Sharp Health Plan: Sharp Silver 70 HMO Network 2 1500/45 w/Child Dental

Coverage Period: 01/01/2016 – 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.sharphealthplan.com** or by calling **1-800-359-2002**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** Individual / **$3,000** Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. Pharmacy **$250** Individual / **$500** Family. There are no other specific deductibles	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,500** Individual / **$13,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, copayments for supplemental benefits, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, see www.sharphealthplan.com or call 1-800-359-2002.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-359-2002** or visit us at **www.sharphealthplan.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.sharphealthplan.com** or call 1-800-359-2002 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45 copay/visit	Not covered	——————none——————
	Specialist visit	$70 copay/visit	Not covered	Prior authorization is required, except for obstetric and gynecologic services.
	Other practitioner office visit	$45 copay/visit	Not covered	Prior authorization is required.
	Preventive care/screening/immunization	No cost share	Not covered	Prior authorization may be required.
If you have a test	Laboratory tests	$35 copay/visit	Not covered	Prior authorization is required.
	Diagnostic test (x-ray, blood work)	$65 copay/visit	Not covered	Prior authorization is required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	**Deductible** applies. Prior authorization is required.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.sharphealthplan.com .	Tier 1	$15/30-day supply $30/90-day supply	Not covered	**Pharmacy Deductible** applies to drugs on Tiers 2, 3 and 4. Brand drugs are not covered if a generic version is available, unless prior authorization is obtained. Prior authorization is required for certain generic drugs. 90-day supply cost-share applies to maintenance medications filled by mail order only.
	Tier 2	$55/30-day supply $110/90-day supply	Not covered	
	Tier 3	$75/30-day supply $150/90-day supply	Not covered	
	Tier 4	20% coinsurance up to $250 per script after pharmacy deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	Prior authorization is required.
	Physician/surgeon fees	20% coinsurance	Not covered	——————none——————
If you need immediate medical attention	Emergency room facility fee Emergency room physician fee	$250 copay/visit (facility) $50 copay/visit (physician)	$250 copay/visit (facility) $50 copay/visit (physician)	**Deductible** applies. Cost-share waived if admitted.
	Emergency medical transportation	$250 copay/trip	$250 copay/trip	**Deductible** applies.
	Urgent care	$90 copay/visit	$90 copay/visit	Services must be approved by your primary care provider in San Diego county. Out-of-network services are covered only when out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	**Deductible** applies to the facility fee and physician/surgeon fee. Prior authorization is required for nonemergency services. Out-of-

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
	Physician/surgeon fee	20% coinsurance	20% coinsurance	network services are covered for emergency care only.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$45 copay/visit	Not covered	Prior authorization is required.
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	**Deductible** applies. Prior authorization is required for nonemergency services. Out-of-network services are covered for emergency care only.
	Substance use disorder outpatient services	$45 copay/visit	Not covered	Prior authorization is required.
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	**Deductible** applies. Prior authorization is required for nonemergency services. Out-of-network services are covered for emergency care only.
If you are pregnant	Prenatal and postnatal care	No cost share	Not covered	——————none——————
	Delivery and all inpatient services	20% coinsurance	20% coinsurance	**Deductible** applies. Out-of-network services are covered for emergency care only.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	Prior authorization is required. Coverage is limited to 100 days per calendar year.
	Rehabilitation services	$45 copay/ visit	Not covered	Prior authorization is required.
	Habilitation services	$45 copay/ visit	Not covered	Prior authorization is required.
	Skilled nursing care	20% coinsurance	Not covered	**Deductible** applies. Prior authorization is required. Coverage is limited to 100 days per benefit period.
	Durable medical equipment	20% coinsurance	Not covered	Prior authorization is required.
	Hospice service	No cost share	Not covered	Prior authorization is required.
If your child needs dental or eye care	Eye exam	No cost share	Not covered	Limited to one exam per year.
	Glasses	No cost share	Not covered	Limited to one pair of glasses per year.
	Dental check-up	No cost share	Not covered	Limited to 2 in a 12 month period. Sharp Health Plan's pediatric dental benefits are provided by Access Dental. Please refer to the Access Dental schedule of benefits for further details about your pediatric dental benefits.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Chiropractic care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Hearing aids

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact Sharp Health Plan at 1-800-359-2002. You may also contact the California Department of Managed Health Care at 1-888-466-2219 or www.hmohelp.ca.gov, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Sharp Health Plan at 1-800-359-2002 or the California Department of Managed Health Care at 1-888-466-2219 or www.hmohelp.ca.gov. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/heatlhreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-359-2002.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,850
- **Patient pays** $2,690

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,500
Copays	$20
Coinsurance	$1,020
Limits or exclusions	$150
Total	**$2,690**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,435
- **Patient pays** $1,965

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$1,205
Coinsurance	$260
Limits or exclusions	$0
Total	**$1,965**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Member Handbook

Health Maintenance Organization (HMO)

Evidence of Coverage for Non-Grandfathered Small Group Plans
Effective January 1, 2015

SHARP HEALTH PLAN
make life better.

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

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

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

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

Please contact us with questions about this Member Handbook.

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

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

sharphealthplan.com

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WELCOME TO SHARP HEALTH PLAN

Thank you for selecting Sharp Health Plan for your Health Plan Benefits. Your health and satisfaction with our service are most important to us.
We encourage you to let us know how we may serve you better by calling us at (858) 499-8300 or toll-free at 1-800-359-2002. Our Customer Care Representatives are available Monday through Friday from 8 a.m. to 6 p.m. to answer any questions you may have. Additionally, after hours and on weekends, you have access to a specially trained registered nurse for immediate medical advice by calling the same Customer Care phone number.

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

Booklets and Information

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

Member Handbook

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

Health Plan Benefits and Coverage Matrix

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

Provider Directory

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

Member Newsletter

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

HOW DOES THE PLAN WORK?

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

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

Choice of Plan Physicians and Plan Providers

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

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

Call Your PCP When You Need Care

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

Present Your Member ID Card and Pay Copayment

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

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

HOW DO YOU OBTAIN MEDICAL CARE?

Use Your Member ID Card

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

Access Health Care Services Through Your Primary Care Physician

Call Your PCP for All Your Health Care Needs

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

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

Use Sharp Health Plan Providers

You receive Covered Benefits from Plan Providers who are affiliated with your PMG and who are part of your Plan Network. To find out which Plan Providers are affiliated with your PMG and part of your Plan Network, refer to the Provider Directory for your Plan Network or call Customer Care.

If Covered Benefits are not available from Plan Providers affiliated with your PMG, you will be referred to another Plan Provider to receive such Covered Benefits. You are responsible to pay for any care not provided by Plan Providers affiliated with your PMG, unless your PMG has prior-Authorized the service or unless it is an emergency.

Schedule Appointments

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

Referrals to Non-Plan Providers

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

Use Sharp Health Plan Hospitals

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

Changing Your PCP

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

Obtain Required Authorization

Except for PCP services, Emergency Services and obstetric and gynecologic services, you are responsible for obtaining valid Authorization before you receive Covered Benefits. To obtain a valid Authorization:

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

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

A decision will be made on the Authorization request within five business days. A letter will be sent to you within two business days of the decision.

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

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

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

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

Second Medical Opinions

When a medical or surgical procedure is recommended, and either the Member or the Plan Physician requests, a second medical or surgical opinion may be obtained. You may request a second opinion for any reason, including the following:

1. You question the reasonableness or necessity of recommended surgical procedures.
2. You question a diagnosis or plan of care for a condition that threatens loss of life, limb or bodily function, or substantial impairment, including, but not limited to, a serious Chronic Condition.
3. The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and you would like to request an additional diagnosis.

4. The treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis and plan of care, and you would like a second opinion regarding the diagnosis or continuance of the treatment.

5. You have attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

6. You or the Plan Physician who is treating you has serious concerns regarding the accuracy of the pathology results and requests a specialty pathology opinion.

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

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

Emergency Services and Care

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

Emergency Services means those Covered Benefits, including Emergency Services and Care, provided inside or outside the Service Area that are medically required on an immediate basis for treatment of an Emergency Medical Condition. Sharp Health Plan covers 24 hour emergency care.

An Emergency Medical Condition is a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable lay person could reasonably expect the absence of immediate attention to result in:

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

2. Serious impairment of bodily functions; or

3. Serious dysfunction of any bodily organ or part.

Emergency Services and Care means:

1. Medical screening, examination and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an Emergency Medical Condition or Active Labor exists and, if it does, the care, treatment and surgery by a physician necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and

2. An additional screening, examination and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric Emergency Medical Condition within the capability of the facility.

What To Do When You Require Emergency Services

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

- If you are unsure whether your condition requires Emergency Services, call your PCP (even after normal office hours). Your PCP can help decide the best way to get treatment and can arrange for prompt emergency care. However, do not delay getting care if your PCP is not immediately available. Members are encouraged to use the "911" emergency response system appropriately when they have an Emergency Medical Condition that requires an emergency response.

- If you go to an emergency room and you do not have an emergency, you may be responsible for payment.
- If you are hospitalized in an emergency, please notify your PCP or Sharp Health Plan within 48 hours or at the earliest time reasonably possible. This will allow your Plan Physician to share your medical history with the hospital and help coordinate your care. If you are hospitalized outside of the Service Area, your Plan Physician and the Plan may arrange for your transfer to a Plan Hospital if your medical condition is sufficiently stable for you to be transferred.
- Paramedic ambulance services are covered when provided in conjunction with Emergency Services.
- If you need follow-up care after you receive Emergency Services, call your PCP to make an appointment or for a referral to a specialist. Do not go back to the hospital emergency room for follow-up care, unless you are experiencing an Emergency Medical Condition.
- You are not financially responsible for payment of Emergency Services, in any amount the Plan is obligated to pay, beyond your Copayment and/or Deductible. You are responsible only for applicable Copayments or Deductibles, as listed on the Health Plan Benefits and Coverage Matrix.
- Some non-Plan Providers may require that you pay for Emergency Services and seek reimbursement from the Plan. On these occasions, obtain a complete bill of all services rendered and a copy of the emergency medical report, and forward them to the Plan right away for reimbursement.

Urgent Care Services

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

What to Do When You Require Urgent Care Services

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

Language Assistance Services

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

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

Access for the Vision Impaired

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

Pre-existing Conditions

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

Case Management

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

HOW DO YOU USE YOUR PEDIATRIC DENTAL BENEFITS?

Your benefit plan includes pediatric dental benefits for Members under the age of 19. Sharp Health Plan's pediatric dental benefits are provided through the Plan's dental provider Access Dental Plan. Attached with this Member Handbook is your Access Dental Plan schedule of benefits that sets forth applicable benefit and cost-sharing information for the pediatric dental benefits included with this plan. Beginning on page 59 of this Member Handbook, you will find information about your covered pediatric dental benefits, how to obtain those benefits, and your rights and responsibilities pertaining to your pediatric dental benefits. Cost-sharing for covered pediatric dental benefits will contribute towards the Out-of-Pocket Maximum amount under your Sharp Health Plan medical benefit plan.

WHO CAN YOU CALL WITH QUESTIONS?

Customer Care

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

Sharp Nurse Connection®

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

Utilization Management

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

WHAT DO YOU PAY?

Premiums

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

Copayments

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

You are responsible to pay applicable Copayments for any Covered Benefit you receive. Copayment amounts vary depending on the type of care you receive. Copayments may be either a set dollar amount, such as $20 for a primary care office visit, or a percentage of the cost Sharp Health Plan pays for the care, such as 20 percent of contracted rates for inpatient services (also called "Coinsurance"). These specific Copayments can be found in the Health Plan Benefits and Coverage Matrix included with this Member Handbook. For a quick reference and for your convenience, Copayments for the most commonly used benefits are also shown on your Member ID card.

Deductibles

Some, but not all, benefit plans include one or more Deductibles. If you have a Deductible, it will be listed on the Health Plan Benefits and Coverage Matrix. You may have one Deductible for medical services and a separate Deductible for brand name prescription drugs, or you may have a combined Deductible for medical services and prescription drugs. A Deductible is the amount you must pay each calendar year for certain Covered Benefits before we will start to pay for those Covered Benefits. The amounts you are required to pay for the Covered Benefits subject to a Deductible are based upon Sharp Health Plan's cost for the Covered Benefit. Once you have met your yearly Deductible, you pay the applicable Copayment for Covered Benefits and we pay the rest. The Deductible starts over each year.

How Does the Annual Deductible Work?

- If a Member satisfies the Individual Deductible amount, no further Deductible payments are required for that Member for the specified Covered Benefits for the remainder of the year. Premium payments are still required.
- Once a Member in a family satisfies the Individual Deductible amount for the specified Covered Benefits, the remaining enrolled family members must continue to pay applicable Deductible amounts until either (a) the sum of Deductibles paid by the family reaches the Family Deductible amount or (b) each enrolled family member meets his/her Individual Deductible amount, whichever occurs first.
- When the sum of Deductibles paid for all enrolled Members for the specified Covered Benefits equals the Family Deductible amount, no further Deductibles for the specified Covered Benefits are required from any enrolled Member of that family for the remainder of the calendar year.
- Only amounts that are applied to the Individual Deductible amount may be applied to the Family

Deductible amount. Any amount you pay for the specified Covered Benefits for yourself that would otherwise apply to your Individual Deductible amount but which exceeds the Individual Deductible amount will be refunded to you, and will not apply toward your Family Deductible amount. Individual Members cannot contribute more than their Individual Deductible amount to the Family Deductible amount.

Annual Out-of-Pocket Maximum

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

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

- If a Member pays amounts for Covered Benefits that equal the Individual Out-of-Pocket Maximum, no further Copayments or Deductibles are required for that Member for Covered Benefits (excluding supplemental benefits) for the remainder of the year. Premium contributions are still required.
- Once a Member in a family satisfies the Individual Out-of-Pocket Maximum, the remaining enrolled family members must continue to pay applicable Copayments 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 you pay for Covered Benefits for yourself that would otherwise apply to your Individual Out-of-Pocket Maximum but which exceeds the Individual Out-of-Pocket Maximum will be refunded to you, and will not apply toward your Family Out-of-Pocket Maximum. Individual Members cannot contribute more than their Individual Out-of-Pocket Maximum amount to the Family Out-of-Pocket Maximum.

Exceptions to the Annual Out-of-Pocket Maximum

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

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

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

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

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

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

Health Savings Account (HSA) Qualified High Deductible Health Plans

If you are enrolled in an HSA-qualified high deductible health plan (HDHP), your Deductible and Out-of-Pocket Maximum will work differently. In HDHPs linked to HSAs, an individual in a self-only coverage plan must meet the Self-Only Deductible. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Individual Deductible in a HSA family plan must be at least $2,600 under IRS rules. The Out-of-Pocket Maximum includes the Deductible, Copayments and Coinsurance. In a self-only plan, the Member is responsible for all applicable Deductibles, Copayments, and Coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all Deductibles, Copayments, and Coinsurance up to the Individual Out-of-Pocket Maximum, until the combined Deductibles, Copayments and Coinsurance equal the family Out-of-Pocket Maximum. When the family's combined Deductibles, Copayments and Coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of-Pocket Maximum. If you are unsure whether you are enrolled in this type of HDHP, please call Customer Care.

Deductible Credits

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

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

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

What if You Get a Medical Bill?

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

Some doctors and hospitals that are not contracted with Sharp Health Plan (for example, emergency Departments outside Sharp Health Plan's Service Area) may require you to pay at the time you receive care. If you pay for Covered Benefits, you can request reimbursement from Sharp Health Plan. Go to **sharphealthplan.com** or call Customer Care to request a member reimbursement form. You will also need to send written evidence of the care you received and the amount you paid (itemized bill, receipt, medical records). We will reimburse you for Covered Benefits within 30 calendar days of receiving your complete information. You must send your request for reimbursement to Sharp Health Plan within 180 calendar days of the date you received care. If you are unable to submit your request within 180 calendar days from the date you received care, please provide documentation showing why it was not reasonably possible to submit the information within 180 days.

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

WHAT ARE YOUR RIGHTS & RESPONSIBILITIES AS A MEMBER?

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

You have the right to:

- Be treated with dignity and respect.
- Have your privacy and confidentiality maintained.
- Review your medical treatment and record with your health care provider.
- Be provided with explanations about tests and medical procedures.
- Have your questions answered about your care.
- Have a candid discussion with your health care provider about appropriate or Medically Necessary treatment options, regardless of cost or benefit coverage.
- Participate in planning and decisions about your health care.
- Agree to, or refuse, any care or treatment.
- Voice complaints or Appeals about Sharp Health Plan or the services you receive as a Sharp Health Plan Member.
- Receive information about Sharp Health Plan, our services and providers, and Member rights and responsibilities.
- Make recommendations about these rights and responsibilities.

You have the responsibility to:

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

Security of Your Confidential Information (Notice of Privacy Practices)

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

PLEASE REVIEW IT CAREFULLY.

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

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

A. HOW WE MAY USE AND SHARE INFORMATION ABOUT YOU

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

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

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

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

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

B. OTHER USES FOR YOUR HEALTH INFORMATION

1. Sometimes a court will order us to give out your health information. We also will give information to a court, investigator, or lawyer under certain circumstances. This may involve fraud or actions to recover money from others.

2. You or your doctor, hospital and other health care providers may Appeal decisions made about claims for your health care. Your health information may be used to make these Appeal decisions.

3. We also may share your health information with agencies and organizations that check how our health plan is providing services.

4. We must share your health information with the federal government when it is checking on how we are meeting privacy rules.

5. We may share your information with researchers when an Institutional Review Board (IRB) has reviewed and approved the reason for the research, and has established appropriate protocols to ensure the privacy of the information.

6. We may disclose health information, when necessary, to prevent a serious threat to your health or safety or the health and safety of another person or the public. Such disclosures would be made only to someone able to help prevent the threat.

7. We provide Employers only with the information allowed under the federal law. This information includes summary data about their group and information concerning Premium and enrollment data. The only other way that we would disclose your Protected Health Information to your Employer is if you Authorized us to do so.

C. WHEN WRITTEN PERMISSION IS NEEDED

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

D. WHAT ARE YOUR PRIVACY RIGHTS?

- You have the right to ask us not to use or share your personal health care information in the ways described in this notice. We may not be able to agree to your request.

- If you pay for a service or a health care item Out-of-Pocket in full, you can ask your Provider not to share that information with us or with other health insurers.

- You have the right to ask us to contact you only in writing or at a different address, post office box, or by telephone. We will accept reasonable requests when necessary to protect your safety.

- You and your personal representative have the right to get a copy of your health information. You will be sent a form to fill out and may be charged a fee for the costs of copying and mailing records. (We may keep you from seeing certain parts of your records for reasons allowed by law.)

- You have the right to ask that information in your records be amended if it is not correct or complete. We may refuse your request if: (i) the information is not created or kept by Sharp Health Plan, or (ii) we believe it is correct and complete. If we do not make the changes you ask, you may ask that we review our decision. You also may send a statement saying why you disagree with our records, and that statement will be kept with your records. **Important:** Sharp Health Plan does not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.

- When we share your health information after April 14, 2003, you have the right to request a list of what information was shared, with whom we shared it, when we shared it and for what reasons. This list will not include when we share information: with you; with your permission; for treatment, payment, or health plan operations; or as required by law.

- You have a right to receive written notification if we discover a breach of your unsecured PHI, and determine through a risk assessment that notification is required.

- You have a right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing, for most uses or disclosures of psychotherapy notices, or if we intend to sell your PHI.

- You may revoke an authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.

- You have a right to request a copy of this Notice of Privacy Practices. You also can find this Notice on our website at: **sharphealthplan.com**.

- You have the right to complain about any aspect of our health information practices, per Section F.

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

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

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

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

F. COMPLAINTS

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

- **Sharp Health Plan** by sending a letter to the address shown in Section E or by calling us toll-free at 1-800-359-2002.

- **U.S. Department of Health and Human Services, Office for Civil Rights** by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling: 1-877-696-6775, or by visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

WHAT IS THE GRIEVANCE OR APPEAL PROCESS?

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

You may file a Grievance or Appeal with Sharp Health Plan up to 180 calendar days following any incident that is subject to your dissatisfaction. You can obtain a copy of the Plan's Grievance and Appeal Policy and Procedure from your Plan Provider or by calling Customer Care. To begin the Grievance process, you or your Authorized Representative can call, write or fax Sharp Health Plan at:

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

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

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

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

Binding Arbitration – Voluntary

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

You may begin the arbitration process by submitting a demand for arbitration to Sharp Health Plan. Sharp Health Plan will utilize a neutral arbiter from an appropriate entity. Arbitration will be conducted in accordance with the rules and regulations of the arbitration entity. Upon receipt of your request, we will forward to you a complete copy of the Arbitration Rules from the arbitration entity and a confirmation that we have submitted a request to the arbitration entity for a list of arbitrators.

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

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

Additional Resources

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

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

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

Mediation

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

Independent Medical Reviews (IMR)

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

If the IMR specialist so determines, the Plan will provide coverage for the health care service.

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

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

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

1. You must have a life-threatening or seriously debilitating condition. "Life-threatening" means either or both of the following: (a) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or (b) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

2. Your Plan Physician must certify that you have a condition, as described in paragraph (1) above, for which standard therapies have not been effective, or for which standard therapies would not be medically appropriate, or for which there is no more beneficial standard therapy covered by the Plan than the proposed therapy.

3. Either (a) your Plan Physician has recommended a drug, device, procedure or other therapy that the doctor certifies in writing is likely to be more beneficial to you than any available standard therapies or (b) you or your specialist Plan Physician (board eligible or board certified) has requested a therapy that, based on documentation from the medical and scientific evidence, is likely to be more beneficial than any available standard therapy.

4. You have been denied coverage by the Plan for a drug, device, procedure or other therapy recommended or requested as described in paragraph (3) above.

5. The specific drug, device, procedure or other therapy recommended would be a Covered Benefit, except for the Plan's determination that the therapy is experimental or investigational.

If there is potential that you would qualify for an IMR under this section, the Plan will send you an application within five days of the date services were denied. If you would like to request an Independent Medical Review, return your application to the DMHC. Your physician will be asked to submit the documentation that is described in paragraph (3). An expedited review process will occur if your doctor determines that the proposed therapy would be significantly less effective if not promptly initiated. In such cases the analyses and recommendations of the experts on the panel shall be rendered within seven days of the request for independent review.

Denial of a Health Care Service as Not Medically Necessary

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

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

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

1. (a) Your Plan Provider has recommended a health care service as Medically Necessary;
   (b) You have received an Urgent Care or Emergency Service that a provider determined was Medically Necessary, or
   (c) You have been seen by a Plan Provider for the diagnosis or treatment of the medical condition for which you seek IMR;

2. The disputed health care service has been denied, modified or delayed by the Plan or a Plan Medical Group, based in whole or in part on a decision that the health care service is not Medically Necessary; and

3. You have filed an Appeal with the Plan and the Plan's decision was upheld or your Appeal remains unresolved after 30 days. If your Appeal requires expedited review, you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow the Plan's Grievance process in extraordinary and compelling cases.

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

WHAT ARE YOUR COVERED BENEFITS?

Covered Benefits

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

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

The Covered Benefits described in this Member Handbook do not include dental services for members age 19 and older except as specifically described under **"Dental Services/Oral Surgical Services,"** chiropractic services or assisted reproductive technologies. These may be covered through supplemental benefits made available by your Employer and described in supplemental benefits brochures. Copayments made for supplemental benefits do not apply toward the annual Out-of-Pocket Maximum.

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

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

Acupuncture Services

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

Acute Inpatient Rehabilitation Facility Services

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

Ambulance and Medical Transportation Services

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

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

Blood Services

Costs of processing, storage and administration of blood and blood products are covered.

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

Bloodless Surgery

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

Chemical Dependency and Alcoholism Treatment

The following services are covered:

- Hospitalization in a Plan Hospital for medical management of withdrawal symptoms, including room and board, Plan Physician services, drugs, dependency recovery services, education and counseling.
- Outpatient chemical dependency care: day-treatment programs, intensive outpatient programs, individual and group chemical dependency counseling and medical treatment for withdrawal symptoms.
- Chemical dependency treatment in a nonmedical transitional residential recovery setting if Authorized in writing by Psychiatric Centers at San Diego. These settings provide counseling and support services in a structured environment.

Chemotherapy

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

Circumcision

Routine circumcision is a Covered Benefit only when the procedure is performed in the Plan Physician's office, outpatient facility or prior to discharge during the neonatal period. The neonatal period is defined as the period immediately following birth and continuing through the first 28 days of life.

For a premature infant, requiring inpatient care due to a medical condition, routine circumcision is covered for the duration of the inpatient stay, and for three months post-hospital discharge.

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

Clinical Trials

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

1. The Member is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition. The term "life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.
2. Either (a) the referring health care professional is a Plan Provider and has concluded that the Member's participation in such trial would be appropriate based upon the Member meeting the conditions of the clinical trial; or (b) the Member provides medical and scientific information establishing that the Member's participation in the clinical trial would be appropriate based upon the Member meeting the conditions of the clinical trial.

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

1. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   a) The National Institutes of Health
   b) The Centers for Disease Control and Prevention
   c) The Agency for Health Care Research and Quality
   d) The Centers for Medicare & Medicaid Services

e) A cooperative group or center of any of the entities described in clauses (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
g) Any of the following if the conditions described in paragraph (2) are met:

i. The Department of Veterans Affairs
ii. The Department of Defense
iii. The Department of Energy

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

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

Covered Benefits for clinical trials include the following:

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

Please note that if a clinical trial is conducted by a doctor who does not participate in your Plan Network, the doctor may hold the Member responsible to pay for services that are billed above the Plan's normally contracted rates.

Dental Services/Oral Surgical Services

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

In addition to the pediatric dental benefits described in the Access Dental Plan schedule of benefits and the summary beginning on page 59, dental services for all Members are covered only as described below:

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

Oral surgical services are covered only as described below:

- Reduction or manipulation of fractures of facial bones.
- Excision of lesions of the mandible, mouth, lip or tongue.
- Incision of accessory sinuses, mouth, salivary glands, or ducts.
- Reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect or accidental injury.
- Oral or dental examinations performed on an inpatient or outpatient basis as part of a comprehensive workup prior to transplantation surgery.
- Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol.

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

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

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

Diabetes Treatment

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

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

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

Disposable Medical Supplies

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

Durable Medical Equipment (DME)

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

1. Intended for repeated use over a prolonged period;

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

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

The following DME is covered for use in your home (or another location used as your home):

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

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

Emergency Services

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

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

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

The Member pays an applicable Copayment to the hospital for Emergency Services provided in a hospital emergency room. The Member pays the same Copayment for Emergency Services whether the hospital is a Plan Hospital or not.
The Copayment is waived if the Member is admitted to the hospital from its emergency room.

Family Planning Services

The following family planning services are covered:

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

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

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

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

Health Education Services

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

Home Health Services

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

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

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

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

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

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

Hospice Services

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

Covered Benefits include:

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

Special coverage is also provided for:

- Periods of Crisis: Nursing care services are covered on a continuous basis for 24 hours a day during periods of crisis as necessary to maintain a Member at home. Hospitalization is covered when the interdisciplinary team makes the determination that inpatient skilled nursing care is required at a level that cannot be provided in the home. Either homemaker or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis, but the care provided during these periods must be predominantly nursing care. A period of crisis is a period in which the Member requires continuous care to achieve palliation or management of acute medical symptoms.

Respite Care: Respite care is short-term inpatient care provided to the Member only when necessary to relieve the family members or other persons caring for the Member. Coverage for respite care is limited to an occasional basis and to no more than five consecutive days at a time.

Hospital Facility Inpatient Services

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

- A hospital room of two or more beds, including meals, services of a dietitian and general nursing care.
- Intensive care services.

- Operating and special treatment rooms.
- Surgical, anesthesia and oxygen supplies.
- Administration of blood and blood products.
- Ancillary services, including laboratory, pathology and radiology.
- Administered drugs.
- Other diagnostic, therapeutic and rehabilitative services as appropriate.
- Coordinated discharge planning including planning of continuing care, as necessary.

Hospital Facility Outpatient Services

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

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

Infertility Services

Infertility services, including diagnosis and treatment of the Member's infertility condition (other than conception by artificial means), are covered. Infertility is defined as (1) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual intercourse without contraception, or (2) the presence of a demonstrated condition recognized by a physician as a cause of infertility. A woman without a male partner who is unable to conceive may be considered infertile if she is unable to conceive or produce conception after at least twelve (12) cycles of donor insemination; these 12 cycles are not covered by the Plan. The Member pays a Copayment equal to fifty percent (50%) of the Plan's contracted rate of payment to each Plan Provider of services for all covered infertility services.

Conception by artificial means is not covered unless supplemental benefits have been purchased by the Employer. If your Employer has purchased this supplemental benefit, you will receive an additional supplemental benefit plan document that will outline the applicable benefits and cost-sharing.

Infusion Therapy

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

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

Injectable Drugs

Outpatient injectable medications and self-injectable medications are covered. Outpatient injectable medications include those drugs or preparations which are not usually self-administered and which are given by the intramuscular or subcutaneous route. Outpatient injectable medications (except insulin) are covered when administered as a customary component of a Plan Physician's office visit and when not otherwise limited or excluded (e.g., certain immunizations, infertility drugs, or off-label use of covered injectable medications). Self-injectable medications (except insulin) are defined as those drugs which are either generally self-administered by intramuscular injection at a frequency of one or more times per week, or which are generally self-administered by the subcutaneous route. Insulin is covered under the outpatient prescription drug benefit.

Maternity and Pregnancy Services

The following maternity and pregnancy services are covered:

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

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

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

Mental Health Services

Sharp Health Plan covers Mental Health Services only for the diagnosis or treatment of Mental Disorders. The following services are covered:

- Individual and group mental health evaluation and treatment.
- Psychological testing when necessary to evaluate a Mental Disorder.
- Outpatient services for the purpose of monitoring drug therapy.
- Behavioral Health Treatment for pervasive developmental disorders or autism.
- Inpatient psychiatric hospitalization. Coverage includes room and board, drugs and services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license.
- Intensive psychiatric treatment programs. Coverage includes short-term hospital-based intensive outpatient care (partial hospitalization), short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program, short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis and psychiatric observation for an acute psychiatric crisis.

Members have direct access to Plan Providers of mental health services without obtaining a PCP referral. Covered mental health benefits must be obtained through Plan Providers. Mental health services that are not provided by Plan Providers are not covered, and you will be responsible to pay for those services. Please call Psychiatric Centers at San Diego toll-free at 1-877-257-7273 whenever you need mental health services. All calls are confidential.

MinuteClinic®

As a Sharp Health Plan Member, you may receive the covered services listed below at any MinuteClinic® location. These services are not an alternative to Emergency Services or ongoing care.

These services are provided in addition to the Urgent Care Services available to you as a Sharp Health Plan Member. MinuteClinic is the walk-in medical clinic located inside select CVS/pharmacy® stores. MinuteClinic provides convenient access to basic care. It is staffed with certified family nurse practitioners and physician assistants and is the largest provider of retail health care in the United States. In addition, it is the only retail health care provider to receive three consecutive accreditations from The Joint Commission, the national evaluation and certifying agency for nearly 15,000 health care organizations and programs in the United States.

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

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

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

For more information about these services and age restrictions, please visit **www.MinuteClinic.com.** If you receive these services at a MinuteClinic, the cost is $40 Copay per visit except for flu vaccinations, which are $10. If you receive these services at your PCP's office, a lower cost-share may apply and flu vaccinations have $0 cost-share. Please see your Health Plan Benefits and Coverage Matrix for the cost-sharing information for services received at locations other than the MinuteClinic.

You have access to all MinuteClinic locations, including 10 within San Diego County and over 600 other locations in 25 states. To locate a participating MinuteClinic near you visit **www.MinuteClinic.com** or call MinuteClinic directly at 1-866-389-ASAP (2727).

Ostomy and Urological Services

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

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

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

Outpatient Prescription Drugs

Outpatient prescription drugs are covered. Except for certain specialty medications, you may obtain covered Outpatient Prescription Drug Benefits from any Plan Pharmacy. Information about how to obtain specialty medications is provided on the following pages. Except for Emergency Services and Out-of-Area Urgent Care Services, outpatient prescription drugs that are not obtained from a Plan Pharmacy are not covered and you will be responsible for payment. Look in your Provider Directory or on **sharphealthplan.com** to find a Plan Pharmacy near you. Always present your Sharp Health Plan Member ID card to the Plan Pharmacy. Ask them to inform you if something is not going to be covered. You pay the Copayments for Covered Benefits as listed in your Health Plan Benefits and Coverage Matrix. If the retail price for your prescription drug is less than your Copayment, you will only pay the retail price. Cost-sharing for covered orally administered anticancer medications will not exceed $200 for an individual prescription of up to a 30-day supply. In addition, orally administered anticancer medications will not be subject to a Deductible unless you are enrolled in an HSA-compatible high deductible health plan.

Covered outpatient prescription medications include:

Tier I: Generic drugs on the Sharp Health Plan Drug Formulary.

Tier II: Brand name drugs, peak flow meters and inhaler spacers listed on the Sharp Health Plan Drug Formulary.

Tier III: Generic and brand name prescription drugs that are specifically listed as Tier III or that are not listed on the Drug Formulary, but are not specifically excluded from coverage.

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

Sharp Health Plan Drug Formulary

The Sharp Health Plan Drug Formulary (Formulary) is the approved list of medications covered for illnesses and conditions. It was developed to identify the safest and most effective medications for Members while attempting to maintain affordable pharmacy benefits.

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

Updates to the Formulary and drug usage guidelines are made as new clinical information and new drugs become available.

In order to keep the Formulary current, the P&T Committee evaluates clinical effectiveness, safety and overall value through:

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

To obtain a copy of Sharp Health Plan's current Drug Formulary, please visit our website at **sharphealthplan.com** or call or email Customer Care.

Outpatient Prescription Drug Prior Authorization Process

Some Tier I, Tier II and Tier III prescription medications require prior Authorization. This means that your doctor must contact Sharp Health Plan in advance to provide the medical reason for prescribing the medication. Routine and urgent requests from doctors are processed in a timely fashion, not to exceed 2 business days after Sharp Health Plan's receipt of the information reasonably necessary and requested by Sharp Health Plan to make the determination, as appropriate and Medically Necessary for the

nature of the Member's condition. Upon receiving your doctor's request for prior Authorization, Sharp Health Plan will evaluate the information submitted and make a determination based on established clinical criteria for the particular medication.

Selected prescription drugs require step therapy. This means that a Member must try an alternative prescription drug first that Sharp Health Plan determines will be clinically effective. There may be a situation where it may be Medically Necessary for a Member to receive certain medications without first trying an alternative drug. In these instances, your doctor may request prior Authorization. The list of prescription drugs subject to step therapy is subject to change by Sharp Health Plan. An updated copy of the list of drugs subject to step therapy is available upon request.

The criteria used for prior Authorization and step therapy are developed and based on input from the Sharp Health Plan P&T Committee as well as physician specialist experts. Your doctor may contact Sharp Health Plan to obtain the usage guidelines for specific medications.

Maintenance Drugs Available by Mail Order

Mail order is a convenient, cost-effective way to obtain maintenance drugs. A maintenance drug is one that is prescribed to treat or stabilize Chronic Conditions such as diabetes or hypertension. Certain maintenance drugs are available for up to a 90-day supply through our prescription home delivery service administered by Wellpartner. To use this service:

1. Have your doctor write a prescription for up to a 90-day supply of your maintenance drug.
2. Complete the order form in the Wellpartner brochure that you received with your New Member materials or available online at **sharphealthplan.com.**
3. Mail your original prescription along with the applicable Deductible and Copayment, using the pre-addressed, postage-paid envelope attached to the order form. Your prescription will arrive at your home in two to three weeks.
4. If your prescription includes refills, you can re-order by phone. Simply call toll-free 1-877-935-5797. If you have any questions or do not have a Wellpartner brochure, call or email Customer Care.

Certain medications, such as proton pump inhibitors, narcotics and central nervous system stimulants, are not available through mail order. Please use the Drug List tool at **sharphealthplan.com** to determine if your medication is available through Wellpartner, or call Customer Care.

Specialty Medications

Certain specialty medications are generally provided exclusively by Diplomat Specialty Pharmacy via mandatory mail order. Specialty medications are drugs that may require specialized delivery and administration on an ongoing basis. They are often for Chronic Conditions and involve complex care issues that need to be managed. Examples include Xeloda, Temodar, Sensipar and Zortress.

Sharp Health Plan has partnered with Diplomat Specialty Pharmacy to supply specialty medications for our Members. Diplomat Specialty Pharmacy's dedicated team of pharmacists, nurses, specialty technicians and patient care coordinators are available to answer all of your therapy and medication support needs. The Diplomat Specialty team works in cooperation with your doctors to coordinate your care for optimal outcomes.

Specialty drugs are dispensed through a mandatory mail order program, using free, discreet, next-day delivery to your home, office or other location. Specialty drugs are available for a maximum of a 30-day supply. The 30-day Copayments for Outpatient Prescription Drugs listed in your Health Plan Benefits and Coverage Matrix apply to specialty drugs.

Diplomat Specialty Pharmacy will contact you each month to arrange for delivery of your refills. Diplomat will confirm that you are still taking your specialty medication. They will also confirm the date and location of your delivery, as well as your payment information. Diplomat will deliver your refill one week before your supply runs out.

During this call you will be asked questions to determine whether or not you are experiencing medication side effects or are taking any new medications that may interact with your specialty medication.

If your condition requires immediate access to a specialty medication or if a drug is not delivered timely, Sharp Health Plan may Authorize an exception to the mandatory mail order requirement. This exception will enable you to obtain your prescription through a retail pharmacy for one fill. Such an exception may be requested by calling Customer Care. The Plan will review the exception request and issue a determination in a timely fashion appropriate for the nature of the Member's condition, not to exceed 2 business days. If the Plan authorizes the exception, the prescription will be limited to a 30-day supply or less. Less than a 30-day supply may be authorized, for example, when your medication has already been mailed to you but you have not received it. The Plan may authorize a quantity sufficient to supply you with medication until your prescription arrives. You will not be charged an additional Copayment for the emergency supply of medication.

All Specialty medications require prior Authorization from Sharp Health Plan. To use this service:

1. Your doctor will submit a prior Authorization request to Sharp Health Plan.
2. If approved by the Plan, your physician and Diplomat will be notified of the approval.
3. Your physician will fax your prescription to Diplomat Specialty Pharmacy.
4. After Diplomat receives your prescription information, they will contact you to enroll you in their service, obtain payment information and arrange for delivery of your medication.

If you have any questions about specialty pharmacy services, Diplomat can be reached toll-free at 1-877-319-6337.

Deductibles and Copayments for Prescription Drug Benefits

You pay Copayments for prescription drugs as listed in your Health Plan Benefits and Coverage Matrix. If the retail price for your prescription drug is less than your Copayment, you will only pay the retail price.

The following Copayments apply to prescription drugs prescribed by a Plan Provider and dispensed by a Plan Pharmacy and to prescription drugs prescribed and dispensed for Emergency Services or Out-of-Area Urgent Care Services. Please see your Health Plan Benefits and Coverage Matrix for the Copayment amount for each tier.

A. Retail Pharmacy

1. For up to a 30-day supply of a Tier I drug listed on the Drug Formulary, you pay one Tier I Copayment.
2. For up to a 30-day supply of a Tier II drug listed on the Drug Formulary, you pay one Tier II Copayment.
3. For up to a 30-day supply of a Tier III drug (if covered), you pay one Tier III Copayment.

B. Mail Order Pharmacy

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

Some benefit plans also have a Deductible that applies to any brand name medications covered by Sharp Health Plan. If your benefit plan includes a Deductible, you are responsible for paying all costs for covered brand name medications each calendar year, up to the amount of the Deductible, before Sharp Health Plan will cover those drugs at the

applicable Copayment. See the section entitled **"Deductibles"** for more information.

Members with a two-tier benefit plan: Drugs that are not in the Sharp Health Plan Drug Formulary are not excluded from coverage if they are Medically Necessary (unless the drug is specifically identified below as excluded). Non-formulary drugs are available to Members if formulary alternatives have been tried and failed, and prior Authorization is obtained. Costs for non-formulary drugs will not apply to the Deductible unless prior Authorized by the Plan.

Members with a three-tier benefit plan: Drugs that are not in the Sharp Health Plan Drug Formulary are not excluded from coverage, unless the drug is specifically identified in the Member Handbook as excluded. Non-formulary drugs are available at a higher (Tier III) Copayment. Selected non-formulary drugs may require prior Authorization. If a non-formulary drug requiring prior Authorization is approved, the Member is responsible for the Tier III Copayment. Costs for non-formulary drugs, except those specifically excluded from coverage, will apply to the Deductible.

Prescription Refills

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

Exceptions to filling a medication before the approved refill date can be made in certain circumstances. If your doctor increases your daily dose, the pharmacy or prescribing physician can submit a prior Authorization form to Sharp Health Plan requesting that the Plan override the "refill too soon" denial. If you need to refill a medication early because you are going on an extended vacation, you can call Sharp Health Plan to request a "vacation override." Please allow five working days for Sharp Health Plan to review your request and make a decision. If you have any questions regarding when your prescription is eligible to be refilled, please call or email Customer Care.

Drugs, Services and Supplies Covered Elsewhere

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

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

- Medically Necessary formulas and special food products prescribed by a Plan Physician to treat phenylketonuria (PKU) provided that these formulas and special foods exceed the cost of a normal diet.
- Medically Necessary injectable and non-injectable drugs and supplies that are administered in a physician's office.
- FDA approved medications used to induce spontaneous and non-spontaneous abortions that may only be dispensed by or under direct supervision of a physician.
- Immunization or immunological agents, including but not limited to, biological sera, blood, blood plasma or other blood products administered on an outpatient basis, allergy sera and testing materials.
- Equipment and supplies for the management and treatment of diabetes, including insulin pumps and all related necessary supplies, blood glucose monitors, testing strips and lancets and lancet puncture devices. Insulin, glucagon and insulin syringes are covered under these Outpatient Prescription Drug Benefits.

Outpatient Rehabilitation Therapy Services

Outpatient rehabilitation services, including occupational, physical and speech therapy, are covered. The Member pays an applicable Copayment to the Plan Physician or other health professional for each visit. Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, Skilled Nursing Facility, or home. The goal of rehabilitation therapy is to assist Members to become as independent as possible, using appropriate adaptations if needed to achieve basic Activities of Daily Living including bathing, dressing, feeding, toileting and transferring (e.g., moving from the bed to a chair). Speech therapy is covered when there is a delay in obtaining services through the school system and when additional services are determined to be Medically Necessary, i.e., where injury, illness or congenital defect is documented (e.g., hearing loss, chronic otitis media, brain tumor, cerebral palsy, cleft palate, head trauma). Sharp Health Plan will require periodic evaluations of any therapy to assess ongoing medical necessity.

Phenylketonuria (PKU)

The diagnosis and treatment of phenylketonuria are covered as follows:

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

Preventive Care Services

The following preventive care services are covered:

- Well Child physical examinations (including vision and hearing screening in the PCP's office) and all periodic immunizations and related laboratory services in accordance with the current recommendations from the American Academy of Pediatrics, U.S. Preventive Services Task Force, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the Health Resources and Services Administration and the American Academy of Family Physicians.
- Well adult physical examinations, episodic immunizations and related laboratory services in accordance with the current recommendations from the U.S. Preventive Services Task Force, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the Health Resources and Services Administration and Sharp Health Plan medical policies.
- Routine gynecological examinations, mammograms and cervical cancer screening tests, in accordance with the guidelines of the American College of Obstetrics and Gynecology and the Health Resources and Services Administration. Members may directly access OB/GYN care within their PMG without a referral from their PCP.
- All generally accepted cancer screening tests, as determined by the United States Preventive Services Task Force and approved by the federal Food and Drug Administration, including the conventional Pap test, any cervical cancer screening test and human papillomavirus screening test and prostate cancer screening.
- Other preventive diagnostic tests that may be delivered in an outpatient surgical facility, including but not limited to colonoscopy and endoscopy.
- HIV testing regardless of whether the testing is related to a primary diagnosis.
- Screening for tobacco use.
- For those who use tobacco products, two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
  - Four tobacco cessation counseling sessions, without prior authorization; and
  - All FDA-approved tobacco cessation medications (including over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider, without prior authorization.

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

Professional Services

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

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

Prosthetic and Orthotic Services

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

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

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

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (This coverage does not include electronic voice-producing machines, which are not prosthetic devices.)
- Prostheses needed after a Medically Necessary mastectomy, including:
  - Custom-made prostheses when Medically Necessary.
  - Up to three brassieres required to hold a prosthesis every 12 months.
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist.
- Compression burn garments and lymphedema wraps and garments.
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines.
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.

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

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

- Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care.
- Prosthetic shoes that are an integral part of a prosthesis.
- Special footwear needed by persons who suffer from foot disfigurement including disfigurement from cerebral palsy, arthritis, polio, spinabifida, diabetes and foot disfigurement caused by accident or developmental disability.

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

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

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

Radiation Therapy

Radiation therapy (standard and complex) is covered.

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

Radiology Services

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

Reconstructive Surgical Services

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

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

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

Skilled Nursing Facility Services

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

Covered Benefits include:

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

Sterilization Services

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

Termination of Pregnancy

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

Transplants

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

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

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

1. Preoperative evaluation, surgery and follow-up care must be provided at Plan centers having documented skills, resources, commitment and record of favorable outcomes to qualify the centers to provide such care.
2. Patients are selected by the patient-selection committee of the Plan facilities.

3. Only anti-rejection drugs, biological products and procedures that have been established as safe and effective, and no longer experimental or investigational, are covered.

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

There are no age limitations for organ donors. The factor deciding whether a person can donate is the person's physical condition, not the person's age. Newborns as well as senior citizens have been organ donors. Donate Life California allows you to express your commitment to becoming an organ, eye and tissue donor. The Donate Life California Registry guarantees your plans will be carried out when you die. Individuals who renew or apply for a driver's license or ID with the DMV, now have the opportunity to also register their decision to be a donor in the Donate Life California Registry, and the pink "DONOR" dot symbol is pre-printed on the applicant's driver license or ID card. You have the power to donate life. Sign up today at **www.donatelifecalifornia.org** to become an organ and tissue donor.

Urgent Care Services

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

However, if you are in the Plan's Service Area and access Urgent Care Services that are not Authorized, then those services will not be paid for by Sharp Health Plan and you will be responsible to pay for the care.

Vision Services

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

The following special contact lenses are covered:

- Up to two contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris).
- Up to six aphakic contact lenses per eye (including fitting and dispensing) per calendar year to treat aphakia (absence of the crystalline lens of the eye) for Members through age 9.

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

- Routine vision exam. One exam every calendar year (including dilation, if professionally indicated) at no cost to the Member.
- Lenses for glasses. One pair of lenses covered in full (no cost to the Member) every calendar year, including single vision, bifocal, trifocal and lenticular; choice of glass, plastic, or polycarbonate.
- Frames for glasses. Standard frames with a generic collection of choices are covered in full (no cost to the Member) once each calendar year.
- Contact lenses. One pair of contact lenses (monthly, biweekly, or daily contact lenses) once every calendar year, in lieu of eyeglasses (unless Medically Necessary).
- Medically Necessary contact lenses. Medically Necessary contact lenses are covered. Contact lenses may be determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions. In general, contact lenses may be Medically Necessary and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including

avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the treatment of the following conditions: keratoconus, pathological myopia, aphakia, anisometropia, aniseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism.

- Low vision services. Low vision is a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining usable vision for Members with low vision. Covered low vision services will include one comprehensive low vision evaluation every year, with a maximum Copayment of $125; approved low vision aids, such as high-power spectacles, magnifiers and telescopes are covered in full.

WHAT IS NOT COVERED?

Exclusions and Limitations

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

Exclusions include any services or supplies that are:

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

Ambulance and Medical Transportation Services

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

Chemical Dependency Services

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

Chiropractic Services

Chiropractic services are not covered, unless provided as a supplemental benefit. Copayments made for supplemental benefits do not apply toward the annual Out-of-Pocket Maximum.

Clinical Trials

The following are not Covered Benefits:

- The provision of non FDA approved drugs or devices that are the subject of the trial.
- Services other than health care services, such as for travel, housing and other non clinical expenses that the Member may incur due to participation in the trial.
- Any items or services that are provided solely to satisfy data collection and/or analysis needs and that are not used in the clinical management of the Member.

- Health care services that are otherwise excluded from coverage (other than those that are excluded on the basis that they are experimental or investigational).
- Health care services that are customarily provided by the research sponsors free of charge for enrollees in the trial.
- The investigational item, device, or service itself.
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Cosmetic Surgical Services

The following are not Covered Benefits:

- Cosmetic services or supplies that retard or reverse the effects of aging or hair loss or alter or reshape normal structures of the body in order to improve appearance.
- Treatment of obesity by medical and surgical means, except for treatment of morbid obesity. In no instance shall treatment for obesity be provided primarily for cosmetic reasons.
- Implants, unless they are Medically Necessary and are not cosmetic, experimental, or investigational.

Custodial Care

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

Dental Services/Oral Surgical Services

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

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

Disposable Medical Supplies

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

Durable Medical Equipment (DME)

The following items are not covered:

- Equipment that basically serves comfort or convenience functions (e.g., physical fitness equipment, trays, backpacks, wheelchair racing equipment).
- DME that is primarily for the convenience of the Member or caretaker.
- Exercise and hygiene equipment.
- Experimental or research equipment.

- Devices not medical in nature such as sauna baths and elevators or modifications to the home or automobile.
- Generators or accessories to make home dialysis equipment portable for travel.
- Deluxe equipment.
- More than one piece of equipment that serve the same function.
- Replacement of lost or stolen DME.

Emergency Services

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

Experimental or Investigational Services

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

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

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

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

Family Planning Services

The following services are not Covered Benefits:

- Reversal of voluntary sterilization.
- Nonprescription contraceptive supplies.

Foot Care

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

Genetic Testing, Treatment or Counseling

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

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

Government Services and Treatment

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

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

with respect to expenses for Covered Benefits solely because the expenses were incurred in a state or county hospital; however, the Plan's liability with respect to expenses for Covered Benefits provided in a state or county hospital is limited to the reimbursement that the Plan would pay for those Covered Benefits if provided by a Plan hospital.

Hearing Services

Hearing aids and routine hearing examinations are not covered except as specifically listed as covered in this Member Handbook or unless provided as a supplemental benefit. Copayments made for supplemental benefits do not apply toward the annual Out-of-Pocket Maximum.

Hospital Facility Inpatient and Outpatient Services

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

Immunizations and Vaccines

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

Infertility Services

The following services are not Covered Benefits:

- Assisted Reproductive Technologies (ART) procedures, otherwise known as conception by artificial means, including but not limited to artificial insemination, in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), multi-cell embryo transfer (TET), intracytoplasmic sperm injections (ICSI), blastocyst transfer, assisted hatching and any other procedures that may be employed to bring about conception without sexual intercourse, unless provided as a supplemental benefit. Copayments made for supplemental benefits do not apply toward the annual Out-of-Pocket Maximum.
- Any service, procedure, or process which prepares the Member for noncovered ART procedures.
- Collection, preservation, or purchase of sperm, ova, or embryos.
- Reversal of voluntary sterilization.
- Testing, services or supplies for conception by a surrogate who is not enrolled in Sharp Health Plan.

If the surrogate is enrolled in Sharp Health Plan, medical expenses related to the pregnancy will be covered by the Plan, subject to the lien described in the **"What Happens if you Enter Into a Surrogacy Arrangement?"** section of this Handbook.

Massage Therapy Services

Massage therapy is not covered unless the massage therapy services is are part of a physical therapy treatment plan described as covered in this Handbook.

Maternity and Pregnancy Services

The following services are not Covered Benefits:

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

Mental Health Services

The following services are not Covered Benefits:

- Services for conditions that the DSM-5 identifies as something other than a Mental Disorder.

- Any service covered under the Member's Employee Assistance Program (EAP).
- Counseling for activities of an educational nature.*
- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation, custody, or visitation.
- Diagnosis and treatment of developmental disorders, developmental reading disorder, developmental arithmetic disorder, developmental language disorder, or developmental articulation disorder that do not qualify as a mental health condition identified as a "mental disorder" in the DSM-5.*
- Diagnosis and treatment for learning disorders or those services primarily oriented toward treatment of social or learning disorders.*
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- Counseling for marital problems.
- I.Q. testing.
- Psychological testing on Children required as a condition of enrollment in school.*
- Treatment for a mental health diagnosis other than a Severe Mental Illness or Serious Emotional Disturbance, unless specified as covered in the Health Plan Benefits and Coverage Matrix or provided as a supplemental benefit.

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

Non-Preventive Physical or Psychological Examinations

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

Ostomy and Urological Supplies

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

Outpatient Prescription Drugs

The services and supplies listed below are not covered:

- Drugs dispensed by other than a Plan Pharmacy, except as Medically Necessary for treatment of an Emergency or Urgent Care condition.
- Drugs when prescribed by non-contracting providers that are not authorized by the Plan except when coverage is otherwise required in the context of Emergency Services.
- Over-the-counter medications or supplies, even if written on prescription, except as specifically identified as covered in the Sharp Health Plan Drug Formulary.
- Vitamins (other than pediatric or prenatal vitamins listed on the Drug Formulary).
- Drugs and supplies prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes and mental performance. (Drugs for mental performance are not excluded from coverage when they are used to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.)
- Herbal, nutritional and dietary supplements.
- Drugs prescribed solely for the purpose of shortening the duration of the common cold.
- Drugs and supplies prescribed in connection with a service or supply that is not a covered benefit unless required to treat a complication that arises as a result of the service or supply.
- Travel and/or required work related immunizations.

- Infertility drugs are excluded, unless added by the employer as a supplemental benefit.
- Drugs obtained outside of the United States unless they are furnished in connection with Urgent Care or an Emergency.
- Drugs that are prescribed solely for the purposes of losing weight, except when Medically Necessary for the treatment of morbid obesity. Members must be enrolled in a Sharp Health Plan approved comprehensive weight loss program prior to or concurrent with receiving the weight loss drug.
- Off-label use of FDA approved prescription drugs unless the drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or the safety and effectiveness of use for this indication has been adequately demonstrated by at least two studies published in a nationally recognized, major peer reviewed journal.
- Replacement of lost, stolen, or destroyed medications.
- Compounded medications, unless prior Authorization is obtained and determined to be Medically Necessary.

Private-Duty Nursing Services

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

Prosthetic and Orthotic Services

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

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

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

Sexual Dysfunction Treatment

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

Sterilization Services

Reversal of sterilization services is not covered.

Vision Services

Vision services are not covered unless specifically listed as covered in this Member Handbook or provided as a supplemental benefit. Copayments made for supplemental benefits do not apply toward the annual Out-of-Pocket Maximum. Vision services that are specifically not covered for Members age 19 and older without a supplemental benefit include, but are not limited to:

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

Other

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

HOW DO YOU ENROLL IN SHARP HEALTH PLAN?

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

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

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

As the employee, you are eligible if you:

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

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

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

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

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

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

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

Dependent Children remain eligible up to age 26 regardless of student, marital, or financial status.

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

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

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

If you decline enrollment for yourself or your eligible Dependents because of other group medical coverage, you may be able to enroll yourself and your eligible Dependents in Sharp Health Plan if you involuntarily lose eligibility for that other coverage. However, you must request enrollment within 60 days after your other coverage ends and will be required to submit documentation indicating the coverage termination date.

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

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

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

- To add a new Spouse to your coverage, you must complete and submit an Enrollment Change Form to your Employer within the 60-day period following your marriage.
- Your newborn Child is covered for 30 days from the date of birth, and your adopted Child is covered for 30 days from the date you are legally entitled to control the health care of the adopted Child. If you wish to add your newborn or adopted Child to your coverage for more than the initial 30 calendar days, you must complete and submit an Enrollment Change Form to your Employer within the 30 day period following the birth or legal adoption.

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

How Do You Update Your Enrollment Information?

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

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

What if You Have Other Health Insurance Coverage?

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

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

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

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

What if You Are Eligible for Medicare?

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

What if You Are Injured at Work?

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

What if You Are Injured by Another Person?

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

When Can Your Coverage Be Changed Without Your Consent?

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

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

When Will Your Coverage End?

Loss of Subscriber Eligibility

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

- When the Group Agreement between your Employer and the Plan is terminated. If you are in the hospital on the effective date of termination, you will be covered for the remainder of the hospital stay if you continue to pay all applicable Premiums and Copayments, unless you become covered earlier under other group or COBRA coverage.
- When your employment is terminated. Coverage will end on the last day of the month in which your employment is terminated unless otherwise determined by your Employer.

You may be eligible to continue coverage through COBRA (your Employer will advise you if you are eligible) or Cal-COBRA (the Plan will advise you if you are eligible). Members of the United States Military Reserve and National Guard who terminate coverage as a result of being ordered to active duty may have their coverage reinstated without waiting periods or exclusion of coverage for preexisting conditions. Please contact Customer Care for information on how to apply for reinstatement of coverage following active duty as a reservist. If your Employer is providing your health coverage through the Small Business Health Options Program (SHOP), please contact Covered California for information about how to apply for reinstatement.

- When your Employer terminates coverage with the Plan. Coverage will end on the last day of the month in which your Employer terminated.
- When you no longer meet any of the other eligibility requirements under your Plan contract. Coverage will end on the last day of the month in which your eligibility ended.

Coverage for your Dependent will end when a Dependent no longer meets the eligibility requirements, including divorce, no longer living or working inside of the Service Area or termination of Total Disability status. Coverage will end on the last day of the month in which eligibility ends. The Dependent may be eligible to elect COBRA or Cal-COBRA.

Fraud or Intentional Misrepresentation of Material Fact

Coverage for you or your Dependent(s) will also end if either you or that Dependent(s) commit(s) an act of fraud or intentional misrepresentation of a material fact to circumvent state or federal laws or the policies of the Plan, such as allowing someone else to use your Member ID card, providing materially incomplete or incorrect enrollment or required updated information deliberately, including but not limited to incomplete or incorrect information regarding date of hire, date of birth, relationship to Enrolled Employee or Dependent, place of residence, other group health insurance or workers' compensation benefits, or disability status. In this case, Sharp Health Plan will send you a written notice 30 days before your coverage will end. In addition, Sharp Health Plan may decide to retroactively end your coverage to the date the fraud or misrepresentation occurred, but only if Sharp Health Plan identifies the act within your first 24 months of coverage. This type of retroactive termination is called a rescission. If your coverage is retroactively terminated, Sharp Health Plan will send you the written notice 30 days prior to the effective date of the rescission. The notice will include information about your right to Appeal the decision.

Cancellation of the Group Agreement for Nonpayment of Premiums

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

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

- That the Group Agreement has been cancelled for non-payment of Premiums.
- The specific date and time when your group coverage ended.
- Sharp Health Plan's telephone number to call to obtain additional information, including whether your Employer obtained reinstatement of the Group Agreement.
- An explanation of your options to purchase continuation coverage, including coverage effective as of the termination date so you can avoid a break in coverage, and the deadline by

which you must elect to purchase such continuation coverage, which will be 63 calendar days after the date the Plan mails you the Notice Confirming Termination of Coverage.

If your Employer is providing your health coverage through the Small Business Health Options Program (SHOP), the notices described above will be provided by Covered California.

INDIVIDUAL CONTINUATION OF BENEFITS

Total Disability Continuation Coverage

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

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

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

COBRA Continuation Coverage

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

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

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

Cal-COBRA Continuation Coverage

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

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

between the Employer and Sharp Health Plan terminates while you are still eligible for Cal-COBRA, you may elect to continue Cal-COBRA coverage under the Employer's subsequent group health plan. If you fail to comply with all the requirements of the new plan (including requirements pertaining to enrollment and Premium payments) within 30 days of receiving notice of termination from the Plan, Cal-COBRA coverage will terminate. If you move out of the Plan's Service Area, Cal-COBRA coverage will terminate.

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

Qualifying Events

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

- As an Enrolled Employee, you may be eligible for Cal-COBRA continuation coverage if you would lose group health plan coverage due to the termination of your employment (for reasons other than gross misconduct) or due to a reduction in your work hours.
- As a Member who is the Dependent of an Enrolled Employee, you may be eligible for Cal-COBRA continuation coverage if you would lose group health plan coverage under Sharp Health Plan for any of the following reasons:
  1. Death of the Enrolled Employee.
  2. Termination of the Enrolled Employee's employment (for reasons other than gross misconduct) or a reduction in the Enrolled Employee's work hours.
  3. Divorce or legal separation from the Enrolled Employee.
  4. Enrolled Employee's Medicare entitlement.
  5. Your loss of Dependent status.
- A Member who has exhausted COBRA continuation coverage may be eligible for Cal-COBRA continuation coverage if your COBRA coverage was less than 36 months and your COBRA coverage began on or after January 1, 2003. COBRA and Cal-COBRA continuation coverage is limited to a combined maximum of 36 months.

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

How to Elect Cal-COBRA Coverage

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

Adding Dependents to Cal-COBRA

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

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

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

Premiums for Cal-COBRA Coverage

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

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

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

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

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

When Do You Qualify for Continuity of Care?

New Members of Sharp Health Plan and Members Who Change Plan Networks

If you were receiving services from a provider who is not a member of your Plan Network shortly before the time that you became covered by this Plan, or you changed Plan Networks during open enrollment and the provider is not a member of your new Plan Network, you may be eligible to complete your care with this provider under certain circumstances that are explained below. Please note that you do not qualify for this temporary continuity of care coverage if you were offered an open network option or the option to continue with your previous health plan, and instead you chose to change to Sharp Health Plan.

Existing Members of Sharp Health Plan

If you were receiving services from a PMG or hospital in your Plan Network that has been terminated (leaving the network), you should receive a notice letter from this Plan informing you of the upcoming termination at least 60 calendar days prior to the termination date. You may be eligible to complete your care under certain circumstances that are explained below.

Conditions for Eligibility

Newly covered Members receiving care from a non-Plan provider, existing Members whose Plan Network changed, and existing Members whose PMG or provider is terminated are eligible for continuity of care benefits when you have been in an active course of treatment for the following conditions or circumstances:

- An Acute Condition.
- A serious Chronic Condition.
- A pregnancy.
- A terminal illness.
- A pending surgery or procedure that was previously scheduled to occur within 180 days of either your effective date of coverage with this Plan or the date your provider is being terminated from the Plan Network.
- A Child age 0-36 months.

Other conditions apply. Completion of care is subject to time limits under law. Your provider must agree to terms, conditions and payment rates similar to those that are followed by other Plan Providers. If your provider does not agree, continuity of care cannot be provided. If your circumstances meet one of the criteria listed above, please contact Customer Care and request a continuity of care benefits form. You may also request a copy of the Sharp Medical Policy on Continuity of Care for a detailed explanation of eligibility and applicable limitations.

What Is the Relationship Between the Plan and Its Providers?

- Most of our Plan Medical Groups receive an agreed-upon monthly payment from Sharp Health Plan to provide services to you. This monthly payment is a fixed dollar amount for each Member. The monthly payment typically covers Professional Services directly provided by the medical group, and may also cover certain referral services.
- Some doctors receive a different agreed-upon payment from us to provide services to you. Each time you receive health care services from one of these providers, the doctor receives payment for that service.
- Some hospitals in our network receive an agreed-upon monthly payment in return for providing hospital services for Members. Other hospitals are paid on a fee-for-service basis or receive a fixed payment per day of hospitalization.
- On a regular basis, we agree with each Plan Medical Group and some of our contracted hospitals on the monthly payment from Sharp Health Plan for services, including referral services, under the program for any Plan Members treated by the PMG/Hospital.

- At the end of the year, the actual cost of services is compared to the agreed upon budget. If the actual cost of services is less than the agreed upon budget, the PMG/hospital may share in the savings as an incentive to continue providing quality health care services to Plan Members.
- If you would like more information, please contact Customer Care. You can also obtain more information from your health care provider or the PMG you have selected.

How Can You Participate in Plan Policy?

The Plan has established a Member advisory committee (called the Public Policy Advisory Committee) for Members to participate in making decisions to assure patient comfort, dignity and convenience from the Plan's Providers that provide health care services to you and your family.

At least annually, the Plan provides Members, through the Member Newsletter, a description of its system for Member participation in establishing Plan policy, and communicates material changes affecting Plan policy to Members.

What Happens if You Enter Into a Surrogacy Arrangement?

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

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

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

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

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

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

GLOSSARY

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

Active Labor means an Emergency Medical Condition that results in a labor at a time at which any of the following would occur:

1. A woman experiences contractions (A woman experiencing contractions is presumed to be in true labor unless a physician or qualified individual certifies, after a reasonable time of observation, that the woman is in false labor);
2. there is inadequate time to effect a safe transfer to another hospital prior to delivery; or
3. a transfer may pose a threat to the health and safety of the patient or the unborn Child.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Emergency Services and Care means:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mental Disorder means a mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. Mental Disorders include, but are not limited to, Serious Mental Illness of a person of any age and Serious Emotional Disturbance of a Child under age 18.

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

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

Plan means Sharp Health Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Serious Emotional Disturbance or SED means 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 no otherwise specified (including Atypical Autism), in accordance with diagnostic and statistical manual for Mental Disorders–IV-Text revisions(June 2000), other than a primary substance use disorder or developmental disorder, that result in behavior

inappropriate to the Child's age according to expected developmental norms.

One or more of the following must also be true:

1. As a result of the mental disorder, the Child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either of the following 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; or
2. the Child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or
3. the Child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Service Area means the geographic area of San Diego County, California and southern Riverside County, California as defined by specific zip codes.

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

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

Small Business Health Options Program or SHOP means the program offered by Covered California to provide health insurance and health plan choices to small businesses and their employees.

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

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

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

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

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

PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFIT – ACCESS DENTAL PLAN

About the Dental Plan

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

Access Dental Plan (ADP) has a panel of dentists from whom you select to receive necessary dental care. Many dental procedures covered require no Copayment.
In addition, ADP has made the process of dental treatment convenient by eliminating cumbersome claim forms when a Member receives routine care from his or her Primary Care Dentist.

If you move, you should contact ADP Member Services to assist in selecting a new Primary Care Dentist if desired. If you move temporarily outside of Sharp Health Plan's Service Area, such as to attend school, you may obtain Emergency Care or Urgent Care from any dentist and ADP will reimburse the Member for the costs, less applicable Copayments. If you have any questions regarding the material you are reading or ADP, please contact ADP Member Services toll-free number at 1-866-650-3660.

Please review the information included in this section and contact your Primary Care Dentist to arrange an initial assessment appointment.
This appointment is necessary if you have not received treatment from a dentist within the last 12 months. If you have any questions regarding this appointment or the materials in this section, please call ADP Member Services at 1-866-650-3660.

Using the Dental Plan

Facilities / Locations

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

ADP's Primary Care Dentists are located throughout San Diego County. You may obtain a list of Access Dental Plan's participating providers and their hours of availability by calling ADP at 1-866-650-3660. A list of ADP's participating providers can be found in the Provider Directory or online at **www.accessdental.com**.

Choosing a Primary Care Dental Provider

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

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

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

Referrals to Non-Participating Providers

ADP has an extensive network of high quality Plan Providers throughout the Service Area. If you are unable to find a Plan Provider in your area, please contact ADP. ADP may be able to help you find a Plan Provider or refer you to a Non-Participating provider where the services you need may be available. You should make sure that these services are Authorized in advance. If the services are Authorized, you pay only the Copayments you would pay if the services were provided by a Plan Provider.

Scheduling Appointments

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

Primary Care Dentists are required to provide Covered Services to Members during normal working hours and during such other hours as may be necessary to keep Member's appointment schedules on a current basis.

Appointments for routine, preventive care and specialist consultation shall not exceed four weeks from the date of the request for an appointment. Wait time in the Primary Care Dentist's office shall not exceed 30 minutes.

Changing Your Provider

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

Continuity of Care for New Members

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

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

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

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

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

Continuity of Care for Termination of Provider

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

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

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

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

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

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

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

Prior Authorization for Services

Your Primary Care Dentist will coordinate your dental care needs and, when necessary, arrange Specialty Services for you. In some cases, ADP must authorize certain services and/or Specialty Services before you receive them. Your Primary Care Dentist will obtain the necessary referrals and authorizations for you. Some services, such as Emergency Care, do not require Prior Authorization before you receive them.

If you see a specialist or receive Specialty Services before you receive the required authorization, you will be responsible to pay for the cost of the treatment. If ADP denies a request for Specialty Services, ADP will send you a letter explaining the reason for the denial and how you can appeal the decision if you do not agree with the denial.

Referrals to Specialists

Your Primary Care Dentist may refer you to another dentist for consultation or specialized treatment. Your Primary Care Dentist will submit a request to ADP for authorization to see a specialist. Once your Primary Care Dentist determines that you require the care of a specialist, your Primary Care Dentist will determine if you need an emergency referral or a routine referral. ADP processes emergency referrals immediately by calling a specialist to coordinate the scheduling of an appointment for you with the specialist. Routine referrals are processed in a timely fashion appropriate for your condition, not to exceed five (5) business days of receipt. Referrals affecting care where you face an imminent and serious threat to your health or could jeopardize your ability to regain maximum function shall be made in a timely fashion appropriate for your condition, not to exceed 72-hours after ADP's receipt of the necessary documentation requested by ADP to make the determination.

Copies of authorizations for regular referrals are sent to you, the specialist and your Primary Care Dentist. Decisions resulting in denial, delay or modification of requested health care services are communicated to you in writing within two (2) days of the decision. ADP reserves the right to determine the facility and Plan provider from which Specialty Services are obtained.

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

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

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

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

Obtaining a Second Opinion

Sometimes you may have questions about your condition or your Primary Care Dentist's recommended treatment plan.

You may want to get a Second Opinion. You may request a Second Opinion for any reason, including the following:

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

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

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

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

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

Getting Urgent Care

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

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

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

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

Once you have received Urgent Care, you must contact you Primary Care Dentist (if your Primary Care Dentist did not perform the dental care) for follow-up care. You will receive all follow-up care from your Primary Care Dentist.

Getting Emergency Care

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

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

Benefits for Emergency Care not provided by the Primary Care Dentist are limited to a maximum of $100 per incident, less the applicable Copayment. If the maximum is exceeded, or the above conditions are not met, you are responsible for any charges for services by a provider other than your Primary Care Dentist.

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

If you receive Emergency Care, you may be required to pay the provider who rendered such Emergency Care and submit a claim to ADP for a reimbursement determination.

Claims for Emergency Care should be sent to ADP within 180 days of the end of treatment. Valid claims received after the 180-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. Decisions relating to payment or denial of the reimbursement request will be made within thirty (30) business days of the date of all information reasonably required to render such decision is received by ADP.

Non-Covered Services

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

Important: If you opt to receive dental services that are not Covered Services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide you with a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call ADP's Member Service at 1-866-650-3660.

Follow-Up Care

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

Copayments

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

Member Liabilities

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

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

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

Grievances and Appeals Process

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

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

Grievances

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

Access Dental Plan
Complaint/Grievance Dept.
P.O. Box 659005
Sacramento, CA 95865-9005
Telephone: (800) 270-6743 ext. 6013
Fax: (916) 646-9000
GrievanceDept@accessdental.com
www.accessdental.com

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

You may also file a written grievance via ADP's website at **www.accessdental.com**.

There will be no discrimination against a Member (including cancellation of the contract) on the grounds that the Member filed a grievance.

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

You are not required to file a Grievance with ADP before asking the Department of Managed Health Care to review your case on an expedited review basis. If you decide to file a Grievance with ADP in which you ask for an expedited review, ADP will immediately notify you in writing that:

1. You have the right to notify the Department of Managed Health Care about your Grievance involving an imminent and serious threat to health, and

2. ADP will respond to you and the Department of Managed Health Care with a written statement on the pending status or disposition of the Grievance no later than 72 hours from receipt of your request to expedite review of your Grievance.

Independent Medical Review

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

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

Independent Medical Review for Denials of Experimental / Investigational Services

You may also be entitled to an Independent Medical Review through the Department of Managed Health Care when ADP denies coverage for treatment ADP has determined to be an Experimental or Investigational Service.

- ADP will notify you in writing of the opportunity to request an Independent Medical Review of a decision denying an Experimental or Investigational Service within five (5) business days of the decision to deny coverage.

- You are not required to participate in ADP's Grievance process prior to seeking an Independent Medical Review of ADP's decision to deny coverage of an Experimental or Investigational Service.

- If a physician determines that the proposed service would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within seven (7) days of the completed request for an expedited review.

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against ADP, you should first telephone ADP at 1-866-650-3660 (TDD/TTY for the hearing impaired at 1-800-735-2929) and use ADP's grievance process before contacting the department. Using this grievance procedure does not prohibit any 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 ADP, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial view 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 and urgent medical services. The Department of Managed Health Care has a toll-free telephone number, 1 (888) HMO-2219, to receive complaints regarding health plans.

The hearing and speech impaired may use the department's TDD line (1-877-688-9891) number, to contact the department.
The Department's Internet website (www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions online.

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

Benefits Plan Summary

This section lists the dental benefits and services you are allowed to obtain through ADP when the services are necessary for your dental health consistent with professionally recognized standards of practice, subject to the exceptions and limitations listed here and in the Exclusions section. Please refer to your Co-Payment schedule for your cost associated with each procedure.

Diagnostic and Preventive Benefits

Description
Benefit includes:

- Initial and periodic oral examinations.
- Consultations, including specialist consultations.
- Topical fluoride treatment.
- Preventive dental education and oral hygiene instruction.
- Roentgenology (X-rays).
- Prophylaxis services (cleanings) (once every six months).
- Dental sealant treatments.
- Space maintainers, including removable acrylic and fixed band type.

Limitations
Roentgenology (X-rays) is limited as follows:

- Bitewing X-rays in conjunction with periodic examinations are limited to one series of four films in any 6 consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
- Full mouth X-rays in conjunction with periodic examinations are limited to once every 24 consecutive months.
- Panoramic film X-rays are limited to once every 24 consecutive months.
- Prophylaxis services (cleanings) are limited to two in a 12-month period (once every six months).
- Dental sealant treatments are limited to permanent first and second molars only.

Restorative Dentistry

Description
Restorations include:

- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries.
- Micro filled resin restorations that are non-cosmetic.
- Replacement of a restoration.
- Use of pins and pin build-up in conjunction with a restoration.
- Sedative base and sedative fillings.

Limitations
Restorations are limited to the following:

- For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations; any other restoration such as a crown or jacket is considered optional.
- Composite resin or acrylic restorations in posterior teeth are optional.

- Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

Oral Surgery

Description
Oral surgery includes:

- Extractions, including surgical extractions.
- Removal of impacted teeth.
- Biopsy of oral tissues.
- Alveolectomies.
- Excision of cysts and neoplasms.
- Treatment of palatal torus.
- Treatment of mandibular torus.
- Frenectomy.
- Incision and drainage of abscesses.
- Post-operative services, including exams, suture removal and treatment of complications.
- Root recovery (separate procedure).

Limitation
The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists

Endodontic

Description
Endodontics benefits include:

- Direct pulp capping.
- Pulpotomy and vital pulpotomy.
- Apexification filling with calcium hydroxide.
- Root amputation.
- Root canal therapy, including culture canal and limited retreatment of previous root canal therapy as specified below:
  - Apicoectomy.
  - Vitality tests.

Limitations
Root canal therapy, including culture canal, is limited as follows:

- Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
- Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

Periodontics

Description
Periodontics benefits include:

- Emergency treatment, including treatment for periodontal abscess and acute periodontitis.
- Periodontal scaling and root planing, and subgingival curettage.
- Gingivectomy.
- Osseous or muco-gingival surgery.

Limitation
Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any 12 consecutive months.

Crown and Fixed Bridge

Description
Crown and fixed bridge benefits include:

- Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel.
- Related dowel pins and pin build-up.
- Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold.
- Recementation of crowns, bridges, inlays and onlays.
- Cast post and core, including cast retention under crowns.

- Repair or replacement of crowns, abutments or pontics.

Limitation
The crown benefit is limited as follows:

- Replacement of each unit is limited to once every 36 consecutive months, except when the crown is no longer functional as determined by ADP.
- Only acrylic crowns and stainless steel crowns are a benefit for children under 12 years of age. If other types of crowns are chosen as an optional benefit for children under 12 years of age, the covered dental benefit level will be that of an acrylic crown.
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

The fixed bridge benefit is limited as follows:

- Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person 16 years of age or older and the patient's oral health and general dental condition permits. For children under the age of 16, it is considered optional dental treatment. If performed on a member under the age of 16, the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- Fixed bridges are optional when provided in connection with a partial denture on the same arch.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment.

Removable Prosthetics

Description
The removable prosthetics benefit includes:

- Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers.
- Office or laboratory relines or rebases.
- Denture repair.
- Denture adjustment.
- Tissue conditioning.
- Denture duplication.
- Stayplates.

Limitations
The removable prosthetics benefit is limited as follows:

- Partial dentures will not be replaced within 36 consecutive months, unless:
  1. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
  2. The denture is unsatisfactory and cannot be made satisfactory.
- The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.

- A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
- Full upper and/or lower dentures are not to be replaced within 36 consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
- The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.
- Office or laboratory relines or rebases are limited to one (1) per arch in any 12 consecutive months.
- Tissue conditioning is limited to two per denture.
- Implants are considered an optional benefit.
- Stayplates are a benefit only when used as anterior space maintainers for children.

Other Benefits

Description
Other dental benefits include:

- Local anesthetics.
- Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure.
- Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure.
- Emergency treatment, palliative treatment.
- Coordination of benefits with member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.

Orthodontic Benefits

Orthodontic treatment includes medically necessary orthodontia only.

Exclusions and Limitations

Exclusions
The following dental Benefits are excluded:

1. Services which, in the opinion of the attending dentist, are not necessary to the member's dental health.
2. Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in the Benefits section above.
3. Cosmetic dental care.
4. General anesthesia or intravenous/conscious sedation unless specifically listed as a benefit or is given by a dentist for covered oral surgery.
5. Experimental or Investigational Services, including any treatment, therapy, procedure or drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supply which is not recognized as being in accordance with generally accepted professional standards or for which the safety and efficacy have not been determined for use in the treatment for which the item or service in question is recommended or prescribed.
6. Services that were provided without cost to the member by State government or an agency thereof, or any municipality, county or other subdivisions.
7. Hospital charges of any kind.
8. Major surgery for fractures and dislocations.
9. Loss or theft of dentures or bridgework.
10. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the member became eligible for such services.
11. Any service that is not specifically listed as a covered benefit.

12. Malignancies.
13. Dispensing of drugs not normally supplied in a dental office.
14. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the Member.
15. The cost of precious metals used in any form of dental benefits.
16. The surgical removal of implants.
17. Services of a pedodontist/pediatric dentist, except when the member is unable to be treated by his or her panel provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her panel provider is a pedodontist/pediatric dentist.
18. Dental Services that are received in an Emergency Care setting for conditions that are not emergencies if the subscriber reasonably should have known that an Emergency Care situation did not exist.

Definitions

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

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

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

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

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

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

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

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

Notes

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California Children's Dental HMO Embedded Benefit

SCHEDULE OF BENEFITS

This Schedule of Benefits, along with the Exclusions and Limitations describe the benefits of the California Children's Dental HMO Embedded Benefit. In addition it lists the services available to you under this dental plan as well as the Copayments associated with each procedure. Please review the Benefits Description, Limitations, and Exclusions Section below for additional information about how your Plan works.

CC DMHO	In-Network
Annual Maximum	N/A

** This plan is available for pediatric Members up to age 19.*

COPAYMENTS

The following Copayments apply when services are performed by your assigned Primary Care Dentist or a Contracted Specialist (with prior approval from Access Dental). If Specialist Services are recommended by your Primary Care Dentist, the treatment plan must be preauthorized in writing by Access Dental prior to treatment in order for the services to be eligible for coverage. All services are subject to Exclusions and Limitations of this plan and must be medically necessary.

ACCESS DENTAL

California Children's Dental HMO Embedded Benefit

ADA Code	Code Description	EHB Copay
Diagnostic (D0100-D999)		
D0120	Periodic oral examination - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation – problem focused, by report	$0
D0170	Re-evaluation - limited, problem focused (established patient: not post-operative visit)	$0
D0210	Intraoral - complete series (including bitewings	$0
D0220	Intraoral - periapical first film	$0
D0230	Intraoral - periapical each additional film	$0
D0240	Intraoral - occlusal film	$0
D0250	Extraoral - first film	$0
D0260	Extraoral - each addditional film	$0
D0270	Bitewing - single film	$0
D0272	Bitewings - two films	$0
D0273	Bitewings - three films	$0
D0274	Bitewings - four films	$0
D0277	Vertical bitewings – 7 to 8 films	$0
D0330	Panoramic film	$0
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
Preventive (D1000-D1999)	**Code Description**	**EHB Copay**
D1110	Prophylaxis – adult	$0
D1120	Prophylaxis – child	$0
D1203	Topical application of fluoride (prophylaxis not included) - child	$0
D1310	Nutritional counseling for control of dental disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth	$0
D1510	Space maintainer - fixed – unilateral	$0
D1515	Space maintainer - fixed – bilateral	$0
D1520	Space maintainer - removable - unilateral	$0
D1525	Space maintainer - removable - bilateral	$0
D1550	Recementation of space maintainer	$0

Restorative (D2000-D2999)	Code Description	EHB Copay
D2140	Amalgam - one surface, primary or permanent	$25
D2150	Amalgam - two surfaces, primary or permanent	$40
D2160	Amalgam - three surfaces, primary or permanent	$40
D2161	Amalgam - four or more surfaces, primary or permanent	$40
D2330	Resin-based composite - one surface, anterior	$40
D2331	Resin-based composite - two surfaces, anterior	$40
D2332	Resin-based composite - three surfaces, anterior	$40
D2390	Resin-based composite crown, anterior	$40
D2391	Resin-based composite – one surface, posterior	$40
D2392	Resin-based composite – two surfaces, posterior	$40
D2393	Resin-based composite – three surfaces, posterior	$40
D2394	Resin-based composite – four or more surfaces, posterior	$40
D2542	Onlay – metallic - two surfaces	$160
D2543	Onlay - metallic – three surfaces	$160
D2544	Onlay – metallic – four or more surfaces	$160
D2710	Crown – resin-based composite (indirect)	$300
D2720	Crown – resin with high noble metal	$300
D2721	Crown – resin with predominantly base metal	$300
D2722	Crown – resin with noble metal	$300
D2740	Crown – porcelain/ceramic substrate	$350
D2750	Crown - porcelain fused to high noble metal	$300
D2751	Crown - porcelain fused to predominantly base metal	$300
D2752	Crown - porcelain fused to noble metal	$300
D2780	Crown - 3/4 cast high noble metal	$365
D2781	Crown - 3/4 cast predominantly base metal	$365
D2782	Crown - 3/4 cast noble metal	$365
D2783	Crown – ¾ porcelain/ceramic	$365
D2790	Crown - full cast high noble metal	$365
D2791	Crown - full cast predominantly base metal	$365
D2792	Crown - full cast noble metal	$365
D2910	Recement inlay, onlay, or partial coverage restoration	$0
D2915	Recement cast or prefabricated post and core	$0
D2920	Recement crown	$0
D2930	Prefabricated stainless steel crown - primary tooth	$150
D2931	Prefabricated stainless steel crown - permanent tooth	$150
D2940	Sedative filling	$50
D2950	Core buildup, involving and including any pins	$100
D2951	Pin retention - per tooth, in addition to restoration	$0
D2952	Post and core in addition to crown, indirectly fabricated	$100
D2954	Prefabricated post and core in addition to crown	$100
D2980	Crown repair necessitated by restorative material failure	$40
Endodontics (D3000-D3999)	**Code Description**	**EHB Copay**
D3110	Pulp cap - direct (excluding final restoration)	$50
D3120	Pulp cap – indirect (excluding final restoration)	$50
D3220	Therapeutic pulpotomy (excluding final restoration)	$50
D3310	Anterior Root Canal Therapy(excluding final restoration)	$300
D3320	Bicuspid Root Canal Therapy (excluding final restoration)	$365

D3330	Molar (excluding final restoration)	$300
D3346	Retreatment of previous root canal therapy – anterior	$390
D3347	Retreatment of previous root canal therapy – bicuspid	$390
D3348	Retreatment of previous root canal therapy - molar	$390
D3351	Apexification/recalcificaion – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$104
D3352	Apexification/recalcification – interim medication replacement	$104
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair perforations, root resorption, etc.)	$104
D3410	Apicoectomy – anterior	$201
D3421	Apicoectomy – bicuspid (first root)	$215
D3425	Apicoectomy – molar (first root)	$228
D3426	Apicoectomy (each additional root)	$130
D3450	Root amputation – per root	$111
Periodontics (D4000-D4999) {TMI: Surgery 4000-4299}	**Code Description**	**EHB Copay**
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant	$150
D4260	Osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per	$507
D4261	Osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per	$403
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$75
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$0
Removable Prosthodontics (D5000-D5899)	**Code Description**	**EHB Copay**
D5110	Complete denture – maxillary	$365
D5120	Complete denture – mandibular	$365
D5130	Immediate denture – maxillary	$365
D5140	Immediate denture – mandibular	$365
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$365
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$365
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including. any conventional clasps, rests and teeth)	$365
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$365
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	$365
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	$365
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)	$365
D5410	Adjust complete denture – maxillary	$50
D5411	Adjust complete denture – mandibular	$50
D5421	Adjust partial denture – maxillary	$50

D5422	Adjust partial denture – mandibular	$50
D5510	Repair broken complete denture base	$125
D5520	Replace missing or broken teeth - complete denture (each tooth)	$125
D5610	Repair resin denture base	$125
D5620	Repair cast framework	$125
D5630	Repair or replace broken clasp	$125
D5640	Replace broken teeth - per tooth	$125
D5650	Add tooth to existing partial denture	$125
D5660	Add clasp to existing partial denture	$125
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$234
D5671	Replace all teeth an acrylic on cast metal framework (mandibular)	$234
D5730	Reline complete maxillary denture (chairside)	$125
D5731	Reline complete mandibular denture (chairside)	$125
D5740	Reline maxillary partial denture (chairside)	$125
D5741	Reline mandibular partial denture (chairside)	$125
D5750	Reline complete maxillary denture (laboratory)	$150
D5751	Reline complete mandibular denture (laboratory)	$150
D5760	Reline maxillary partial denture (laboratory)	$150
D5761	Reline mandibular partial denture (laboratory)	$150
D5820	Interim partial denture (maxillary)	$250
D5821	Interim partial denture (mandibular)	$250
D5850	Tissue conditioning, maxillary	$75
D5851	Tissue conditioning, mandibular	$75
Fixed Prosthodontics (D6200-D6999)	**Code Description**	**EHB Copay**
D6210	Pontic - cast high noble metal	$365
D6211	Pontic - cast predominantly base metal	$365
D6212	Pontic - cast noble metal	$365
D6240	Pontic - porcelain fused to high noble metal	$365
D6241	Pontic - porcelain fused to predominantly base metal	$365
D6242	Pontic - porcelain fused to noble metal	$365
D6250	Pontic – resin with high noble metal	$365
D6251	Pontic – resin with predominantly base metal	$365
D6252	Pontic – resin with noble metal	$365
D6720	Crown – resin with high noble metal	$365
D6721	Crown – resin with predominantly base metal	$365
D6722	Crown – resin with noble metal	$365
D6750	Crown – porcelain fused to high noble metal	$365
D6751	Crown – porcelain fused to predominantly base metal	$365
D6752	Crown – porcelain fused to noble metal	$365
D6790	Crown – full cast high noble metal	$365
D6791	Crown – full cast predominantly base metal	$365
D6792	Crown – full cast noble metal	$365
D6930	Re-cement or re-bond fixed partial denture	$33
D6980	Fixed partial denture repair denture repair necessitated by restorative	$91

Oral and Maxillofacial Surgery (D7000-D7999)	Code Description	EHB Copay
D7111	Extraction, coronal remnants – deciduous tooth	$45
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65
D7210	Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$135
D7220	Removal of impacted tooth - soft tissue	$135
D7230	Removal of impacted tooth - partially bony	$135
D7240	Removal of impacted tooth - completely bony	$160
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$135
D7250	Surgical removal of residual tooth roots (cutting procedure)	$135
D7285	Incisional biopsy of oral tissue – hard (bone, tooth)	$40
D7286	Incisional biopsy of oral tissue – soft	$40
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$156
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$156
D7472	Removal of torus palatinus	$76
D7473	Removal of torus mandibularis	$130
D7510	Incision and drainage of abscess – intraoral soft tissue	$130
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	$40
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure not incidental to another procedure	$52
Orthodontics (D8000-D8999)	**Code Description**	**EHB Copay**
D8010	Limited orthodontic treatment of the primary dentition	$875
D8020	Limited orthodontic treatment of the transitional dentition	$875
D8030	Limited orthodontic treatment of the adolescent dentition	$875
D8040	Limited orthodontic treatment of the adult dentition	$875
D8050	Interceptive orthodontic treatment of the primary dentition	$875
D8060	Interceptive orthodontic treatment of the transitional dentition	$875
D8070	Comprehensive orthodontic treatment of the transitional dentition	$875
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$875
D8090	Comprehensive orthodontic treatment of the adult dentition	$875
D8210	Removable appliance therapy	$875
D8220	Fixed appliance therapy	$875
D8660	Pre-orthodontic treatment visit	$875
D8670	Periodic orthodontic treatment visit (as part of contract)	$875
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s)) per arch	$ 50
D8690	Orthodontic treatment (alternative billing to a contract fee)	$875
D8691	Repair of orthodontic appliance	$875
D8999	Orthodontic treatment plan and records (pre/post x-rays (cephalometric, panoramic, etc.), photos, study models)	$ 25

Adjunctive General Services (D9000-D9999)	Code Description	EHB Copay
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia	$0
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$0
D9248	Non-intravenous conscious sedation	$0
D9310	Consultation **- (**diagnostic service provided by dentist or physician other than requesting dentist or physician)	$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$0

If services for a listed procedure are performed by the assigned PCD, the member pays the specified co-payment.

Benefits are provided if the plan determines the services to be medically necessary.

A Member may be charged for missed appointments if the dental office is not given at least 24 hours notice of cancellation.

Listed procedures, which require a dentist to provide specialized services, and are referred by the assigned PCD, must be preauthorized in writing by the Plan. The member pays the co-payment specified for such services. Procedures not listed above are not covered, however may be available at the PCD's contracted fees. "Contracted fees" means the PCD's fees on file with the Plan.

Minimum coverage plan benefits are covered at 100% by the plan after the member meets the medical plan deductible and Annual Out-of-Pocket maximum. Members are responsible for the total cost of the benefit until the deductible is met. Covered preventive and diagnostic services are covered at 100% regardless of deductible and Annual Out of Pocket.

Benefits Description

This section lists the dental benefits and services you are allowed to obtain through the Plan when the services are necessary for your dental health consistent with professionally recognized standards of practice, subject to the exceptions and limitations and exclusions listed here.

Diagnostic and Preventive Benefits

Description

Benefit includes:

- Initial and periodic oral examinations
- Consultations, including specialist consultations
- Topical fluoride treatment
- Preventive dental education and oral hygiene instruction
- Roentgenology (X-rays)
- Prophylaxis services (cleanings)
- Dental sealant treatments
- Space Maintainers, including removable acrylic and fixed band type
- Preventive dental education and oral hygiene instruction

Limitations

Roentgenology X-rays are limited as follows:

- Bitewing x-rays in conjunction with periodic examinations are limited to one (1) series of four (4) films in any six (6) consecutive month period. Isolated bitewing or periapical films are allowed on an emergency or episodic basis.
- Full mouth x-rays in conjunction with periodic examinations are limited to once every twenty-four (24) consecutive months
- Panoramic film x-rays are limited to once every twenty-four (24) consecutive months
- Prophylaxis services (cleanings) are limited to two (2) in a twelve (12)-month period.
- Dental sealant treatments are limited to permanent first and second molars only.

Restorative Dentistry

Description

Restorations include:

- Amalgam, composite resin, acrylic, synthetic or plastic restorations for the treatment of caries
- Micro filled resin restorations which are non-cosmetic.
- Replacement of a restoration
- Use of pins and pin build-up in conjunction with a restoration
- Sedative base and sedative fillings

Limitations

Restorations are limited to the following:

- For the treatment of caries, if the tooth can be restored with amalgam, composite resin, acrylic, synthetic or plastic restorations; any other restoration such as a crown or jacket is considered optional.
- Composite resin or acrylic restorations in posterior teeth are optional.
- Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary
- Actual metal fees will apply for any procedure involving noble, high noble, or titanium metals.

Oral Surgery

Description
Oral surgery includes:

- Extractions, including surgical extractions
- Removal of impacted teeth
- Biopsy of oral tissues
- Alveolectomies
- Excision of cysts and neoplasms
- Treatment of palatal torus
- Treatment of mandibular torus
- Frenectomy
- Incision and drainage of abscesses
- Post-operative services, including exams, suture removal and treatment of complications
- Root recovery (separate procedure)

Limitation

- The surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

Endodontics

Description
Endodontic benefits include:

- Direct pulp capping
- Pulpotomy and vital pulpotomy
- Apexification filling with calcium hydroxide
- Root amputation
- Root canal therapy, including culture canal and limited retreatment of previous root canal therapy as specified below
- Apicoectomy
- Vitality tests

Limitations
Root canal therapy, including culture canal, is limited as follows:

- Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present and/or the patient is experiencing symptoms.
- Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology, is not a covered benefit.

Periodontics

Description
Periodontics benefits include:

- Emergency treatment, including treatment for periodontal abscess and acute periodontitis
- Periodontal scaling and root planing, and subgingival curettage
- Gingivectomy
- Osseous or muco-gingival surgery

Limitation

- Periodontal scaling and root planing, and subgingival curettage are limited to five (5) quadrant treatments in any twelve (12) consecutive months.

ACCESS DENTAL

Crown and Fixed Bridge

Description

Crown and fixed bridge benefits include:

- Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three quarter crown, and stainless steel
- Related dowel pins and pin build-up
- Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold
- Recementation of crowns, bridges, inlays and onlays
- Cast post and core, including cast retention under crowns
- Repair or replacement of crowns, abutments or pontics

Limitation

The crown benefit is limited as follows:

- Replacement of each unit is limited to once every thirty-six (36) consecutive months, except when the crown is no longer functional as determined by the Dental Plan.
- Only acrylic crowns and stainless steel crowns are a benefit for children under twelve (12) years of age. If other types of crowns are chosen as an optional benefit for children under twelve (12) years of age, the covered dental benefit level will be that of an acrylic crown.
- Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.
- Veneers posterior to the second bicuspid are considered optional. An allowance will be made for a cast full crown.

The fixed bridge benefit is limited as follows:

- Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.
- A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth in a person sixteen (16) years of age or older and the patient's oral health and general dental condition permits. For children under the age of sixteen (16), it is considered optional dental treatment. If performed on a Member under the age of sixteen (16), the applicant must pay the difference in cost between the fixed bridge and a space maintainer.
- Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.
- Fixed bridges are optional when provided in connection with a partial denture on the same arch.
- Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.
- There is an additional co-payment of $125 per unit for treatment plans of 7 or more units.
- Actual fees will apply for any procedure involving noble, high noble, or titanium metals.
- Implants and implant-related procedures are not covered.
- The program allows up to five (5) units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is optional treatment

Removable Prosthetics

Description

The removable prosthetics benefit includes:

- Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers
- Office or laboratory relines or rebases

- Denture repair
- Denture adjustment
- Tissue conditioning
- Denture duplication
- Space Maintainer
- Stayplates

Limitations

The removable prosthetics benefit is limited as follows:

- Partial dentures will not be replaced within thirty-six (36) consecutive months, unless:
  1. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, or
  2. The denture is unsatisfactory and cannot be made satisfactory.
- The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.
- A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.
- Full upper and/or lower dentures are not to be replaced within thirty-six (36) consecutive months unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair.
- The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. If a more personalized or specialized treatment is chosen by the patient and the dentist, the patient will be responsible for all additional charges.
- Office or laboratory relines or rebases are limited to one (1) per arch in any twelve (12) consecutive months.
- Tissue conditioning is limited to two per denture
- Implants are considered an optional benefit
- Stayplates are a benefit only when used as anterior space maintainers for children
- There is an additional copayment of $125 per unit for treatment plans of 7 or more units.
- Actual metal fees will apply for any procedure involving noble, high noble, or titanium metals.
- The replacement of retainers and pontics requires the existing bridge to be 3+ years old.

Other Benefits

Description

Other dental benefits include:

- Local anesthetics
- Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure
- Emergency treatment, palliative treatment
- Coordination of benefits with member's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services

Orthodontic Benefits

Orthodontic treatment includes medically-necessary orthodontia only

Excluded Benefits

The following dental benefits are excluded under the plan:

1. Services which, in the opinion of the attending dentist, are not necessary to the Member's dental health.
2. Procedures, appliances, or restorations to correct congenital or developmental malformations are not covered benefits unless specifically listed in the "Benefits" section above.
3. Cosmetic dental care.
4. General anesthesia or intravenous/conscious sedation, unless specifically listed as a benefit or is given by a dentist for covered oral surgery
5. Experimental procedures.
6. Dental conditions arising out of and due to a Member's employment for which Worker's Compensation or an Employer's Liability Law is payable. The participating dental plan shall provide the services at the time of need, and the Member or applicant shall cooperate to assure that the participating dental plan is reimbursed for such benefits.
7. Services which were provided without cost to the Member by the State government or an agency thereof, or any municipality, county or other subdivisions.
8. Hospital charges of any kind.
9. Major surgery for fractures and dislocations.
10. Loss or theft of dentures or bridgework.
11. Dental expenses incurred in connection with any dental procedures started after termination of coverage or prior to the date the Member became eligible for such services.
12. Any service that is not specifically listed as a covered benefit.
13. Malignancies.
14. Dispensing of drugs not normally supplied in a dental office.
15. Additional treatment costs incurred because a dental procedure is unable to be performed in the dentist's office due to the general health and physical limitations of the Member.
16. The cost of precious metals used in any form of dental benefits.
17. The surgical removal of implants.
18. Services of a pedodontist/pediatric dentist for a Member, except when the Member is unable to be treated by his or her panel Provider, or treatment by a pedodontist/pediatric dentist is medically necessary, or his or her panel Provider is a pedodontist/pediatric dentist.
19. Services which are eligible for reimbursement by insurance or covered under any other insurance, health care service plan, or dental plan. The participating dental plan shall provide the services at the time of need, and the Member or applicant shall cooperate to assure that the participating dental plan is reimbursed for such benefits.

Sharp Health Plan Supplemental Information to the Member Handbook for Small Group Plans

The following information is attached to this Member Handbook, representing your Combined Evidence of Coverage and Disclosure Form, in compliance with the Knox-Keene Health Care Service Plan Act of 1975, as amended. **The following sections of your Member Handbook are either deleted from, added to, deleted and replaced or amended and restated as follows upon the effective date indicated:**

Effective January 1, 2016

A. The following language replaces the subsection "*Health Savings Accounts (HSA) Qualified High Deductible Health Plans*" in the "Annual Out-of-Pocket Maximum" section under "WHAT DO YOU PAY?" in the Member Handbook:

If you are enrolled in an HSA-qualified high deductible health plan (HDHP), your Deductible and Out-of-Pocket Maximum will work differently. In HDHPs linked to HSAs, an individual in a self-only coverage plan must meet the Self-Only Deductible. In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Individual Deductible in an HSA family plan must be at least $2,600 in 2016 under IRS rules. The Out-of-Pocket Maximum includes the Deductible, Copayments and Coinsurance. In a self-only plan, the Member is responsible for all applicable Deductibles, Copayments and Coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all Deductibles, Copayments and Coinsurance up to the Individual Out-of-Pocket Maximum, until the combined Deductibles, Copayments and Coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined Deductibles, Copayments and Coinsurance equal the family Out-of-Pocket Maximum, all family members have met the Out-of-Pocket Maximum. If you are unsure whether you are enrolled in this type of HDHP, please call Customer Care.

B. The following underlined language is added to the subsection "*Chemical Dependency and Alcoholism Treatment*" in the "WHAT ARE YOUR COVERED BENEFITS?" section of the Member Handbook:

The following Chemical Dependency services are a Covered Benefit:

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

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

C. The following underlined language is added to the subsection "*Emergency Services*" in the "WHAT ARE YOUR COVERED BENEFITS?" section of the Member Handbook:

Emergency services and care include both physical and psychiatric emergency conditions, and active labor.

D. Infertility services, including diagnosis and treatment of the Member's underlying condition, are not Covered Benefits.

E. The following underlined language is added to the subsection "*Mental Health Services*" in the "WHAT ARE YOUR COVERED BENEFITS?" section of the Member Handbook:

Sharp Health Plan covers Mental Health Services only for the diagnosis or treatment of Mental Disorders. The following services are covered:

Outpatient mental health Services

- Individual office visits and group mental health evaluation and treatment.
- Psychological testing when necessary to evaluate a Mental Disorder.
- Outpatient services for the purpose of monitoring drug therapy.
- Behavioral Health Treatment for pervasive developmental disorders or autism.

- Intensive outpatient treatment (programs usually less than 5 hours per day)
- Partial hospitalization (programs usually more than 5 hours per day)
- Case management services

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

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs

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

Members have direct access to Plan Providers of mental health services without obtaining a PCP referral. Covered mental health benefits must be obtained through Plan Providers. Mental health services that are not provided by Plan Providers are not covered, and you will be responsible to pay for those services. Please call Psychiatric Centers at San Diego toll-free at 1-877-257-7273 whenever you need mental health services. All calls are confidential.

F. The following subsection is added to "WHAT ARE YOUR COVERED BENEFITS?" section of the Member Handbook:

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

G. The following underlined language is added to and stricken language is removed from the subsection "*Outpatient Prescription Drugs*" in the "WHAT ARE YOUR COVERED BENEFITS?" section of the Member Handbook:

Covered outpatient prescription medications include
~~Tier I: Generic drugs on the Sharp Health Plan Drug Formulary~~
~~Tier II: Brand name drugs, peak flow meters and inhaler spacers listed on the Sharp Health Plan Drug Formulary~~
~~Tier III: Generic and brand name prescription drugs that are specifically listed as Tier III or that are not listed on the Drug Formulary but are not specifically excluded from coverage~~

Tier 1: most generic drugs and low cost preferred brands
Tier 2: non-preferred generic drugs, or preferred brand name drugs, or recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost
Tier 3: non-preferred brand name drugs, or recommended by P&T committee based on drug safety, efficacy and cost, or generally have a preferred and often less costly therapeutic alternative at a lower tier
Tier 4: Food and Drug Administration (FDA), or drug manufacturer limits distribution to specialty pharmacies, or self-administration requires training, or clinical monitoring, or drug was manufactured using biotechnology, or plan cost (net of rebates) is >$600

H. The following underlined language is added to the subsection in "*Outpatient Prescription Drugs*" entitled "Specialty Medications?" in the "WHAT ARE YOUR COVERED BENEFITS?" section of the Member Handbook:

Certain specialty medications are generally provided exclusively by Diplomat Specialty Pharmacy via mandatory mail order. Specialty medications are drugs that may require specialized delivery and administration on an ongoing basis. They are often for chronic conditions and involve complex care issues that need to be managed. Examples include Xeloda, Temodar, Sensipar, and Zortress. Other criteria that would classify a drug as a specialty medication are as follows: the Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or; self-administration requires training, clinical monitoring or; drug was manufactured using biotechnology or; self-administration requires training or clinical monitoring or; the Plan's cost (net of rebates) is more than $600. The Plan's specialty medications are also called "Tier 4" drugs. Some specialty medications may also be classified as Tier 1, 2 or 3 drugs if all FDA-approved drugs in the same drug class would otherwise qualify for Tier 4 and at least 3 drugs in that class are available as FDA-approved drugs.

I. The following underlined language is added to and stricken language is removed from the subsection "*Genetic Testing, Treatment, or Counseling*" in the "WHAT ARE YOUR COVERED BENEFITS?" section of the Member Handbook:

Genetic Testing or Treatment ~~or Counseling~~
Genetic testing or treatment ~~or counseling~~ is not covered for any of the following:

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

J. The website for Access Dental Plan has changed to www.premierlife.com.