Protected Health Care....68
Sexual and Reproductive Health Care....69
Retention of Medical Records....70
Plan Provider Directory Requirements....70
Medical Providers....70
Service Ancillary Providers....72
Plan Provider Updates....73
Tax Identification Number (TIN) Changes....74
Provider's Panel Status....74
Provider Directory Verification and Attestation....74
Delegated Provider Attestations....75
Independent Provider Attestations....75
Credentialing Program....75
Credentialing....76
Provider Rights during Credentialing....77
Standards and Guidelines....78
Delegated Credentialing/Recredentialing....79
Credentialing Appeals Process....80
Recredentialing....80
Notifications to Authorities and Provider Appeal Rights....80
Accessibility and Appointment Availability....81
Number and Distribution of Primary Care, Specialist, Ancillary Providers and Hospitals....81
Primary Care Physician (PCP) Appointments....85
Timely Access to Care....85
Appointment Wait Times....86
Rescheduling Appointments....86
Extended Wait Times....86
Advance Scheduling....87
Telephone Wait Times....87
Interpreter services at scheduled appointments....87
Concerns about timely referral to an appropriate provider....87
Standards for Office Wait Times....87
After-Hours Telephone Access for Primary Care and Behavioral Health Providers....88
Emergency Instructions....88
Non-Emergency Instructions....88
Documenting Telephone Calls....89
Behavioral Health (BH) Telephone Access....89
Failed Appointments....89

Provider-Initiated Member Dismissal 89
Member Dismissal Request Form 94
Culturally and Linguistically Appropriate Services 95
Provider Responsibilities for Cultural and Linguistic Services 96

SECTION VI 98

Utilization Management 98
Utilization Management Program 99
Referral and Prior Authorization Process 100
Medical and Behavioral Health Services 100
Direct Referral 101
Prior Authorization Required 101
Utilization Review 102
Contact Information 103
Prior Authorization Review Timelines 104
Provider Notification of UM Decision 104
Concurrent Hospitalization Review 104
Discharge Planning 105
Retrospective Authorization Review 105
Emergency Services 105
Denial of Services 106
Communication to Providers 106
Second Medical Opinions 107
Case Management Program 108
Maternal Mental Health 110
Doula Benefit 111
Doula Benefit Eligibility 111
Autism Services 112
Disease Management Program 113
Out-of-Network Services 113
Delegated Utilization Management 113

SECTION VII 114

Pharmacy Benefit Services 114
Formulary 115
Pharmacy and Therapeutics (P&T) Committee 116
Tiered Copay Programs 116
Prior Authorization 119
Step Therapy 119
Dispense as Written (DAW) Prescriptions 120
Emergency Supply 121
Dispensing Limitations 121
Vacation Overrides 122

Preventive Health Medications 122
Prescription Mail Order 123
Specialty Medications 123
Non-Covered Services and Medications 124
Large Group Plans 124
Small Group Plans 125
Prior Authorization and Exception Process 125
Coverage Determination Notification Process 126
Additional Appeal Rights for FEHB Members 127
Pharmacy Policies and Procedures (Pharmacy Management Procedures) 128
FDA Recalls 128
Outpatient Injectable Medications 128
HMO and POS Plans 128
PPO Plans 129
Pharmacy Benefits Manager (PBM) 129
Medication Restriction 130
Opioid Management Strategies 130

SECTION VIII 131

Quality Improvement 131
Quality Improvement Program 132
Quality Management Committee 133
Participation in the QI Program 134
Quality Measurement 134
HEDIS 135
BMI Assessment 136
BMI Assessment Codes 137
Counseling for Nutrition and Physical Activity Codes 137
Well Care Visit Codes 137
Blood Pressure 139
Diabetic Eye Exam 139
HEDIS Medical Record Review 140
Clinical Practice and Preventive Health Guidelines 140
Summary of Preventive Care Services 141
All Members 142
Women's Health 143
Men's Health 144
Pediatrics 144
Preventive vs. Diagnostic Services 146
Coverage Limitations and Exclusions 147
Preventive Services Monitoring 148
References 148

SECTION IX 150

Claims and Encounters 150
Claims 151
Claims Addresses 151
Claim Submission Requirements 151
Electronic Claims Submissions 152
Sharp Health Plan Approved Clearinghouses 152
Claims Receipt Verification and Claim Status Inquiries 153
Claims Payment Editing System 153
Claims Policy Administration Module 153
Encounter Data 154
Fee Schedules 154
Adjustment Requests 155
Coordination of Benefits 155
Third-Party Liability 156
Member Costs and Out-of-Pocket Maximum 157
Balance Billing 159
Bills for Prenatal Genetic Testing 159
Immediate Postpartum Contraception 160
Dispute Resolution 160
Claims Acknowledgement Sample 162
Remittance Advice Summary Sample 163
Remittance Advice Terms 165
Required Network Provider Types 166
Glossary 169

We are here for you! 181

SECTION I

Introduction and Overview



About Us

We believe better health insurance matters.

Sharp Health Plan is a nonprofit health plan that has been connecting San Diegans to better health insurance since 1992. As part of the Sharp HealthCare family, we provide direct access to The Sharp Experience® with high-quality healthcare coverage for San Diegans of all ages. Our benefit plans combine affordability and choice, and give members access to valuable plan enhancements, like:

- **After-Hours Nurse Advice** — When members have a health concern after regular business hours, our After-Hours Nurse Advice line connects them with a registered nurse.

MinuteClinic — When members need treatment for a minor illness or injury, they can visit a MinuteClinic®. Clinics are in select CVS Pharmacy® store locations and are staffed by certified family nurse providers. They are open every day, including evenings and weekends.

- **Global Travel Assistance Services** — When members have a medical need while traveling 100 miles or more away from home or in another country, we connect them to doctors, hospitals, pharmacies, and other services.

Best Health Wellness Program — Best Health® is one of a select group of health plan wellness programs in the nation to receive the National Committee for Quality Assurance's (NCQA) accreditation. With Best Health, members can access one-to-one health coaching, classes, and other no-cost wellness services.

Sharp Health Plan is one of the highest member-rated commercial health plans in the state of California. We were also voted San Diego's best health insurance for the sixth year in a row. Visit our honors, awards, and ratings to learn more about our commitment to excellence.

We continually improve the quality of our services and benefits and seek innovative solutions to today's complex healthcare issues. From helping members find the right health plan and the right doctor, to being a great place to work, we are here to help.

Resource Guide

Resource	Contact Information
General Information	Sharp Heath Plan 8520 Tech Way, Suite 200 San Diego, CA 92123 Phone: 1-858-499-8300 Toll-free: 1-800-359-2002 sharphealthplan.com
Appeals & Grievances (Medical)	Help members with appeals and grievances by contacting Customer Care. Phone: 1-858-499-8300 Toll-free: 1-800-359-2002 Fax: 1-619-740-8572
Appeals & Grievances (Behavioral Health)	OptumHealth Behavioral Solutions of CA Behavioral Health Complaints/Grievances P.O. Box 30768 Salt Lake City, UT 84130-0768 Confidential Fax: 1-248-524-7603 OptumHealth Behavioral Solutions of CA Attn: Appeals Department P.O. Box 30512 Salt Lake City, UT 84130-0512 Fax: (855) 312-1470
Attestations & Rosters	For inquiries regarding roster updates or verifications. Phone: 1-858-499-8273 Email: shp.providerattestations&rosters@sharp.com

Resource	Contact Information
Capitation	For inquiries about capitation, contact your affiliated Plan Medical Group (PMG). Independent Network providers may contact Provider Account Management. Phone: 1-858-499-8330 Email: provider.relations@sharp.com
Claims (paid by Sharp Health Plan)	Sharp Health Plan Attn: Claims Department P.O. Box 939036 San Diego, CA 92193-9036 Fax: 1-858-636-2276 (Sharp Health Plan does not accept faxed/emailed claims unless approval is given by Sharp Health Plan Claims Manager prior to documents being sent. Sharp Health Plan also does not accept claims or provider dispute resolutions submitted via EpicLink Email: shp.claimsresearch@sharp.com
Claims (third party liability)	Sharp Health Plan Attn: Third Party Liability 8520 Tech Way, Suite 200 San Diego, CA 92123
Claims – Behavioral Health (paid by OptumHealth Behavioral Solutions of California	OptumHealth Behavioral Solutions of California P.O. Box 30757 Salt Lake City, UT 84103-0757 Phone: 1-844-483-9013
Contracts	For inquiries about provider contracts, contact Provider Account Management. Phone: 1-858-499-8330

Resource	Contact Information
Customer Care	For member or provider assistance, contact Customer Care Phone: 1-858-499-8300 Toll-free: 1-800-359-2002 Provider Designated Line: 1-844-483-9014 Fax: 1-619-740-8571 Email: customer.service@sharp.com
Eligibility Information	Check eligibility using your Sharp Health Plan Account (provider portal). Web: sharphealthplan.com/login
Eligibility via Interactive Voice Response (IVR)	Verify eligibility using Interactive Voice Response (IVR) system Toll-free: 1-800-359-2002, option 1
Find a medical provider	www.sharphealthplan.com/find-a-doctor
Find a behavioral health provider	Web: https://www.liveandworkwell.com/?pin=sharp&redirectURL=/services/providerSearch
Fraud, Waste and Abuse	For concerns regarding fraud, waste, and abuse, contact Compliance and Regulatory Affairs. Email: SHPCompliance@sharp.com
Medical Policies	Review medical policies in your Sharp Health Plan Account (provider portal). Web: sharphealthplan.com/login
Provider Directories	Report corrections to information in Sharp Health Plan's Provider Directory by contacting Provider Account Management. Phone: 1-858-499-3830 Email: shp.directory@sharp.com Web: sharphealthplan.com/report-incorrect-provider-information

Resource	Contact Information
Provider Portal	Access your Sharp Health Plan Account (provider portal) for member eligibility, medical policies, and benefit information. Log in or create an account. Web: sharphealthplan.com/login
Provider Account Management	For general assistance and questions about Sharp Health Plan, contact Provider Account Management. Phone: 1-858-499-8330 Fax: 1-858-303-9049 Email: provider.relations@sharp.com Web: sharphealthplan.com/for-providers
Payment Disputes	For inquiries about payment disputes or to complete a Provider Dispute Resolution Form. Phone: 1-858-499-8300 Toll-free: 1-800-359-2002 Email: shp.claimsresearch@sharp.com Web: sharphealthplan.com/for-providers/forms-and-materials
Prior Authorization – Medical Services	Find information about obtaining prior authorization for medical services. Fax: 1-619-740-8111 Web: sharphealthplan.com/for-providers/utilization-management
Prior Authorization – Behavioral Health Services	Information for prior authorization for Behavioral Health Services. OptumHealth Behavioral Solutions of California Phone: 1-844-483-9013

Resource	Contact Information
Prior Authorization – Pharmacy Only	Find information about obtaining prior authorization for pharmacy services. Specialty Medications Phone: 1-866-814-5506 Fax: 1-866-249-6155 Non-Specialty Medications Phone: 1-855-582-2022 Fax: 1-888-836-0730 Web: sharphealthplan.com/for-providers/forms-and-materials

Sharp Health Plan's Responsibilities

Sharp Health Plan is committed to serving members and providers with highest quality of service. Participating providers have the right to expect the following:

- Respect
- Confidentiality
- Orientation and in-service training (by medical group or Sharp Health Plan's Provider Account Management staff)
- Information about changes in policies, procedures, and plan benefits
- Prompt responses to inquiries
- Consideration of your suggestions
- Accurate and timely claims processing
- Timely resolutions of appeals and grievances
- Accurate representation in Sharp Health Plan directories and publications

Much of Sharp Health Plan's success is a credit to our network of dedicated providers. We are committed to providing resources and support for our providers who serve our members. This Provider Operations Manual is a means of providing the information you need as a partner in Sharp Health Plan's provider network. Providers are also acquainted with new policies, changes within the Plan, and updates through in-service trainings, fax alerts, and notices through our website and your Sharp Health Plan Account (provider portal) at www.sharphealthplan.com/login. Providers who identify additional educational needs are encouraged to contact Provider Account Management at 1-858-499- 8330 or by email at provider.relations@sharp.com.

Service Area

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. Sharp Health Plan offers Southern Riverside County only in connection with benefit plans offered outside the Covered California Health Benefits Exchange. For more information about Sharp Health Plan's Service Area, please visit our website at sharphealthplan.com/our-plans/service-area or call Customer Care 1-858-499- 8330.

Compliance Program

Sharp Health Plan has a comprehensive commitment to compliance based on trust, integrity, and accountability, which reflects how fundamental components of Sharp Health Plan's business operations are conducted. Regulatory compliance is not an option. It is required. Non-compliance with Sharp Health Plan's commitment and all regulatory statutes undermines the Plan's reputation and credibility with its members, providers, employees, and the community.

The compliance program addresses all aspects of regulatory compliance, including quality of care, business ethics, protected health information, health insurance law, and employment practices. Compliance training attendance is a vital component of new employee orientation and required annually thereafter for continued employment.

Sharp Health Plan recognizes that its employees and providers are the keys to providing quality healthcare services and is committed to managing its business operations in an ethical manner, in accordance with contractual obligations, and consistent with all applicable state and federal requirements.

Health Care Fraud, Waste, and Abuse Prevention

Sharp Health Plan is committed to complying with all federal and state statutory, regulatory, and other requirements related to health plan operations. In accordance with state and federal regulations, Sharp Health Plan has a comprehensive plan to detect, correct, and prevent fraud, waste, and abuse.

Fraud, waste, and abuse are defined as:

- **Fraud** – Knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud Sharp Health Plan or any healthcare benefit program or to obtain (by means of false or fraudulent pretenses, representations, or promises) any of the money or property owned by, or under the custody or control of, Sharp Health Plan or any healthcare benefit program.
- **Waste** – Overutilization of services, or other practices that, directly or indirectly, result in unnecessary costs to Sharp Health Plan or any health benefit program. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.
- **Abuse** – Includes actions that may, directly or indirectly, result in unnecessary costs to Sharp Health Plan or any healthcare benefit program. Abuse involves paying for items or services when there is no legal entitlement to that payment, and the provider has not knowingly or intentionally misrepresented facts to obtain payment. The distinction between "fraud" and "abuse" depends on specific facts and

circumstances, intent and prior knowledge, and available evidence, among other factors. *(Adapted from Medicare Managed Care Manual, Chapter 21.)*

The purpose of Sharp Health Plan's Anti-Fraud Plan is to detect, prevent, and control fraud, waste, and abuse in order to reduce the cost caused by fraudulent activities, and to protect members in the delivery of healthcare services. The Anti-Fraud Plan is designed to establish methods to identify, investigate, and report incidents of suspected fraud and/or abuse in Sharp Health Plan's delivery systems.

It is the goal of Sharp Health Plan to improve the detection and investigation of fraud. In pursuit of that goal, we have joined forces with the legal and regulatory community to prosecute those parties attempting to abuse the healthcare system. Sharp Health Plan monitors, investigates, and corrects possible fraud, waste, and abuse issues.

Provider Responsibilities

Participating providers are expected to cooperate with Sharp Health Plan's efforts to detect, prevent, and report fraud, waste, and abuse. This includes:

- Reporting suspected FWA promptly.
- Maintaining accurate and complete documentation.
- Ensuring staff complete required FWA training.
- Cooperating with audits and investigations.

Sharp Health Plan prohibits retaliation against any individual who reports suspected fraud, waste, or abuse in good faith.

Help us stop healthcare fraud. Your support in this area helps us all. If you suspect fraud, please contact our Compliance Department at 1-858-499-8237 or email shpcompliance@sharp.com. Or send a letter to:

Sharp Health Plan
Fraud and Abuse Investigations
8520 Tech Way, Suite 200
San Diego, CA 92123

Reporters of suspected fraud have the right to remain anonymous, if so desired. Just tell us why you think fraud is occurring. Give us the name of the provider or member and tell us what you are concerned about. We take your questions and input seriously. You can help us stop healthcare fraud.

Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires covered entities such as health plans, healthcare clearinghouses, and most healthcare providers, including pharmacies, to safeguard the privacy of patient information. Covered entities are required to conduct HIPAA Privacy training on an annual basis and to ensure ongoing organizational compliance with the regulations.

A major goal of the Privacy Rule is to ensure that an individual's personal health information is properly protected, while still allowing the flow of health information needed to provide and promote high-quality health care, as well as to protect the public's health and well-being. A covered entity must maintain reasonable and appropriate administrative, technical, and physical safeguards to prevent inappropriate uses and disclosures of Protected Health Information (PHI). The following are examples of appropriate safeguards that providers should take to protect the security and privacy of PHI:

- Ensure that data files are not saved on public or private computers while accessing corporate email through the Internet.
- Ensure that electronic systems for member mailings are properly programmed to prevent documents containing PHI from being sent to the wrong recipients.
- Ensure that PHI on all portable devices is encrypted.
- Implement security measures to restrict access to PHI based on an individual's need to access the data.
- Perform an internal risk assessment, or engage an industry-recognized security expert, to conduct an external risk assessment of the organization to identify and address security vulnerabilities.
- Shred documents containing PHI before discarding them.
- Secure medical records with lock and key or pass code.
- Limit access to keys and pass codes.
- Lock computer screens when away from your desk or workstation.
- Refrain from discussing member information outside the workplace or in public places.

Providers who disclose PHI to another entity may be limited in how this information can be shared. Members have the right to request to see a list of all persons and organizations with whom their personal health information has been shared. For more detailed information regarding these regulations, go to the Department of Health and Human Services website at hhs.gov/ocr/privacy.

This information regarding HIPAA privacy compliance is provided as a courtesy to the Plan providers. While every attempt is made to keep the information as accurate as possible, it is designed for educational purposes only and should not be used as a substitute for legal or other professional advice.

California Mental Health Parity Law

California law (Health and Safety Code Sections 1367.045, 1374.72, and 1374.721 enacted via SB 855) broadened the California Mental Health Parity Law. It took effect on January 1, 2021, and applies to California healthcare service plans and disability insurers. The law:

- Requires coverage of the full range of mental illnesses and substance use disorders identified in the most recent versions of the American Psychiatric Association's Diagnostic and Statistical Manual (DSM).
- Requires coverage of "medically necessary treatment" and that "medical necessity" determinations be consistent with generally accepted standards of care applied in mental health and substance use disorder care.
- Requires health plans and insurers to use specified clinical criteria and guidelines for level of care determinations and prohibits the application of additional, different, or conflicting criteria.
- Prohibits limiting benefits or coverage for mental health or substance use disorders to short term or acute treatment.
- Prohibits denying medically necessary services on the basis that they should be or could be covered by a public entitlement program.
- Provides for administrative or civil penalties by the Department of Managed Health Care (DMHC) or the Department of Insurance (DOI).

SECTION II

Sharp Health Plan Benefits



Product Overview

Sharp Health Plan offers various coverage options for individuals and families, as well as large and small employer group benefit plans. Group healthcare coverage may be purchased directly through Sharp Health Plan, insurance brokers, CalChoice or the California Health Benefits Exchange. Individual and Family coverage is available directly through Sharp Health Plan, insurance brokers, or the California Health Benefits Exchange.

Benefit Coverage Options

Health Maintenance Organization (HMO)

An HMO is a plan that provides Covered Benefits for a fixed monthly fee, through defined networks of provider groups called plan medical groups (PMGs) from which members choose a primary care physician (PCP) and receive specialty provider care or access to hospitals and other facilities. In some instances, members may select a PCP contracted directly with Sharp Health Plan. The PMG listed on the member's card for these PCPs will be "Independent." HMO members must obtain covered benefits through their PCP and providers affiliated with the PCP's PMG. The PCP is responsible for coordinating and directing necessary care to the appropriate Plan providers.

Benefit plans offered by Sharp Health Plan include copay and coinsurance HMO plans. Some of the plans qualify as a high-deductible health plan (HDHP) that can be paired with a health savings account (HSA). See the HDHP and HSA sections below.

Point of Service (POS)

A POS plan is a combination between an HMO and a PPO. This plan is known as a POS plan because members have an option between the HMO and the PPO each time, they access services; the type of service is based on the point of service. Sharp Health Plan offers a 3-Tier POS plan.

3-Tier POS

Under a 3-Tier POS plan, members select a PCP responsible to manage and coordinate their care within network. The 3-Tier POS plan offers flexibility through three distinct options for coverage. Members can choose to receive care within Sharp Health Plan's HMO network (Tier 1), the Aetna Open Choice PPO network (Tier 2), or any other licensed care provider in the U.S (Tier 3).

- Tier 1 is the Sharp Health Plan Performance or Choice Network. Members select any PCP from Sharp Health Plan's HMO Network. The PCP is the main point of contact and is responsible for coordinating care within the assigned PMG. Care that is rendered by providers affiliated with the PCP's PMG (or that is authorized

by the PMG) is covered at the HMO level of care. Referrals and prior authorization may be required.

- Tier 2 is the Aetna Open Choice PPO® Network. Members may direct their own care and access covered services from any licensed healthcare professional or facility within the Aetna Open Choice PPO Network without a referral. Members are responsible for ensuring the provider(s) obtain required pre- certification prior to receiving services to minimize out-of-pocket costs.
- Tier 3 is out-of-network. Members can receive care from any licensed provider in the U.S., including physicians, specialists, hospitals, or laboratories, without a referral. Members are responsible for ensuring the provider(s) obtain required pre- certification prior to receiving services to minimize out-of-pocket costs.

    Referrals are required on Tier 1, when care is coordinated by a PCP. Some services require precertification or approval from Sharp Health Plan or OptumHealth Behavioral Solutions of California (for mental health and substance use disorder services). Providers and members can verify which services require precertification by calling customer care and or review of the precertification list on Sharp Health Plan website (www.sharphealthplan.com).

Medical and behavioral injectables and infusions for all tiers require precertification or authorization. Medical Pharmacy Precertification Phone Number: 844-345-2803, Fax Number: 833-897-0029.

Covered California

Covered California, the California Health Benefit Exchange, has selected Sharp Health Plan as a Qualified Health Plan (QHP) certified to offer coverage through the Exchange for individual and family plans as well as Covered California for Small Business (CCSB) every year since Covered California started accepting enrollment in 2014. Covered California has established standardized plan designs that each QHP must offer on the Exchange. In addition, QHPs must offer identical plans off the Exchange, known as “mirrored” plans.

The benefit plans offered both on and off the Exchange are identified by metal tiers based on the actuarial value of services paid by a QHP. The metal tiers, from richest to least rich in benefits, are Platinum, Gold, Silver, and Bronze, and they range in copayments, coinsurance, and deductibles. Sharp Health Plan also offers on-Exchange health plans for federally recognized American Indians and Alaska Natives (AI-AN) at all metal tiers; out-of-pocket medical expenses are provided at zero cost-share for individuals in this population meeting certain requirements. A minimum-coverage plan (also called a catastrophic plan) is also available for individuals under age 30, or those who meet certain other requirements.

Note that pediatric dental and vision services are embedded benefits for on- and off-exchange Covered California plans for individuals and small group plans. Sharp Health Plan partners with the following providers:

Dental Services – Pediatric

Sharp Health Plan members under the age of 19 may have coverage for pediatric dental services as part of the Essential Health Benefits (EHB) required for most small group employer plans and individual and family plans (on and off-exchange). Sharp Health Plan partners with Delta Dental of California to provide access to dental services for children. Members enrolled in DeltaCare® USA can call **1-855-370-4215** toll-free or go to www.deltadentalins.com to find a dentist.

Vision Services – Pediatric

Sharp Health Plan members under the age of 19 may have coverage for pediatric vision services as part of Essential Health Benefits (EHB) required for most small group employer plans and individual and family plans (on and off-exchange). Sharp Health Plan partners with Vision Service Plan (VSP) to provide access to pediatric vision services. VSP's new pediatric vision plan, VSP® Elements, offers a comprehensive eye exam and quality eyewear annually from a collection of frames designed specifically for our youngest members.

VSP Elements provides a covered-in-full annual eye exam, lenses and a frame from the Otis and Piper Eyewear Collection. In lieu of glasses, elective contact lens services and materials are covered in full (service limitations apply).

Lenses

- Polycarbonate: plastic or glass is covered in full.
- Single vision; lined bifocal; lined trifocal; or lenticular lenses are covered in full.

The following lens enhancements are covered in full:

- Scratch-resistant coating
- Ultraviolet coating

Some Sharp Health Plan adult members with specific conditions may have coverage for vision services related to requirements of the Affordable Care Act. For a complete benefit description and to find a VSP doctor, members can visit vsp.com or call toll-free 1-800-877-7195

Preferred Provider Organization (PPO)

A PPO is a plan that has contracts with a network of preferred providers from which members can choose. Members do not select a PCP and do not need referrals to see other Plan providers in the network. Beginning January 1, 2026, new and renewing group members will be enrolled in the Options Plus PPO network.

Sharp Health Plan offers a 3-tier PPO plan:

- Tier 1 is the Sharp Health Plan Options Plus PPO network. Members can seek care with any provider in the Tier 1 network without a referral. Tier 1 PPO providers are expected to direct members to Tier 1 network providers whenever possible. Directing members to non–Tier 1 PPO providers should occur only when medically necessary, in emergency situations, when Tier 1 network adequacy is insufficient, or when a member requests an out-of-tier provider and provides written acknowledgment of the applicable cost share. For mental health and substance use disorders, members can seek care with any provider in the OptumHealth Behavioral Solutions of California network.

- Tier 2 is the First Health Complementary network as part of the Plan's Options Plus PPO. Members can seek services from any provider within the First Health Complementary network without a referral nationwide. For mental health and substance use disorders, Members can seek care with any provider in the OptumHealth Behavioral Solutions of California National Network.

- Tier 3 is out-of-network. Members can seek services from any qualified, licensed provider in the U.S. without a referral.

Referrals are not required on any tier. Some services require precertification or approval from Sharp Health Plan or OptumHealth Behavioral Solutions of California (for mental health and substance use disorder services). Providers and members can verify which services require precertification by calling customer care and or review of the precertification list on Sharp Health Plan website.

Medical and behavioral injectables and infusions for all tiers require precertification or prior authorization.

Medical Pharmacy Precertification:
Phone Number: 844-345-2803
Fax Number: 833-897-0029

High-Deductible Health Plans (HDHP)

An HDHP is a health insurance plan with lower premiums and higher deductibles than a traditional health plan. Some HDHP plans also offer additional wellness benefits or health activities provided before a deductible is applied.

Health Savings Accounts (HSA) – Compatible Health Plan

An HSA is a tax-advantaged medical savings account available for members enrolled in a qualified plan. HDHP plans and individual and family Bronze and Minimum Coverage plans are qualified plans (on and off exchange). Funds contributed to the HSA are not subject to federal income tax at the time of deposit or when used to pay for qualified medical expenses and will roll over and accumulate year to year if not spent. A qualified plan

(meets certain Internal Revenue Service criteria) can be paired with an HSA to give members the ability to take advantage of these tax savings.

Behavioral Health Services

Sharp Health Plan is committed to mental health parity. The behavioral health coverage that we provide to our members is equal to similar medical and surgical coverage. This applies to both cost of treatment and how treatment is managed for mental health services. Our Behavioral health services include both mental health and substance use disorders and is available to all Sharp Health Plan members across all networks and benefit plans. Members have direct access to Plan providers for behavioral health services without obtaining a PCP referral. Sharp Health Plan has partnered with OptumHealth Behavioral Solutions of California (Optum Behavioral Health) to provide a large network for mental health and substance use disorder services. Please visit our website for more information about our behavior health providers at sharphealthplan.com/providers/bh or by calling Optum Behavioral Health Customer Care toll free at 1-844-483-9013.

Ancillary Benefits

Sharp Health Plan's coverage options allow us to meet the specialized, supportive care that enhances patient outcomes and effective management of our members' health conditions. Here are the benefit coverage options that we offer.

Acupuncture/Chiropractic — American Specialty Health Plans of California, Inc. (ASH)

Some Sharp Health Plan members may have coverage for limited acupuncture services for specific conditions related to requirements of the Affordable Care Act. Sharp Health Plan members may have access to medically necessary acupuncture and chiropractic services through a supplemental coverage policy.

To find an acupuncture or chiropractic provider, members should contact ASH at 1-800-678-9133 or www.sharphealthplan.com/chiroacu. No referral from Sharp Health Plan or the PCP is required. Check member eligibility on your Sharp Health Plan Account (provider portal) at www.sharphealthplan.com/login.

Vision Services Plan – VSP

Sharp Health Plan members may have access to vision services through a supplemental coverage policy. Sharp Health Plan offers comprehensive vision coverage through its partnership with VSP. All services are coordinated through VSP. Members enrolled in supplemental vision services can visit vsp.com or call toll-free 1-800-877-7195 for more information. Note that pediatric vision coverage is embedded in on- and off-exchange Covered California plans. Refer to the Covered California section.

Delta Dental

Sharp Health Plan offers pediatric dental coverage options for large group members through Delta Dental, one of the nation's leading providers of dental benefits. Delta Dental is the largest network of dentists across the country, aiming to improve oral and overall health by providing access to dental care, focusing on preventive services, and investing in community health programs. Note that pediatric dental coverage is embedded in on- and off-exchange Covered California plans. Refer to the "Covered California" section.

Members should call Delta Dental at 1-855-370-4215 to speak with Delta Dental's customer service team. Providers can check member eligibility on your Sharp Health Plan Account (provider portal).

Value-Added Services

Sharp Health Plan's unique services and key partnerships enable us to provide the full array of value-added enhanced and supplemental services. These are additional services available for purchase under group plans, supplement traditional health coverage, and are coordinated by the applicable vendor.

Best Health

Sharp Health Plan offers a comprehensive wellness program called Best Health to all Sharp Health Plan members 18 years of age and older. Best Health is Sharp Health Plan's comprehensive, integrated, and NCQA-accredited wellness program that drives quality of health care and affordability through employer, and member engagement. Members can learn more and access their wellness portal at www.sharphealthplan.com/besthealth.

- Wellness assessment: quick and easy assessment to identify potential risk factors
- Health Coaching: free one-on-one health coaching for weight loss, nutrition, stress reduction, and smoking cessation and more
- Online educational wellness resources
- Wellness Workshops and Webinars: guide employees through fun, engaging activities and help them to identify their personal health goals
- Wellness challenges and activities: Sync a compatible device and participate in team and individual challenges to boost your motivation.
- Alternative Care Discounts: for massage, acupuncture, chiropractic, and dietitians

Best Health offers robust online wellness tools; educational resources; a comprehensive wellness assessment; fitness and health trackers; and a health library. For those who are ready to take the next step in improving their health, one-on-one health coaching provides members with a dedicated Best Health Coach who will assist them in making positive changes in the areas of healthy weight management, tobacco cessation, healthy eating, physical activity, and stress management.

In addition, all Sharp Health Plan members receive discounts of 15 to 40 percent off over 2,400 health and wellness products, as well as up to 25 percent off alternative care services. For more information, email besthealth@sharp.com.

Through Sharp Weight Management and Health Education, members also have access to a variety of health education and intervention programs provided at convenient locations throughout San Diego County. Please refer to the Health Promotion Programs flyer available on sharphealthplan.com for descriptions of current health education classes, or call Customer Care at 1-858-499-8300 or toll-free 1-800-359-2002 or customer.service@sharp.com for additional information. Members may telephone Sharp Weight Management and Health Education at 1-800-82-SHARP (1-800-827-4277) for additional information on class descriptions, dates, times, and locations.

Sharp Health Plan is aware that health benefits can be gained by identifying behaviors that promote optimum health and reduce the risk for preventable disease and injury. We recognize that the health education interventions conducted by providers are a critical component of influencing these positive behaviors. To assist providers in that role, the Plan distributes provider information and resources for working with our members in need of health education counseling and services on a regular basis in newsletters and fax alerts.

Global Travel Assistance Services

Assist America® provides global travel assistance services for Sharp Health Plan members. The travel assistance services are available worldwide, while traveling domestically or internationally, when members are traveling more than 100 miles from home or in another country for up to 90 consecutive days. Members will contact Assist America for medical services or Sharp medical management will contact Assist America on behalf of a member traveling to coordinate care. Contact Assist America: within the U.S. by calling 1-800-872-1414, outside the U.S. using +1- 609-986-1234, or by downloading the free Assist America Mobile App for Android and iPhone. The Assist America Reference number is 01-AA-SHP-09073 for general members or 01-AA-SHP-09073M for Medicare/Direct Advantage. *Note: Assist America will not accept claims for reimbursement*. *Members and Providers must submit claims to Sharp Health Plan for reimbursement or payment.*

The ChooseHealthy® Program

The ChooseHealthy program provides access to health and wellness promotions and deals to Sharp Health Plan members. The ChooseHealthy program is not insurance.

The program allows members to:

- Save 15%-50% on wellness products. Get access to the Active&Fit Direct™ program. Access 12,900+ participating fitness centers nationwide with a Sharp Health Plan member promo rate.

- Enjoy access to 18,000+ workout videos designed for every style and fitness level at no cost.

For more information, members can learn more at ChooseHealthy.com.

MinuteClinic at CVS®

MinuteClinic at CVS has more than 11 locations in San Diego and Southern Riverside Counties and over 900 locations across the nation located inside select CVS Pharmacy® stores to provide convenient access for several basic care services by board-certified providers without prior Authorization. Members seeking services need to present their Sharp Health Plan member identification card. The following services are covered by Sharp Health Plan at MinuteClinic at CVS:

- Diagnosis and treatment for common family illnesses such as strep throat, flu-like symptoms seasonal allergy symptoms, pink eye, infections of the ears, nose, and throat, urinary tract infections, and sexually transmitted infections
- Flu, COVID, and shingles vaccinations
- Treatment of minor wounds or burns, abrasions, and joint sprains
- Treatment for skin conditions such as poison ivy, ringworm, and acne

Services are available for members aged 18 months or older, but ages for specific services may vary. Members can schedule appointments and find more information about these services, age restrictions and more at MinuteClinic.com.

With the member's permission, a summary of the visit will be sent to their assigned PCP. Visit summaries are also available in Epic "Care Everywhere" or select large interoperability organizations. The MinuteClinic at CVS provider will refer members with more severe symptoms or those requiring treatment in a different setting to their PCP, Urgent Care, or an Emergency Room.

Sharp Nurse Connection®

After regular business hours, weekends and holidays, members can contact the Sharp Health Plan After-hours Nurse Advice line, also known as Sharp Nurse Connection, by calling Customer Care and selecting the appropriate prompt. This after-hours telephone service is staffed with registered nurses to help members decide when and where to seek care and provide medical advice regarding healthcarequestions or concerns. The primary care physician (PCP) receives an electronic notification regarding their assigned members who call Nurse Connection. In some instances, the nursetaking the call may need to speak with the PCP directly regarding a member's healthcare needs. In those cases, the nurse will contact the PCP's office by telephone. A response to such inquiries must be provided within 30 minutes, to ensure appropriate triage of Sharp

Health Plan members. Sharp Nurse Connection is available 5 p.m. to 8 a.m., Monday to Friday and 24 hours a day on weekends and holidays.

Enhanced Provider Services

Sharp Health Plan Web-Based App for Providers

The Sharp Health Plan web-based app for providers is designed to provide quick and easy access to the information you need to work effectively with our Plan and ensure the best possible service to our members. While this information is as up-to-date and accurate as possible, it does not take the place of the terms of any contract your office or organization may have with Sharp Health Plan.

Your Sharp Health Plan Account (provider portal) provides a centralized location for all forms, resources, and tools you need to care for our members. An easy-to-use web-based portal that offers providers 24/7 access to member eligibility and other provider resources such as:

- Access to specific member benefit/evidence of coverage (EOC) documents
- Downloadable medical prior authorization forms
- Request pharmacy prior authorization
- Downloadable policies, manuals, guides, and quick reference guides
- Provider news and alerts
- Provider Operation Manuals

To create your Sharp Health Plan Account (provider portal) at sharphealthplan.com/login, please reach out to your designated site administrator. Site administrators for provider groups are listed on www.sharphealthplan.com/login under "Find my site administrator to register." For further assistance, please contact our Provider Account Management team at provider.relations@sharp.com or 1-858-499-8330. To ensure compliance with HIPAA security standards, each user must have a unique user ID. We can process your application and assist you with access within 2 business days of your request.

Smart Partnership

Sharp Health Plan offers special health insurance plans to all Plan providers. This Smart Partnership provides an opportunity to offer the same benefits and services to your employees that Sharp Health Plan members receive.

These plans are available for any provider office in Sharp Health Plan's provider network that employs from 1 to 100 employees. For rates and additional information, call your insurance broker or Sharp Health Plan's Commercial Sales department at 1-858-499-8235.

SECTION III

Member Enrollment and Eligibility



Member Enrollment Overview

Sharp Health Plan members enrolled on an HMO or POS plan select a primary care physician (PCP) affiliated with a specific plan medical group (PMG) upon enrollment. PPO members do not select a PCP. Members who select a PCP affiliated with Sharp Rees-Stealy Medical Group (SRS) or a Community Clinic are assigned to the clinic or medical group, not an individual provider. Sharp Health Plan encourages selection of a PCP located within 30 minutes or 15 miles of a member's residence. In the event Sharp Health Plan cannot reach the member, the Plan will assign a PCP based on the following factors:

- The member's Plan Network
- The existence of established relationships and family linkages
- The member's residence
- The member's language preference
- The member's age

Members are notified by mail of the plan-assigned PCP and of the right to select a different PCP by contacting Customer Care. Generally, a PCP assignment becomes effective on the first of the following month. For example, if the member calls to select a PCP on May 8, the assignment to that PCP becomes effective on June 1. If the member insists on assigning a PCP the first of the current month, for example today is May 8 and member is requesting PCP change for May 1, the Enrollment team must approve exceptions.

If a PCP change requires a plan medical group (PMG) change or is starting as a new member within a specified PMG, please know that urgent care locations may change; the member will be responsible for obtaining new PCP authorizations, new referrals to specialists; and the member must request new prescriptions for medication. In addition, the member must attest to not accessing care including medical, laboratory, or pharmacy services within the current month. If later it is deemed that the member accessed services within the same month, between two PMGs, the member will be held financially responsible for services rendered.

Members with newborns may select a PCP or PMG for their newborn effective the first day of the month following the baby's birth. In most cases, newborns are assigned to the mother's PMG until the first day of the month following birth. Verification of eligibility can be obtained by contacting Customer Care.

Eligibility Verification

Unless it is an emergency, Plan providers are responsible for verifying eligibility each time a member schedules an appointment and before medical services are provided.

Because events leading to ineligibility can occur at any time, providers are encouraged to

verify eligibility on the day services are to be rendered. Specialist should always verify member eligibility on the day of the appointment. Primary care providers must verify both eligibility and member assignment on the day of the appointment. *Verification of eligibility and/or benefit coverage is NOT a guarantee of payment by Sharp Health Plan.* All members are issued a health plan identification card, which should be presented each time services are requested. Sharp Health Plan member ID cards include the following information:

- Member Name
- Member ID Number
- Date of Birth (DOB)
- Coverage Effective Date
- Group Name
- Group Number
- Primary Care Physician (PCP)
    - Except PPO
- PCP Telephone/After Hours Number
- Plan Medical Group
    - Except PPO
- Plan Network
- Deductible
- Copayments/Coinsurance
- Medical Claims Mailing Address
- Customer Care toll-free number

Examples of Sharp Health Plan member ID cards are located on subsequent pages within this section.

Although the member ID card is a primary method of identification, possession of the card does not guarantee eligibility, coverage, or benefits. Eligibility to receive services depends on verification from Sharp Health Plan. A new identification card is issued for primary care physician (PCP) and plan medical group (PMG) changes, but members may forget to present the most recent card when accessing services. Therefore, it is important to verify eligibility for each visit.

Providers may verify member eligibility through any of the following Sharp Health Plan methodologies:

- Online via your Sharp Health Plan Account (provider portal), which gives provider offices the ability to view member-specific eligibility information, including effective

date, benefits, and copayments. To log in or create an account, go to sharphealthplan.com/login. If you are not currently set up, please contact your site administrator to register your account or if your site administrator is having any difficulties they can contact Provider Account Management at 1-858-499-8330 or provider.relations@sharp.com.

1. Sharp Health Plan's dedicated provider line at 1-844-483-9014 (toll-free). This number is available 24/7 and links to an automated system (called IVR) that allows you to verify member eligibility status, PCP assignment, and copays/coinsurance for most used services.

   To use our automated system, call 1-844-483-9014 (toll-free)

   - Enter your 10-digit NPI number followed by pound (#)
   - Press 1 for provider
   - Press 1 for member eligibility
   - Enter the member's 8- or 11-digit member ID number followed by pound (#)
   - Press 1 if correct
   - Enter the member's date of birth as a 2-digit month, 2-digit day and 4-digit year followed by pound (#)
   - Once authenticated, providers will hear the following details for active members:
   - Member Eligibility Status
   - PCP Name
   - Primary Medical Group
   - Plan Network
   - Member Cost Shares (Copay/Coinsurance)

     PCP

     Specialist

     Urgent Care

     Emergency Visit

     Hospital Admission

   - Member's Individual Deductible

     While listening to the member details, the following navigation options are available:

   - Press star (*) to repeat information
   - Press pound (#) to skip to the end

- If a member insists that they are enrolled in Sharp Health Plan, but the provider is not able to confirm eligibility via your Sharp Health Plan Account (provider portal) or telephone automated (IVR) system, please call our Customer Care Department at 1-844-483-9014 and speak to a Customer Care representative. They are available to assist you 8 am to 6 pm on weekdays.

Eligibility List

To ensure the proper management of care for members enrolled with Sharp Health Plan, eligibility files are transmitted regularly to each PMG at mutually agreed-upon intervals. These lists contain information regarding the member's enrollment status. It is the responsibility of the PMG to share this information with its PCPs and other contracted providers. In the event of a reported discrepancy between the eligibility file and the member's current enrollment, please use the options listed above under the Eligibility Verification section to confirm the member's current status.

Member ID Cards

HMO Member ID Cards

The following information appears on Sharp Health Plan HMO member ID cards:

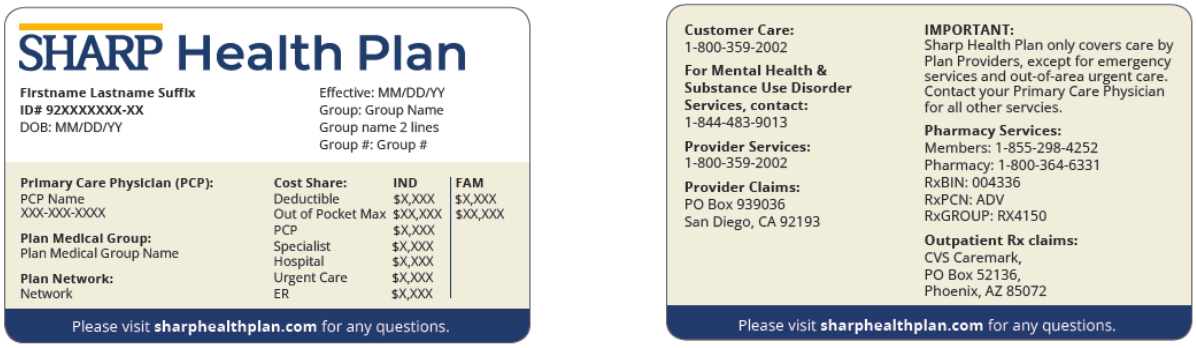
- Member Name: The member's name as entered by the Plan.
- ID #: The number assigned to the member by Sharp Health Plan (commercial member numbers will always start with a "92").
- DOB: Member's date of birth.
- Effective: Date the member is eligible with the Plan (not PCP).
- Group Name: The employer group associated with the member's coverage (e.g., employer).
- Group #: The number assigned by the Plan to the employer group associated with the member's coverage.
- Primary Care Physician: The provider to whom the member is assigned.
- Telephone: The phone number where the PCP can be reached during and after office hours.
- Plan Medical Group: The plan medical group to which the member is assigned.
- Plan Network: The network of providers and hospitals associated with the member's benefit coverage.
- Pharmacy: Used by pharmacies to submit claims through an electronic clearinghouse (RxBIN, RxPCN and RxGROUP).

- Deductible: Deductible amount for individual and family plan members, if applicable.
- Out-of-Pocket Max: Maximum out-of-pocket amount for individual and family plan members.
- PCP: The copayment for services provided in a provider's office.
- Specialist: Specialist copayment amount.
- Hospital: Inpatient Hospital care copayment amount.
- Urgent: Urgent care services copayment amount.
- ER: The emergency room services copayment amount (waived if the member is admitted or is a victim of rape or sexual assault).

The back of the card includes information specific to the member's benefit plan and coverage, for example:

- Customer Care: The Customer Care number may vary by employer group.
- Mental Health Benefits: Phone number for mental health services.
- Provider Services: Phone number for Customer Care team.
- Provider Claims: Address to submit medical claims.
- Pharmacy Services: Phone numbers, claims routing for the Pharmacy Benefit Manager (PBM).
- Emergent and urgent care services statement.
- Dental coverage claims address and phone number.

Sample: Employer-Sponsored Plans



Sample: Custom Account





Sample HMO Member ID Card with Pediatric Dental





Sample HMO Member ID Card without Pediatric Dental





CalPERS HMO Member ID Cards

Please know the following about member ID cards for CalPERS members:

Sharp Performance Plus is the name of the CalPERS HMO benefit plan.

CalPERS members have a unique Customer Care team phone number.

CalPERS members have a customized microsite for CalPERS members at www.sharphealthplan.com/calpers.

Pharmacy benefits are covered through our pharmacy benefit manager CVS Caremark.

Please refer to "Sample HMO Member ID Card" for more information.

Sample CalPERS HMO Member ID Card





Covered California Member ID Cards

Below is a sample of member ID cards for Covered California members:

Sample Covered California Member ID Card

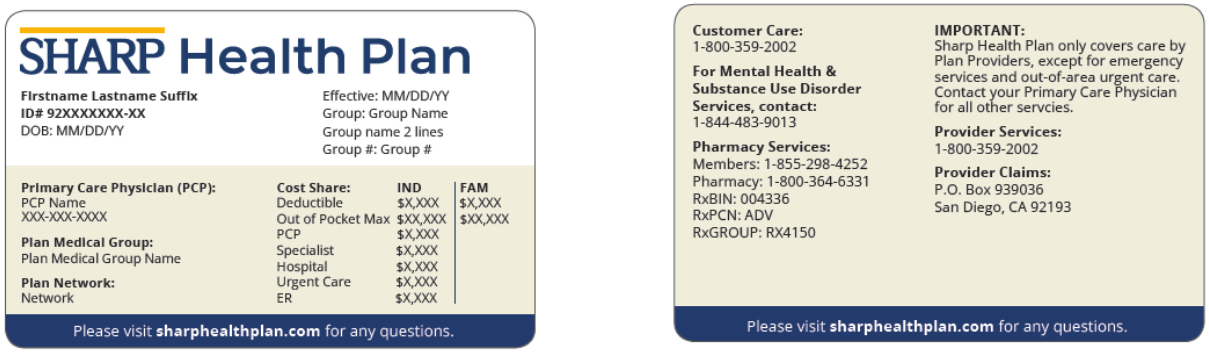




City of San Diego / SDPEBA Member ID Cards

City of San Diego/SDPEBA members have a unique Customer Care team phone number. Please refer to "Sample HMO Member ID Card" for more information.

Sample City of San Diego / SDPEBA Member ID Card



Point of Service (POS) Member ID Cards (3-Tier)

The following information appears on point-of-service (POS) member ID cards:

- Member Name: Member's name as entered by the Plan.
- DOB: Member's date of birth.
- Group name: The employer group associated with the member's coverage.
- Group #: The number assigned by the Plan to the employer group associated with the member's coverage.
- ID #: The number assigned to the member by Sharp Health Plan.
- Effective: Date the member is eligible with the Plan (not PCP).
- Tier 1 HMO Plan Network: The network of providers and hospitals associated with the member's benefit coverage under the Tier 1 level of benefit coverage.
- Out of Network: Contracted network for Tier 2 benefits.
- Primary Care Physician: The provider to whom the member is assigned.
- Telephone/After Hours: The phone number where the PCP can be reached during and after office hours.
- Pharmacy: Used by pharmacies to submit claims through an electronic clearinghouse (RxBIN, RxPCN and RxGROUP).
- Plan Medical Group: The plan medical group to which the member is assigned
- Deductible (IND/FAM): Deductible amount for individual and family, if applicable.
- Out of Pocket Max (IND/FAM): Maximum out of pocket amounts for individual and family plan members.

- PCP: The copayment for services provided in a provider's office.
- Specialist: Specialist copayment amount.
- Hospital: Inpatient hospital care copayment amount.
- Urgent: Urgent care services copayment amount.
- ER: The emergency room services copayment amount (waived if the member is admitted or is a victim of rape or sexual assault).

POS members may seek services on a Tier 1 (HMO) network or a Tier 2 (PPO) network.

- Tier 1 services are subject to prior authorization requirements of the member's plan medical group.
- Tier 2 services may require precertification.
    - Members are responsible for ensuring precertification is obtained when required. Precertification may be requested by calling Sharp Health Plan.

Sample Point of Service (POS) Member ID Card (3-Tier)



Sample Point of Service (POS) Member ID Card (3-Tier) with No Pharmacy Coverage



San Diego County Teamsters & Tri-City Medical Center Member ID Cards

Below is a sample of member ID cards for Teamsters and Tri-City Medical Center members:

Sample San Diego County Teamsters & Tri-City Medical Center Member ID Card





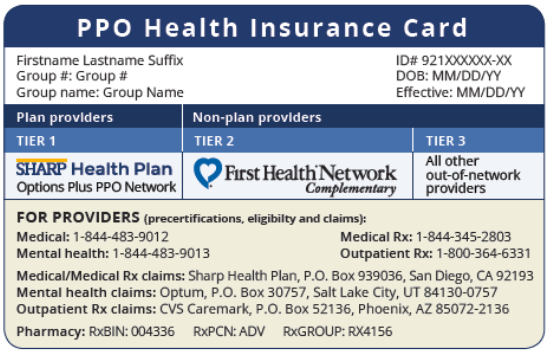
PPO Member ID Cards

The following information appears on member ID cards for PPO members:

- Member Name: Member's name as entered by the Plan.
- DOB: Member's date of birth.
- Group Name: The employer group associated with the member's coverage.
- Group #: The number assigned by the Plan to the employer group associated with the member's coverage.
- ID #: The number assigned to the member by Sharp Health Plan.
- Effective: Date the member is eligible with the Plan (not PCP).
- Tier 1 Sharp Options Plus PPO Network: The network of providers and hospitals associated with the member's benefit coverage under the Tier 1 level of benefit coverage.
- Tier 2 First Health Network (as part of the Options Plus PPO): The network of providers and hospitals associated with the member's benefit coverage under the Tier 2 level of benefit coverage.
- Tier 3 Out of Network: Services rendered by non-contracted providers are covered under the Tier 3 level of benefit coverage.
- Provider contact numbers for precertification, eligibility, and claims.
- Medical, mental health, and outpatient Rx claims addresses.
- Pharmacy: Used by pharmacies to submit claims through an electronic clearinghouse (RxBIN, RxPCN and RxGROUP)

- Deductible (IND/FAM): Deductible amount for individual and family members, if applicable.
- Out of Pocket Max (IND/FAM): Maximum out of pocket for individual and family members.
- PCP: The copayment for services provided in a provider's office.
- Specialist: Specialist copayment amount.
- Hospital: Inpatient hospital care copayment amount.
- Urgent Care (UC): Urgent care services copayment amount.
- Emergency Room (ER): The emergency room services copayment amount (waived if the member is admitted or is a victim of rape or sexual assault).
- Member contact numbers for Customer Care, mental health services, and pharmacy benefits.
- Online provider search links.

Sample PPO Member ID Card



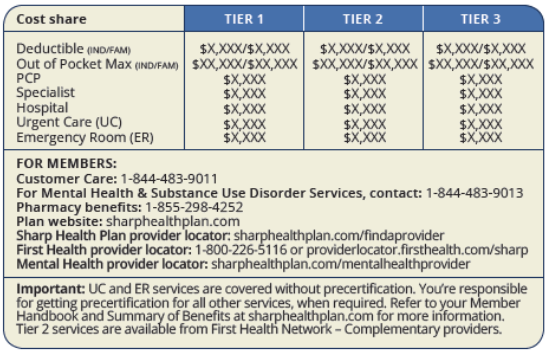
PPO Health Insurance Card

Firstname Lastname Suffix
Group #: Group #
Group name: Group Name

ID# 921XXXXXX-XX
DOB: MM/DD/YY
Effective: MM/DD/YY

Plan providers	Non-plan providers	
TIER 1	TIER 2	TIER 3
SHARP Health Plan Options Plus PPO Network	First Health Network Complementary	All other out-of-network providers

FOR PROVIDERS (precertifications, eligibilty and claims):
Medical: 1-844-483-9012
Mental health: 1-844-483-9013
Medical Rx: 1-844-345-2803
Outpatient Rx: 1-800-364-6331
Medical/Medical Rx claims: Sharp Health Plan, P.O. Box 939036, San Diego, CA 92193
Mental health claims: Optum, P.O. Box 30757, Salt Lake City, UT 84130-0757
Outpatient Rx claims: CVS Caremark, P.O. Box 52136, Phoenix, AZ 85072-2136
Pharmacy: RxBIN: 004336 RxPCN: ADV RxGROUP: RX4156

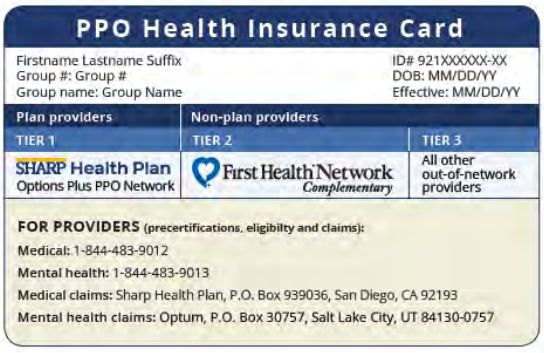


Cost share	TIER 1	TIER 2	TIER 3
Deductible (IND/FAM)	$X,XXX/$X,XXX	$X,XXX/$X,XXX	$X,XXX/$X,XXX
Out of Pocket Max (IND/FAM)	$XX,XXX/$XX,XXX	$XX,XXX/$XX,XXX	$XX,XXX/$XX,XXX
PCP	$X,XXX	$X,XXX	$X,XXX
Specialist	$X,XXX	$X,XXX	$X,XXX
Hospital	$X,XXX	$X,XXX	$X,XXX
Urgent Care (UC)	$X,XXX	$X,XXX	$X,XXX
Emergency Room (ER)	$X,XXX	$X,XXX	$X,XXX

FOR MEMBERS:
Customer Care: 1-844-483-9011
For Mental Health & Substance Use Disorder Services, contact: 1-844-483-9013
Pharmacy benefits: 1-855-298-4252
Plan website: sharphealthplan.com
Sharp Health Plan provider locator: sharphealthplan.com/findaprovider
First Health provider locator: 1-800-226-5116 or providerlocator.firsthealth.com/sharp
Mental Health provider locator: sharphealthplan.com/mentalhealthprovider

Important: UC and ER services are covered without precertification. You're responsible for getting precertification for all other services, when required. Refer to your Member Handbook and Summary of Benefits at sharphealthplan.com for more information. Tier 2 services are available from First Health Network – Complementary providers.

Sample PPO Member ID Card with No Pharmacy Coverage



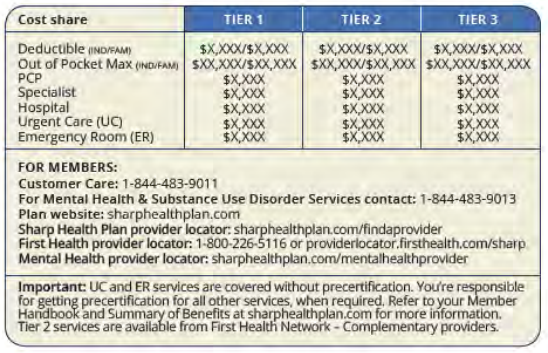
PPO Health Insurance Card

Firstname Lastname Suffix
Group #: Group #
Group name: Group Name

ID# 921XXXXXX-XX
DOB: MM/DD/YY
Effective: MM/DD/YY

Plan providers	Non-plan providers	
TIER 1	TIER 2	TIER 3
SHARP Health Plan Options Plus PPO Network	First Health Network Complementary	All other out-of-network providers

FOR PROVIDERS (precertifications, eligibilty and claims):
Medical: 1-844-483-9012
Mental health: 1-844-483-9013
Medical claims: Sharp Health Plan, P.O. Box 939036, San Diego, CA 92193
Mental health claims: Optum, P.O. Box 30757, Salt Lake City, UT 84130-0757



Cost share	TIER 1	TIER 2	TIER 3
Deductible (IND/FAM)	$X,XXX/$X,XXX	$X,XXX/$X,XXX	$X,XXX/$X,XXX
Out of Pocket Max (IND/FAM)	$XX,XXX/$XX,XXX	$XX,XXX/$XX,XXX	$XX,XXX/$XX,XXX
PCP	$X,XXX	$X,XXX	$X,XXX
Specialist	$X,XXX	$X,XXX	$X,XXX
Hospital	$X,XXX	$X,XXX	$X,XXX
Urgent Care (UC)	$X,XXX	$X,XXX	$X,XXX
Emergency Room (ER)	$X,XXX	$X,XXX	$X,XXX

FOR MEMBERS:
Customer Care: 1-844-483-9011
For Mental Health & Substance Use Disorder Services contact: 1-844-483-9013
Plan website: sharphealthplan.com
Sharp Health Plan provider locator: sharphealthplan.com/findaprovider
First Health provider locator: 1-800-226-5116 or providerlocator.firsthealth.com/sharp
Mental Health provider locator: sharphealthplan.com/mentalhealthprovider

Important: UC and ER services are covered without precertification. You're responsible for getting precertification for all other services, when required. Refer to your Member Handbook and Summary of Benefits at sharphealthplan.com for more information. Tier 2 services are available from First Health Network – Complementary providers.

SECTION IV

Member Services



Customer Care

The Customer Care Department is designed to assist both members and providers with all of Sharp Health Plan's Value-Added Services and health plan benefit coordination. Customer Care can be reached toll-free at 1-800-359-2002 mailto:customer.service@sharp.com. The Customer Care Department has friendly, knowledgeable, and bilingual representatives available Monday through Friday from 8:00 a.m. to 6:00 p.m.

Our Customer Care representatives assist members by answering questions regarding, but not limited to eligibility, general benefits, PCP assignments, and hospital information. The Customer Care Department can also assist with information about any of the following:

- Status of medical referrals and authorizations
- Premium billing questions
- Health plan options
- Community resources and support groups
- Grievances and appeals process
- Member ID card replacements

Optum Health Behavioral Health Solutions of California (Optum) supports provider and member behavioral health inquiries. Members can reach Optum's Customer Care team by calling 1-844-483-9013. The Customer Care department is available from 7am to 8pm, seven days a week, all year round. Clinical staff are available 24 hours a day, 7 days a week for crisis calls and urgent behavioral healthcare needs.

Our pharmacy benefit manager (PBM) CVS Caremark supports member pharmacy inquiries. Members can reach CVS Caremark by calling 1-855-298-4252.

Members associated with the following can contact their designated PBM customer care lines or refer to the pharmacy information located on the back of their member ID card for support.

San Diego County Teamsters: SAV RX, 800-228-3108
CalPERS: Optum Rx, 855-505-8110
San Diego Electrical Health and Welfare Plan Trust (SDEHW): Navitus, 866-333-2757

- Retail pharmacy claim inquiries
- Drug coverage inquiries
- Plan design education
- Drug coinsurance questions

- Mail service order status
- Plan benefit overrides
- Escalated member requests
- Eligibility inquiries
- Prescription billing/payment inquiries
- Prescription prior authorization and formulary exception requests

Interpreter Services

Plan providers may request interpreters for members whose primary language is not English by calling Sharp Health Plan at 1-858-499-8300 or toll-free at 1-800-359-2002. The customer care representative will request the following information:

- Member name, identification number, age, sex, language, and country of origin (to determine the appropriate version of the requested language).
- Provider information, including appointment date and time, office location, name, provider's phone number, and type of appointment (e.g., OB/GYN, well-care, etc.).

For face-to-face interpreting services, requests must be made at least three days prior to the appointment date. However, even with advance notice, face-to-face interpreters for some languages may not be available. If an interpreter is not available for face-to-face interpreting, Sharp Health Plan can arrange telephone interpreting services. Please call Sharp Health Plan at 1-858-499-8300 or 1-800-359-2002 to arrange for timely language assistance services for our members.

Member Rights and Responsibilities

Members are given a Member Handbook upon request that contains a list of member Rights and Responsibilities, which are provided below. Printable versions (in English and Spanish) suitable for distribution to members are also available online at sharphealthplan.com.

Member Rights

Sharp Health Plan members have the right to:

- Receive information about your rights and responsibilities.
- Receive information about your Plan, the services your Plan offers you, and the healthcare providers available to care for you.
- Make recommendations regarding the Plan's member rights and responsibilities policy.

- Receive information about all healthcare services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
- Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
- Choose a healthcare provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a healthcare provider in your Plan's network, including one with a specialist.
- Have an appointment with a healthcare provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network healthcare provider.
- Certain accommodations for your disability, including:
- Equal access to medical services, which includes accessible examination rooms and medical equipment at a healthcare provider's office or facility.
- Full and equal access, as other members of the public, to medical facilities.
- Extra time for visits if you need it.
- Taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
- Trans-inclusive health care, which includes all medically necessary services to treat gender dysphoria or intersex conditions.
- To be addressed by your preferred name and pronoun.
- Receive from your health care provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or medically necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your healthcare providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.

- A discussion of appropriate or medically necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive healthcare coverage even if you have a pre-existing condition.
- Receive medically necessary treatment of a mental health or substance use disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic healthcare services.
- Keep eligible dependent(s) on your Plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a healthcare provider.
- Request from your Plan a second opinion by an appropriately qualified healthcare provider.
- Expect your Plan to keep your personal health information private by following its privacy policies and state and federal laws.
- Ask most healthcare providers for information regarding who has received your personal health information.
- Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
- Protect your medical information related to sensitive services.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive healthcare services.
- Have an interpreter provided at no cost for you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your healthcare provider or medical group leaves your plan or you are a new plan member.
- Have an Advanced Health Care Directive.
- Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.

- File a complaint, grievance, or appeal in your preferred language about:
- Your Plan or healthcare provider.
- Any care you receive, or access to care you seek.
- Any covered service or benefit decision that your Plan makes.
- Any improper charges or bills for care.
- Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
- Not meeting your language needs.
- Know why your Plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing healthcare services or have questions about your Plan.
- To ask for an independent medical review if your Plan denied, modified, or delayed a healthcare service.

Member Responsibilities

Sharp Health Plan members have the following responsibilities:

- Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.
- Share the information needed with your Plan and healthcare providers, to the extent possible, to help you get appropriate care.
- Participate in developing mutually agreed-upon treatment goals with your healthcare providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or healthcare providers.
- Notify your Plan if you have any changes to your name, address, or family members covered under your Plan.
- Timely pay any premiums, cost sharing, and charges for non-covered services.
- Notify your Plan as soon as reasonably possible if you are billed inappropriately.

Primary Care Provider (PCP) Assignment and Selection

All Sharp Health Plan HMO and POS members must select a primary care physician (PCP) to manage their medical needs. Individual family members may choose the same or different PCPs in the following practice areas:

Medical Doctor (MD), including internist, family practice provider, pediatrician, select OB/GYN providers and general medicine providers.

Osteopathic provider (DO), including internist, family practice provider, pediatrician, select OB/GYN providers and general medicine providers.

Members who select a PCP affiliated with a community clinic are assigned to the clinic, not an individual provider within the clinic.

A member, who is also a provider, may not select themselves as their PCP.

If a member does not select a PCP at enrollment, the Plan will assign a PCP based on the following factors:

- The member's plan network
- The existence of established relationships and family linkages
- The member's residence
- The member's language preference
- The member's age

Members are notified by mail of the Plan-assigned PCP and of the right to select a different PCP by contacting the Customer Care department.

- Generally, a PCP assignment becomes effective on the first of the following month. For example, if the member calls to select a PCP on May 8, the assignment to that PCP becomes effective on June 1. If the member insists on assigning a PCP the first of the current month, exceptions may be made. If a PCP change requires a Primary Medical Group (PMG) change or is starting as a new member within a specified PMG, urgent care locations may change, members will be responsible for obtaining new PCP authorizations, new referrals to specialists, and new prescriptions for medication. In addition, the member must attest to not accessing care including medical, laboratory, or pharmacy services within the current month. If later it is deemed that the member accessed services within the same month, between two PMGs, the member will be held financially responsible for services rendered.
- A member identification card is sent to the member when the PCP assignment is effective and any time thereafter when a PCP change is made. The identification

card lists the PCP, the PCP's telephone number, the plan medical group, and the Plan Network.

- Sharp Health Plan encourages members to find a PCP they are comfortable with and stay with that PCP. This way the member and doctor can establish a relationship, and the doctor will be familiar with the member's medical history. However, members can change PCPs at any time.
- PCP changes will be made based on the request from the member or the member's parent or guardian if the member is a minor. PCP changes cannot be made by a provider or the provider's office staff without authorization from the member, but they can be made from the provider's office if the member confirms the change by telephone.

Member Grievances and Appeals

An important part of Sharp Health Plan's Quality Improvement Program is the mechanism through which members can ask questions and solve problems. Often, members will address their questions directly to their PCP, who can answer many questions without the Plan's intervention. When the PCP cannot resolve a question or problem, the member should be advised of his/her right to file a grievance and instructed to contact Sharp Health Plan Customer Care at 1-858-499-8300 or toll-free 1-800-359-2002, or by email at customer.service@sharp.com.

Providers may occasionally receive grievances directly from Sharp Health Plan members. A grievance is an indication that a member is dissatisfied with an aspect of his/her health care and/or the delivery of care. Grievances received by Sharp Health Plan may include complaints about the quality of healthcare services rendered or appeals of service denials. Members (or their designees) may call Customer Care or submit their grievance in writing, via email or fax:

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

If the member prefers, he/she can complete the Grievance and Appeal Form available on Sharp Health Plan's website at sharphealthplan.com/Members/file-a-grievance-or-appeal. Plan providers are required to make grievance, and appeal forms available to members upon request. Providers may also download a copy of the current form by going to sharphealthplan.com/for-providers/forms-and-materials. The forms are also available by contacting the Provider Account Management team at 1-858-499-8330 or by email at provider.relations@sharp.com.

SHARP HEALTH PLAN

Member Grievance & Appeal Form

Purpose

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

Instructions

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

   Examples of urgent requests may include:

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

   Examples of relevant documents may include:

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

Submit

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

By mail or in person:*
Attention: Appeals & Grievances
Sharp Health Plan
8520 Tech Way, Suite 200
San Diego, CA 92123

By fax:
Attention: Appeals & Grievances
1-619-740-8572

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

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

* Pending safety guidelines.

04-2025

Mailing address:		
City:	State:	ZIP code:
Subscriber Information (If Subscriber is Different Than Patient)		
First name:	Last name:	Middle initial:
Employer:	Plan medical group:	Birth date: MM/DD/YY / /
ID#:	Daytime phone number: ( )	Evening phone number: ( )
Home address:		
City:	State:	ZIP code:
Mailing address:		
City:	State:	ZIP code:
Provider Information		
Doctor or provider:		Phone number: ( )
Address:		
City:	State:	ZIP code:
Description of Concern		
Briefly outline the specific details of the problem and identify when the event(s) occurred. PLEASE BE SPECIFIC. Please include a statement regarding the outcome desired and what you believe Sharp Health Plan can do to resolve your concern. If you have copies of documents, bills, checks, or other correspondence related to this problem that may help in the investigation and resolution, please include them with this form. If you need more pages to describe the issue, please attach them to this form.		

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

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

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

You have the right to submit grievances to the plan and the DMHC for the failure of Plan staff to provide trans-inclusive health care, which may include Plan services or health care services rendered by Plan providers. Trans-inclusive health care is defined in Section 1367.043(d)(3) as comprehensive health care that is consistent with the standards of care for individuals who identify as TGI, honors an individual's personal bodily autonomy, does not make assumptions about an individual's gender, accepts gender fluidity and nontraditional gender presentation, and treats everyone with compassion, understanding, and respect.

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

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

City:	State:	ZIP code:



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

Sharp Health Plan's Customer Care representatives try to answer any questions and/or resolve complaints during the member's telephone call. Sharp Health Plan encourages all members to first discuss questions and concerns with their PCP or other Plan providers involved in their care. If Customer Care and the provider cannot resolve the concern, the matter is forwarded to the Plan's Appeal/Grievance Department.

Sharp Health Plan will acknowledge receipt of the grievance within five days and will send the member a decision letter within 30 days. If the grievance involves an imminent and serious threat to the member's health, including but not limited to, severe pain, potential loss of life, limb, or major bodily function, the Plan will provide a response within 72 hours. In most cases, Plan providers involved in the member's care will be contacted by the Plan to request medical records or other information needed to research the member's grievance. It is important to respond promptly to such requests, in order to ensure that grievances are resolved within the timelines established by state regulations. Copies of medical records sent to Sharp Health Plan for an Appeal will be provided to the member upon request.

Sharp Health Plan understands that there are two sides to every issue, so it is very important for Plan providers to respond to inquiries about member grievances. Sharp Health Plan uses responses from providers to identify opportunities to educate members regarding realistic expectations of access, office wait times, appropriate member–provider and member–office staff interaction, etc. The responses also highlight opportunities for Sharp Health Plan to work more closely with providers on interactions that are perceived to be problematic by Sharp Health Plan member(s) and to work together to improve processes.

All clinical grievances (those that require a clinical body of knowledge to render a decision) are reviewed by a physician or other appropriately licensed professional. After a decision is rendered, clinical grievances and the responses to those grievances are blinded and forwarded to the Plan's Peer Review Committee. The Peer Review Committee reviews grievances for appropriateness of the resolution and to identify any trends. If the Peer Review Committee determines that additional follow-up is needed, the Plan provider is notified. If the Committee determines member care was impacted, the case is also reviewed during the recredentialing process.

Sharp Health Plan views every grievance as a chance to improve the experience members have with Plan providers and vice versa. Sharp Health Plan asks that each Plan provider who receives a request from the Plan to respond to a member grievance takes the time to document a full response. Each member's grievance is an opportunity to educate, dispel myths, or raise awareness.

Independent Medical Review (IMR)

If care that is requested for a member is denied, delayed, or modified by the Plan or a Plan Medical Group, the member may be eligible for an Independent Medical Review (IMR). If the case is eligible for IMR, information about the case will be submitted to an independent "like" medical specialist not affiliated with the Plan who will review the information provided and make an independent determination. If the IMR specialist determines the service should be approved, the Plan or delegated medical group will provide coverage for the healthcare service.

The IMR process is in addition to any other procedures or remedies that may be available to the members. A member may request an Independent Medical Review of certain medical-necessity determinations. Choosing not to request an IMR may affect the member's ability to challenge the determination through certain administrative or legal processes, depending on the circumstances. Members pay no application or processing fees of any kind for IMR. Members 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 Department of Managed Health Care (DMHC) will provide its determination within 30 days of receipt of the application and supporting documents. For urgent cases involving an imminent and serious threat to 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 health, the IMR organization will provide its determination within seven days.

At the request of the IMR expert, the deadline can be extended by up to three days if there is a delay in obtaining all necessary documentation.

Independent Medical Review is available in the following situations:

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

If a service is denied because it is deemed to be an investigational or experimental therapy, the member may be entitled to request an IMR of this decision. All of the following conditions must be true:

1. The member must have a life-threatening or seriously debilitating condition. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity. "Life-threatening" means either or both of the following:
    a. disease or conditions where the likelihood of death is high unless the course of the disease is interrupted
    b. disease or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival
2. The provider must certify that the member has 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) the Plan provider has recommended a drug, device, procedure, or other therapy that he/she certifies in writing is likely to be more beneficial to the member than any available standard therapies, or (b) the member or a specialist provider (board eligible or 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. The member has 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 service, except for the Plan's determination that the therapy is experimental or investigational.

If there is potential that a member would qualify for IMR under this section, the Plan will send the member an application within five days of the date services were denied. To request IMR, the member should return the application to the DMHC. The treating provider will be asked to submit the documentation described in paragraph 3 above. An expedited review will occur if the provider 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 will be rendered within seven days of the request for IMR.

Denial of a Health Care Service as Not Medically Necessary

Members may request an Independent Medical Review if the member believes that healthcare services have been improperly denied, modified, or delayed by the Plan or one of its contracting providers. A "disputed healthcare service" is any healthcare service eligible for coverage that has been denied, modified, or delayed by the Plan or one of its Plan providers, in whole or in part, because the service is not medically necessary.

The Plan will provide the member with an IMR application form with any Appeal findings letter that denies, modifies, or delays healthcare services because the service is not Medically Necessary. To request an IMR, the member should return the application to the DMHC. The application for IMR will be reviewed by the DMHC to determine whether the case meets all the following conditions:

1. The Plan provider has recommended a healthcare service as medically necessary.
2. The member received an Urgent Care or Emergency Service that a provider determined was Medically Necessary, or the member was seen by a Plan

provider for the diagnosis or treatment of the medical condition for which the IMR is requested.

3. The disputed healthcare service has been denied, modified, or delayed by the Plan or a Plan provider, based in whole or in part on a decision that the healthcare service is not medically necessary.

   The member filed an appeal with the Plan and the Plan's decision was upheld or the Appeal remains unresolved after 30 days. If the appeal requires expedited review, it may be brought immediately to the DMHC's attention. The DMHC may waive the requirement that the member follow the Plan's grievance process in extraordinary and compelling cases.

Additional Resources for Members

DMHC Help Center

The California Department of Managed Health Care ("Department") is responsible for regulating healthcare service plans. If a member has a grievance against the Health Plan, the member should first telephone the Plan toll-free at **1-800-359-2002** and use the Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not negate any potential legal rights or remedies that may be available to the member. If the member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by the Plan, or a grievance that has remained unresolved for more than 30 days, the member may call the department for assistance. Members may also be eligible for an Independent Medical Review (IMR). If eligible for an 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 website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions.

SECTION V

Provision of Professional Services



Plan Provider Responsibilities

Sharp Health Plan relies on Plan providers to provide high-quality healthcare service and care in the following manner:

- Provide services only as medically necessary in accordance with generally accepted medical, surgical, and scientific practices and community standards.
- Provide and coordinate continuity of care in the member's best health interest.
- Maintain quality standards for all healthcare services.
- Provide all services in a culturally competent manner.
- Ensure that office sites where care is provided is physically accessible to members with disabilities, has adequate parking, restroom facilities, seating, and a well-lit waiting area.
- Ensure office areas where care is provided is maintained, clean, and orderly at all times.
- Maintain open provider-member communication regarding appropriate treatment alternatives or when recommending any procedure which Plan provider deems medically appropriate. The provider communication does not guarantee coverage, as an authorization of said treatment may be required.
- Effectively communicate with members regarding their healthcare needs.
- Encourage members to be active in decisions about their own treatment while discussing appropriate medically necessary treatment options.
- Be accessible to Sharp Health Plan members, including emergency access via telephone per California timely access to care standards.
- The PMG or provider's office, as appropriate, is responsible for notifying members when telehealth services are available and responsible for explaining the process to be used to schedule a telehealth visit.
- Ensure that the member provides either verbal or written consent prior to receiving care via telehealth and that the consent is documented in the chart note.
- Members should be notified at the time of scheduling an appointment about any cost-sharing associated with a telehealth visit and cost-sharing must reflect the cost for either a PCP or specialist visit
- Assist members who may be dissatisfied with his/her health care and/or the delivery of care to report their grievance to the Plan and to make Grievance Forms available to members upon request. (Refer to Section IV: Member Services – Member Grievance and Appeals).

- Maintain licensures and other applicable credentials as required by law and Plan's policy.
- Verify each member's eligibility prior to rendering services unless it is an emergency as defined in member handbook. Refer to Section III: Member Enrollment and Eligibility.
- Cooperate with Sharp Health Plan's Medical Director or designee in the review and supervision of the quality of care administered to members.
- Respond within the designated amount of time to all requests for information related to potential quality of care issues and/or peer reviews and either respond personally or cosign an office or hospital staff's response or information.
- Maintain and preserve all records, including but not limited to medical and billing records, as required by law and medical standards.
- Provide medical histories, financial, administrative, and other records of Sharp Health Plan members as requested by Sharp Health Plan or Sharp Health Plan's designee.
- Actively participate in the Plan's quality and utilization management initiatives.
- Treat all members with respect and provide healthcare services without discriminating based on health status, race, religion, color, national origin, gender, age, disability, marital status, sexual orientation, and source of payment or any other unlawful category.
- Notify Sharp Health Plan within five (5) business days of any change in practice, including but not limited to a change of group affiliation, name, address, telephone number, type of practice, willingness to accept new members, and/or languages spoken.
- Respond within 30 business days to Sharp Health Plan's annual or bi-annual request for affirmative updates, or risk deletion from the provider directory.
- Comply with this provider manual and the terms of your agreement.

Conflicts of Interest

Plan providers are expected to conduct their affairs to avoid Conflicts of Interest by maintaining appropriate and ethical relationships with third parties, including members and their families, other healthcare providers, as well as suppliers, pharmaceutical companies, device manufacturers, and subcontractors ("vendors") so that no third-party has, or appears to have, an opportunity to inappropriately influence Plan providers' decisions and activities.

A Plan provider must not currently have and will not have throughout the term of any agreement with Sharp Health Plan, any direct interest that may present a conflict in any

manner with the performance of services required under the agreement. Plan providers should carefully consider all financial and personal interests that are or may potentially lead to a Conflict of Interest and should be disclosed. Plan providers must conduct their affairs to avoid Conflicts of Interest and must respond appropriately when Conflicts of Interest actually or potentially arise.

A Plan provider has a continuing obligation to disclose the existence and nature of any actual or potential Conflict of Interest he or she may have. Each Plan provider has an individual responsibility to disclose any potential Conflict of Interest, and it is the expectation that each Plan provider must comply with all federal and California state regulations related to referrals required for the provision of certain covered services, including federal and California anti-kickback and anti-self-referral laws, and other rules and regulations related to conflicts of interest. If you have question, please contact our Provider Account Management team at provider.relations@sharp.com or 1-858-400-8330.

Role of the Primary Care Physician (PCP)

Primary care physicians (PCPs) are responsible for providing certain basic healthcare services to Sharp Health Plan members. The PCP has primary responsibility for coordinating the member's overall health care, which may include care planning during the member's transition of care from one care setting to the next, as well as ensuring the appropriate use of pharmaceutical medications. All Sharp Health Plan members enrolled on an HMO or POS plan must choose a PCP or clinic at the time of enrollment, or one will be chosen for them. PPO plan members are not required to choose a PCP.

The PCP provides primary care, including preventive health care, treatment for acute illnesses and minor accidents, and follow-up care for ongoing medical problems. In addition, the PCP manages all the health care provided to the member, such as initiating referrals for specialty care and coordinating follow up after inpatient discharge to assure continuity of care. The PCP's responsibilities include the following services:

Provide member's primary healthcare services.

Provide coverage 24 hours a day, seven days a week (members are instructed to contact the PCP prior to seeking care in all cases except emergencies. Members should be referred to the nearest emergency department for emergency services and to the nearest contracted urgent care facility in their Plan Medical Group (PMG) for urgent care services that cannot be addressed in the PCP's office. PCPs are not responsible for identifying a contracted urgent care facility when a member is outside the plan's service area.

Refer members to a participating specialist in the member's PMG when specialized care is indicated. Women enrolled in Sharp Health Plan may self-refer directly to an OB/GYN affiliated with the member's plan medical group for obstetric and gynecologic

services and can choose an OB/GYN as their PCP, if desired and the OB/GYN agrees.

Manage behavioral health issues within the scope of a PCP.

For those members, whose requirements are out of scope of a PCP, assist members with obtaining behavioral healthcare services. Behavioral Health is a self-referral to OptumHealth Behavioral Solutions of California (Optum) network providers. If further assistance is needed, refer member to call Optum Customer Care at 1-844-483-9013.

Request authorization for referrals, services, procedures, and medications when required by the Plan. Review and incorporate the specialist's documentation into the member's primary medical record. Use contracted network laboratories and radiology services.

Notify members of test results and document the notification in the medical record within 72 hours of receipt and acknowledgement of the results.

On-Call Providers Coverage

The PCP shall provide coverage for Sharp Health Plan members 24 hours a day, seven days a week and shall make coverage arrangements with another qualified health provider (preferably one who is also contracted with Sharp Health Plan and in the member's Plan Medical Group) in the event of the provider's absence. A PCP contracted directly with Sharp Health Plan shall notify the Plan in advance, or as soon as is reasonably possible, of the use of a non-participating provider in a coverage arrangement.

It is the responsibility of the PCP to ensure that the covering provider will comply with the Plan's peer review procedures and accept the fee from Sharp Health Plan as payment in full for services delivered to the member (except applicable Copayments). Capitated providers must arrange directly with the covering provider for payment of all Covered Benefits provided to Sharp Health Plan members. Covering providers must not bill Sharp Health Plan members for Covered Benefits.

Role of the Specialty and Ancillary Provider

Collaboration between the PCP and specialty or ancillary providers is crucial to achieve continuity and quality of care. When a member requires or requests specific services, treatment, or referral for specialty or ancillary services, the PCP is responsible for reviewing the request for medical necessity and referring the member to the appropriate contracted provider defined by the member's affiliated PMG or Sharp Health Plan.

Depending on the member's benefit plan, if a member calls the specialist provider office directly, the specialist will determine if a referral is needed by the member's PCP.

The specialty provider may provide treatment authorized by the referral, which may include ordering appropriate lab tests, imaging services, or therapies. Services must be performed

at a contracted facility with appropriate authorization, if required. The specialist is responsible for contacting the PMG or Sharp Health Plan for necessary authorizations.

The specialist is responsible for documentation of the services provided, including results of any diagnostic studies or procedures and recommendations for treatment or follow-up. The specialist is responsible for discussing any results of ordered labs or tests with the member. The specialist is also responsible for sharing records with the member's PCP.

Contract Terminations

Terminations may be initiated by either the provider, plan medical group, or the Plan. All parties are required to continue to provide services as outlined within the contract until the effective termination date. A minimum of 120 days prior written notice is required for contracted primary care physicians, specialty and ancillary providers, and medical groups, unless otherwise noted in the contract. It is not necessary for termination dates of hospitals to be strictly at the end of the month; they are pursuant to the termination provision in the agreement. Please refer to your contract for details on terminations.

Provider Terminations

Contracted providers must provide Sharp Health Plan with 45-day advance notification of any provider terminations within their practice. A minimum of 45 days is required to allow for 30-day advance notification to Sharp Health Plan members. The Plan sends its members letters notifying them of changes to primary care physicians only. Specialists are reviewed internally to ensure continuity of care for impacted members. Terminations will be processed for the last day of the month.

Providers affiliated with a delegated plan medical group (PMG) should send term notifications to the PMG. Providers contracted directly with Sharp Health Plan should send written notifications to Provider Account Management via email at provider.relations@sharp.com or fax at 1-858-408-9444.

Block Transfers

A block transfer occurs when a provider contract termination results in the reassignment of 2,000 or more members from a terminating provider group or hospital to one or more receiving provider groups, or the termination of a significant Plan contract between the Plan or Plan-contracted entity and a terminating hospital. The Plan notifies the Department of Managed HealthCare (DMHC) of a block transfer at least 75 business days prior to contract termination date. Additionally, enrollee transfer notices are mailed to impacted members at least 60 days prior to the contract termination date, which includes a statement that the member may contact the Plan's Customer Care department to request completion of care for an ongoing course of treatment from a terminating provider. If your provider group anticipates a block transfer impacting Sharp Health Plan members, please contact the Provider Account Management team at provider.relations@sharp.com.

Contract Suspensions

In lieu of termination, the Plan may suspend a contract. Suspensions can occur until conditions of reinstatement, as determined by the Plan, have been satisfied.

Disabled Member Services

The Americans with Disabilities Act (ADA) requires public accommodations, including the professional office of a healthcare provider, to provide goods and services to people with disabilities on an equal basis as people without disabilities. For inquiries or assistance, please contact Sharp Health Plan Customer Care Department at 1-800-359- 2002.

Emergency Services

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:

- Placing the member's health in serious jeopardy; or
- Serious impairment of bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency services are 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.

The determination is based on a reasonable layperson's determination of an emergency not on the treating provider's assessment. Retrospective denial of services for what appears to the reasonable layperson to be an emergency is prohibited.

If a member is a victim of rape or sexual assault the cost sharing associated with their emergency visit is waived. This includes up to nine months of follow-up medical care, after the initial Emergency Services are received. Members are not required to file a police report, press charges, or participate in any legal proceedings to qualify for the waived cost share. Follow up healthcare treatment means medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault. For Sharp Health Plan to be notified that you provided emergency room care or follow up healthcare treatment to a victim of rape or sexual assault, you must indicate a primary diagnosis code of rape or sexual assault on the claim or encounter data that is sent to Sharp Health Plan. Rape and Sexual assault are defined in Penal Code Sections 261, 261.6, 263, 263.1, 286, 287, and 288.7.

Telehealth Services

California state law defines telehealth as a method of delivering healthcare services and public health through communication technologies that allow for the ability to diagnose, consult, treat, educate, facilitate care management, and self-management as it relates to a member's health care.

It is required that providers obtain either verbal or written consent from the member for the use of telehealth services prior to providing care via telehealth. Consent for telehealth services must be documented in the chart note. In addition, members should be notified at the time of scheduling an appointment about any cost-sharing associated with a telehealth visit.

Additional information regarding telehealth can be obtained from the Department of Managed Health Care Services.

Confidentiality and Disclosure of Medical Information

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires all providers and healthcare professionals to make reasonable efforts to limit the disclosure of Protected Health Information (PHI), or individually identifiable health information that is transmitted or maintained, in any form or medium. The HIPAA Privacy Rule has established that written member authorization is required for any use or disclosure of PHI that is not related to treatment, payment, or healthcare operations. The person or entity that is seeking to obtain medical information must obtain authorization from the member and is to use that information only for the purpose it was requested and retain it only for the duration needed.

Plan providers shall ensure that their policies and procedures related to HIPAA compliance are up to date. Detailed information can be obtained from the Department of Health and Human Services as well as other resources, including the American Medical Association.

Medical Record Standards

Sharp Health Plan medical records standards are measurable and are based on relevant regulatory requirements and evidence-based best practices. These medical record documentation standards promote consistency in practice and support the communication of clinical information among practitioners for continuity and coordination of care. The standards are:

- All medical record entities must be legible and should establish the stated diagnosis from the included history and physical findings.

- The therapies noted should be current therapies.

Drug allergies and idiosyncratic medical problems are conspicuously noted.

- Pathology, laboratory, and other diagnostic and screening reports are available, documented as reviewed and noted in the assessment if abnormal or significant.

The health professional responsible for each entry is identifiable, and each entry is dated.

- Consultation and progress notes are available and noted as reviewed.

- Health care treatment recommendations are noted as having been provided to the member.
- Appropriate preventative care is documented.
- Discussion about advance directives or a copy of the advance directives is in the chart.
    - Two member identifiers are on each page of the medical record.
    - Consent, either verbal or written, for telehealth visits.

Medical records shall reflect the following:

- All services provided directly by a provider who provides healthcare services.
    - All ancillary services and diagnostic tests ordered by a provider.
    - All diagnostic and therapeutic services for which a member was referred by a provider, such as but not limited to:
        - Home health nursing reports
        - Specialty provider reports
        - Hospital discharge reports
        - Physical therapy reports
    - Each provider visit shall include the documentation of:
        - Medical history and physical
        - Vital signs
        - Height and weight measurements
        - Allergies and adverse reactions
        - Problem list
        - Current Medications
        - Clinical finding, evaluation, and plan for each visit
        - Preventive services/high-risk screening

Amendment to Member Medical Record

According to Health and Safety Code section 123111, an adult member can write an "Addendum" to their medical file and request the file placed in his or her medical record. Member shall have the right to provide the healthcare provider a written addendum with respect to any item or statement in his or her record that the member believes to be incomplete or incorrect. The addendum shall be limited to 250 words per alleged incomplete or incorrect item in the member's record and shall clearly indicate in writing that the member wishes the addendum would be a part of his or her medical record.

The healthcare provider shall attach the addendum to the member's record and shall include the addendum whenever the healthcare provider makes a disclosure of the allegedly incomplete or incorrect portion of the member's record to any third party. The new information signed and dated by the member shall be placed in the file and the original information should not be removed.

Confidentiality and Availability of Medical Records

All medical records are required to be organized and stored in a manner that allows easy retrieval. Medical records should be kept in a secure location that allows access to authorized personnel only. Plan providers and their employees are required to receive periodic training in member information confidentiality and must sign confidentiality statements. Plan providers must also have policies and procedures in place to protect and ensure the confidentiality of member information at all times. In addition, Plan providers must have a written policy regarding the release of medical records.

Confidentiality of Medical Information Act

Providers must adhere to the Confidentiality of Medical Information Act (California Civil Code Sections 56.10-56.16) and have policies and procedures in place to protect the confidentiality of a member's medical information.

Additionally, providers must comply with all applicable rules related to confidentiality of information related to members' receipt of sensitive services.

Providers must:

- Not require a protected individual to obtain the primary subscriber or other enrollee's authorization to receive sensitive services or to submit a claim for sensitive services if the protected individual has the right to consent to care.
- Direct communications regarding a protected individual's receipt of sensitive services as follows:

    - Directly to the protected individual's designated alternative mailing address, email address, or telephone number; OR,
    - In the absence of a designated alternative mailing address, email address, or telephone number: to the address or telephone number on file in the name of the protected individual.
    - Communications (written, verbal, or electronic communications) regarding a protected individual's receipt of sensitive services shall include:
        - Bills and attempts to collect payment.
        - A notice of adverse benefits determinations.
        - An explanation of benefits notice.
- A 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 plan that contains protected health information.
- Not disclose medical information related to sensitive healthcare services provided to a protected individual to the primary subscriber or any plan enrollees other than the protected individual receiving care, absent an express authorization of the protected individual.
- Permit and accommodate requests from protected individuals for confidential communication in the form and format requested, if readily producible in the requested form and format, or at alternative locations.

Legally Protected Health Care

Sharp Health Plan and its contracted entities will not release medical information related to a person seeking or obtaining gender-affirming health care or gender-affirming mental health care or a person or entity allowing a child to receive gender-affirming health care or gender-affirming mental health care in response to any subpoena or request, including a foreign subpoena, based on another state's law that interferes with an individual's right to seek or obtain gender-affirming health care or gender-affirming mental health care or authorizes a person to bring a civil or criminal action against a person or entity that allows a child to receive gender-affirming health care or gender-affirming mental health care.

The Plan and its contracted entities will not release medical information to persons or entities who have requested that information and who are authorized by law to receive that information, pursuant to Civil Code section 56.10(c), if the information is related to an individual seeking or obtaining gender-affirming health care or gender-affirming mental health care or to a person or entity allowing a child to receive gender-affirming health care or gender-affirming mental health care, and the information is being requested pursuant to another state's law that authorizes a person to bring a civil or criminal action against a

person or entity that provides, seeks, obtains, or receives gender-affirming health care or gender-affirming mental health care or who allows a child to receive gender-affirming health care or gender-affirming mental health care.

The plan and its contracted entities will not cooperate with any inquiry or investigation by, or providing medical information to, any individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify an individual and that is related to an individual seeking or obtaining gender-affirming health care or gender-affirming mental health care that is lawful under the laws of this state.

Sexual and Reproductive Health Care

Sharp Health Plan will not include any terms in provider contracts that would result in termination or nonrenewal of the contract or otherwise penalize the provider, based solely on either of the following:

- A civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state, if the judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in this state.

- The manufacture, transport, distribution, delivery, receipt, acquisition, sale, possession, furnishment, dispensation, repackaging, or storage of brand name or generic mifepristone or any drug used for medication abortion that is lawful under the laws of the state.

The Plan will not discriminate with respect to the provision of, or contracts for, professional services, against a licensed provider solely on the basis of either of the following:

- A civil judgment issued in another state, a criminal conviction in another state, or another disciplinary action in another state, if the judgment, conviction, or disciplinary action is based solely on the application of another state's law that interferes with a person's right to receive care that would be lawful if provided in this state.

- The manufacture, transport, distribution, delivery, receipt, acquisition, sale, possession, furnishment, dispensation, repackaging, or storage of brand name or generic mifepristone or any drug used for medication abortion that is lawful under the laws of the state.

Retention of Medical Records

Medical records and member related data shall be retained in a locked storage area according to the following time periods:

Chart Type	Retention Requirement
Adult Member	10 years
Minor Member (< 18 years of age)	Until 1 year after the 18th birthday, but not less than 10 years
X-rays	10 years

Plan Provider Directory Requirements

Sharp Health Plan maintains provider directory information in accordance with applicable state and federal regulatory requirements. These requirements build upon established guidance governing provider directory accuracy, completeness, and timeliness.

Participating providers are required to comply with all applicable provider directory requirements, including the submission of accurate and current information through the Plan's established roster submission processes. These processes support the Plan's ongoing responsibility to ensure that provider directory information remains accurate, up to date, and reflective of network participation.

The Department of Managed Health Care (DMHC) has issued amendments to the Knox-Keene California Health & Safety Code §1367.27 regarding provider directories. These changes supplement the existing SB 137 requirements and Uniform Provider Directory Standards.

Medical Providers

Plan providers must adhere to the following DMHC requirements as part of the established quarterly roster submission process.

- **Practice address formatting and "no address" requirements**
    - All practice addresses must follow USPS Publication 28 (October 2024) addressing standards.

- When a provider does not maintain a traditional practice location, e.g., services are delivered exclusively in the patient's home, via telehealth, or at the patient's care setting, Sharp Health Plan will apply the appropriate "No Address" designation based on the provider's service model, using the required regulatory statements.

- **Provider specialty display standards**
  - All provider specialty information must follow the DMHC's standardized provider type methodology.
  - Specialties listed in the directory must be reported consistent with the specialty or specialties:
    - contracted with the Plan or your provider group;
    - issued by American Board of Medical Specialties (ABMS) recognized board certifications;
    - associated with the provider's NPI; or
    - the accrediting organization.
  - Providers must identify the accrediting organization used for displaying specialty certifications on the provider directory.

- **Telehealth service indicators**
  - Provider listings must state whether the provider:
    - delivers services at a physical location and via telehealth, or
    - exclusively delivers health care services via telehealth.

- **Disability accommodations**
  - Directories must indicate whether the provider's office/facility offers:
    - Accommodations for individuals with disabilities, including auxiliary aids and services, ensuring effective communication in-person and via telehealth.
    - A description of available physical accessibility accommodations.

Service Ancillary Providers

Providers that maintain a provider directory are expected to ensure directory information is accurate, current, verifiable, and accessible, consistent with the regulatory standards outlined below:

- Review current provider directory content for alignment with these standards.
- Implement processes to verify and update directory information on a regular and ongoing basis.
- Promptly correct and document any identified inaccuracies.
- Ensure directory information accurately reflects provider availability, services offered, accessibility accommodations, and contact information.
- Maintain written policies and procedures that support the accuracy and completeness of provider directory information.
- Clearly display the date the information was last verified or updated.
- Include, for each provider listing, the following statement using the same font size and format as the listing: "This information was last verified or updated on [mm/dd/yy]."
- Maintain archived copies of provider directories for five (5) years, in a format that is retrievable upon request.
- Ensure provider directory links are clearly identified and easily accessible, such as "Provider Directory" or "Find a Provider."
- Treat inaccurate, incomplete, or misleading information as a reported inaccuracy, investigate the issue, and document any corrections made.
- Display provider information in a consistent and orderly format.
- Include a link to the provider's public website, if available, for online directories.
- Describe how individuals may obtain archived provider directories from the preceding five years, including a phone number or email address.
- Identify whether providers offer accommodations for individuals with disabilities, including:
- Auxiliary aids and services for communication
- Physical accessibility features
- Language assistance services at no cost
- Exclude providers who are retired, deceased, or no longer providing services, unless inclusion is required for limited regulatory or safety purposes.

- Prominently display a method for reporting inaccurate or misleading information, accessible to providers, enrollees, and the public.
- The directory must allow for searches or filtering, as applicable, by:
  - Provider specialty or service type
  - City and ZIP code
  - Languages spoken
  - Accessibility features
  - Provider group or affiliation (if applicable)
  - New patient availability
  - Telehealth availability
  - Facility or service location

Plan Provider Updates

To keep provider directories and member records current, Sharp Health Plan or the provider's affiliated PMG must be notified in writing within five business days of any of the following changes:

- New or additional office locations.
- New, modified billing or mailing addresses.
- New office email addresses and/or office websites.
- Provider terminates, joins another clinic or plan medical group, including Federally Qualified Health Centers (FQHC)
- Plan provider specialty or board certification status changes.
- Changes in languages spoken (non-English) by provider and the provider's office staff.
- Change in Plan provider's panel status.
- Change in practice name or ownership.
- Changes in practice Federal Tax Identification Number (TIN).
- Changes in gender-affirming services.
- Adding/updating age restrictions.
- Updating office hours.
- Updating phone number(s) and/or fax numbers.
- Updating telehealth modalities/status

- Updating directory suppression statuses
- Updating AHP supervising physicians.

Notice of any of the above-mentioned changes and the applicable effective date shall be submitted to the affiliated PMG. If you are also contracted directly with the Plan, please send updates to the Credentialing team at shp.credentialing@sharp.com. Updates may also be requested via your Sharp Health Plan Account (provider portal) at www.sharphealthplan.com/login.

Tax Identification Number (TIN) Changes

TIN changes shall be submitted in writing in a federal W-9 form (available at the IRS website, IRS.gov). Federal guidelines require Sharp Health Plan to have this form before any payments can be made using the new TIN. In some instances, a new agreement between Sharp Health Plan and the Plan provider may be necessary. Please submit updated W-9 forms to the Credentialing team at shp.credentialing@sharp.com.

Provider's Panel Status

Primary care physicians (PCPs) may close their panels to new members with notice provided within five business days. Notice should be sent to the provider's affiliated PMG or Sharp Health Plan's Credentialing team, if the provider is part of the Independent Network. The closed panel will be noted in the next printing of the provider directory and the next scheduled update of the online directory. The PCP shall notify Sharp Health Plan or the PMG in writing within five business days when the PCP elects to reopen the panel to new members. If a Plan provider is contacted by an enrollee or potential enrollee seeking to become a new member and the Plan provider is not accepting new members, the Plan provider or his/her staff member shall direct the enrollee or potential enrollee to both the Plan for additional assistance in finding a provider with an open panel or to the Department of Managed Health Care (DMHC) to report any inaccuracy with the Plan's directories.

Provider Directory Verification and Attestation

Sharp Health Plan is committed to the accuracy of the information listed in the Plan's provider directories. Pursuant to the federal No Surprises Act under statute 42 U.S.C.A. § 300gg-115(1)(2)(b), Sharp Health Plan reaches out for quarterly verification of data and provider rosters. In pursuant to (Section 1367.27 of the California Health and Safety Code) SB 137, the Plan verifies provider rosters quarterly and collects attestations of accuracy of the information that is provided to the Plan on an annual or bi-annual basis, depending on provider type. Providers are also required to notify the Plan of provider demographic changes within five (5) business days of the change.

Delegated Provider Attestations

Delegated provider groups must ensure that the health plan has the most up to date provider roster information, including new providers, locations, and providers no longer with the practice. In compliance with SB 137, Sharp Health Plan reaches out to delegates annually and requests attestations of accuracy of the provider roster information. If there are required changes, delegates must provide an updated roster within 30 business days. If there are no required changes, there will be an option to attest to no changes in that quarter. Providers must attest within 30 business days of the original request, even if there are no changes.

Failure to respond to attestation requests may result in removal from the provider directories or delay of payment/reimbursement of a claim. The Plan will notify providers ten days in advance prior to removal from the directory but will revoke the action if the Plan providers respond within the ten-day notification period.

Independent Provider Attestations

Independent providers must ensure that the Plan has the most current provider roster information and complete provider roster verifications and attestations as requested by the Plan. Provider roster verifications may include updates related to new providers, provider locations, and providers who are no longer affiliated with the practice. Providers may submit roster updates to the Plan as changes occur.

Providers are required to attest to the accuracy of the information submitted to the Plan. In compliance with SB 137, providers must complete attestation requests within 30 business days of the original request, even if there are no changes to report.

Failure to respond to attestation requests may result in removal from provider directories or delay of claim payment or reimbursement. The Plan will provide providers with a ten-day advance notice prior to removal from the directory and will revoke the action if the provider responds within the ten-day notification period.

Credentialing Program

Credentialing and recredentialing files are processed by Sharp Health Plan's Credentialing Verification Organization (CVO). Final credentialing approval is coordinated through Sharp Health Plan's Peer Review Committee, under the guidance of the Chief Medical Officer. Sharp Health Plan retains the right to approve, suspend, and terminate individual Plan providers and sites. The Sharp Health Plan process meets the California State and NCQA credentialing requirements.

Credentialing

Sharp Health Plan or a delegated entity credentials all Sharp Health Plan affiliated providers. Providers must meet the Plan criteria for acceptance and are required to maintain compliance with all standards as a condition for continued participation.

To begin the credentialing process, providers are required to submit a completed signed California Participating Provider Application with the following attachments:

- Licensure to practice in California.
- Addendums A and B in the provider credentialing application.
- Current DEA certificate.
- Proof of professional liability insurance with a minimum of $1M occurrence and $3M aggregate.
- A written explanation of malpractice suits filed against the provider that must include the case number; court number; and a brief case summary of the charge, facts, status, and outcome.
- A signed release granting the Plan access to records of any medical society, medical board, college of medicine, hospital, or other institution, organization, or entity that does or may maintain records concerning the applicant.
- A signed statement by the provider at the time of application regarding any physical or mental health problems, any current history of chemical dependency/substance abuse, history of loss of license and/or felony convictions, and/or history of loss or limitation of privileges or disciplinary actions.
- Work history over the last 5 years with explanation of any gaps in employment that exceeds 6 months.
- Sharp Health Plan admitting arrangements form indicating hospital privileges are valid, current, unrestricted, and in good standing at a Plan contracted hospital, or have a Plan-approved admitting arrangement.
- Current board certification status with documentation.
- Medical staff membership or affiliations.

The Plan-contracted Credentialing Verification Organization (CVO) initiates the credentialing process and completes the primary source verifications in accordance with NCQA standards and other pertinent information supplied or collected during the application process.

Per NCQA, providers must provide requested information in a timely manner to process their applications. The CVO/Plan will initiate four attempts to contact providers to obtain required information within 60 days. If providers are non-responsive and do not provide all required information after four attempts, the CVO/Plan will consider the providers as non-

responsive, and their application will be closed. Providers in the initial credentialing cycle may re-apply. Existing providers in the recredentialing cycle will be terminated, according to NCQA guidelines, and may reapply as a new applicant.

Provider Rights during Credentialing

The following rights apply to providers during the credentialing process.

1. The right to review information submitted to support an application.
    - Providers and applicants have the right to review information obtained from outside sources, such as malpractice insurance carriers or state licensing boards, to support their credentialing application. Sharp Health Plan's delegated Credentialing Verification Organization (CVO) is not required to make available information obtained from references, recommendations, or peer-review protected information.

2. The right to correct erroneous information.
    - If information is obtained during the credentialing process that varies substantially from the information submitted by the provider, Sharp Health Plan or CVO notifies the provider of the discrepancy via certified letter. The applicant is notified by the credentialing department in writing within 30 calendar days of receipt of the discrepant information. The notification includes a description of the discrepancy, the source of the information as appropriate and the provider's right to correct erroneous information submitted by another party. Sharp Health Plan and/or CVO is not required to reveal the source of information that was not obtained to meet verification requirements or if federal or state law prohibits disclosure.

3. The right to receive status of a credentialing or recredentialing application, upon request.
    - Providers and applicants are notified of the right to receive status information from a statement on the provider application stating requests may be made in writing or by telephone. The CVO staff responds to requests in writing within ten business days after receiving the request. The response to providers does not include disclosure of information prohibited by law, references, recommendations, or other information that is peer-review protected.

The credentialing information is presented to the Peer Review Committee for review and approval. The Peer Review Committee meets quarterly. Providers are notified in writing of the Peer Review Committee's decision. Final credentialing approval is granted by the Sharp Health Plan Board of Directors, which also meet on a quarterly basis.

No applicant is automatically entitled to participate with the Plan via participation with a Medical Group or professional organization, via board certification or via staff membership or privileges for a particular health facility or practice setting.

Standards and Guidelines

At a minimum, the following requirements must be met for the Plan to consider acceptance of the applicant for participation in the Plan's network:

- Acceptable compliance with general guidelines
- A participation agreement in the form prescribed by the Plan and signed by the provider
- The provider applicant has not been rejected or terminated by the Plan within the previous twelve months
- No felony, misdemeanor convictions nor evidence of committing other act involving moral turpitude, dishonesty, fraud, deceit, or misrepresentation
- Unrestricted license to practice in California
- Use of Plan facilities for his/her regular practice and routinely makes rounds at participating facilities. If the provider does not have privileges at a Plan hospital, he/she must have formal admitting arrangements with a Plan provider who does.
- Listing of office locations, names, and addresses of associates in the practice of medicine or osteopathy, and any provider or other Plan provider who provides on-call services.

Additionally, primary care physicians (PCPs) and specialty providers are required to meet the following standards to be considered for participation in the Plan's network:

- Current unrestricted license to practice medicine or osteopathy in California.
- Current, valid federal Drug Enforcement Agency (DEA) certificate.
- Current staff membership, clinical privileges, and admitting privileges granted by a Plan hospital within the service area or arrangements with a Plan provider who has such privileges.
- Graduation from medical school and completion of a residency for MDs and DOs. (An exception may be made for a provider who has only completed a rotating internship, if the provider agrees to be classified as a general provider and practices in an underserved area of the county.)
- Documentation of board certification, if applicable. Providers must provide documentation of certification at the time of initial credentialing and recredentialing every three years thereafter, by the appropriate Board for provider specialty or of active and current involvement in the board certification and examination process.

- Professional liability insurance policy of not less than $1,000,000 per incident and $3,000,000 per year.
- 24 hour-a-day coverage for all plan members with another participating primary care physician or with another Plan provider who agrees to abide by the guidelines of the Plan.
- PCPs must be able to perform the following in the office setting:
    - EKG (pediatric offices as appropriate)
    - Office gynecology including routine pelvic and pap smears (excluding pediatrics)
    - Blood draws (not applicable if contracted with a national laboratory)
    - Minor surgery to include incision and drainage of abscess and suture of superficial lacerations
- Availability and accessibility to include:
    - Minimum of 20 hours each week of regularly scheduled office hours for treatment of members for a one-provider practice and minimum of 30 hours for a practice of two or more providers
    - Response time to calls not greater than 30 minutes after notification
    - Ability to accept a minimum of 250 new members at time of application
    - No more than an average of five members scheduled and seen each hour for routine office visits for adult medicine and six members per hour for pediatrics
- Compliance with state continuing education requirements
- Absence of felony convictions, sound moral character, and in good professional standing in the community
- Provision of quality, appropriate, and timely care.
- Supportive of the philosophy and concept of managed care and of Sharp Health Plan
- Good standing with Centers for Medicare and Medicaid Services (CMS) in any state where the provider has been licensed.

Delegated Credentialing/Recredentialing

Sharp Health Plan delegates credentialing/recredentialing to the following entities: Sharp Rees-Stealy Medical Group, Greater Tri Cities IPA, Optum Care Network-North County SD, Sharp Community Medical Group, OptumHealth Behavioral Solutions of CA, Rady Children's Health Network and Family Health Centers of San Diego. Delegation status is granted only to entities that perform the credentialing/recredentialing activities according to NCQA standards. Annual credentialing delegation oversight audits are conducted by Sharp Health Plan or by NCQA-accredited health plans in California via the Health Industry

Collaboration Effort, Inc. (HICE) shared delegation oversight credentialing audit process.

Credentialing Appeals Process

Sharp Health Plan's appeal process allows for adverse credentialing decisions to be discussed and understood, and for any errors to be corrected. This process ensures providers will be treated fairly and uniformly.

Recredentialing

According to NCQA standards, a review of credentials for recredentialing Plan providers is performed no less than every three years. Recredentialing applications are distributed approximately five months prior to the recredentialing period expires. The Plan's Credentialing Verification Organization (CVO) can take up to 120 days to process a recredentialing application. For a provider to keep the application in an active status, the provider must supply the needed information within three months prior to their recredentialing date.

The CVO/Plan will initiate four attempts to contact providers to obtain required information within 60 days. If providers are non-responsive and do not provide all required information after four attempts, the CVO/Plan will consider the providers as non-responsive, and their application will be closed. Providers in the recredentialing cycle will be terminated, according to NCQA guidelines, and may reapply as a new applicant.

Plan providers are responsible for producing adequate information for a complete evaluation of experience, background, training, and ability to perform as a clinician without limitations, including physical and mental health status as allowed by law. Sharp Health Plan uses a universal reapplication and only information that may have changed since the last credentialing will be requested.

View the Plan's credentialing policies and procedures on your Sharp Account (provider portal) at www.sharphealthplan.com/login.

Notifications to Authorities and Provider Appeal Rights

In the event that, through a formal peer review process, an adverse action is taken against clinical privileges for contracted healthcare providers, Sharp Health Plan will report such adverse action to the Medical Board of California (MBC) and the National Practitioner Data Bank (NPDB) in accordance with the Plan's policies and procedures, as well as applicable state and federal law. Sharp Health Plan will also report healthcare related civil judgments and other adjudicated actions or decisions against network healthcare providers, providers, or suppliers to the NPDB, in accordance with the Plan's policies and procedures, as well as applicable state and federal law. Sharp Health Plan will promptly notify affected

practitioners, providers, or suppliers in the event of such reporting, and in the case of adverse actions, will include information on appeal rights in these communications in accordance with the Plan's policies and procedures, as well as applicable state and federal law.

Accessibility and Appointment Availability

Appropriate and timely access to healthcare services for members is a primary concern of Sharp Health Plan. Each office is required to provide a sufficient number of available appointments and adequate telephone capabilities to serve the needs of the members assigned to that office. Provider locations must be accessible to members during posted hours of business. Plan providers shall not unlawfully discriminate against any member based on factors including, but not limited to, race, religion, color, national origin, gender, age, disability, marital status, sexual orientation, or source of payment.

Access standards have been developed to ensure that all healthcare services are provided in a timely manner. These standards are based on community norms and required by law under California Health and Safety Code Section 1367.03 and Title 28 of the California Code of Regulations Rules 1300.67.2, 1300.67.2.1, and 1300.67.2.2

Number and Distribution of Primary Care, Specialist, Ancillary Providers and Hospitals

The Plan maintains a sufficient network of providers and facilities throughout its service area to meet the primary, specialty, ancillary, mental health, inpatient, and emergency service needs of plan members through contracting or referral to ensure timely and geographic accessibility in compliance with the Department of Managed Health Care (DMHC) and the following access standards:

A. Physicians
    1. 1 full-time equivalent (FTE) physician per 1,200 members
B. Primary Care Physicians (PCPs):
    1. 1 PCP per 2,000 members
    2. 1 PCP within 30 minutes or 15 miles of a member's residence or workplace
C. The geographic access benchmark is 100% or an alternative access standard approved by the Department.
D. Accepting New Patients
    1. The Plan strives to meet an 85% benchmark for open panel statuses across its networks and counties, which exceeds the Department's benchmark of 60%.

Geoaccess and Adequacy Ratios Standards for Regulated Specialties

Required Specialist Physician	Distance Standard	Adequacy Ratio	Benchmark
Allergy/Immunology	25 miles	1 FTE : 32000 Enrollees	90%
Cardiovascular Disease	20 miles	1 FTE : 8000 Enrollees	90%
Dermatology	20 miles	1 FTE : 15000 Enrollees	90%
Diagnostic Radiology	25 miles	N/A	90%
Emergency Medicine	25 miles	N/A	90%
Endocrinology	25 miles	1 FTE : 22000 Enrollees	90%
Gastroenterology	20 miles	1 FTE : 15000 Enrollees	90%
Hematology	25 miles	1 FTE : 22000 Enrollees	90%
HIV/AIDS Specialist	60 miles	N/A	90%
Infectious Disease	35 miles	N/A	90%
Maternal and Fetal Medicine	60 miles	N/A	90%
Nephrology	25 miles	1 FTE : 22000 Enrollees	90%
Neurology	20 miles	1 FTE : 8000 Enrollees	90%
Obstetrics/Gynecology	20 miles	1 FTE : 5500 Enrollees	90%
Oncology	20 miles	1 FTE : 15000 Enrollees	90%
Ophthalmology	20 miles	1 FTE : 15000 Enrollees	90%
Otolaryngology	25 miles	1 FTE : 22000 Enrollees	90%
Pain Medicine	25 miles	1 FTE : 22000 Enrollees	90%
Pediatric PCP	15 miles	N/A	90%
Physical Medicine and Rehabilitation	25 miles	1 FTE : 22000 Enrollees	90%
Podiatry	20 miles	1 FTE : 15000 Enrollees	90%
Psychiatry	20 miles	1 FTE : 5500 Enrollees	90%
Pulmonology	20 miles	1 FTE : 15000 Enrollees	90%
Radiation Oncology	25 miles	1 FTE : 32000 Enrollees	90%
Reproductive Endocrinology/Infertility	60 miles	N/A	90%
Rheumatology	25 miles	1 FTE : 32000 Enrollees	90%
Surgery - Cardiothoracic	60 miles	N/A	90%
Surgery - Colon/Rectal	60 miles	N/A	90%
Surgery - General	20 miles	1 FTE : 5500 Enrollees	90%
Surgery - Neurological	35 miles	N/A	90%
Surgery - Orthopedic	20 miles	1 FTE : 8000 Enrollees	90%
Surgery - Plastic	35 miles	N/A	90%
Surgery - Vascular	35 miles	N/A	90%
Urology	25 miles	1 FTE : 22000 Enrollees	90%

High-Volume Specialties

Specialty	Distance Standard	Adequacy Ratio	Benchmark
Primary Care Physician	15 miles	1 FTE : 2,000 Enrollees	100%
Cardiovascular Disease	20 miles	1 FTE : 8,000 Enrollees	90%
Dermatology	20 miles	1 FTE : 15,000 Enrollees	90%
Gastroenterology	20 miles	1 FTE : 15,000 Enrollees	90%
OB/GYN	20 miles	1 FTE : 5,500 Enrollees	90%
Pediatrics	15 miles	1 FTE : 2,000 Enrollees	90%
Surgery – Orthopedic	20 miles	1 FTE : 8,000 Enrollees	90%

High-Impact Specialties

Specialty	Distance Standard	Ratio	Benchmark
Oncology	20 miles	1 FTE : 2,000 Enrollees	90%
Cardiovascular Disease	20 miles	1 FTE : 8,000 Enrollees	90%

Facilities and Clinics

Service Type	Distance Standard	Benchmark
Ambulatory Surgery Center/Surgical Clinic Services	30 miles	90%
Cardiac Surgery Services	40 miles	90%
Cardiac Catheterization Services	40 miles	90%
Emergency Room Services	25 miles	90%
Intensive Care Services	30 miles	90%
Skilled Nursing Facility	25 miles	90%
Urgent Care Center	30 miles	90%

Ancillary Providers

Service Type	Distance Standard	Benchmark
Chiropractic	20 miles	90%
Dental	15 miles	90%
Infusion/IV Therapy	30 miles	90%
Mammography	25 miles	90%
Occupational Therapy	35 miles	90%
Physical Therapy	20 miles	90%
Speech Therapy	35 miles	90%

Behavioral Health Providers

USBHPC	*Large Metro*		*Metro*		*Micro*		*Rural*		*CEAC*		*Compliance Threshold for Geographic Access Standards*
Provider Types	**Miles**	**Minutes**	**Miles**	**Minutes**	**Miles**	**Minutes**	**Miles**	**Minutes**	**Miles**	**Minutes**	
Child/Adolescent Clinician (Prescriber, Doctoral and Master's-Level)	**10**	**20**	**30**	**45**	**45**	**60**	**60**	**75**	**100**	**110**	**90%**
Applied Behavior Analysis (ABA)	**15**	**30**	**45**	**70**	**75**	**100**	**75**	**90**	**140**	**155**	**90%**
Intermediate Care/Partial Hospitalization/ Residential (Mental health & substance abuse)	**15**	**30**	**45**	**70**	**75**	**100**	**75**	**90**	**140**	**155**	**90%**
Intensive Outpatient Care (Mental health & substance abuse)	**15**	**30**	**45**	**70**	**75**	**100**	**75**	**90**	**140**	**155**	**90%**
Medication Assisted Treatment (MAT) (Prescribers with an expertise in buprenorphine or naltrexone injectable, methadone clinics)	**15**	**30**	**45**	**70**	**75**	**100**	**75**	**90**	**140**	**155**	**90%**

Provider Types	**Large Metro Counties (miles)**	**Metro Counties (miles)**	**Micro Counties (miles)**	**Rural Counties (miles)**	**Counties with Extreme Access Consideration (CEAC) (miles)**	**Compliance Threshold for Geographic Access Standards**
Specialist Physicians-Psychiatry	15	20	55	55	100	90%
Counseling non-physician mental health professional or Counseling MHP *(Licensed Clinical Social Worker, Licensed Marriage & Family Therapist, Licensed Professional Clinical Counselor, Psychologist)*	15	15	35	35	65	90%
Mental health facilities *(Acute psychiatric hospital, psychiatric health facility, or chemical dependency recovery hospital and/or residential detoxification facility. "Inpatient mental health facilities" also includes those facilities categorized as a general acute care hospital, where such hospital maintains an inpatient psychiatric unit)*	15	45	90	90	120	90%

Provider Types	Large Metro Counties (miles)	Metro Counties (miles)	Micro Counties (miles)	Rural Counties (miles)	Counties with Extreme Access Consideration (CEAC) (miles)	Compliance Threshold for Geographic Access Standards
Specialist Physicians-Psychiatry	15	20	55	55	100	90%
Counseling non-physician mental health professional or Counseling MHP *(Licensed Clinical Social Worker, Licensed Marriage & Family Therapist, Licensed Professional Clinical Counselor, Psychologist)*	15	15	35	35	65	90%
Mental health facilities *(Acute psychiatric hospital, psychiatric health facility, or chemical dependency recovery hospital and/or residential detoxification facility. "Inpatient mental health facilities" also includes those facilities categorized as a general acute care hospital, where such hospital maintains an inpatient psychiatric unit)*	15	45	90	90	120	90%

Primary Care Physician (PCP) Appointments

Members are instructed through the Member Handbook and new member orientation calls from Customer Care Department to contact their PCP and schedule an introductory appointment and health assessment. The PCP shall ensure timely access to visits for plan members. If the need for specialty care arises, the PCP is responsible for coordinating all services that fall out of the PCP's scope of practice.

Timely Access to Care

Sharp Health Plan monitors compliance to the access standards through a variety of means. Monitoring methods may include annual mystery caller audits, appeals and grievances, access surveys, and wait-time studies. Plan providers will be monitored annually for access to health care, and monitoring results will be shared with the provider. If deficiencies are identified, Plan providers will be asked to respond to a Notice of Non-Compliance to ensure compliance with Plan standards.

Sharp Health Plan is obligated under California law to provide or arrange for timely access to care. Plan provider shall provide appointments and telephone screening services to Sharp Health Plan's members according to the following guidelines:

Appointment Wait Times

Urgent Appointments	Maximum wait time after request
No prior authorization required	48 hours
Prior authorization required	96 hours
Dental services	Within 72 hours of the time of the request.
Non-Urgent Appointments	**Maximum wait time after request**
Primary care physician (excludes preventive care appointments)	10 business days
Non-physician behavioral health care or substance use disorder providers (includes follow-up appointments)	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
Dental services	Within 36 business days of the request.
Preventive dental care appointments	Within 40 business days of the request.

Rescheduling Appointments

If an appointment requires rescheduling, the appointment shall promptly be rescheduled in a manner that is appropriate for the member's healthcare needs and continuity of care, consistent with good professional practice.

Extended Wait Times

Plan providers may extend the applicable wait time for an appointment if they have determined and noted in the member's record that a longer wait time will not be detrimental to the member's health.

Advance Scheduling

Plan providers may schedule appointments in advance 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 or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease) consistent with professionally recognized standards of practice.

Telephone Wait Times

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

Interpreter services at scheduled appointments

Sharp Health Plan provides free interpreter services for members at scheduled appointments whose primary language is not English. Plan providers can request interpreters by calling Customer Care at 1-800-359-2002. Plan providers must make requests for face-to-face interpreting services at least five (5) business days prior to the appointment date. Coordination of interpreter services shall not impose delays on the scheduling of the appointment. In the event that an interpreter is unavailable for face-to-face interpreting, Customer Care can arrange for telephone interpreting services.

Concerns about timely referral to an appropriate provider

If a member is unable to obtain a timely referral to an appropriate provider, the Plan provider or member may contact Customer Care at 1-800-359-2002 for assistance.

They may also contact the Department of Managed Health Care to file a complaint about a timely referral to an appropriate provider: 1-888-466-2219.

Standards for Office Wait Times

The maximum wait time for the following services should be:

Office Wait Time	Maximum wait time
PCP and Specialist	Within 30 minutes

After-Hours Telephone Access for Primary Care and Behavioral Health Providers

Sharp Health Plan requires PCP and Behavioral Health (BH) providers or designees to be available so that assigned members have access to urgent and emergency care 24 hours per day, seven days per week. Plan providers must maintain 24-hour, seven days per week telephone access capability to provide immediate response to emergency inquiries by members. Plan providers must maintain a procedure for triaging or screening member telephone calls which includes 24/7 employment of a telephone answering system, answering service and/or office staff that will inform the caller of the following:

- Regarding the wait time for a return call from the provider, and
- How the caller may obtain urgent or emergency care, including how to contact another provider who has agreed to be on call to triage by phone or, if needed, deliver urgent or emergency care.

Emergency Instructions

Every member that calls a PCP's office after normal business hours shall first receive the following emergency instructions, regardless of whether a line is answered by a person or by recording:

- Hang up and dial 911, or
- Go to the nearest emergency room, or
- Hang up and dial 911 or go to the nearest emergency room.

Non-Emergency Instructions

Members who reach a recording at the PCP's office and have non-emergency situations that cannot wait until the next business day should receive the following instructions:

- Stay on the line to be connected to the doctor on call.
- Leave a name and phone number for a call back from a provider or qualified healthcare professional within 30 minutes.
- Call the PCP at another number.

The waiting time for a member to speak by telephone with a provider, registered nurse, or other qualified health professional acting within his or her scope of practice and who is trained to screen or triage a member who may need care, may not exceed 30 minutes.

Documenting Telephone Calls

All members telephone calls must be documented on a phone message form or within an electronic health record, with the response given documented on the same form.

Documentation of phone calls must be affixed to the progress notes and become a permanent part of the medical record. At a minimum, the phone message record shall include:

- Member name
- Date and time of call
- Member's question/concern
- Advice/response provided
- Signature of individual who triaged the call

Behavioral Health (BH) Telephone Access

Behavioral Health providers will maintain access to BH screening and triage to ensure that members reach a non-recorded voice within 30 seconds. Telephone abandonment rates shall not exceed five percent (5%) at any time. Calls must be returned by a psychiatrist or qualified behavioral healthcare professional within 30 minutes.

Failed Appointments

Failed appointments are those where a member does not arrive for a scheduled medical appointment, either with or without notice from the member. Failed appointments shall be documented in the member's medical record according to the PMG's or Plan provider's written policy and procedure, with provisions for a case-by-case review of members with repeated failed appointments.

Some Plan providers have established a missed-appointment fee for their members. Sharp Health Plan reserves the right to review and approve such policies. Plan providers shall demonstrate that members were notified in advance regarding missed appointment fees and shall waive such fees under extenuating circumstances. Sharp Health Plan does not reimburse Plan providers for missed appointment fees.

Provider-Initiated Member Dismissal

Rarely, a Plan provider cares for a member who is disruptive or excessively difficult. However, in these instances, Plan providers can contact Sharp Health Plan's dedicated provider line at 1-844-483- 9014 to request assistance with difficult members. Plan providers are obligated to provide medically necessary care and access to services for as long as the member requires medical care, or until the relationship is ended appropriately. A member may not be dismissed or denied care due to diagnosis, health status/needs, or

language barriers. To dismiss a plan member, Plan providers must follow Sharp Health Plan's policy as outlined below

A. Member Dismissal from Independent Network Provider

1. Independent providers must submit a member dismissal request and obtain approval from Sharp Health Plan before dismissal of a member.
2. To obtain approval, independent providers must submit supporting documentation for consideration per section B. 2 – 3, 5 – 6 below.
3. If approved, the Provider Account Management team will assist independent Plan providers in member communications and reassigning members to a new primary care physician (PCP) in the Independent network in a timely manner.
4. When an independent PCP is approved to dismiss a member, all referral authorizations for that member are invalidated. Members must contact their new PCP to obtain new referrals and authorizations.
5. When an Independent provider wishes to move a member from a PCP to a different PCP within its group practice, there is no requirement to request approval. Follow instructions per section C. 1 – 4 below.

B. Member Dismissal from Plan Medical Group (PMG)

1. Plan Medical Groups must obtain approval from Sharp Health Plan to dismiss a Plan member. Before requesting dismissal, the PMG must first make multiple attempts to reassign the member to a different primary care provider (PCP) within their PMG network.
2. Member dismissals are considered under the following circumstances:
   a. The PMG demonstrates multiple attempts to reassign the member to a different PCP within the PMG. If these efforts fail to resolve the issue, The PMG can submit a member dismissal form for SHP to evaluate whether the member can be dismissed and reassigned to another Sharp Health Plan provider.
   b. Member demonstrates a pattern of verbally abusive and/or threatening behavior toward the provider, ancillary or administrative office staff, or other members.
   c. Member physically assaults a provider, staff member, or member, or threatens any individual with any type of weapon on Plan or provider premises or verbalizes the intent to cause bodily harm. In such cases, appropriate charges should be brought against the member, and a copy of the police report submitted along with the request.

d. The plan medical group must ascertain if a mental health issue is present and take appropriate action, including but not limited to a referral to behavioral health services or request for a psychological evaluation.
e. Member refuses to meet financial obligations such as copayments or coinsurance.
f. Member attempts to fraudulently obtain health care services, including allowing others to use the member's Plan identification card to receive services.
g. Member is non-compliant with recommended treatment plans to the extent that member's health is endangered and is not due to financial reasons such as inability to afford medication or special diet.
h. Member is disruptive to provider or Plan operations with potential for limitations on access to care by other members.
i. Member habitually uses non-contracted providers for non-emergency services without the required authorization.

3. The PMG should counsel the member about the conflict or problem prior to requesting dismissal unless there is imminent danger or threat of danger to provider, staff, or other persons on site.
   a. Counseling should include written education that conveys a clear set of instructions, compliance requirements, and the consequences, if any, for not following the instructions, placing responsibility for compliance directly on the member. Counseling should include resources for the member to obtain behavioral health services support.
   b. If these attempts fail, the PMG must request authorization from the Plan to dismiss the member from the panel.
4. The PMG can submit the member dismissal request form to request dismissal and reassignment of the member to another medical group.
   a. The PCP should not initiate dismissal communication with the member prior to Plan authorization unless imminent threat or advised by law enforcement.
5. Upon receipt of the member dismissal request form, the Provider Account Management team reviews the form to ensure its completion and includes supportive documentation detailing the situation prior to any member termination. Supporting documentation may be in the form of copies of medical records and office notes, and may include:
   a. Pertinent dates
   b. Member's product line of business, i.e., Medicare, Exchange, Commercial. If the member is on a group benefit plan, provide the member's employer.

c. Documentation of all interactions between the member, provider(s), PMG representatives, and provider office staff in written format and/or audio files.
d. Documentation of multiple attempts to reassign the member to a different PCP within the PMG.
e. The PMG's request must demonstrate that the member's behavior is not due to mental illness or another medical condition. The PMG must demonstrate evidence of interventions to manage the member through case management, social worker, and/or behavioral health referral to address potential healthcare overlying issues.
f. Documentation of previous attempts to educate members regarding noncompliance with recommended treatment plans or office practices.
g. Billing statements, including amount due, letters advising members to pay their bill.

6. The Provider Account Management team may request additional documentation from the PMG, if necessary. The request must be fulfilled within five business days.
    a. If the request for additional documentation is not fulfilled within this timeframe, the dismissal request is denied.
7. The Provider Account Management team submits the completed form with supporting documentation to the Plan Chief Medical Officer for approval.
    a. If the member dismissal request is denied, the Provider Account Management team provides written communication of the decision within 30 days of the Plan's receipt of all supporting documentation.
8. If the member dismissal request is approved, the Provider Account Management team provides written authorization to dismiss the member within 30 days of the Plan's receipt of all supporting documentation.
    a. Upon receipt of the Plan's decision, the PMG must provide written notification in the form of a dismissal letter to the member within five business days. The dismissal letter must include the reason for the dismissal and must not occur prior to the Plan's authorization. Members cannot be terminated or refused service at any point during this process.
    b. The Provider Account Management team receives a copy of the dismissal letter sent to the member by the PMG.
9. Upon receipt of the dismissal letter from the PMG, the PMG can then contact the member for reassignment.

a. The Plan must receive the PMG's letter to the member within 10 business days following the Plan's approval to dismiss.

    i. If the Plan does not receive this copy within the required timeframe, the dismissal becomes invalid.
    ii. The PMG can initiate the process again to pursue dismissal.
    iii. The Plan provider must provide treatment and access to services until the member selects a new PCP or a new PCP is assigned.

10. When a PCP dismisses a member, all referral authorizations for that member are invalidated.
    a. Members must contact the new PCP to obtain new referrals and authorizations.

C. Member Reassignment to another Primary Care Provider within Plan Medical Group (PMG)

1. PMGs do not need the Plan's approval to reassign members to another PCP within their medical group.
2. The PMG must inform members of its intention to assign a different PCP and ensure that members understand that they can choose their own PCP, if they should want different primary care providers.
3. The PMG can either reassign the member and inform Sharp Health Plan through enrollment workflows established with EDI Management or ask the member to initiate the process.
    a. The PMG can submit the online member reassignment request form to assign members to a new PCP via the Plan website.
        i. The EDI Management department receives the request and processes the reassignment change in the Plan's core administrative system, which triggers an automated PCP reassignment letter.
        ii. Members receive the PCP reassignment letter via mail. The letter identifies the new PCP and outlines how the member can change the assigned PCP by calling Customer Care or completing an online PCP change form.
    b. The member can request a new PCP by:
        i. Calling the Customer Care at 858-499-8300 for assistance.
        ii. Submitting a PCP change form request via the member's Sharp Health Plan online account.
4. The PMG must notify the Provider Account Management team via email of member reassignments within five business days.

Member Dismissal Request Form

SHARP Health Plan

Member dismissal request form

Purpose

This form is to be used by a plan provider's office to request dismissal of a current member assigned under a Sharp Health Plan policy.

Instructions

Please include all supporting details and documentation for dismissal along with this request form. Please refer to the Provider Operations Manual (POM) for additional information regarding the memberdismissal process. For questions, please contact the Provider Account Management team at provider.relations@sharp.com or 1-858-499-8330.

Submit

By Email:
Attention: Provider Account Management
provider.relations@sharp.com

By Fax:
Attention: Provider Account Management
1-858-303-9049

Provider Information		
Provider name:	Medical Group name:	
Telephone #:	Fax #:	
Provider signature:	Date (MM/DD/YYYY):	Dismissing from entire group? ☐ Yes ☐ No
Name of person completing form:	Role / title:	
Member Information		
Name:	ID number:	Date of birth (MM/DD/YYYY):
Reason for Dismissal		
☐ Financial ☐ Fraud ☐ Abusive or threatening ☐ Other (specify) _____		

Sharp Health Plan Use Only	
Date dismissal request received:	Date all supporting documentation received:
Date review completed by Sharp Health Plan CMO:	Date Sharp Health Plan decision sent to requesting provider:
If Dismissal is Authorized	
Member must elect new PCP by this date:	Date Sharp Health Plan decision sent to requesting provider:

10-2025

Culturally and Linguistically Appropriate Services

Effective January 1, 2009, California law (Section 1367.04 of the California Knox-Keene Act and Section 1300.67.04, Title 28, California Code of Regulations) requires that health plans establish a Language Assistance Program (LAP) for members with Limited English Proficiency (LEP). Under this law, contracted providers are required to cooperate and comply with Sharp Health Plan's LAP by facilitating LEP enrollment to access LAP services. Sharp Health Plan provides the following language assistance services at no cost to the member:

Linguistic Matching: Members who do not select a primary care physician are automatically assigned to a PCP based on identified language need and geography.

Access to Interpreters: Plan providers may request interpreters for members whose primary language is other than English by calling Sharp Health Plan at 1-858-499- 8300 or toll free at 1-800-359-2002. The Customer Care representative will request the following information:

- Member demographics, including name, member identification number, age, sex, language, and country of origin (to determine the appropriate version of the requested language)
- Plan provider information, including appointment date and time, office location, provider's name and phone number, and type of appointment (e.g., OB/GYN, well-care, etc.)

Requests for face-to-face interpreting services must be made at least five (5) days prior to the appointment date. In the event that an interpreter is not available for face-to-face interpreting, Sharp Health Plan can arrange telephone interpreting services.

Translation of Written Material: Written informational material including the Member handbook, form letters, member newsletters, and medical care reminders are translated into Spanish and other languages as requested, at no cost to the member. Please inform our members that they may request such translated materials by calling Sharp Health Plan at 1-858-499-8300 or toll-free 1-800-359-2002.

Notices Available from the Department of Managed Health Care: Informational notices explaining how members may contact Sharp Health Plan, file a complaint with the Plan, obtain assistance from the Department of Managed Health Care (DMHC), and seek an Independent Medical Review are available in non-English languages through the Department's website. The notice and translations can be obtained online at dmhc.ca.gov for downloading and printing. In addition, hard copies may be requested by submitting a written request to:

Department of Managed Health Care
Attention: HMO Help Notices
980 Ninth Street, Suite 500, Sacramento, CA 95814

Provider Responsibilities for Cultural and Linguistic Services

Health care providers are responsible for ensuring that members fully understand their diagnosis and treatment guidelines regardless of their preferred language. To ensure that all LEP members receive appropriate access to Covered Benefits, Plan providers are expected to comply with federal and state requirements regarding cultural and linguistic services. It is not permissible to turn a member away or limit participation because of language barriers, to subject a member to unreasonable delays due to language barriers, or to provide services to LEP members that are lower in quality than those offered in English.

Following the tips below will help providers and their staffs communicate effectively with Limited English Proficient (LEP) members and ensure compliance with federal and state regulations:

Prior to meeting with a member, look to see if a member's language needs have been documented in the file.

Document members' language requirements in medical charts.

Inform member of their right to interpreter services, at no cost to the member, even when a member is accompanied by a family member or friend who can provide interpretation services. Document all requests and refusals in members' charts.

Remember that a member should never be required to bring his or her own interpreter, and a member's family members should not be encouraged to serve as interpreters. In addition, minors should not be used as interpreters.

To decrease the wait time and to provide timely access to care, arrange for interpreting services at the time appointments are made.

Post signs in appropriate languages informing members of the availability of free interpreter services.

Inform members that they may call Sharp Health Plan to request translated documents at no cost to the member and to register their preferred languages with the Plan.

Provide periodic training to office staff on cultural competency and use of interpreters.

Call Customer Care at 1-858-499-8300 if you need assistance providing language assistance services (interpretation, translated documents, etc.) for any of your Sharp Health Plan members.

If the member declines an interpreter, please document the refusal in the medical record.

If you would like more information on working with LEP members, there is a training on the website in the provider section.

If you're comfortable, please consider sharing your race/ethnicity to the plan. This will not be reported in the provider directory but will be shared in the event a member is trying to find a provider they would like to see.

For additional information or resources about Sharp Health Plan's Language Assistance Program, contact Provider Account Management at 1-858-499-8330 or provider.relations@sharp.com or visit the "Language Assistance" link on the provider page at sharphealthplan.com.

SECTION VI

Utilization Management



Utilization Management Program

Sharp Health Plan's Utilization Management (UM) Program ensures Medically Necessary services are rendered at the appropriate level of care in a timely and cost-effective manner. UM Program activities include prospective (before), concurrent (during) and retrospective (after) review of medical care and services as well as assistance for appropriate discharge planning. Sharp Health Plan may delegate UM activities to qualified plan medical groups (PMGs) which meet specific regulatory requirements.

All UM decision making is based solely on the appropriateness of care and existence of coverage. Neither Sharp Health Plan nor a PMG shall reward providers or other individuals for issuing denials of coverage for care or services. There are no financial incentives for UM decision makers to encourage decisions that result in underutilization.

Sharp Health Plan and its delegated PMGs require all Authorization requests to be screened by qualified health professionals using decision-making criteria that are objective and based on accepted medical evidence. Medical necessity criteria must be reviewed annually and updated as appropriate. Medical necessity criteria must be available to Plan providers and members upon request. Services not meeting standard medical necessity criteria are forwarded to the Medical Director or provider designee for review.

The following PMGs are delegated by Sharp Health Plan for UM functions. Please contact the PMG directly for information regarding referral and authorization requests and requirements.

PMGs	Phone	Fax/Out-of-Network (OON)
Greater Tri-City IPA	1-760-941-7309 1-877-207-7600	1-760-941-7332 OON Coastal Hospitalists 1-760-988-2499
Optum Care Network – North County SD	1-760-542-6757	1-866-321-1465 OON Coastal Hospitalists 1-760-988-2499
Rady Children's Health Network (CPMG)	1-858-309-6270	1-858-309-7977
Sharp Community Medical Group (SCMG)	1-858-499-2550 1-877-518-7264	1-858-636-2227 OON 1-858-636-2210

PMGs	Phone	Fax/Out-of-Network (OON)
SCMG Palomar Health Medical Group (PHMG)	1-858-675-3200	1-858-636-2227
SCMG PHMG Temecula	1-760-291-6700	1-760-737-7367
SCMG Graybill North Coastal SCMG Inland North	1-760-291-6615 1-858-499-2550	1-760-291-6647 1-858-636-2214
Sharp Rees-Stealy Medical Group (SRS)	1-858-499-2532	1-858-499-5956 OON 1-858-636-2263

Referral and Prior Authorization Process

Medical and Behavioral Health Services

Prior authorization requests for medical services not handled by the member's Plan Medical Group (PMG), including referrals and notifications, must be submitted to Sharp Health Plan via fax at 1-619-740-8111. You may find the prior authorization form located on your Sharp Health Plan Account, our provider portal. If you are not yet signed-up for this easy-to- use and secure on-line resource, please contact Sharp Health Plan Provider Account Management at 1- 858-499-8330 or email provider.relations@sharp.com.

Prior authorization request for behavioral health services see Behavioral Health section on page 26.

Prior authorization forms are also available on sharphealthplan.com/for-providers/forms-and-materials. Urgent requests may be submitted via fax or by calling Customer Care at 1-858-499-8300 or toll-free at 1-800-359-2002.

PLEASE NOTE: Pharmacy authorization requests must be sent directly to our Pharmacy Benefit Manager (PBM). Refer to Section VII of this guide – Pharmacy Benefit Services.

The Prior Authorization Guide for providers contracted directly with Sharp Health Plan is available on sharphealthplan.com/for-providers/utilization-management and outlines two different types of referral processes for covered services:

Direct Referral

Referral, authorization, or notification to Sharp Health Plan is not required. Services must be medically necessary and ordered by the member's PCP or Sharp Health Plan contracted specialist, and services must be referred from and provided by a member's network contracted provider. No referral form or referral number is required for direct referrals.

Tier 1 PPO providers are expected to direct members to Tier 1 network providers whenever possible. Directing members to non–Tier 1 PPO providers should occur only when medically necessary, in emergency situations, when Tier 1 network adequacy is insufficient, or when a member requests an out-of-tier provider and provides written acknowledgment of the applicable cost share.

Prior Authorization Required

Prior Authorization is the process of evaluating medical services prior to the provision of services to determine Medical Necessity, appropriateness, and benefit coverage. Services requiring Prior Authorization should not be scheduled until a provider receives approval from Sharp Health Plan. Sharp Health Plan reserves the right to deny payment for authorized services if it is determined that inaccurate information was provided to support the authorization request. Requests should be submitted by the requesting provider via Sharp Health Plan's online referral management system.

Requests must be accompanied by all pertinent medical records and supporting documents to avoid unnecessary delays. Medical information, including but not limited to the following, should accompany all prior authorization requests, as appropriate (the records should also be provided to the "refer to" provider to ensure that consulting provider has all pertinent clinical information prior to a member visit:

- Medical history related to the diagnosis
- Results of any diagnostic tests previously performed (including lab and radiology reports)
- Consultation reports related to the diagnosis from other providers
- Information on referrals pending for other providers

Experimental/investigational services are not a Covered Benefit unless they meet the criteria of our Clinical Policy HS-CP-E1 titled "Experimental and Investigational Treatment," which is available on your Sharp Health Plan Account (provider portal). Providers may submit a completed prior authorization request to Sharp Health Plan to determine whether a requested service is considered experimental or investigational.

Certain services require a service specific prior authorization form. These forms are available under the provider forms section of the provider page on sharphealthplan.com/for-providers/forms-and-materials. Prior authorization requests may

be faxed to 1-619-740-8111. Urgent requests may be submitted via fax or by calling Customer Care at 1-858-499-8300 or toll-free at 1-800-359-2002.

Please note: "Second opinion consultation only" prior authorizations allow the specialist one authorized member visit. No labs, imaging, procedures, or other services are included in the authorization for second opinion, unless specifically approved.

Utilization Review

Sharp Health Plan's UM staff uses a wide range of approved criteria, guidelines, and reference tools to assist in the review of medical necessity including, but not limited to, in the following sequence:

- Member Handbook
- MCG Care Guidelines
- National Comprehensive Cancer Network (NCCN) (Used prior to MCG for Hematology/Oncology Diagnoses)
- Hayes Knowledge Center
- Recognized standards of care from third parties e.g., National Professional Organizations, UpToDate
- Peer reviewed published articles

OptumHealth Behavioral Solutions of California makes medical necessity determinations for behavioral health services by applying the most recent criteria and guidelines developed by the nonprofit professional association for the relevant clinical specialty when conducting utilization review of treatment of mental health and substance use disorders. More information on medical necessity criteria can be found at:

- American Society of Addiction Medicine (ASAM): asam.org
- Level of Care Utilization System (LOCUS): locusreporter.com
- Child & Adolescent Level of Care Utilization System (CALOCUS): locusreporter.com
- Early Childhood Service Intensity Instrument (ECSII): aacap.org

World Professional Associations for Transgender Health (WPATH): wpath.org

Clinical policies utilized by the Sharp Health Plan's UM department in the evaluation of requests for authorization may be accessed through your Sharp Health Plan Account (provider portal) at www.sharphealthplan.com/login.

Clinical criteria developed by the following nonprofit professional associations, or a successor organization thereto, shall be used to make utilization review determinations that are within the scope of the criteria for behavioral health and substance use disorder:

1. American Academy of Child and Adolescent Psychiatry
2. American Academy of Family Physicians
3. American Academy of Neurology
4. American Academy of Pediatrics
5. American Academy of Sleep Medicine
6. American Association for Community Psychiatry
7. American College of Physicians
8. American Medical Association
9. American Psychiatric Association
10. American Psychological Association
11. American Society of Addiction Medicine
12. Canadian Network for Mood and Anxiety Treatments
13. Counsel of Autism Providers
14. World Professional Association for Transgender Health

Contact Information

- Sharp Health Plan Utilization Management staff is available 8 a.m. to 5 p.m. Monday through Friday to answer questions from providers and members regarding utilization management issues.
- After office hours, providers may call Customer Care at 1-858-499-8300 or toll-free 1- 800-359-2002 to be transferred to Sharp Nurse Connection for urgent medical requests or to CVS Health for urgent prescription drug requests.
- Callers also have the option of leaving a voice mail message for return call by the next business day.
- Sharp Health Plan staff will identify themselves by name, title and organization name when making inbound or outbound calls about utilization management issues.
- The toll-free number 1-800-359-2002 is available 24 hours a day, seven days a week to accept collect calls regarding utilization management issues.

- Language assistance is available through our toll-free Customer Care line at 1-858-499-8300 or toll free at 1-800-359-2002.

Prior Authorization Review Timelines

Sharp Health Plan and its delegated plan medical groups (PMGs) are required to provide prompt and timely decisions on prior authorization requests appropriate to the member's condition.

Determinations are made based upon the established Health Industry Collaboration Effort (HICE) standards for turnaround times. Determinations for routine requests are not to exceed five business days from the receipt of the information necessary to make the determination.

For medical management, requests that are received as urgent are adjudicated within 72 hours, and the provider and member are notified within 24 hours of the decision. For routine requests, the turnaround time is five (5) business days.

For pharmacy review timelines please see Pharmacy Benefits Services, Section VII.

Provider Notification of UM Decision

The requesting provider is informed via fax, telephone, or email of the final status of any authorization request. When a requested service is approved, notification is sent to both the provider and the member. The notification may also be sent to the member's primary care physician. The notification of approval specifies the servicing provider the service authorized, number of treatments, date range for which the authorization is valid, and expected length of stay (if appropriate). Notification is also sent regarding any services that are denied or modified. A copy of the denial or modification letter is sent to the member, facility (if applicable), PCP, and/or specialist. The denial or modification letter includes a clear and concise description of the criteria used to deny or modify the authorization. All letters of denial or modification include an explanation of the reason for denial or modification as well as a description on how to file an appeal. For questions regarding the status of a prior authorization request, contact Sharp Health Plan by phone at 1-858-499-8300, toll-free at 1- 800-359-2002, or online via your Sharp Health Plan Account (provider portal) application, or the appropriate PMG.

Concurrent Hospitalization Review

All inpatient stays, not handled by member's delegated PMG, are reviewed to determine the appropriate level of care in accordance with MCG Length of Stay guidelines. Telephonic and/or on-site chart reviews are conducted at all plan hospitals and skilled nursing facilities by licensed UM staff. An initial review of all hospitalizations will occur within one business

day of the notification to Sharp Health Plan. Subsequent reviews are conducted in accordance with the MCG Length of Stay Guidelines and as deemed necessary by the UM staff to ensure that the length of stay and level of care meet clinical criteria. If the criteria have not been met or medical record documentation is inadequate to authorize continued stay, the nurse reviewer and/or SHP Medical Director will consult with the member's attending provider, provider advisors, or other appropriate hospital staff to obtain additional information.

In the event that a member is admitted to a facility outside the Plan's service area, the Plan's UM department will work with the out-of-area provider and (as applicable) the member's Plan Medical Group to determine when the member can safely be transferred back into the service area and to coordinate the transfer. The UM nurse reviews admissions at non-contracted facilities telephonically and with electronically transmitted medical records and updates. The goal of this review is to facilitate transfer of the member to a Sharp Health Plan contracted hospital as soon as medically appropriate.

Discharge Planning

Discharge planning is a process that begins at the time of an inpatient admission and includes an assessment of each member's potential discharge needs. Discharge planning activities are carried out by Sharp Health Plan or a delegated PMG's UM staff in coordination with hospital staff, which may include discharge planners, social workers, or nurse case managers in conjunction with the treatment team.

Retrospective Authorization Review

Medical record review to determine appropriate utilization of services may be conducted for cases in which Sharp Health Plan was not notified before or during the provided service. Cases for retrospective review are often identified upon receipt of an unauthorized claim. Cases may also be identified through requests for retrospective authorization from out-of-network or out-of-area providers. Retrospective reviews will be processed within 30 working days of receipt.

Emergency Services

Emergency services providers may screen and stabilize a member without prior authorization in cases where a member, acting reasonably, would have believed that an emergency existed. Sharp Health Plan must be notified within 24 hours of stabilization by contacting Sharp Health Care Out-of-Network department at 1-858-499-2346.

Denial of Services

A denial may occur at any time during the review process: prospective, concurrent, or retroactive to services being rendered. Only a physician or a pharmacist for a pharmaceutical decision may issue a denial for reasons of medical necessity. Nurse reviewers or designated UM Department staff under the supervision of an RN may issue denials for other reasons, such as lack of benefit coverage or member ineligibility. Providers requiring additional information on denials may contact Sharp Health Plan or PMG UM personnel to discuss the case. Notification of a denial to the requesting provider must include a clearly defined reason for denial, the criteria utilized in the decision-making process, a statement indicating that the reviewing physician or pharmacist for a pharmaceutical denial decision is available to discuss any UM denial, and a direct phone number to the physician or pharmacist reviewer who adjudicated the case.

Communication to Providers

Sharp Health Plan communicates changes or updates to policies, procedures, and regulatory requirements to Plan providers via:

- This Provider Operations Manual, which is provided upon contracting with the Plan, and for which updates are posted online at: sharphealthplan.com/pom.
- Sharp Health Plan Fax Blasts, which are sent directly to provider offices to announce an update to UM criteria posted on the website.
- Sharp Health Plan Fax Blasts that are sent to the UM Departments of select Medical Groups that prefer to distribute information to their affiliated providers.
- Sharp Health Plan provides required notification to Plan providers about:
- Sharp Health Plan's policy requiring an appropriate provider reviewer to be available to discuss any UM denial decision.

How to contact the provider reviewer (by listing a direct phone number in the provider denial letter).

- The opportunity to discuss a behavioral or non-behavioral healthcare UM denial decision with a provider or other appropriate reviewer.
- How to access UM criteria online at sharphealthplan.com.
- How to connect via email using the Contact Us form at sharphealthplan.com or by calling Provider Account Management at 1-858-499-8330.

Current information contained in directory listings. It is the provider's responsibility to respond affirmatively or with modifications within 30 business days or risk deletion from the next directory.

Second Medical Opinions

When requested by the member or the Plan provider, Sharp Health Plan may cover a second medical or surgical opinion, after the first opinion by the same specialty has been rendered. There must be a first opinion rendered within the prior year to request a second opinion. A second opinion may be requested for any of the following reasons:

- The member questions the reasonableness or necessity of recommended surgical procedures.
- The member questions 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.
- 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 the member would like to request an additional evaluation.
- The treatment plan in progress is not improving the member's medical condition within an appropriate period of time given the diagnosis and plan of care, and the member would like a second opinion regarding the diagnosis or continuance of the treatment.
- The member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.
- The member or provider treating the member has serious concerns regarding the accuracy of the pathology results and requests a specialty pathology opinion.

Members and Plan providers request a second opinion through the Plan or the member's PMG, if the requesting provider is unable to treat the member and there is no one else in the PMG to treat the member. Requests will be reviewed and facilitated through the authorization process according to the following:

- If the member requests a second opinion regarding care from a specialist, the second opinion shall be provided by an appropriately qualified health professional of the member's choice within the member's Plan Network (Premier, Performance, Choice, and Value) of the same specialty as the first opinion.
- If an appropriately qualified health professional of the same or equivalent specialty is not available within the plan network, the second opinion will be provided by a Sharp Health Plan provider who is an appropriately qualified health professional. The Plan shall consider the ability of the member to travel to the provider.
- A second opinion from a non-contracted qualified health professional will be authorized only when there is not a Plan provider who is a qualified health professional.

- The qualified health professional rendering the second opinion must supply the member, PCP and Plan with the consultation report and treatment recommendations in a timely manner. The time frame for submission of the consultant report will be stated in the referral authorization document. If the qualified health professional is unable to comply with the time frame proposed, a written request for extension should be made prior to the expiration of the original time frame or an opinion from another qualified health professional will be sought.
- The qualified health professional rendering the second opinion is limited to consultation only, and no service (including labs or x-rays), procedure, or care will be covered.
- Any costs related to travel, lodging, meals, or incidentals such as parking fees are the member's responsibility and will not be covered by the Plan.

For questions about second opinions or a copy of the Sharp Health Plan's policy, please visit sharphealthplan.com/for-providers/clinical-resources/clinical-practice-guidelines.

Case Management Program

Sharp Health Plan's Case Management Program uses a client/caregiver approach to promote availability of appropriate care and resources while maximizing the member's quality of life and healthcare benefits. Case management is a collaborative process with the member, family, provider, and other treating entities, designed to meet the individual's needs while promoting quality outcomes.

Sharp Health Plan offers a Case Management Program for complex cases. Our case management nurses work closely with Plan providers to develop and implement the most appropriate treatment plan for the member's needs. Providers interested in referring a member to the Case Management Program can call Sharp Health Plan Customer Care at 1-858-499-8300 or toll-free 1-800-359-2002, or complete the case management referral form available on sharphealthplan.com/for-providers/forms-and-materials. Any individual involved in the care of a member may make a referral to the Case Management Program, including but not limited to, the following:

- Primary care physician (PCP)
- Specialist
- Discharge planner
- Plan staff

Each case is considered on an individual basis. Cases not accepted into the Case Management Program are kept on file for future reference. Referrals to the Case Management Program are screened for medical, psychosocial, financial, and related needs no later than 30 calendar days from the date the member is referred to case management.

The case manager assesses each referral through medical records and discussion with the PCP and other involved parties, as needed. Referrals for case management services include, but are not limited to, the following situations in which care coordination is needed to meet members' needs while promoting appropriate utilization of services and cost-effective outcomes:

- Transplants
- Chronic pain management
- Medication management
- Out-of-Area/Out-of-Network services
- Transgender services
- Comorbid or complex behavioral health conditions
- Maternal mental health
- Care facilitation
- Social support issues

As appropriate, the case manager will facilitate care coordination for members who have the following indicators:

- Three or more acute hospital admissions per year
- Two or more emergency department visits in a three-month period
- Non-compliance with medical recommendations and care
- Complex medical needs that require close monitoring
- Behavioral health conditions, including maternal mental health
- Life expectancy of six months or less
- Inpatient hospital stays for more than ten days
- Complex psychosocial or functional requirements
- Quality issues related to clinical care
- When a member is accepted into the Case Management Program, the case manager performs the following functions:
- Serves as a liaison and resource for providers and members and their families.
- Communicates information to caregivers to obtain consensus on a plan of care.

- Develops and coordinates a plan of care with realistic and appropriate goals/outcomes.
- Facilitates provider-to-provider communication and other communication when needed.
- Manages all authorizations for services for the assigned member.
- The Case Manager closes a case when one or more of the following endpoints have been established:
- Services are no longer needed due to resolution of the member's illness or the member's death.
- Reasonable goals and objectives in the plan of care have been met, and the member's condition is stabilized.
- Family and other support systems can adequately provide needed services.
- Care coordination is ongoing without the need for oversight by the case manager.
- The member has moved out of the service area.
- The member declines further case management services.

Maternal Mental Health

The Maternal Mental Health law, as described in the Health and Safety Code (Section 1367.625) requires that a licensed healthcare practitioner (provider) who provides prenatal or postpartum care for a member shall ensure that the mother is offered screening or is appropriately screened for maternal mental health conditions, including both prenatally and postpartum. In addition, Health Plans are required to develop a mental health program designed to promote quality and cost-effective outcomes that include at least one screening conducted during pregnancy, one screening to be conducted in the first six weeks of the postpartum period, and additional postpartum screenings, if determined to be medically necessary and clinically appropriate in the judgement of the treating provider.

Maternal mental health means a mental health condition that occurs during the perinatal period, which includes prenatal period, during pregnancy and during the postpartum period. It includes, but is not limited to, postpartum depression.

California Senate Bill (SB) 1207 amends the current law to include the addition of quality measures to encourage screening, diagnosis, treatment, and referral to appropriate mental health services. These quality measures will be monitored by the health plan for compliance and reported. Additionally, the Plan's Maternal Mental Health program

guidelines and criteria shall be provided to relevant medical providers, including all contracting obstetric providers.

Sharp Health Plan has a maternal mental health program which is designed to assist mothers (prenatal and postpartum) with healthcare needs, including mental health and substance use disorder needs. Assistance includes explanation of healthcare benefits; making appointments; and providing and connecting with health plan and community resources. Sharp Health Plan offers case management services to members who qualify and includes members with a maternal mental health condition. Referrals will be accepted from any source, including, but not limited to, providers, members, and hospital staff.

Providers who have a positive screening can direct mothers to a Sharp Health Plan network behavioral health provider. A referral for behavioral health is not required. In addition, providers can refer mothers to Sharp Health Plan's case management department. A case management referral can be made by completing the Case Management Referral form found in the Forms section of the Sharp Health Plan website, or by calling 1-858-499-8300.

Doula Benefit

California Assembly Bill 904 (AB-904) requires health insurers to develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through utilization of doulas. CalPERS and FEHB also require doula services be made available to their members through health plans.

Doula Benefit Eligibility

To meet these requirements, SHP offers doula benefit coverage at no cost to eligible commercial members through doulas contracted with SHP (list is available in the SHP provider directory).

To be eligible, the commercial member must be pregnant or have been pregnant within the last 12 months, and one of the following must also be true:

Eligibility Option	Comments
Member belongs to CalPERS group	Member may contact a doula provider contracted with SHP for services.
Member belongs to the Federal Employees Health Benefits (FEHB) group	Member may contact a doula provider contracted with SHP for services.

Eligibility Option	Comments
Member is enrolled in SHP's Maternal Mental Health Case Management Program (see section titled "Maternal Mental Health" for information about that program)	If not already enrolled in SHP's Maternal Mental Health Case Management program, members or their PCP/OB can request inclusion. This process may also be initiated by the member through Customer Care. Once a member is enrolled in SHP's Maternal Mental Health Case Management Program, SHP Case Managers will contact the member and provide authorization for doula services if they are interested. Authorization is required prior to engaging a contracted doula.
Member meets criteria for SHP's Health Equity Quality Program's analysis for maternal care based on racial disparities	SHP has an existing Health Equity Quality Program that analyzes racial disparities within certain conditions. SHP will directly invite members eligible through this option through targeted correspondence to contact Customer Care to express interest in doula services and be authorized. Authorization is required prior to engaging a contracted doula.

Autism Services

It is the policy of Sharp Health Plan to adhere to the California regulatory requirements for providing coverage for behavioral health treatment for members diagnosed with autism spectrum disorder. Sharp Health Plan is responsible for arranging and provide coverage for medically necessary medical services, such as occupational, physical, or speech therapy, for all diagnoses including autism spectrum disorder. Sharp Health Plan will cover behavioral health treatment, such as applied behavioral analysis (ABA) therapy or evidence-based intensive behavioral health treatment, for members diagnosed with autism spectrum disorder when medically necessary.

Sharp Health Plan is partnered with OptumHealth Behavioral Solutions of California for all behavior health services, including autism services. Providers can visit www.liveandworkwell.com to search for providers.

Disease Management Program

Sharp Health Plan offers disease management programs for members diagnosed with diabetes and/or chronic cardiovascular conditions, including hypertension and/or hyperlipidemia. Providers can refer a member to the Plan's Disease Management Program by calling Customer Care at 1- 858-499-8300 or toll-free 1-800-359-2002, or by completing the Case Management/Disease Management Referral Form available at www.sharphealthplan.com.

Out-of-Network Services

For services that are the financial responsibility of Sharp Health Plan, HMO members must be directed to a provider within Sharp Health Plan's contracted network. If a member requires Out-of-Network services because Sharp Health Plan is not contracted with a provider of a like specialty, a Letter of Agreement (LOA) must be obtained for the non-contracted provider.

For services that are the financial responsibility of the PMG, the PMG will follow its organization's policy in reference to authorization of out-of-network providers. Sharp Health Plan requires all delegated and non-delegated plan medical groups and providers to adhere to Sharp Health Plan's out-of-network policy and procedure (Policy HS-MM-121: Referrals to Non-Contracted Providers), available on your Sharp Health Plan Account (provider portal) at www.sharphealthplan.com/login.

Delegated Utilization Management

When Utilization Management is delegated to another Medical Group, their Utilization Management operations and activities are conducted by their qualified UM staff who must follow all regulatory requirements. Audits occur annually to confirm that key components are in place to ensure that the delegated entity adheres to Sharp Health Plan requirements and policies. Each delegated organization must have a utilization management program that is approved by Sharp Health Plan's Delegation Oversight Committee, and a signed delegation agreement must be in place. Each delegation agreement details the key components, processes, and reporting requirements of the delegates. Sharp Health Plan requires all delegated plan medical groups and providers to adhere to Sharp Health Plan's medical and pharmacy management policies, available on your Sharp Health Plan Account (provider portal) at www.sharphealthplan.com

SECTION VII

Pharmacy Benefit Services



Formulary

Sharp Health Plan maintains a Drug Formulary (or Drug List) designed to support the achievement of positive member outcomes through the selection of high-quality, cost-effective pharmaceuticals. The Drug Formulary includes drugs that are identified as prescription drug benefits in the member's Evidence of Coverage (EOC). To find the most up- to-date coverage and utilization management information for a drug, visit www.sharphealthplan.com/search-drug-list or your Sharp Health Plan Account (provider portal) at www.sharphealthplan.com/login and view the searchable formulary PDF assigned to the member's benefit plan. Updated formularies and formulary changes are posted monthly. If your Electronic Health Record (EHR) includes Real Time Benefit Check (RTBC), you can view formulary status, drug utilization management strategies, and member cost share information through your EHR. You can also run a mock drug claim. If your EHR has not activated RTBC, please check with your EHR vendor.

RTBC allows you to:

- Review member's formulary, plan design and out of pocket cost.
- Run a mock claim.
- See up to five clinically appropriate formulary alternatives.
- Review member deductible status.
- View utilization management requirements.
- Instantly submit a prior authorization. Approval decisions may be provided in as little as six seconds.

Members can log into the CVS Caremark pharmacy portal on the Plan's website to view pricing, utilization management, and coverage information.

The Plan covers drugs listed on the formulary and prescribed by licensed Plan providers operating within the scope of their practice. As the prescribing provider, Plan providers are essential to the appropriate use of pharmaceuticals. This includes:

- Choosing the best, most economical drug, and dosage form to treat the member's condition.
- Making sure each member clearly understands the drug's use, the correct dose and possible side effects.
- Looking for drug interactions and discontinuing ineffective drugs.
- Reviewing each member's drug list and dosages at every visit.
- Carefully monitoring therapeutic drug levels, as necessary.

Pharmacy and Therapeutics (P&T) Committee

SHP Formularies are created by our Pharmacy Benefit Manager (PBM). The PBM designs the formulary and utilization management edits under the guidance of its Pharmacy and Therapeutics (P&T) Committee. The PBM's P&T Committee evaluates the safety, efficacy, and cost-effectiveness of drugs and approves utilization management edits such as prior authorization, step therapy, and quantity limits. Sharp Health Plan maintains its own P&T Committee, which conducts oversight of the PBM's Formulary and utilization management decisions on a quarterly basis. The SHP P&T Committee is comprised of pharmacists and providers representing various clinical specialties. Formulary updates are available on sharphealthplan.com.

The PBM P&T Committee may move a drug from preferred to non-preferred status or remove a drug from the Formulary for one or more of the following reasons:

- Withdrawal of a drug licensure by the Food and Drug Administration
- The risk of toxicity outweighs the benefits of the drug as judged by the Committee
- Replacement by another drug with significant advantage regarding efficacy, toxicity, and/or cost
- Low usage of a drug

Recommendations for formulary or utilization management changes may come from members, Plan providers, or SHP P&T Committee members. To make a request, please call Customer Care at 1-858-499-8300 or toll-free 1-800-359-2002 or email provider.relations@sharp.com.

Tiered Copay Programs

Sharp Health Plan has several tiered copay and cost share programs. The Pharmacy Copayment Program places all covered drugs on a tier. The program gives members and providers a wide range of drug product choices. It is important for the member and provider to work together to determine which drug is most appropriate.

Sharp Health Plan offers a 3-Tier Pharmacy Cost Share Program.

- Tier 1: Medications on Tier 1 have the lowest copayment. Tier 1 includes formulary preferred generic drugs.
- Tier 2: Medications on Tier 2 are subject to the middle copayment. This tier includes formulary preferred brand-name drugs and inhaler spacers.
- Tier 3: Medications on Tier 3 have the highest copayment and include non-preferred generic and brand-name drugs.

Additionally, members pay $0 for preventive formulary medications listed with an A or B recommendation by the USPSTF or for contraception. These are listed as Tier PV (preventive) on the formulary.

Sharp Health Plan offers a Large Group and a FEHB (Federal Employee Health Benefits) plan with a 4-Tier Pharmacy Cost Share program.

- Tier 1: Medications on Tier 1 have the lowest copayment. Tier 1 includes formulary preferred generic drugs.
- Tier 2: Medications on Tier 2 are subject to a Tier 2 copayment. This tier includes formulary preferred brand-name drugs and inhaler spacers.
- Tier 3: Medications on Tier 3 are subject to a Tier 3 copayment. This tier includes non-preferred generic and brand-name drugs.
- Tier 4: Medications on Tier 4 are subject to a member percentage cost share. Specialty medications are on Tier 4.

Additionally, members pay $0 for preventive formulary medications listed with an A or B recommendation by the USPSTF or for contraception. These are listed as Tier PV (preventive) on the formulary.

Sharp Health Plan offers a PPO plan with a 4-Tier Pharmacy Cost Share program.

- Tier 1: Medications on Tier 1 have the lowest copayment. Tier 1 includes formulary preferred generic drugs.
- Tier 2: Medications on Tier 2 are subject to the Tier 2 copayment. This tier includes formulary preferred brand-name drugs and inhaler spacers.
- Tier 3: Medications on Tier 3 are subject to the Tier 3 Copayment and include non-preferred generic and brand-name drugs.

Tier 4: Medications on Tier 4 are subject to a member percentage cost share. Specialty medications are on Tier 4.

Additionally, members pay $0 for preventive formulary medications listed with an A or B recommendation by the USPSTF or for contraception. These are listed as Tier PV (preventive) on the formulary.

Sharp Health Plan offers a Non-Grandfathered Small Group Plan with a 4-Tier Pharmacy Cost Share program.

Tier 1: Most generic drugs and low-cost preferred brand name drugs.

Tier 2: Non-preferred generic drugs, preferred brand name drugs, and any other drugs recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost.

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

Tier 4: Specialty drugs.

Additionally, members pay $0 for preventive formulary medications listed with an A or B recommendation by the USPSTF or for contraception. These are listed as Tier PV (preventive) on the formulary.

Sharp Health Plan offers members with coverage through Covered California or Covered California “mirrored” plans a 4-Tier Pharmacy Copayment Program.

Tier 1: Most generic drugs and low-cost preferred brand name drugs.

Tier 2: Non-preferred generic drugs, preferred brand name drugs, and any other drugs recommended by the Pharmacy and Therapeutics Committee based on safety, efficacy, and cost.

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

Tier 4: Drugs that the FDA or the drug 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.

PV (Preventative): Select drugs covered with no copayment, including certain generic and over-the-counter contraceptives

MB (Medical Benefit): Drugs evaluated under the Medical Benefit. Please refer to the medical benefit coverage information

The placement of medications on drug tiers is subject to change throughout the year. When a prescription drug becomes available over the counter, Sharp Health Plan may discontinue coverage of the drug. To find the most up-to-date drug coverage information and utilization management edits for a specific drug, visit the Sharp Health Plan website and view a PDF of the formulary assigned to the member’s benefit plan or use the online drug look-up tool. You may also use Real Time Benefit Check (RTBC) in your EHR to instantly check the member’s pharmacy benefit drug coverage information. If you do not have RTBC enabled, please contact your medical group or EHR vendor for assistance.

Prior Authorization

Coverage of drugs that require a prior authorization (PA) is dependent upon member satisfying plan criteria.

Routine prior authorization requests are reviewed within seventy-two (72) hours of receipt of all necessary information.

Urgent prior authorization requests are reviewed within twenty-four (24) hours of receipt of all necessary information.

PA requests may be submitted by phone, FAX, or electronically through CoverMyMeds.

Requests should be submitted to one of the numbers listed below.

Written requests are only accepted when they are on the Prior Authorization Form 61-211, "Pharmacy Authorization or Step Therapy Exception Request", available on www.sharphealthplan.com. PLEASE NOTE: Any request not submitted on this form will not be reviewed and will be returned to the provider.

Medication samples and medications obtained outside of the Sharp Health Plan pharmacy benefit, for example, with a coupon card, do not satisfy prior authorization requirements.

Commercial Plans	Fax number	Phone number
Specialty medications	866-249-6155	866-814-5506
Non-specialty medications	888-836-0730	855-582-2022
Exchange Plans	**Fax number**	**Phone number**
Specialty medications	866-249-6155	866-814-5506
Non-specialty medications	888-836-0730	855-582-2022

Prior authorization policies and procedures and other utilization management guidelines are available on your Sharp Health Plan Account (provider portal) at www.sharphealthplan.com/login.

Step Therapy

The Step Therapy program encourages safe and cost-effective medication use. Plan physicians may request prior authorization by calling or faxing Sharp Health Plan. The list of Prescription Drugs that require step therapy is subject to change. 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.

When a Plan provider determines that the drug required under step therapy is inconsistent with good professional practice, the Plan provider should submit their justification and clinical documentation supporting the Plan provider's determination with a 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, Sharp Health Plan will notify the Plan 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 Sharp Health Plan fails to notify a Plan 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 a Plan 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 shall be deemed approved for the duration of the prescription, including refills.

Dispense as Written (DAW) Prescriptions

With the exception of FEHB plans, Sharp Health Plan exclusively covers the generic formulation of covered brand name drugs when available. A brand name drug with an available generic equivalent will not be covered based solely upon member request. If the request is based on medical necessity, Prior authorization may be requested and must include the medical justification/explanation for why member cannot use the generic formulation, as well as dates the generic was tried and member's response to the generic.

If the brand name drug is dispensed with Plan approval or at the request of the Plan provider, the member will be charged a higher copayment or cost share (depending on plan design).

FEHB members may receive a covered brand name drug when its generic equivalent is available and medical necessity is established. They will be charged a higher cost share when this occurs.

Emergency Supply

The Plan's Pharmacy Benefits Manager (PBM) Help Desk handles requests for emergency prior authorizations and overrides. If the Plan's emergency criteria are met, PBM staff may enter an override for up to a 5-day supply of medication. The caller will be advised to submit a prior authorization or exception request for any additional quantity. Help Desk phone numbers for an emergency override are:

Commercial Plan Help Desk	Phone number
Specialty medication	866-814-5506
Non-Specialty medication	855-582-2022
Exchange Plan Help Desk	**Phone number**
Specialty medication	866-814-5506
Non-Specialty medication	855-582-2022

For quantity in excess of an emergency 5-day supply, requests should be sent to one of the following numbers based on member's benefit:

Commercial Plan PA/Exception Request	Fax number
Specialty medication	866-249-6155
Non-Specialty medication	888-836-0730
Exchange Plan PA/Exception Request	**Fax number**
Specialty medication	866-249-6155
Non-Specialty medication	888-836-0730

Dispensing Limitations

The Plan may limit the quantity of a drug covered in a given time period. Limits are based on recognized standards of care such as FDA recommendations for use. If a member needs a greater quantity than the quantity limit, an exception request may be submitted.

Some drugs are designated as maintenance medications. The Plan follows the MediSpan classification system for maintenance designation. Maintenance medications may be filled for up to a 90-day supply through mail order or at certain network pharmacies.

Non-maintenance medications are available for up to a 30-day supply.

Specialty drugs are limited to a 30-day maximum supply per fill.

Vacation Overrides

The following limitations apply to the member's pharmacy benefit:

- Vacation overrides may be approved for up to a 90-day supply
- Controlled substances may or may not be approved for vacation overrides
- Requests for greater than a 90-day supply will be considered on a case-by-case basis

Preventive Health Medications

Covered preventive medications, as defined by the Affordable Care Act, are covered without member cost share for non-grandfathered plans. Medical necessity and utilization management edits apply.

Preventive medications include:

- Prenatal vitamins
- Fluoride preparations
- Vitamin D supplementation as recommended by the USPSTF
- Folic acid supplementation as recommended by the USPSTF
- Aspirin
- Iron preparations
- Contraceptives and select over the counter (OTC) barrier methods of contraception (Grandfathered plans and certain religious organizations are exempt from covering these products)
- Bowel prep medications
- Medications recommended by the USPSTF, grade A or B, which are covered through the outpatient pharmacy benefit

Prescriptions for over-the-counter items listed above must be written on a prescription and filled at a Sharp Health Plan Network pharmacy to be covered. However, with the exception of FEHB members, over-the-counter FDA approved contraceptives are not required to be written on a prescription to be covered at a Sharp Health Plan network pharmacy

Prescription Mail Order

- Sharp Health Plan members have access to a contracted mail order pharmacy to obtain maintenance drugs
- Maintenance drugs are available for up to a 90-day supply through the mail service program
- Maintenance drugs are prescribed to treat or stabilize chronic conditions such as diabetes or hypertension
- Members need a prescription written for a 90-day supply in order to obtain a 90-day supply
- Medications not designated by the Plan as a maintenance medication are not available through mail order. Medications such as antibiotics and controlled substances are not designated as maintenance medications.
- Members are responsible for submitting their prescriptions to the mail order pharmacy. Details on how members enroll for mail order are available on sharphealthplan.com/members/pharmacy-and-prescription-drugs.

Specialty Medications

Specialty medications are drugs that may require specialized delivery and administration on an ongoing basis. They are often used to treat complex disease states that require frequent follow-up and monitoring. In addition, drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) for a one-month (30-day) supply are specialty medications.

- Specialty medications may be dispensed for up to a maximum of a 30-day supply
- Specialty medications require prior authorization

Specialty medications covered under the pharmacy benefit can be filled at Sharp Specialty Pharmacy Services (SSPS). Sharp Specialty Pharmacy Services primarily delivers medication by mail. Send specialty prescriptions to SSPS using one of these channels:

Mail	Phone or Fax	Electronically
Sharp Specialty Pharmacy Services NCPDP ID: 5643259 NPI: 1932485307 3558 Ruffin Road South Ste #101 San Diego CA 92123	Phone: 1-858-627-5644 Fax: 1-858-636-2236	Through your current e-prescribing system

Non-Covered Services and Medications

The services and supplies listed below are exclusions and limitations to the Outpatient Prescription Drug Benefit and are not covered by Sharp Health Plan except as required by law:

Large Group Plans

- When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.
- When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.
- When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of Class III obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.
- When prescribed solely for the purpose of shortening the duration of the common cold.
- Prescription drugs available over the counter or for which there is an over-the counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion does not apply to:
    - Insulin
    - Over-the-counter drugs as covered under preventive services, (e.g., over-the-counter FDA-approved contraceptive drugs),
    - Over-the-counter drugs for reversal of an opioid overdose, or
    - An entire class of Prescription Drugs when one drug within that class becomes available over the counter.
    - Replacement of lost or stolen drugs.
- Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.

- For Federal Employees Benefits Program (FEHB) members, services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Small Group Plans

- When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.
- When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.
- When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of Class III obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.
- When prescribed solely for the purpose of shortening the duration of the common cold.
- Prescription Drugs available over-the-counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to:
    - Insulin
    - Over-the-counter drugs as covered under preventive services, e.g., over-the-counter FDA-approved contraceptive drugs),
    - Over-the-counter drugs for reversal of an opioid overdose, or
    - An entire class of Prescription Drugs when one drug within that class becomes available over-the-counter.
- Replacement of lost or stolen drugs.
- Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.
- Drugs that have been prescribed for one or more uses that are different from the use for which the drug is approved for marketing by the FDA (i.e., off-label use), if the conditions required by law are not met.

Prior Authorization and Exception Process

Medically necessary exceptions to prior authorization, step therapy, and quantity limits may be requested and must be submitted using the State of California created Prior Authorization and Step Therapy Exception Request form. The Pharmacy Prior Authorization and Step Therapy Exception Request Form is available at the following link: sharphealthplan.com/for-providers/forms-and-materials. Coverage decisions are made on a case-by-case basis considering the individual member's healthcare needs.

Drugs not listed in the drug list are non-formulary drugs and are not covered. When it is medically necessary for a member to obtain a medication that is not on the drug list, the member, the member's authorized representative, or the member's doctor may request a formulary exception following the Plan's 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. If a formulary exception request is denied, you have the right to appeal the decision.

Sharp Health Plan's Prior Authorization criteria is available through your Sharp Health Plan Account, our provider portal. If you are not signed up for this easy-to-use and secure Internet resource, visit sharphealthplan.com/SharpConnect to register. You may also contact Sharp Health Plan's Provider Account Management Department at 1-858-499-8330 or via email at provider.relations@sharp.com.

Coverage Determination Notification Process

Coverage determination notification may be provided by fax, telephone, or mail. Prescribers will generally be notified by fax. Members will be notified by mail and by telephone. Denial letters include a clear and concise explanation of the denial reason, the criteria used to make the determination, and a description of how to file an appeal.

If we deny a request for coverage of a non-formulary drug, a step therapy exception, or a prior authorization the member, the member's authorized representative or the member's doctor may request a review by an independent review organization (IRO). The request may be submitted up to 180 calendar days following the 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 85072-208

Faxing a written request to 1-866-443-1172

Completing the Member Grievance and Appeal form on our website at:
sharphealthplan.com

The member 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 the member's 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.

Additional Appeal Rights for FEHB Members

Federal Employees Benefit Program (FEHB) members who disagree with a coverage decision may request a review by the U.S. Office of Personnel Management (OPM). Requests must be submitted within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at:

United States Office of Personnel Management, Healthcare and Insurance, Federal Employees Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly.

Important Notes:

- Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.
- Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.
- Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OMP's review within 60 days. There are no other administrative appeals.

For additional information on how to file an appeal for an adverse determination, please see the section on Appeals and Grievances.

Pharmacy Policies and Procedures (Pharmacy Management Procedures)

Sharp Health Plan's Pharmacy Management Procedures are available online through your Sharp Health Plan Account, at www.sharphealthplan.com/login. A printed copy of any Pharmacy Management Procedure is available upon request by contacting Provider Account Management at 1-858-499-8330.

FDA Recalls

The Plan promptly notifies affected members and prescribers when there is a Food and Drug Administration (FDA) Class I or Class II drug recall. Affected members are identified through outpatient pharmacy benefit claims data. The Plan is not able to identify affected members and prescribers if a recall is drug lot specific.

The FDA uses the following definitions for Prescription Drug Recalls:

- Class I Recall:
  A situation in which there is a reasonable probability that use of, or exposure to, a product will cause serious adverse health consequences or death.
- Class II Recall:
  A situation in which the use of or exposure to a product may cause temporary or medically reversible adverse health consequences or where the probability of serious adverse health consequences is remote.

Outpatient Injectable Medications

HMO and POS Plans

Outpatient injectable medications are covered under the medical benefit except for insulin, glucagon, GLP1 inhibitors prescribed for diabetes, epinephrine pens, and some forms of sumatriptan. Self-injectable medications and drugs or preparations that are not typically self-administered are provided through the medical benefit. Drugs that are given by the intravenous, intramuscular, or subcutaneous route in a provider's office or outpatient infusion center are provided through the medical benefit.

Plan providers are responsible for obtaining outpatient injectable medications. The Sharp Health Plan Medical Management Department or the plan medical group may require prior authorization.

Per California Health and Safety Code 1342.75, Vivitrol is covered as an injectable without prior authorization, step therapy, or utilization review.

A. To be eligible for coverage the member must be a Qualified Individual with active Plan membership, and

B. Vivitrol is considered medically necessary for all members with:

    1. Alcohol dependence who are able to abstain from alcohol in an outpatient setting prior to initiation of Vivitrol. OR

    2. Prevention of relapse to opioid dependence, following opioid detoxification. AND

    3. Member should be in comprehensive management program/treatment that includes psychosocial support. AND

    4. Vivitrol must be prepared and administered by a healthcare provider as a deep intramuscular gluteal injection. AND

    5. Prior to initiating Vivitrol, an opioid free duration of a minimum of 7-10 days is recommended to avoid precipitation of opioid withdrawal.

PPO Plans

Outpatient self-injectable medications are covered under the pharmacy benefit for PPO plans. Drugs or preparations that are not typically self-administered are provided through the medical benefit.

Pharmacy Benefits Manager (PBM)

SHP uses CVS Caremark to manage prescription benefit administration. CVS Caremark reviews prior authorization and exception requests, and CVS Customer Care is available 24 hours a day, seven days a week.

Commercial Plan Customer Care	Phone number
Specialty medication	866-814-5506
Non-specialty medication	855-582-2022

Exchange Plan Customer Care	Phone number
Specialty medication	866-814-5506
Non-specialty medication	855-582-2022

Medication Restriction

At the provider's request and with medical justification based on concern for member safety, member medication coverage may be blocked or limited to a specific quantity, provider, or pharmacy. Requests may be submitted to the Sharp Health Plan Pharmacy Department and will be reviewed by the Plan Medical Director for approval.

Opioid Management Strategies

Sharp Health Plan safety and quality initiatives include opioid management strategies. The following safety initiatives are in place for Commercial and Exchange plans:

- Opioid naïve members ages 18 and over are limited to a maximum of a seven-day supply
- Greater than a seven-day supply may be obtained with an approved prior authorization request
- Cumulative daily morphine milligram equivalent (MME) limitations
- A Cumulative daily MME value of 90 MME – 100 MME requires that the dispensing pharmacist review the claim for appropriateness
- A Cumulative daily MME of 100 MME or higher requires a prior authorization
- Concurrent use of opioid and benzodiazepine medications OR opioid and buprenorphine medications are subject to prior authorization
- Use of an immediate release (IR) opioid is required prior to use of an extended release (ER) opioid

Members with cancer-related pain, sickle cell anemia, end-of-life care, or who are in hospice are exempt from these MME requirements. Prior authorization is not required when obtaining medication used to treat Opioid Use Disorder.

SECTION VIII

Quality Improvement



Quality Improvement Program

Sharp Health Plan's Quality Improvement (QI) Program is based on the mission of the Plan – to offer quality care and services that set community standards, fulfill members' expectations, and ensure that medical services are provided in a caring, effective, cost efficient, and accessible manner. The Plan uses the Continuous Quality Improvement (CQI) process to achieve excellence in quality of care and services. The Sharp HealthCare system has adopted Six Sigma processes and has an integrated CQI culture. The purpose of the QI Program is to promote organization-wide commitment to quality of care and services through ongoing performance improvement activities to identify opportunities for improvement, implement change and reevaluate actions taken. The following CQI processes are employed to achieve this goal.

- Continuous improvement and enhancement of quality care and services through ongoing, objective, and systematic monitoring of both medical and behavioral health care.
- Proactive identification of opportunities for improvement in both the clinical and administrative aspects of SHP operations.
- Change management to address identified opportunities for improvement in a systematic manner and an iterative cycle of re-evaluation to measure/monitor improvement.

The goals and objectives of the QI Program are to:

- Promote and integrate quality across SHP's structure and processes.
- Provide effective monitoring and evaluation of member care and business operations to ensure compliance with standards of care and value for health plan members and contracted healthcare professionals.
- Ensure prompt identification and analysis of opportunities for improvement with implementation of actions for resolution and follow-up.
- Coordinate patient safety, risk management, and quality management activities.
- Serve members with complex needs including multiple health conditions or co-morbidities, physical or developmental disabilities, and severe behavioral health illness.
- Compliance with state and federal regulatory requirements and accreditation standards.

The QI Program provides information and education by various mechanisms to include:

- QI Program Description summary posting on Plan website
- Member newsletter articles

- Special mailings
- Committees with contracted network provider participation
- Plan Medical Group Joint Operating Committee meetings
- Distribution and review of monitoring mechanisms such as oversight audits to include language assistance program for compliance to Plan standards

The QI Program includes implementation and evaluation of improvement activities for both clinical care and administrative services provided to members. The scope of the program includes the important aspects of care related to member population demographics and risk status. All departments in the Plan are involved in the continuous quality improvement process.

Quality Management Committee

The Quality Management Committee (QMC) provides a comprehensive and systematic structure for monitoring, evaluating, and improving the Plan QI program. Members of the QMC are appointed by the Chief Medical Officer for a minimum of a two-year term. The QMC membership includes multidisciplinary representation from the provider's network. Committee membership consists of:

- Chief Medical Officer (Co-Chair)
- Network providers including representatives from Pediatrics, Behavioral Health, Adult Medicine, Obstetrics/Gynecology, and at least one specialist provider
- Senior Medical Director
- Director of Population Health and Medical Management
- Director of Quality Improvement (Co-Chair)
- Director of Operations and Performance Improvement
- Director of Pharmacy Benefits
- Director of Network Management and Application Optimization
- Others as appointed by the Chief Medical Officer

The QMC provides quarterly reports to the Board of Directors. The QMC responsibilities include but are not limited to:

- Review and approval of the annual Program Descriptions, Work Plan(s) and Program Evaluations for the QI, Health Equity, UM, and PHM programs
- Review of member satisfaction reporting and analysis to include CAHPS, EES and ECHO surveys and quarterly complaints and appeals monitoring
- Review of provider satisfaction survey reporting and analysis

- Access and availability measurement and analysis to include appointment availability, after-hours access, telephone access, and geoaccess
- Review and approval of clinical practice guidelines, UM criteria, and medical policies
- Review of network facilities for credentialing and recredentialing
- Review of Peer Review Committee activities and trends
- Review of Pharmacy & Therapeutics Committee activities
- Review of Clinical Policy and Technology Assessment and Medicare Utilization Committee activities
- Review of Medicare Stars Council activities
- Review of Sharp Health Plan Equality Alliance Committee activities
- Oversight of Delegation Oversight Committee

Participation in the QI Program

Participation in QI Program activities is required for all providers. Participation may include providing medical records for various studies such as:

- Annual HEDIS data collection project
- Quality of care Grievances and member Appeals

Provider participation may also include providing evidence of preventive health care as appropriate to their membership. Providers may be invited to participate in the review and provide feedback on potential new and/or ongoing QI activities. Providers allow Sharp Health Plan to use their performance data for public reporting, Pay for Performance and other quality improvement activities as needed.

Quality Measurement

Sharp Health Plan has maintained National Committee for Quality Assurance (NCQA) health plan accreditation since 2013. In 2025, Sharp Health Plan was audited by NCQA and successfully completed the audit, improving the audit score from previous years.

Member satisfaction is measured by the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and the Enrollee Experience Survey (ESS) on an annual basis. The CAHPS survey and EES sample frames are audited and validated by our certified HEDIS compliance auditor and reportable results are submitted directly to NCQA and CMS by our certified survey vendor each June. CAHPS survey and EES results are analyzed and reported to the QMC annually. Action plans are implemented as needed to address opportunities for improvement.

HEDIS

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of standardized performance measures used by purchasers of health care to evaluate the quality of care and service provided by health plans and their contracted networks. The National Committee for Quality Assurance (NCQA) HEDIS measures are considered to be the national standard in performance measurement for health plans. HEDIS measures are related to many significant public health initiatives such as:

- Childhood immunizations
- Adolescent immunizations
- Well-child visits
    - Child and adolescent well-care visits (WCV)
    - Well-child visits in the first 30 months of life (W30)
- Timely prenatal and postpartum care
- Prenatal Immunizations
- Depression screening for adolescents and adults
- Cervical cancer screening
- Comprehensive diabetes care
- Breast cancer screening
- Chlamydia screening
- Colorectal cancer screening
- Body mass index (BMI) measurement for children
- Potentially inappropriate use of opioids

Sharp Health Plan uses HEDIS rates to guide QI efforts to target areas for opportunity to improve quality of care for our members. Providers are central to the Plan's efforts to improve quality of care and access. We share the same goal to improve overall member health by improving member care.

- Providers can support quality improvement activities in the following ways:
- Educate members about standards of care based on clinical efficacy such as making timely prenatal and postpartum visits, getting recommended cancer screening tests as appropriate by age and gender, following routine immunization schedule, and controlling high blood pressure (CBP) for members with hypertension. Provide comprehensive care at the time of the visit.
- For example, if a member comes in for a flu vaccine, review the chart and recommend any other necessary care such as an eye exam for a diabetic or a

complete well-child visit for pediatrics. Promptly submit complete claims and accurate encounter data. Providers receiving capitation payments should submit complete encounter data to accurately reflect all care and treatment provided using the most current, appropriate CPT and ICD-10 coding.

- Sharp Health Plan's goal is to decrease the burden of medical record review to ascertain care provided wherever possible. When medical record review for HEDIS data collection audit is required, complete and thorough documentation of the provision of care and services in the medical record is very important.

Documentation precision to ensure that services are appropriately recognized, and appropriate coding will decrease the requests for medical record review during the HEDIS data collection project.

Child and Adolescent Well-Care Visits (WCV): Child and Adolescent Well-Care Visits include at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year, but the practitioner does not have to be the practitioner assigned to the member.

Well-Child Visits in the First 30 Months of Life (W30): Well-Child Visits in the First 30 Months of Life has two age bands:

- children who received at least six well-child visits during the first 15 months of life
- children who received at least two well-child visits between 15 and 30 months of age.

Well-child visits are essential for monitoring growth and development, providing immunizations, identifying health concerns early, delivering preventive screenings, and educating caregivers on age-appropriate health and safety topics. Timely completion of these visits supports healthy childhood development, strengthens caregiver engagement, and creates opportunities to address preventive care needs.

All three of the following components should be assessed and documented for well-care visits:

1. A health and developmental history both physical and mental health,
2. A complete physical exam to include BMI and BMI percentiles for children and adolescents, and

   3. Age-appropriate health education/anticipatory guidance.

BMI Assessment

Calculate and document BMI percentiles at least annually for children and document BMIs at least every two years for adults in the medical record.

Please use the following ICD-10 codes for billing and encounter data submission. BMI percentile pediatric codes are used for ages 3–17 years old. These percentiles are based on the growth charts published by the Centers for Disease Control and Prevention (CDC). BMI codes are used for persons aged twenty and older.

Children and Adolescents (Ages 3-17): Calculate and document a BMI percentile annually using CDC growth charts. BMI percentile, rather than an absolute BMI value, is required for HEDIS Weight Assessment and Counseling (WCC).

Adults: Document BMI in the medical record. For HEDIS Adult BMI Assessment reporting, BMI documentation from the measurement year or the year prior to the measurement year may be used.

BMI Assessment Codes

Please use the following codes for anticipatory guidance given to parents of children ages 3–17.

ICD-10 codes	Pediatric BMI Percentiles for Ages 3-17
Z68.51	< 5%
Z68.52	5% – <85%
Z68.53	85% – <95%
Z68.54	BMI ≥95%

Counseling for Nutrition and Physical Activity Codes

Description	CPT	ICD-10 codes	HCPCS
Nutrition	97802, 97803, 97804	Z71.3	G0270, G0271, G0447, S9449, S9452, S9470
Physical Activity		Z02.5, Z71.82	G0447, S9451

Well Care Visit Codes

Code	Definition	Code System
Z00.00	General adult medical examination without abnormal findings	ICD10CM
Z00.01	General adult medical examination with abnormal findings	ICD10CM
Z00.110	Health examination for a newborn under 8 days old	ICD10CM
Z00.111	Health examination for a newborn 8 to 28 days old	ICD10CM

Code	Definition	Code System
Z00.121	Routine child health examination with abnormal findings	ICD10CM
Z00.129	Routine child health examination without abnormal findings	ICD10CM
Z00.2	Examination during rapid growth in childhood	ICD10CM
Z00.3	Examination of adolescent developmental status	ICD10CM
Z01.411	Routine gynecological examination with abnormal findings	ICD10CM
Z01.419	Routine gynecological examination without abnormal findings	ICD10CM
Z02.5	Examination for participation in sports	ICD10CM
Z02.84	Encounter for child welfare examination	ICD10CM
Z76.1	Health supervision and care of a foundling	ICD10CM
Z76.2	Health supervision and care of another healthy infant or child	ICD10CM

Code	Definition	Code System
99381	Initial comprehensive preventive visit for a new infant younger than 1 year	CPT
99382	Initial comprehensive preventive visit for a new child age 1 through 4 years	CPT
99383	Initial comprehensive preventive visit for a new child age 5 through 11 years	CPT
99384	Initial comprehensive preventive visit for a new adolescent age 12 through 17 years	CPT
99385	Initial comprehensive preventive visit for a new patient age 18 through 39 years	CPT
99391	Periodic comprehensive preventive visit for an established infant younger than 1 year	CPT
99392	Periodic comprehensive preventive visit for an established child age 1 through 4 years	CPT
99393	Periodic comprehensive preventive visit for an established child age 5 through 11 years	CPT
99394	Periodic comprehensive preventive visit for an established adolescent age 12 through 17 years	CPT
99395	Periodic comprehensive preventive visit for an established patient age 18 through 39 years	CPT
99461	Initial care and evaluation of a normal newborn in a nonfacility setting	CPT

Code	Definition	Code System
G0438	Initial annual wellness visit, including a personalized prevention plan	HCPCS
G0439	Subsequent annual wellness visit, including an updated personalized prevention plan	HCPCS
S0302	Completed early and periodic screening, diagnosis and treatment service	HCPCS
S0610	Annual gynecological examination for a new patient	HCPCS
S0612	Annual gynecological examination for an established patient	HCPCS
S0613	Annual gynecological examination, clinical breast examination without pelvic examination	HCPCS

Maintain an up-to-date problem list of current and active diagnoses and active medication and medication allergy lists. Use CPT II codes for documentation of blood pressure readings.

Blood Pressure

CPT II codes	BP Reading
3074 F	Systolic blood pressure <130 mmHg
3075 F	Systolic blood pressure <130-139 mmHg
3077 F	Systolic blood pressure ≥140 mmHg
3078 F	Diastolic blood pressure <80 mmHg
3079 F	Diastolic blood pressure 80–89 mmHg
3080 F	Diastolic blood pressure ≥90 mmHg

Diabetic Eye Exam

Code	Definition	Code System
2022F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy (DM)	CPT-CAT-II
2024F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed: with evidence of retinopathy (DM)	CPT-CAT-II

2026F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed: with evidence of retinopathy (DM)	CPT-CAT-II
2023F	Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy (DM)	CPT-CAT-II
2025F	7 standard field stereoscopic retinal photos with interpretation by an ophthalmologist or optometrist documented and reviewed: without evidence of retinopathy (DM)	CPT-CAT-II
2033F	Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed: without evidence of retinopathy (DM)	CPT-CAT-II

HEDIS Medical Record Review

Sharp Health Plan's goal is to decrease the burden of medical record review to ascertain care provided wherever possible. Sharp Health Plan conducts annual medical record review to support HEDIS measure documentation. These reviews typically occur from March through May. Requests for medical records are coordinated with provider office sites as needed. During this time provider offices may be contacted by Sharp Health Plan's contracted vendor with a request for medical records or to schedule on-site visits to gather required documentation. Sharp Health Plan's QI Department will make every effort to decrease the intrusion of on-site chart review by conducting a fax campaign with the vendor for off-site review of medical records during the HEDIS data collection project period.

Should providers choose to use their own vendors to copy the records requested, then the provider office is responsible for all service fees charged by their vendors.

Clinical Practice and Preventive Health Guidelines

Sharp Health Plan has adopted evidence-based clinical practice guidelines from nationally recognized sources. The guidelines are intended for provider use for diagnostic and treatment purposes for:

- 2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults – Updated 2025
- American Diabetes Association Standards of Medical Care in Diabetes – 2025
- 2018 ACC/AHA Guideline on the Treatment of Blood Cholesterol – Updated 2025

The Quality Management Committee approved the adoption of three behavioral health clinical practice guidelines for use by behavioral health clinicians:

- The American Psychiatric Association Guidelines
- The American Psychological Association Criteria for Treatment Guidelines
- The American Academy of Child and Adolescent Psychiatry Practice Parameters and Guidelines

Sharp Health Plan is committed to ensuring that members receive timely and appropriate preventive health assessments. Preventive Services are health assessments that include the physical examination of an asymptomatic, healthy member, consistent with The Guide to Clinical Preventive Services, a report of the US Preventive Services Task Force (USPSTF), the Advisory Committee for Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and other clinical preventive service guidelines as applicable or stated by law.

The member's primary care physician (PCP) is responsible for basic medical care management and the provision of an initial and periodic preventive health assessment, unless otherwise indicated. At a minimum, the initial health assessment includes:

- Medical history
- Height/weight
- Blood pressure
- Body Mass Index (BMI) assessment
- BMI percentile assessment for pediatric members, if applicable
- Preventive health screens and tests considered necessary in the best clinical judgment of the provider and consistent with Plan policy (HS-CP-P5 Preventive Services available on sharphealthplan.com).
- Discussion of age-, risk-, and gender-appropriate preventive measures Follow-up appointments as needed

Summary of Preventive Care Services

The Plan covers preventive care services in accordance with United States Preventive Services Task Force (USPSTF) a and b recommendations, Advisory Committee on Immunization Practices (ACIP), Health Resources Service Administration/Women's

Preventive Services (HRSA/WPS), the American Academy of Pediatrics, and Bright Futures for Pediatrics.

Effective September 17, 2025, the Plan covers preventive items and services, including immunizations, the key federal recommendations in effect as of January 1, 2025, or if recommended by the California Department of Public Health (CDPH) per AB 144 Coverage of Preventive Care Services. The law requires the Plan to cover without cost sharing or prior authorization:

- An evidence-based item or service that had in effect on January 1, 2025, a rating of "A" or "B" in the recommendations of the USPSTF.
- Immunization that had in effect on January 1, 2025, a recommendation from the ACIP or HRSA
- Recommended childhood immunization schedule/United States, jointly adopted as of January 1, 2025, by the American Academy of Pediatrics, ACIP and American Academy of Family Physicians.
- Plans must continue to cover these services even if the USPSTF, ACIP or HRSA removes or downgrades its recommendations
- The CDPH is permitted to modify or supplement recommendations and requires plans to cover the modifications or supplements within 15 days after the CDPH publishes the updated recommendations

These guidelines are updated periodically and may not be all-inclusive in the Provider Operations Manual.

All Members

- Age- and/or gender-appropriate preventive medicine visits (Wellness Visits)[1]
- Routine immunizations recommended by ACIP[2]
- Annual COVID-19 immunizations for all children 6 months or older, all adults 18 years or older, and pregnancy (all planning, pregnant, postpartum, or lactating women). Immunization is also recommended for children and adults with risk factors or choosing protection.[9]
- Influenza immunizations for all children 6 months or older, all adults 18 years or older, and pregnancy (all planning, pregnant, postpartum, or lactating women)[9]
- Respiratory syncytial virus (RSV) immunizations for all children 8 months or younger, all children 8 – 19 months with risk factors, all adults 75 years or older, all adults 50 – 74 years with risk factors, and pregnancy (pregnant between 32 – 36 weeks gestational age)[9]
- Clinicians offer pre-exposure prophylaxis (PrEP) with effective antiretroviral therapy to persons who are at high risk of HIV acquisition.

- Age, gender, and/or risk status-appropriate counseling and/or screenings for:
  - Alcohol abuse
  - Colorectal cancer for adults of average risk 45-75 years of age
  - Depression
  - Diabetes
  - Diet and nutrition
  - Elevated cholesterol and lipids for members at higher risk
  - Falls prevention for older adults
  - Hepatitis C virus
  - High blood pressure
  - HIV
  - Lung cancer screenings for smokers who meet criteria
  - Obesity
  - Syphilis and other sexually transmitted infections for adults and adolescents at higher risk
  - TB screening for pediatrics and adults at higher risk[3,4]
  - Tobacco use and cessation interventions

Women's Health

- Screening mammography
- Cervical cancer screening
- Genetic counseling and evaluation for the BRCA testing
- Counseling for chemoprevention for women at high risk for breast cancer
- Screening for gonorrhea, chlamydia, and syphilis
- Osteoporosis screening
- For pregnant women:
  - Instructions to promote and aid breast feeding
  - Screenings for:
    - Anemia
    - Bacteriuria
    - Hepatitis B virus
    - Rh incompatibility

        - Chlamydia
        - Syphilis
        - Gestational diabetes
        - HIV
        - Asymptomatic bacteriuria
    - Prevention:
        - Preeclampsia
        - Well woman preventive visits to include preconception and prenatal services[5]
        - Folic acid supplements for women who may become pregnant (actual medication covered under pharmacy benefit)
        - FDA-approved contraception methods and contraceptive counseling[5]
        - Human papillomavirus (HPV) screening DNA testing for women 30 years and older
        - Breastfeeding support and counseling
        - Domestic violence screening and counseling
        - Annual human immunodeficiency virus (HIV) screening and counseling
        - Annual sexually transmitted infection counseling
        - Screening for gestational diabetes for women 24 – 28 weeks pregnant and those at higher risk that have no prior history of diabetes[5]

Men's Health

- Screening for prostate cancer for men ages 55 and older, earlier discussion at age 45 for high risk individuals.
- Screening for abdominal aortic aneurysm in men 65–75 years old who have ever smoked
- Human papillomavirus (HPV) vaccine for males ages 9–26[1]

Pediatrics

- Measurements[3]
- Height and weight
- Head circumference
- Weight for length

- BMI
- BMI percentile
- Assessments/Examinations/Screening:
- Anticipatory Guidance[3]
- Assessments for:
    - Alcohol and drug use[3]
    - Developmental surveillance[3]
    - Psychosocial/Behavioral[3]
    - Oral health risk[3]
- Counseling for:
    - Fluoride for children without fluoride in their water source (fluoride supplements provided through pharmacy benefit)
    - Obesity, including diet and nutrition
    - Skin cancer behavior
    - Education or brief counseling, to prevent initiation of tobacco use among school-aged children and adolescents
    - Behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections (STIs)
    - Gonorrhea preventive medication for the eyes
    - Iron supplementation for asymptomatic children ages 6-24 months who are at increased risk for iron deficiency anemia (iron supplements covered under pharmacy benefit)
- Screenings for:
    - Adverse Childhood Experiences (ACEs)
    - Autism[3]
    - Anemia[3]

- Basic vision screening and referral to vision provider if necessary
- Cardiac arrest risk for ages 11 - 12
- Cervical dysplasia screening for sexually active females
- Developmental/autism[3]
- Dyslipidemia screening for children at higher risk for lipid disorders[3]
- Hearing screening[3]
- Hemoglobinopathies or sickle cell anemia
- HIV screening for adolescents at higher risk
- Lead[3]
- Major depressive disorders
- Phenylketonuria[3]
- Sexually transmitted infections[3]
- Thyroid disease[3]
- Tuberculosis[3]

Preventive vs. Diagnostic Services

Certain services may be done for preventive or diagnostic reasons. When a service is performed for the purpose of preventive screening and is appropriately reported, it will be adjudicated under the Preventive Care Services benefit.

Preventive services are those performed on a person who has one of the following:

- Not had the preventive screening done before and does not have symptoms or other abnormal studies suggesting abnormalities.
- Had screening done within the recommended interval with the findings considered normal.
- Had diagnostic services results that were normal after which the provider recommendation would be for future preventive screening studies using the preventive services intervals.

- Had a therapeutic service provided at the same encounter and as an integral part of the preventive service (e.g., polyp removal during a preventive colonoscopy).

Diagnostic services will be adjudicated under the applicable non-preventive medical benefit. Diagnostic services are performed on a person who has or has had:

- Symptom(s) that required further diagnosis.
- Abnormalities on previous preventive or diagnostic studies that require repeat of the same studies within shortened time intervals from the recommended preventive screening time intervals.
- Abnormalities in previous preventive or diagnostic studies that require further diagnostic studies, other than a colonoscopy for a finding on another type of colorectal screening test, which is covered with no member cost sharing.

- Preventive services as covered benefits are updated as new recommendations and guidelines are issued, revised, or removed by the applicable regulating authority.

Coverage Limitations and Exclusions

Services not covered under the preventive care benefit may be covered under another portion of the medical, dental, vision, or pharmacy benefit plan.

Drugs, medications, vitamins, supplements, or over the counter contraceptive barrier methods that are recommended or prescribed for preventive measures are covered under the pharmacy benefit. Examples include, but are not limited to:

- Chemoprevention for any indication, including but not limited to, chemoprevention for breast cancer.
- Supplements, including but not limited to oral fluoride supplementation and folic acid supplementation.
- Tobacco cessation products or medications.
- Off-label use for immunization is not covered.
- Examinations, screenings, testing, or immunizations are not covered when:
    - Required solely for the purpose of travel (travel immunizations).

Related to judicial or administrative proceedings or orders.

- Conducted for purposes of medical research, unless covered under an approved Clinical Trial.
- Required to obtain or maintain a license of any type.
- Required solely for school, camp, or occupational purposes.

Services that are investigational, experimental, or not medically necessary are not covered.

Preventive Services Monitoring

The Plan Quality Improvement (QI) department monitors the provision of age-appropriate preventive services via annual HEDIS data collection and other quality monitoring activities. Information from QI monitoring and any action plans developed to improve preventive service compliance are shared with the Plan provider or plan medical group.

These guidelines are used in conjunction with the independent judgment of a qualified licensed provider and do not constitute the practice of medicine or medical advice.

References

1. Knox-Keene Health Care Service Plan Act of 1975 Health and Safety Code §§1345.Retrieved September 15, 2026, from http://wpso.dmhc.ca.gov/regulations/
2. Centers for Disease Control and Prevention. *Vaccine Recommendations of the ACIP: Advisory Committee for Immunization Practices (ACIP).* Retrieved September 15, 2026, from Centers for Disease Control and Prevention: Birth-18 Years Immunization Schedule | CDC
3. American Academy of Pediatrics. *Recommendations for Preventive Pediatric Health Care: Bright Futures/American Academy of Pediatrics.* Retrieved September 15, 2026, from Bright Futures: American Academy of Pediatrics: 2026 Recommendations for Preventive Pediatric Health Care | American Academy of Pediatrics (aappublications.org)
4. Centers for Disease Control and Prevention. (2017,) *Screening for Tuberculosis and Tuberculosis Infection in High-Risk Populations Recommendations of theAdvisory Council for the Elimination of Tuberculosis* Retrieved September 15, 2026, from Centers for Disease Control and Prevention: http://www.cdc.gov/mmwr/preview/mmwrhtml/00038873.htm
5. U.S. Centers for Medicare & Medicaid Services. Retrieved September 15, 2026, from Healthcare.gov: www.healthcare.gov/coverage/preventive-care-benefits/
6. Onecle. (2013, February 22). *California Health and Safety Code Section 104315.* Retrieved September 15, 2026 from onecle.com: http://law.onecle.com/california/health/104315.html
7. Patient Protection and Affordable Care Act, 42 U.S.C. 1800 et seq. (2010). Retrieved August 28,2025.

8. US Preventive Services Task Force. (2013, August). USPSTF A and B Recommendations. USPreventive Services Task Force. A and B Recommendations | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org) Retrieved September 15, 2026, from USPSTF A and B Recommendations.
9. AB 144 Coverage of Preventive Care Services, effective September 17, 2025, codifies the federal regulations in effect on January 1, 2025 for immunizations and allows the California Department of Health to supplement those recommendations.

To view Sharp Health Plan's preventive health guidelines online, visit www.sharphealthplan.com.

SECTION IX

Claims and Encounters



Claims

One of the goals of Sharp Health Plan is to ensure Plan providers' claims and payments are processed accurately and in a timely manner, in accordance with industry standards and state and federal regulations. The guidelines in this section of the Provider Manual can help providers ensure their claims are submitted correctly. Providers who are contracted with Sharp Health Plan through an affiliated plan medical group (PMG) must follow the requirements outlined by the PMG when billing for services that are the responsibility of the PMG.

As required by AB 3275, timeframes for health plans to process and pay provider claims. The Plan must reimburse, contest, or deny a clean claim within 30 calendar days, effective for claims received January 1, 2026. The law also changed the penalty requirements for not paying interest on late paid claims and mandates that member complaints about a delayed or denied payment be treated as a formal grievance.

As required by Assembly Bill 1455, the California Department of Managed Health Care (DMHC) has set forth regulations establishing certain claim settlement practices and the process for resolving claims disputes for managed care products regulated by the DMHC. Sharp Health Plan has posted a notice of claim settlement practices on sharphealthplan.com. Please review the notice in its entirety. It is intended to inform you of your rights and responsibilities, and procedures related to claim settlement practices and claim disputes.

Claims Addresses

Claims for services provided to members assigned to entities delegated for claims processing should be mailed directly to the entity. Current claims address for all entities are available in our provider portal, your Sharp Health Plan Account, at sharphealthplan.com.

Providers contracted directly with Sharp Health Plan should send claims to:

Sharp Health Plan
P.O. Box 939036
San Diego, CA 92193-9036

Claim Submission Requirements

The following is a list of claim timeliness requirements, claims supplemental information, and claims documentation required by Sharp Health Plan. For more information, or to view our policies and procedures, please visit sharphealthplan.com/for-providers/claims-information.

- Contracted providers must submit claims within 90 days or according to their agreement terms. Non-contracted providers have 180 days after the date of service to submit a claim. Claims submitted outside of these time frames may be denied as untimely.
- Claims must be submitted on the most current version of standard claim forms CMS 1500 (non-institutional providers and suppliers) or UB-04 or CMS-1450 (institutional providers). Forms should be completed legibly in black ink with standard fonts on forms printed in red "dropout" ink. Please refer to NUCC.org for instructions. No "Superbills" will be accepted or processed.
- Submit claims with all reasonably relevant information to determine payer liability and to ensure timely processing and payment.
- Non-contracted providers should submit a completed IRS Form W-9 with claims.
- If Sharp Health Plan is the secondary payer, then providers must submit the primary payer explanation of benefits (EOB) with applicable claims to facilitate coordination of benefits.

Electronic Claims Submissions

Providers have the option of submitting claims electronically through electronic data interchange (EDI). The advantages of electronic claims submission include the following:

Prompt acknowledgement of claims receipt

Improved claims tracking and status reporting

Reduced turnaround time for timely reimbursement

Eliminates paper

Improved cost effectiveness

Claims submitted electronically must be compliant with federal HIPAA transaction standards.

Sharp Health Plan Approved Clearinghouses

Capario (Change Healthcare)
1-800-792-5246 | www.capario.com | Sharp Health Plan Payer ID: SHPPN

Office Ally
1-360-957-7000 | cms.officeally.com | Health Plan Payer ID: SHP01

TriZetto (Gateway EDI)
1-800-556-2231 | www.trizettoprovider.com | Sharp Health Plan Payer ID: SHP76

Claims Receipt Verification and Claim Status Inquiries

For verification of claim receipt or claim status inquiries:

Sharp Health Plan will acknowledge the date of claim receipt within two (2) working days of receipt of an electronic claim and within 15 working days of receipt of a hard copy claim. An example of the acknowledgement form is provided on subsequent pages.

Claim status is provided via an explanation of payment (EOP) that is included with all payments. An example of the EOP and explanation of terms are provided on subsequent pages.

Providers can confirm claim receipt and claim status by calling Customer Care at 1-858-499-8300 or toll-free 1-800-359-2002. We are available to assist you Monday through Friday from 8:00 a.m. to 6:00 p.m. To ensure efficient service, the following information is needed at the time of the call: member number, date of service, procedure code, provider name, and claim number (if known). Telephone inquiries are limited to a maximum of five claims per call.

Claims Payment Editing System

The claims editing system in use is based on Correct Coding Initiative edits and National Correct Coding Initiative edits.

Every decision is fully supported with a variety of clinical documentation to ensure complete understanding of the system and communication to the provider community. The edits are based on the information provided on or with the claim. If the claim information is incomplete or invalid, the claim edits will be accurate but may not be the outcome the provider expected.

Please make sure additional documentation to justify coding is included on the claim, such as modifiers and information in box 19 of the CMS 1500 or box 84 of the UB04.

Claims Policy Administration Module

In order to process consistently based on industry-standard guidelines the Policy Administration Module allows the building of custom rules that reflect medical and payment policies. To address the complexity of benefit plan designs, the module allows for the enhancement of code auditing with additional fields and combinations for review or comparison that include:

- Frequency of procedure codes
- Claim lines for code combinations present or not present
- Claim lines for limits based on days before or after the claims date
- Claim lines for the same, different or all providers or the same specialty
- Monitoring for the frequent use of modifier codes
- Industry standard guidelines that will be audited via the new Policy Administration Module include but are not limited to:
- Denying the Add-On Code without the parent code billed
- Procedure allowed once in a lifetime for certain surgical procedures
- Documentation required when billing modifier 62
- Denying Co-Surgeon (mod 62) codes not payable per Medicare guidelines
- Codes not payable with team surgeon modifier 66
- Denying drug admin codes without the drug billed
- New visit frequency editing

Encounter Data

Sharp Health Plan must receive timely Encounter Data to appropriately track member's Deductibles and out-of-pocket costs, meet reporting requirements, and to monitor the value of services provided under capitation. Plan providers reimbursed under capitation must send encounter data to Sharp Health Plan for each member encounter. Encounter data must be submitted either electronically or on the applicable claim form, following standard claims submission guidelines, within 120 days of the date of service. An EOB is sent to acknowledge all encounter data. See Section IX for sample EOB and definition of terms.

Capitated providers also receive a Capitation Listing to support the capitation payment.

Encounter data completeness and quality is monitored regularly by the Plan. If problems are identified with the timeliness, quality or quantity of submissions, Sharp Health Plan will contact the capitated provider to review and correct the identified problems.

Fee Schedules

The current Medicare fee schedule is available on https://www.cms.gov/medicare/physician-fee-schedule/search/overview. The Durable Medical Equipment, Prosthetics/Orthotics, and Supplies Fee Schedule (DMEPOS) can be found on med.noridianmedicare.com.

Please refer to Appendix A of your agreement with Sharp Health Plan for details on how these fee schedules and other mutually agreed upon payment rates are used to determine reimbursement. If you have any questions regarding your agreement, please contact:

Sharp Health Plan
Attention: Contracts Department
8520 Tech Way, Suite 200
San Diego, CA 92123 Phone: 1-858-499-8330
Fax: 1-858-636-2276

Adjustment Requests

Please review all explanation codes listed on the EOB to determine if a claim denial was the result of insufficient information or an incomplete claim. Please submit all requested documents or a corrected claim promptly to ensure appropriate, timely reimbursement.

Corrected claims must be identified as such to avoid being identified as duplicates. Providers who feel their claim was processed incorrectly should contact Customer Care at 1-858-499-8300 or toll-free 1-800-359-2002 or shp.claimsresearch@sharp.com for an explanation, or send in an adjustment request with a copy of the claim to the following address:

Sharp Health Plan
Attention: Claims Research
8520 Tech Way, Suite 200
San Diego, CA 92123
Fax: 1-858-636-2276

After reviewing the request, the Claims Research Specialist will advise if an adjustment is necessary. If an adjustment is necessary, the Specialist will forward the request to the Claims team for reprocessing.

Coordination of Benefits

When a member has coverage under two or more groups or Medicare plans, the benefits of these plans will be coordinated so that the total amount paid out does not equal more than the actual cost of treatment. Coordination of benefits is vital in keeping the cost of coverage as low as possible. Prior to billing Sharp Health Plan or an affiliated PMG, providers must bill primary insurance carriers, including Medicare. The provider must include a copy of the other insurance carrier's explanation of benefits with the claim.

Sharp Health Plan will advance providers covered benefits at the time of member medical need, even if the member illness or injury is suspected to be work-related or otherwise

covered by a third-party payer. If the covered benefits received by the member are found to be covered by workers' compensation or another third-party payer, the Plan will pursue reimbursement. This requirement is consistent with state law (California Code of Regulations § 1300.67.13 (a)(2) and (3), which prohibits delaying or refusing to provide covered benefits because the member may be entitled to other coverage.

Please review your screening protocols to confirm that Sharp Health Plan members are not denied medical attention due to possible coverage by any other plan or insurer.

In no event will Sharp Health Plan's payment for covered services together with the payment made by the primary carrier exceed the amount that would have been payable if Sharp Health Plan had been the primary carrier. The provider agrees to accept the contracted amount as payment in full, whether that amount is paid in whole or part by the member, Sharp Health Plan, or any combination of payers, including other payers that may pay as primary.

On Medicare claims, Sharp Health Plan reimburses the Medicare Deductible and Coinsurance only up to Sharp Health Plan's normal benefit limit. For commercial payers, Sharp Health Plan will reimburse up to the Sharp Health Plan allowed amount, excluding the member out-of-pocket costs.

Third-Party Liability

If a member is injured in an accident 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 the member may receive from the person who caused the injury. Plan providers may not refuse to provide Covered Benefits to members who are injured by another party. Plan providers may not require members to assign any recoveries or reimbursements to the provider as a condition of receiving care. All claims for services rendered in relation to a third-party liability case should be submitted for processing as described in Sharp Health Plan's Notice of Claims Settlement Practices. The claims will follow normal processing guidelines. Any recoveries related to third party or worker's compensation liabilities will be made by Sharp Health Plan.

Sharp Health Plan must be notified in writing of all potential and confirmed third party and worker's compensation liability cases that involve a Sharp Health Plan member.

Notification must include:

- Member name
- Member identification number
- Date of birth

- Date of injury
- Identification of third party, if known
- Provider name and address
- Date(s) of service
- ICD10 code and/or description of injury
- CPT code and/or description of service(s) rendered
- Billed charges for service(s)
- Any amount paid by other coverage (if applicable)
- Date of denial and reason(s) for any applicable denials from other payers
- Send notices of potential third-party liability to:

  Sharp Health Plan
  Attn: Claims Research/Third Party Liability
  8520 Tech Way, Suite 200
  San Diego, CA 92123
  Fax: 1-619-740-8571

Member Costs and Out-of-Pocket Maximum

Copayments, coinsurance, and deductibles are fees paid by the member to the provider for covered benefits at the time the service is received. Sharp Health Plan members may only be charged applicable copayments, coinsurance and deductibles indicated on the member's identification card, through your Sharp Health Plan Account (provider portal) and/or as verified with Customer Care.

A member's financial responsibility will vary based on the member's benefit plan. A copayment may be a flat amount (e.g., $15.00 copayment for an office visit) or a percentage of the contracted rate (e.g., 20% coinsurance for durable medical equipment).

Some benefit plans include a deductible. A deductible is the amount the member must pay each calendar year for certain Covered Benefits before Sharp Health Plan will start to pay for those covered benefits. The amounts the member is required to pay for the covered benefits subject to a deductible are based upon Sharp Health Plan's cost for the covered benefit. Once the member has met the yearly deductible, the member pays the applicable copayment for covered benefits and Sharp Health Plan pays the rest. The deductible starts over each year.

There is a maximum total amount of copayments, coinsurance and deductibles members pay each year for covered benefits, excluding supplemental benefits. The annual out-of-pocket maximum amount is listed in the Health Plan Benefits and

Coverage Matrix and is renewed at the beginning of each calendar year. Copayments and deductibles for supplemental benefits (e.g., chiropractic services) do not apply to the annual out-of-pocket maximum. If a member pays amounts for covered benefits that equal the individual out-of-pocket maximum, no further copayments or deductibles are required for that member for covered benefits (excluding supplemental benefits) for the remainder of the year. Premium contributions will continue to be required.

Once a member in a family satisfies the individual out-of-pocket maximum, the remaining enrolled family members must continue to pay applicable copayments and deductibles until either (a) the sum of the copayments and deductibles paid by the family reaches the family out-of-pocket maximum or (b) each enrolled family member meets his/her individual out-of-pocket maximum, whichever occurs first.

When the sum of the copayments and deductibles paid for all enrolled members equals the family out-of-pocket maximum, no further copayments or deductibles are required from any enrolled member of that family for the remainder of the calendar year.

Only amounts that are applied to the Individual out-of-pocket maximum may be applied to the family out-of-pocket maximum. Any amount the member pays for covered benefits that would otherwise apply to the individual out-of-pocket maximum, but which exceeds the Individual out-of-pocket maximum will be refunded to the member and will not apply toward the family out-of-pocket Maximum. Individual members cannot contribute more than their individual out-of- pocket maximum amount to the family out-of-pocket maximum.

Calculation of out-of-pocket maximums may be different for members enrolled in an HSA-compatible benefit plan.

The following payments do not apply to the out-of-pocket maximum. Members are required to continue to pay the payments listed below even if the annual out-of-pocket maximum has been reached.

- Payments for services or supplies that the Plan does not cover, e.g., excluded drugs, cosmetic surgery, and unauthorized non-emergency services.
- Copayments for supplemental benefits such as chiropractic services and hearing aids.

Sharp Health Plan will provide enrollees with their most up-to-date accrual balance toward their annual deductible and out-of-pocket maximum for every month in which benefits were used until the accrual balance equals the full deductible and/or out-of-pocket amount. The member will receive a confirmation letter to show proof to providers that no additional out-of-pocket costs are due for the calendar year.

Balance Billing

Sharp Health Plan members may only be charged for applicable copayments, coinsurance and deductibles as indicated on the member's identification card and/or as verified with Customer Care. Balance billing occurs when a member receives a bill from a provider for services that are covered by Sharp Health Plan. Under the Knox Keene Act of 1975, health plan enrollees are not liable to a provider contracted with the Plan for any sums owed to the provider by the Plan. Plan providers are prohibited by state law from billing members for services covered by the Plan. For example, if Sharp Health Plan denies a claim for a covered benefit because the claim was submitted after the submission deadline, the provider may appeal the denial to the Plan but may not bill the member for the services regardless of the outcome of the appeal.

The California Supreme Court, in the case of *Prospect Medical Group, Inc. v. Northridge Emergency Medical Group, et al.*, issued a ruling in January of 2009 which makes it unlawful for providers to bill emergency-room patients for the difference between their billed charges and what the health plan has paid for the out-of-network care received by the health plan's member. Providers may contact the department identified in your EOB/Remittance Advice to submit a provider payment dispute relating to the claim in question.

Plan providers may not seek additional payment from Sharp Health Plan enrollees beyond those authorized in the Plan description. At no time should members be balanced billed for appropriately authorized covered benefits. For services that are not covered under the Plan, the member should be notified in advance that the service is not covered, and that the member will be responsible for payment in full for that service.

Sharp Health Plan has a systematic process to assist providers and members with balance billing questions. In most cases, members are informed that they are receiving a statement from providers while billing between the provider and Sharp Health Plan is in process. Please help us ensure that balance billing is not initiated when Plan payment is expected. For assistance with specific member issues and claims status, providers may contact Sharp Health Plan at 1-858-499-8300, or toll-free at 1-800-359-2002, or email customer.service@sharp.com. We are available to assist you Monday through Friday from 8 a.m. to 6 p.m.

Bills for Prenatal Genetic Testing

The California State Genetic Diseases Branch is responsible for conducting prenatal genetic testing and newborn screening for all births in California. Unfortunately, the State does not collect information about the member's insurance when the tests are conducted. As a result, every woman who has the prenatal tests conducted receives bills from the State for the services.

These tests are Covered Benefits for Sharp Health Plan members. Providers should encourage members to forward the bills they receive to the Plan at the following address or Fax number, so the claims can be paid.

Sharp Health Plan
Attn: Claims Research
8520 Tech Way, Suite 200
San Diego, CA 92123
Fax: 858-636-2276

It is important that members not ignore the bills from the Genetic Diseases Branch. If they remain unpaid, the billed amounts will be deducted from any tax refund due to the member from the state.

Immediate Postpartum Contraception

In accordance with Health and Safety Code Section 1367.627, Sharp Health Plan allows providers to separately bill for devices, implants, or professional services, or a combination thereof, associated with Immediate Postpartum Contraception if the birth takes place in a general acute care hospital or licensed birth center.

Dispute Resolution

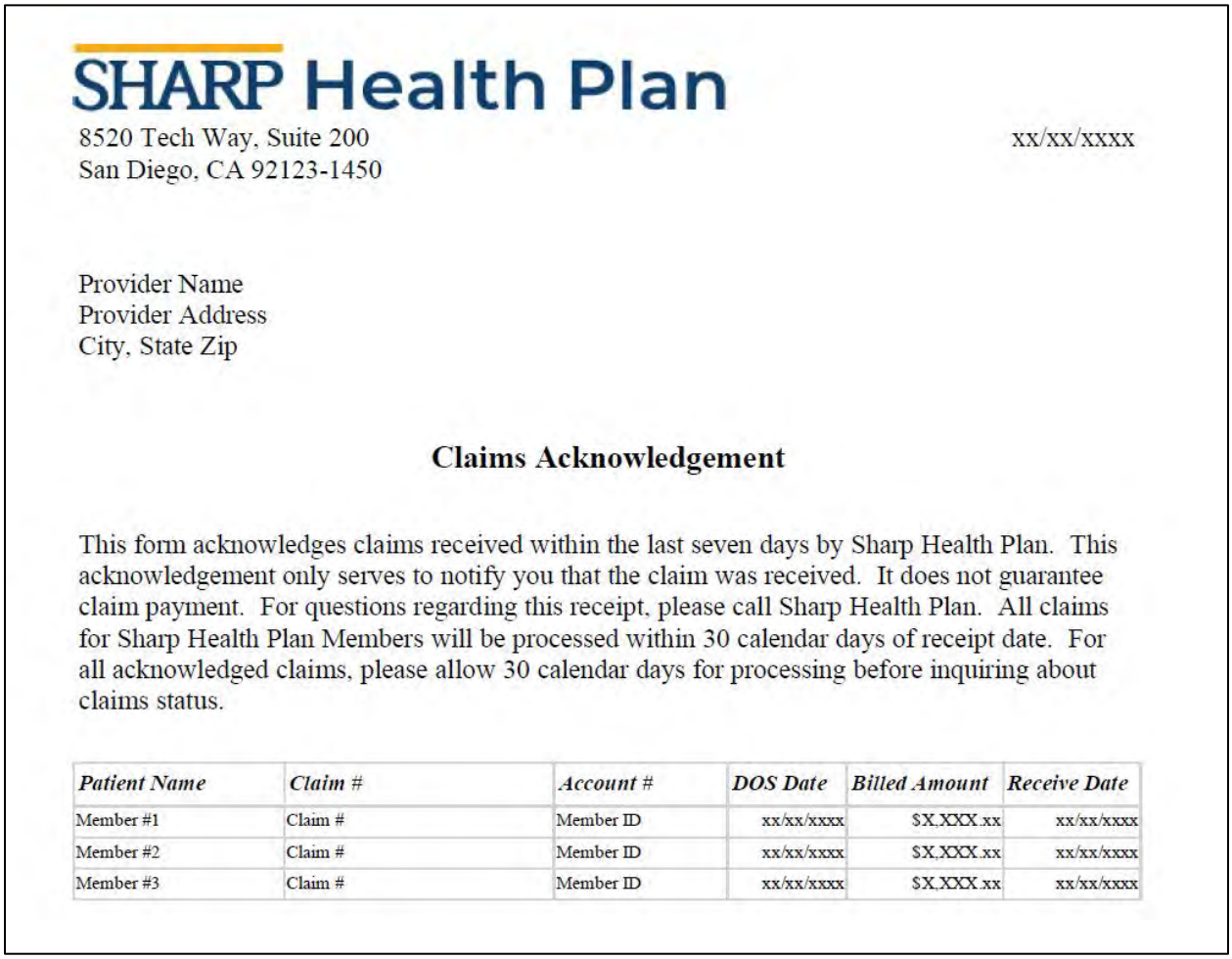
A provider dispute is a provider's written notice to Sharp Health Plan:

- Challenging, appealing, or requesting reconsideration of a claim that has been denied, adjusted, or contested; or
- Seeking resolution of a billing determination or other contract dispute; or
- Disputing a request for reimbursement of an overpayment of a claim.
- Sharp Health Plan's Provider Dispute Resolution Form can be found on www.sharphealthplan.com. Providers without Internet access can contact Customer Care at 1-858-499-8300, toll-free at 1-800-359-2002, or email customer.service@sharp.com to obtain a copy.
- Sharp Health Plan must receive provider disputes within 365 days from Sharp Health Plan's action that led to the dispute (or the most recent action if there are multiple actions).
- In the case of Sharp Health Plan's inaction, the Plan must receive provider disputes within 365 days after the Plan's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

Sharp Health Plan will issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the provider dispute or the amended provider dispute. If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, Sharp Health Plan will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five working days of the issuance of the written determination.

Sharp Health Plan has posted a notice of claim settlement practices and provider dispute resolution on sharphealthplan.com. Please review the notice in its entirety. It is intended to inform you of your rights, responsibilities, and related procedures as they relate to claim settlement practices and provider disputes.

Claims Acknowledgement Sample



SHARP Health Plan

8520 Tech Way, Suite 200
San Diego, CA 92123-1450

xx/xx/xxxx

Provider Name
Provider Address
City, State Zip

Claims Acknowledgement

This form acknowledges claims received within the last seven days by Sharp Health Plan. This acknowledgement only serves to notify you that the claim was received. It does not guarantee claim payment. For questions regarding this receipt, please call Sharp Health Plan. All claims for Sharp Health Plan Members will be processed within 30 calendar days of receipt date. For all acknowledged claims, please allow 30 calendar days for processing before inquiring about claims status.

Patient Name	*Claim #*	*Account #*	*DOS Date*	*Billed Amount*	*Receive Date*
Member #1	Claim #	Member ID	xx/xx/xxxx	$X,XXX.xx	xx/xx/xxxx
Member #2	Claim #	Member ID	xx/xx/xxxx	$X,XXX.xx	xx/xx/xxxx
Member #3	Claim #	Member ID	xx/xx/xxxx	$X,XXX.xx	xx/xx/xxxx

Remittance Advice Summary Sample

Explanation of Payment

This display is a preview for the remittance advice for this claim and not associated with any specific check.
The remittance advice for the check may look differently from what is displayed here.

Remittance Advice for TRI-CITY MEDICAL CENTER CORPORATION

Tri City Medical Center

Individual & Family Plan

Ins. Co. **SHARP HEALTH PLAN [1640000001]** Claim **4346** Group **IFP Off Exchange [1640002993]**
Patient **Palmer,Arnold** Member ID **16400002001** DOB **01/01/1995**
Withhold **0.00** Interest **0.00** Penalty **0.00**

Date	Proc / DRG	Billed	Disallow	Bef Ben Penalty	Allowed	Not Covrd	Deduct	Copay / Coins	Exceed Benefit	Patient Total	Adjust	Adjust Rsn	Aft Ben Penalty	Discount	Codes	Primary Ins	Net Payment
07/09/26	84484 CPT®	100.00	0.00	0.00	25.00	0.00	0.00	0.00	0.00	0.00	0.00		0.00	75.00	45/"", C, HAP07, HTR02, HTR08, HTR09, ITR01, PVC18	0.00	25.00
Totals		**100.00**	**0.00**	**0.00**	**25.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**		**0.00**	**75.00**		**0.00**	**25.00**

Claim Level Codes
- HAP07: Type of Bill Missing - Hold: 9
- HTR02: No Place of Service - Hold: 9
- HTR08: DOFR TBD, MISSING POS - HOLD
- HTR09: Missing VEN/SER Linkage - Hold
- ITR01: Out of Network - Info
- PVC18: Manual Pricing - Pend

Service Level Codes
- ITR01: Out of Network - Info

Reason Codes
- 45: Chgs excd fee sch/max allowable
- C: Contracted Rate Payment

Remark Codes
- "":

Individual & Family Plan Totals	**100.00**	**0.00**	**0.00**	**25.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**75.00**		**0.00**	**25.00**
Tri City Medical Center Totals	**100.00**	**0.00**	**0.00**	**25.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**75.00**		**0.00**	**25.00**

Claims Totals

Interest	Penalty	Billed	Disallow	Bef Ben Penalty	Allowed	Not Covrd	Deduct	Copay / Coins	Exceed Benefit	Patient Total	Adjust	Aft Ben Penalty	Discount	Withhold	Primary Ins	Total Payment
0.00	**0.00**	**100.00**	**0.00**	**0.00**	**25.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**75.00**	**0.00**	**0.00**	**25.00**

Dispute Process for Commercial Providers

Commercial provider disputes for dates of service on or after Jan. 1, 2004, must be submitted to Sharp Health Plan within 365 days of the date of this Explanation of Payment. If the dispute is regarding a claim, it must contain at a minimum: provider name, provider identification number, provider contact information, date of service, clear identification of the disputed item, and a clear explanation of the basis upon which you believe the payment amount, request for additional information, denial adjustment, or other action is incorrect. Dispute requests must be accompanied by the Provider Dispute Request Form, available at sharphealthplan.com or by calling **1-800-359-2002** .

If the dispute involves an enrollee or group of enrollees, provider must submit the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including date of service, provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollee(s). Multiple "Like" claims disputes must be accompanied by the Multiple "Like" Claim Request Form, available at sharphealthplan.com on the Provider Dispute Resolution Request Form link or by calling **1-800-359-2002** .

Please mail the dispute to:

Sharp Health Plan
Attention: Provider Dispute Resolution
8520 Tech Way, Suite 200
San Diego, CA 92123-1450

Appeals Process for Non-contracted Medicare Providers Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may request reconsideration (appeal) of a Medicare Advantage plan payment denial determination. To appeal a claim denial, submit a written request within 65 calendar days of the remittance notification date and include at a minimum: a statement indicating factual or legal basis for appeal; a signed Waiver of Liability Form (you may obtain a copy online at: https://www.sharpmedicareadvantage.com/claims-processes-for-non-contracted-medicare-providers/); a copy of the original claim, a copy of the remittance notice showing the claim denial; any additional information, clinical records or documentation.

Please mail the appeals to:

Sharp Health Plan
Attention: Appeals and Grievance
8520 Tech Way, Suite 200
San Diego, CA 92123-1450

Payment Dispute Process for Non-contracted Medicare Providers Pursuant to federal regulations governing the Medicare Advantage program, non-contracted providers may file a payment dispute for a Medicare Advantage plan payment determination. A payment dispute may be filed when the provider disagrees with the amount paid, including issues related to bundling of services. To dispute a claim payment, submit a written request within 120 calendar days of the remittance notification date and include at a minimum: a statement indicating factual or legal basis for the dispute; a copy of the original claim; a copy of the remittance notice showing the claim payment; any additional information, clinical records or documentation to support the dispute.

Please mail the dispute to:

Sharp Health Plan
Attention: Provider Dispute Resolution
8520 Tech Way, Suite 200
San Diego, CA 92123-1450

Remittance Advice Terms

Glossary of Remittance Advice Terms:

Abbreviation	Definition
From Date	The date services began
To Date	The last date services were provided
Proc Code	Procedure Code, code used to identify the procedure performed
Procedure Mod Description	Procedure Modifier Description, description of modifier used to further identify the procedure
Tot Clm	Total Claim, the total billed amount for the claim
Amount Billed	The amount billed for the claim line
Non Covered	The amount that is not covered for the claim line
Contract Adjustment	Payment adjustments made to the claim line
Capitated	Amount of billed charges applied to capitation payments
Amount Allowed	Allowed amount for the claim line
Deduct Copay Coins	Deduct Copay/Coinsurance, amount deducted from the Allowed Amount for the patient's applicable copayment
COB	Coordination of Benefits, amount deducted from the Allowed Amount that was paid by primary payer
Withhold	Any monies that are subject to being withheld by the Plan
Net Payable	Total payable amount for the claim line

Required Network Provider Types

Sharp Health Plan maintains provider networks that include a sufficient number and mix of participating providers, with appropriate specialties and provider types, to ensure the delivery of all covered services in accordance with applicable regulatory requirements and member needs. Network composition is evaluated on an ongoing basis to ensure compliance with regulatory requirements and to support timely access to medically necessary care.

Providers must staff required provider types, as appropriate, and designate them in their provider rosters using the Department of Managed Health Care's (DMHC) standardized provider type methodology as shown in the chart below.

Provider Type	Specialty Type
Primary Care Providers	Primary Care Physician, which may include any of the following: • Family Practice • General Medicine • Internal Medicine The following may also be considered Primary Care Physicians, but a primary care network comprised only of these primary care physician specialty types will not be considered to meet the requirements set forth in Rule 1300.67.2: • Pediatrician • Obstetrics/Gynecology • HIV/AIDS Specialist
Specialist Physicians	• Addiction Medicine or Addiction Psychiatry • Allergy/Immunology • Anesthesiology • Cardiovascular Disease • Dermatology • Diagnostic Radiology • Emergency Medicine • Endocrinology • Gastroenterology • Genetics • Hematology • HIV/AIDS Specialist

Provider Type	Specialty Type
	• Infectious Disease • Maternal and Fetal Medicine • Neonatology • Nephrology • Neurology • Nuclear Medicine • Obstetrics/Gynecology • Oncology • Ophthalmology • Otolaryngology • Pain Medicine • Pathology • Physical Medicine and Rehabilitation • Podiatry • Psychiatry • Pulmonology • Radiation Oncology • Reproductive Endocrinology/Infertility • Rheumatology • Sleep Medicine • Surgery – Cardiothoracic • Surgery – Colon/Rectal • Surgery – General • Surgery – Neurological • Surgery – Orthopedic • Surgery – Plastic • Surgery – Thoracic • Surgery – Vascular • Urology
Outpatient Ancillary Providers	• Acupuncture • Ambulance/Transport • Audiology • Chiropractic • Dialysis: In-Home • Dialysis: Hospital Outpatient • Dietician/Nutrition • Durable Medical Equipment/Supplies • Family Planning • Licensed Home Health Agency • Hospice

Provider Type	Specialty Type
	• Imaging/Radiology • Infusion/IV Therapy • Laboratory • Mammography • Nurse Practitioner • Occupational Therapy • Optometry/Vision • Orthotics/Prosthetics • Pharmacy • Physical Therapy • Sleep Disorder Center, which includes at least one Registered Polysomnographic Technologist • Speech Therapy
Facilities and Clinics	• General Acute Care Hospital • Acute Psychiatric Hospital (or general acute care hospital with an inpatient psychiatric unit) • Hospice Facility • In Vitro Fertilization (IVF) Clinic • Psychiatric Health Facility • Skilled Nursing Facility • Urgent Care Center • Ambulatory Surgery Center/Surgical Clinic • Chronic Dialysis Clinic • Chemical Dependency Recovery
Hospital Services	• Each of the following particularized hospital services, delivered through an in-network facility: o Cardiac Catheterization Services o Cardiac Surgery Services o Intensive Care Services, including any of the following services: Burn Services, Coronary ICU Services, Intensive Care Services, Neonatal ICU Services, or Pediatric ICU Services o Emergency Room Services o Labor/Delivery Room Services
Mental Health Professionals	• Alcohol and Other Drugs Professional • Qualified Autism Services Provider (QASP) • Counseling Mental Health Professional, including one or more of the following licensed provider types: o Licensed Clinical Social Worker o Licensed Marriage and Family Therapist

Provider Type	Specialty Type
	o Licensed Professional Clinical Counselor o Psychologist
Mental Health Facilities	• Alcohol and Other Drug (Outpatient) • Mental Health Rehabilitation Centers • Partial Hospital Services, including one or both of the following: o Partial Hospitalization o Intensive Outpatient • Residential Treatment • Residential Detox • Eating Disorder (Outpatient or Inpatient)
Dental Providers	• General Dentist • Endodontics • Orthodontics • Pediatric Dentistry • Periodontics • Prosthodontics • Surgery – Oral and Maxillofacial

Glossary

Term	Definition
Active Labor	An emergency medical condition that results in a labor at a time at which any of the following would occur: A woman experiences contraction (a woman experiencing contractions is presumed to be in true labor unless a provider or qualified individual certifies after a reasonable time of observation that the woman is in false labor). There is inadequate time to affect a safe transfer to another hospital prior to delivery; or A transfer may pose a threat to the health and safety of the patient or the unborn child.

Term	Definition
Activities of Daily Living (ADLs)	The basic tasks of everyday life, such as eating, bathing, dressing, toileting, and transferring (e.g., moving from the bed to a chair).
Appeal	A written or oral expression requesting a re-evaluation of a specific determination made by the Plan or any of its authorized subcontractors (Plan Medical Groups). The determination in question may be a denial or modification of a requested service. (It may also be called an adverse benefit determination.)
Authorization	Approval by the member's Plan Medical Group (PMG) or the Plan for covered benefits. (An authorization may also be called a pre-service claim.)
Authorized Representative	An individual designated by the member to receive Protected Health Information about the member for purposes of assisting with a claim, appeal, grievance, or other matter. The authorized representative must be designated by the member in writing on a form approved by Sharp Health Plan.
Chronic Condition	A medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure, or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration.
Coinsurance	The portion of the cost of a covered healthcare service, calculated as a percent (for example, 20%) that is the financial responsibility of the member. The member pays coinsurance plus any deductibles owed. For example, if the Plan's allowed amount for an office visit is $100 and the member has met the deductible, the coinsurance payment of 20% would be $20.
Copayment	A fee that a Plan provider or its subcontractors may collect directly from a member, and which a member is required to pay, for a particular covered benefit at the time service is rendered.

Term	Definition
Covered Benefits	Medically necessary services and supplies that members are entitled to receive under an employer group or individual agreement, and which are described in the Member Handbook.
Deductible	The amount a member must pay in a calendar year under some plans for certain covered benefits before the Plan will start to pay for those covered benefits in that calendar year. Once the member has met either the family or individual yearly Deductible, the member pays the applicable copayment or coinsurance for covered benefits, and the Plan pays the rest.
Dependent	An enrollee's legally married spouse, domestic partner, or child (including an adopted child or stepchild), who meets the eligibility requirements set forth in the Member Handbook, who is enrolled in the Plan, and for whom the Plan receives premiums.
Disposable Medical Supplies	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	A person who has established a domestic partnership as described in Section 297 of the California Family Code by meeting all the following requirements. 1. Both persons agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership. 2. Neither person is married or a member of another domestic partnership. 3. The two persons are not related by blood in a way that would prevent them from being married to each other in this state. 4. Both persons are at least 18 years of age. 5. Both persons are capable of consenting to the domestic partnership. 6. Either of the following: a. Both persons are members of the same sex. b. One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in 42 U.S.C. Section 402(a) for old-age insurance benefits or Title XVI of the Social Security Act as defined in 42. U.S.C. Section 1381 for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both persons are over the age of 62. 7. Neither person has previously filed a Declaration of Domestic Partnership with the Secretary of State pursuant to this division that has not been terminated under Section 299. 8. Both file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division. If documented in the agreement with Sharp Health Plan, Domestic Partner also includes individuals who meet criteria 1–5 above and who sign an affidavit attesting to that fact.

Term	Definition
Drug Formulary (Drug List)	The continuously updated list of drugs that are covered by the Plan. A Drug Formulary enhances quality of care by encouraging the use of those prescription medications that are demonstrated to be safe and effective and produce superior patient outcomes. The Drug Formulary consists of brand and generic drugs. Prescription drugs must be dispensed in generic form when one is available, provided that no medical contraindication exists. Brand-name drugs are charged a higher copayment. Medications that are not listed on the drug formulary are not covered, unless authorized by the Plan.
Durable Medical Equipment	Medical equipment appropriates 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.
Emergency Medical Condition	A medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable lay person could reasonably expect the absence of immediate attention to result in placing the patient's health in jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
Emergency Services	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.

Term	Definition
Emergency Services and Care	1. Medical screening, examination, and evaluation by a provider, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a provider, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery by a provider if 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 provider, 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	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 healthcare service plan contracts and in which a bona fide employer-employee relationship exists.
Health Plan Benefits and Coverage Matrix	A list of the most commonly used covered benefits and applicable copayments for the specific benefit plan purchased by the employer. Members receive a copy of the Health Plan Benefits and Coverage Matrix along with the Member Handbook. The Health Plan Benefits and Coverage Matrix may also be called the Summary of Benefits.
Maintenance Drugs	Medications that represent drugs necessary for members with chronic, potentially life-threatening illnesses that are used by the majority of members and that the P&T Committee determines can be supplied for up to a 90-day supply per fill.

Term	Definition
Medically Necessary	A treatment or service necessary to protect life; to prevent illness or disability; to diagnose, treat, or control illness, disease, or injury; or to alleviate severe pain. The treatment or service should be: 1. Based on generally accepted clinical evidence. 2. Consistent with recognized standards of practice. 3. Demonstrated to be safe and effective for the member's medical condition; and Provided at the appropriate level of care and setting based on the member's medical condition.
Member	An individual who has enrolled in the Plan under the provisions of an employer group or individual plan agreement and for whom the applicable premiums have been paid.
Out-of-Area	Services received while a member is outside the Service Area. Out-of-area coverage includes urgent or emergent services for the sudden onset of symptoms of sufficient severity to require immediate medical attention to prevent serious deterioration of a member's health resulting from unforeseen illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the member returns to the service area. Out-of-area medical services will be covered to meet the member's immediate medical needs. Sharp Health Plan must authorize applicable follow-up for the urgent or emergent service and cover until it is prudent to transfer the member's care into the Plan's service area.
Plan	Sharp Health Plan
Plan Hospital	An institution licensed by the State of California as an acute care hospital that provides certain covered benefits to members through an agreement with the Plan and that is included in the member's Plan network.

Term	Definition
Plan Medical Group (PMG)	A group of providers, organized as or contracted through a legal entity, which 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 Pharmacy	Any pharmacy licensed by the State of California to provide outpatient prescription drug services to members through an agreement with the Plan. Plan pharmacies are listed in the provider directory.
Plan Provider	Any Doctor of Medicine, osteopathy, podiatry, or dental surgery licensed by the State of California who has agreed to provide professional services to members, either through an agreement with the Plan or as a member of a PMG, and who is included in the member's Plan network.
Plan Providers	The providers, hospitals, skilled nursing facilities, home health agencies, pharmacies, medical transportation companies, laboratories, X-ray facilities, durable medical equipment suppliers, and other licensed healthcare entities or professionals that are included in the member's Plan network and which or who provide covered benefits to members through an agreement with the Plan or PMG.
Primary Care Physician (PCP)	A Plan provider, 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, 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 providers, internists, pediatricians, and qualified OB/GYNs who have the ability to deliver and accept the responsibility for delivering primary care services.
Professional Services	Professional diagnostic and treatment services which are listed in the Member Handbook and supplemental benefits brochures, if applicable, and are provided by Plan providers and other health professionals.

Term	Definition
Protected Individual	Any adult covered by the subscriber's healthcare service plan or a minor who can consent to a healthcare service without the consent of a parent or legal guardian, pursuant to state or federal law. "Protected individual" does not include an individual that lacks the capacity to give informed consent for health care pursuant to Section 813 of the Probate Code.
Provider Directory	A listing of Plan-approved providers, hospitals, and other Plan providers, which is updated periodically.
Qualified Health Professional	A primary care physician (PCP) or a specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to a particular illness, disease or condition, or conditions associated with the request for a second opinion.

Term	Definition
Serious Emotional Disturbance (SED)	One or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, to include Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and other pervasive developmental disorders not otherwise specified (including Atypical Autism), in accordance with diagnostic and statistical manual for Mental Disorders–IV-Text revisions (July 2000), other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. One or more of the following must also be true: 1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and one or more of the following occur: a. The child is at risk of removal from the home or has already been removed from the home; or b. The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year if not treated. 2. The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder; or 3. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.
Service Area	The geographic area in which Sharp Health Plan is licensed to provide health services, as approved by the California Department of Managed Health Care.

Term	Definition
Sensitive Services	All healthcare 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.
Severe Mental Illness	One or more of the following nine disorders in persons of any age: schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive- compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, bulimia nervosa.
Skilled Nursing Facility (SNF)	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.
Subscriber	The individual enrolled in the Plan for whom the appropriate premiums have been received by Sharp Health Plan, and whose status, except for family dependency, is the basis for enrollment eligibility.

Term	Definition
Totally Disabled	A member who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition, and who is chiefly dependent upon the Subscriber for support and maintenance. The determination as to whether a member is Totally Disabled will be made based upon an objective review consistent with professionally recognized medical standards. Member requires these services, or the member is Out-of-Area and requires 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 time frame, usually within twenty-four (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	The evaluation of the appropriateness, medical need, and efficiency of healthcare services and facilities according to established criteria or guidelines and under the provisions of the applicable health benefits plan.

SHARP Health Plan

We are here for you!

1-844-483-9014
sharphealthplan.com

