Sharp Health Plan: Sharp Silver 70 HMO 2000/45 + Child Dental Network 2 INF

Coverage Period: 01/01/2017– 12/31/2017

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?	**$2,000** Individual / **$4,000** 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. **$6,800** Individual / **$13,600** 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	$75 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	$40 copay/visit	Not covered	Prior authorization is required.
	Diagnostic test (x-ray, blood work)	$70 copay/visit	Not covered	Prior authorization is required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Not covered	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	$85/30-day supply $170/90-day supply	Not covered	
	Tier 4	20% coinsurance up to $250 per 30-day supply 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	$350 copay/visit (facility)	$350 copay/visit (facility)	Cost-share waived if admitted.
	Emergency room physician fee	No cost share (physician)	No cost share (physician)	
	Emergency medical transportation	$250 copay/trip	$250 copay/trip	**Deductible** applies.
	Urgent care	$45 copay/visit	$45 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 non-emergency services. Out-of-network services are covered for emergency care only.
	Physician/surgeon fee	20% coinsurance	20% coinsurance	

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 have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits and group therapy	$45 copay/visit	Not covered	Prior authorization is required.
	Mental/Behavioral health other outpatient items and services	$45 copay/visit*	Not covered	Prior authorization is required. *Applies to intensive outpatient program and partial hospitalization program
	Mental/Behavioral health inpatient facility fee and inpatient physician fee	20% coinsurance	20% coinsurance	**Deductible** applies. Prior authorization is required for non-emergency services. Out-of-network services are covered for emergency care only.
	Substance use disorder outpatient office visits and group therapy	$45 copay/visit	Not covered	Prior authorization is required.
	Substance use disorder other outpatient items and services	$45 copay/visit*	Not covered	Prior authorization is required. *Applies to intensive outpatient program and partial hospitalization program
	Substance use disorder inpatient services facility fee and inpatient physician fee	20% coinsurance	20% coinsurance	**Deductible** applies. Prior authorization is required for non-emergency 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 facility fee and physician/surgeon fee	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
- 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
- Infertility treatment
- 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** $4,745
- **Patient pays** $2,795

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	$2,000
Copays	$325
Coinsurance	$320
Limits or exclusions	$150
Total	**$2,795**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,520
- **Patient pays** $1,880

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	$250
Copays	$1,330
Coinsurance	$260
Limits or exclusions	$40
Total	**$1,880**

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.

SHARP HEALTH PLAN

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Member Handbook

Health Maintenance Organization (HMO)

we believe in choice.

Evidence of Coverage for Non-Grandfathered Small Group Plans

effective January 1, 2016

SHARP HEALTH PLAN

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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 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.

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:

- 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.

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.

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

Out-of-Area medical services are covered only for urgent and Emergency Medical Conditions resulting from unforeseen illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member returns to the Service Area. Out-of-Area medical services will be covered to meet your immediate medical needs. Follow-up care 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.

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:

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 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 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 more than $600.

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. Sharp Health Plan processes routine and urgent requests from doctors in a timely fashion. Sharp Health Plan processes routine requests within 72 hours and urgent request within 24 hours of receipt of the information reasonably necessary to make a determination, including information the Plan has requested to make such a determination, as

appropriate and Medically Necessary for the nature of the Member's condition. Urgent circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a nonformulary drug. 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. 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 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.

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 72 hours for routine requests and within 24 hours for urgent requests. 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.

Wigs or Hairpieces

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

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. Treatment of morbid obesity is covered when medically necessary.

Custodial Care

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

Dental Services/Oral Surgical Services

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

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

Disposable Medical Supplies

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

Durable Medical Equipment (DME)

The following items are not covered:

- Equipment that basically serves comfort or convenience functions (e.g., physical fitness equipment, trays, backpacks, wheelchair racing equipment).

- DME that is primarily for the convenience of the Member or caretaker.
- Exercise and hygiene equipment.
- Experimental or research equipment.
- Devices not medical in nature such as sauna baths and elevators or modifications to the home or automobile.
- Generators or accessories to make home dialysis equipment portable for travel.
- Deluxe equipment.
- 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 or Treatment

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

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

Government Services and Treatment

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

Services required for injuries or illnesses experienced while under arrest, detained, imprisoned, incarcerated or confined pursuant to federal, state or local law are not covered. However, the Plan will reimburse Members their Out-of-Pocket expenses for services received while confined/incarcerated,

or, if a juvenile, while detained in any facility, if the service were provided or Authorized by the Member's Primary Care Physician or Plan Medical Group in accordance with the terms of the Plan or were Emergency Services or Urgent Care Services. This exclusion does not restrict the Plan's liability with respect to expenses for Covered 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:

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

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

Massage Therapy Services

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.

Newborns

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

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

- If the newborn's date of birth or date you have become legally entitled to control the health care of an adopted child falls on or before the 15th of the month, a premium will be charged for the month of birth or adoption.
- If the newborn's date of birth or date you have become legally entitled to control the health care of an adopted child falls after the 15th of the month, a premium will be charged beginning the month following the month of birth or adoption.

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

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.

Notes

Consider us your personal health care assistant

(858) 499-8300 or 1-800-359-2002
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customer.service@sharp.com

sharphealthplan.com

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Sharp Health Plan Supplemental Information to the Member Handbook

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 2017

1. The following underlined language is added to the *Obtain Required Authorization* subsection of the **"HOW DO YOU OBTAIN MEDICAL CARE?"** section of the Member Handbook:

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

2. The following language replaces the heading and first sentence of the subsection entitled "*Second Medical Opinions*" in the "**HOW DO YOU OBTAIN MEDICAL CARE?"** section of the Member Handbook:

Second Opinions

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

3. The following language in strikethrough is removed from the section entitled "Emergency Services and Care" in the "**HOW DO YOU OBTAIN MEDICAL CARE**?" section of the Member Handbook:

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:

a) Placing the patient's health in serious jeopardy,
b) Serious impairment of bodily functions; or
c) Serious dysfunction of any bodily organ or part.

4. The following underlined language is added to the subsection *Health Savings Account (HSA) Qualified High Deductible Health Plans* of the **"WHAT DO YOU PAY?"** section of your member handbook:

If you are enrolled in an HSA-qualified high deductible health plan (HDHP), your Deductible will work differently. In HDHPs linked to HSAs, an individual in a self-only coverage plan must meet the Self-Only Deductible and the Self-Only Out-of-Pocket Maximum amount.

In a family plan, each individual in the family must meet either the Individual Deductible or $2,600 for plan year 2017, whichever amount is higher, before the plan pays anything for services for any individual in the family. In a family plan, an individual's out of pocket contribution is limited to the Individual Out-of-Pocket Maximum amount. If you are unsure whether you are enrolled in this type of HDHP, please call Customer Care.

5. The following language in strikethrough is removed from the section entitled "Deductible Credits" of the "**WHAT DO YOU PAY?"** section of the Member Handbook:

You can also find the Deductible credit Request form at www.SharpHealthPlan.com under "Member Forms ~~and Resources~~" on the Member page of the website.

6. The following language in strikethrough is removed from the section entitled "*Transitional Residential Recovery Services*" in the "**WHAT ARE YOUR COVERED BENEFITS**" section of the Member Handbook:

Transitional Residential Recovery Services

We cover chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by the Medical Group. These settings provide counseling and support services in a structured environment ~~and are covered as outpatient services.~~

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

"Emergency Services and care include both physical and psychiatric mental health conditions, and active labor."

8. The following section is added to the "**WHAT ARE YOUR COVERED BENEFITS**" section of the Member Handbook:

Habilitative Services

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

9. The following language replaces the section entitled "*Injectable Drugs*" subsection in the **"WHAT ARE YOUR COVERED BENEFITS"** section of the Member Handbook:

Injectable Drugs

Outpatient injectable drugs and self-injectable drugs are covered. Outpatient injectable drugs include those drugs or preparations which are given by the intramuscular or subcutaneous route. Outpatient injectable medications (except insulin) are covered when self-administered or administered as a customary component of a Plan Physician's office visit and when not otherwise limited or excluded (e.g., certain immunizations, infertility drugs, or off-label use of covered injectable drugs). Self-administered drugs are drugs that are injected subcutaneously (under the skin) that are approved by the FDA for self-administration and/or are packaged in patient friendly injections devices along with instructions on how to administer. Self-injectable insulin and GLP1 agents for diabetes are covered under the outpatient prescription drug benefit, most other self-administered injectable drugs are covered as part of the medical benefit

10. The following language replaces the section entitled "*Outpatient Prescription Drugs"* in the "**WHAT ARE YOUR COVERED BENEFITS?"** section of the Member Handbook:

Outpatient Prescription Drugs
Outpatient prescription drugs are covered. You may obtain covered Outpatient Prescription Drug Benefits from any network retail or mail order Plan Pharmacies. Some prescription drugs are subject to restricted distribution by the United States Food and Drug Administration or requires special handling, provider coordination, or patient education that can only be provided by a specific pharmacy. Except for Emergency Services and out-of-area urgent care services, outpatient prescription drugs that are not obtained from a Plan Pharmacy or not obtained through your pharmacy benefits with your Sharp Health Plan Member ID card (for example: paid for by cash or with a coupon) are not covered and you will be responsible for payment. In addition, the amount paid will not count toward your Deductible or Out-of-Pocket Maximum only if prescription drugs are obtained without prior authorization from the Plan. Look in your Provider Directory to find a Plan Pharmacy near you or consult our website at www.sharphealthplan .com and search for a pharmacy that is convenient for you by using the "Find a Pharmacy" function on the "Member Center" page. Always present your Sharp Health Plan Member ID card to the Plan Pharmacy. Ask them to inform you if something is not going to be covered. You pay the Copayments, Coinsurance and/or Deductible for Covered Benefits as listed in your Health Plan Benefits and Coverage Matrix. If the retail price for your prescription drug is less than your Copayment, you will only pay the retail price. Cost-sharing for covered orally administered anticancer medications will not exceed $200 for an individual prescription of up to a 30-day supply. In addition, orally administered anticancer medications will not be subject to a deductible unless you are enrolled in a HSA-compatible high deductible health plan.

Your outpatient prescription drug benefit will have a different number of tiers depending on your benefit plan. Please consult your Health Plan Benefits and Coverage Matrix for specific information about your benefit.

Covered outpatient prescription drugs for plans with a three tier benefit structure include:

Tier 1: Preferred generic drugs listed on the Sharp Health Plan Drug List
Tier 2: Preferred brand name drugs and inhaler spacers listed on the Sharp Health Plan Drug List
Tier 3: Non-preferred generic and brand name prescription drugs that are specifically listed as Tier 3 or that are not listed on the Drug List but are not specifically excluded from coverage

Preferred generic drugs listed on the Sharp Health Plan Drug List

Covered outpatient prescription drug for plans with a benefit structure with more than three tiers (such as plans purchased through Covered California) include:

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

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

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

Tier 4: Biologics, drugs that the FDA or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the enrollee to have special training or clinical monitoring for self-administration, or drugs that cost the health plan more than six hundred dollars ($660) net of rebates for a one-month supply

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

MB: Drugs typically covered under the Medical Benefit

Please consult your Health Plan Benefits and Coverage Matrix for specific information about your benefit.

For additional information about your Copayments, Coinsurance and/or Deductible, please consult the benefits information available online by logging onto SharpConnect at www.sharphealthplan.com. When you create an account at SharpConnect, you can access your benefits information online 24 hours a day, 7 days a week.

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

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

11. The following language replaces the subsection entitled "*SHARP HEALTH PLAN DRUG FORMULARY*" in the **"WHAT ARE YOUR COVERED BENEFITS**?" section of the Member Handbook:

SHARP HEALTH PLAN DRUG LIST

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

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

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

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

Some drugs are commercially available as both a brand and a generic version. It is the policy of Sharp Health Plan that when a generic is available, Sharp Health Plan does not cover the corresponding brand-name drug. If a generic version of a drug is available, the brand version will not be listed in this

document and will require prior authorization. The Plan requires the dispensing pharmacy to dispense the generic drug unless prior authorization for the brand is obtained.

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

12. The following language replaces the "*Outpatient Prescription Drug Prior Authorization Process*" subsection of the "**WHAT ARE YOUR COVERED BENEFITS**?" section of the Member Handbook:

WHAT IS THE OUTPATIENT PRESCRIPTION DRUG PRIOR AUTHORIZATION PROCESS?

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

WHAT IS STEP THERAPY?

Drugs with the ST symbol next to the drug name in the Drug List are subject to step therapy. This means that a Member must try an alternative prescription drug first that Sharp Health Plan determines will be clinically effective.

There may be a situation where it may be medically necessary for a Member to receive certain medications without first trying an alternative drug. In these instances, your Provider may request prior authorization by calling or faxing Customer Care. The list of prescription drugs subject to step therapy is subject to change by Sharp Health Plan.

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

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

WHAT IS QUANTITY LIMIT?

Drugs with the QL symbol next to the drug name in the Drug List are subject to quantity limits. It is the policy of Sharp Health Plan to maintain effective drug utilization management procedures. Such procedures include quantity limits on prescription drugs. The Plan ensures appropriate review when determining whether or not to authorize a quantity of drug that exceeds the quantity limit. Quantity

limits exist when drugs are limited to a determined number of doses based on criteria including, but not limited to, safety, potential overdose hazard, abuse potential, or approximation of usual doses per month, not to exceed the FDA maximally approved dose. Your doctor may follow the prior authorization process when requesting an exception to the Sharp Health Plan quantity limit for a drug.

WHAT IS "THERAPEUTIC INTERCHANGE?"

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

WHAT IS GENERIC SUBSTITUTION?

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

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

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

Additional information about specific prescription drug benefits and drug benefit exclusions can be found in your Sharp Health Plan Summary of Benefits and Evidence of Coverage.
The following language replaces the "Maintenance Drugs by Mail Order" subsection of the "WHAT ARE YOUR COVERED BENEFITS" section of the Member Handbook:

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

1. Have your doctor write a prescription for up to a 90-day supply of your maintenance drug.

2. Complete the mail service order form brochure that you received with your New Member materials. If you did not receive a mail order form brochure you can call customer care at 1-800-359-2002 to have one mailed to you.

3. Mail your original prescription along with the Copayment, using the pre-addressed, postage-paid envelope attached to the order form. Your prescription will arrive at your home in two to three weeks.

4. If your prescription includes refills, you can re-order by phone. Simply call the tollfree1-number on your prescription bottle to order a refill. If you have any questions or do not have a brochure, contact our Customer Services Department by calling (858) 499-8300 or toll free at 1-800-359-2002 or via e-mail at customer.service@sharp.com.

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

13. The following language replaces the subsection entitled "*Specialty Medications*" subsection of the "**WHAT ARE YOUR COVERED BENEFITS?"** section of the Member Handbook:

HOW DO I OBTAIN SPECIALTY DRUGS?

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

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

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

14. The following language replaces the subsection entitled "*Deductibles and Copayments for Prescription Drug Benefits*" of the "**WHAT ARE YOUR COVERED BENEFITS?**" section of the Member Handbook:

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

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

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

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

B. Mail Order Pharmacy

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

Some benefit plans also have a deductible that applies to drugs covered by Sharp Health Plan or have a combined pharmacy and medical Deductible. If your benefit plan includes a deductible, you are responsible for paying all costs for the covered drugs or the combined pharmacy and medical Deductible, if applicable, each calendar year, up to the amount of the deductible, before Sharp Health Plan will cover those drugs at the applicable Copayment or Coinsurance amount. Please see your Health Plan Benefits and Coverage Matrix for further detail.

15. The following section is added to the "*Outpatient Prescription Drugs*" subsection of the "**WHAT ARE YOUR COVERED BENEFITS?**" section of the Member Handbook:

<u>YOU HAVE THE RIGHT TO APPEAL</u>

If you don't agree with a coverage decision, you or your doctor may request an appeal. You must submit your request within 180 days from the postmark date of the denial notice. There are two kinds of appeals you can request.

Standard (72 hours): Your or your doctor can request a standard appeal. Sharp Health Plan must make a decision no later than 72 hours after receipt of a standard request.

Urgent (24 hours): You or your doctor can request an urgent appeal if you or your doctor believes that your health could be seriously harmed by waiting up to 72 hours for a decision. Sharp Health Plan must make a decision no later than 24 hours after receipt of an urgent request.

16. The following language in strikethrough is deleted from the "*Vision Services*" subsection of the "**WHAT ARE YOUR COVERED BENEFITS**?" section of the Member Handbook:

We cover the following special contact lenses at Plan Medical Offices when prescribed by a Plan Physician or Plan Optometrist:

- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris).

- Up to six Medically Necessary 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.~~

17. The following language in strikethrough is deleted from the "*Mental Health Services*" subsection of the "**WHAT IS NOT COVERED?**" section of the Member Handbook:

~~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 as provided as a supplemental benefit.~~

18. The following language replaces the subsection entitled "*Outpatient Prescription Drugs*" in the "**WHAT IS NOT COVERED?**" section of the Member Handbook:

EXCLUSIONS AND LIMITATIONS TO THE OUTPATIENT PRESCRIPTION DRUG BENEFIT
The services and supplies listed below are exclusions and limitations to your outpatient prescription drug benefits and are not covered by Sharp Health Plan:

1. Drugs dispensed by other than a Plan Pharmacy, except as Medically Necessary for treatment of an Emergency or urgent care condition.
2. Drugs when prescribed by non-contracting providers that are not authorized by the Plan except when coverage is otherwise required in the context of Emergency Services.
3. Over-the-Counter Items: Drugs, devices and products, or Prescription Legend Drugs with over the counter and equivalents and any drugs, devices or products that are therapeutically comparable to an over-the-counter drug, device or product. This includes Prescription Legend Drugs when any version of strength becomes available over-the-counter. This exclusion does not apply to over-the-counter products that we must cover as "Preventative Care" benefit under federal law with a Prescription or if the prescription legend drug is medically necessary due to a documented treatment failure or intolerance to the over-the-counter equivalent or therapeutically comparable drug.
4. Drugs dispensed in institutional packaging (such as unit dose) and drugs that are repackaged.
5. Drugs that are packaged with over the counter drugs or other non-prescription items/supplies.
6. Vitamins (other than pediatric or prenatal vitamins listed on the Drug Formulary).
7. Drugs and supplies prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. (Drugs for mental performance are not excluded from coverage when they are used to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.)
8. Herbal, nutritional and dietary supplements.
9. Drugs prescribed solely for the purpose of shortening the duration of the common cold.
10. Drugs prescribed by a dentist or when prescribed for a dental treatment.
11. Drugs and supplies prescribed in connection with a service or supply that is not a covered benefit unless required to treat a complication that arises as a result of the service or supply.
12. Travel and/or required work related immunizations.
13. Infertility drugs are excluded, unless added by the employer as a supplemental benefit.
14. Drugs obtained outside of the United States unless they are furnished in connection with urgent care or an Emergency.
15. Drugs that are prescribed solely for the purposes of losing weight, except when medically necessary for the treatment of morbid obesity. Members must be enrolled in a Sharp Health Plan approved comprehensive weight loss program prior to or concurrent with receiving the weight loss drug and meet Plan criteria for coverage.
16. Off-label use of FDA approved prescription drugs unless the drug is recognized for treatment of such indication in one of the standard reference compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information) or the safety and effectiveness of use for this indication has

been adequately demonstrated by at least two studies published in a nationally recognized, major peer reviewed journal.

17. Smoking cessation prescription drugs unless the Member is concurrently enrolled in or has completed a Sharp Health Plan approved smoking cessation program.
18. Replacement of lost, stolen, or destroyed medications.
19. Compounded medications, unless prior authorization is obtained and determined to be medically necessary.
20. Brand name drugs when a generic equivalent is available. Some drugs are commercially available as both a brand and a generic version. It is the policy of Sharp Health Plan that when a generic is available, Sharp Health Plan does not cover the corresponding brand-name drug. If a generic version of a drug is available, the brand version will not be listed in this document and will require prior authorization. The Plan requires the dispensing pharmacy to dispense the generic drug unless prior authorization for the brand is obtained.

The following Covered Benefits are not subject to the Copayments, exclusions, or limitations that apply to your outpatient prescription drug benefits. Please refer to the applicable sections of your Member Handbook for specific information about the Copayments, exclusions, and limitations that apply to these Covered Benefits.

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

19. The following language replaces the subsection entitled "*Newborns*" in the "**HOW DO YOU ENROLL IN SHARP HEALTH PLAN?"** section of the Member Handbook:

Newborns

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

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

You must submit an Enrollment Application to Your Employer for a newborn or adopted child even

if you currently have Dependent coverage. Grandchildren of the Subscriber are not eligible for enrollment, unless the Enrolled Employee has been appointed legal guardian of the grandchild(ren).

20. The following language in strikethrough is removed from the "*Annual Enrollment Period*" subsection of the "**HOW DO YOU ENROLL IN SHARP HEALTH PLAN**?" section of the Member Handbook:

~~For benefit years beginning on or after January 1, 2016~~

21. The following language has been added to the "*Suspension of Coverage for Nonpayment of Premiums – Members Receiving a Premium Tax Credit*" subsection of the "**WHEN WILL YOUR COVERAGE END?**" section of the Member Handbook:

If payment in full is not received from you within the 3-month grace period, Sharp Health Plan will cancel the Membership Agreement and mail you a Notice Confirming Termination of Coverage, which will provide you with the following information:

- That the Membership Agreement has been cancelled for non-payment of Premiums.
- The specific date and time when your coverage ended.
- Sharp Health Plan's telephone number to call to obtain additional information
- Information about other health care coverage options and rights under the law

22. The following underlined language has been added to the "*Cancellation of the Membership Agreement for Nonpayment of Premiums – Members NOT receiving a Premium Tax Credit*" subsection of the "**WHEN WILL YOUR COVERAGE END?**" section of the Member Handbook:

- That the Membership Agreement has been cancelled for non-payment of Premiums.
- The specific date and time when your coverage ended.
- Sharp Health Plan's telephone number to call to obtain additional information
- <u>Information about other health care coverage options and rights under the law.</u>

Access Dental Plan - Children's Dental HMO
Sharp Health Plan Member Handbook Supplement

About the Dental Plan

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

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

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

Using the Dental Plan Facilities / Locations

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

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

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

Choosing a Primary Care Dental Provider

Members must select a Primary Care Dentist from the list of providers listed in the Provider

Directory. The Member should indicate his/her choice of Primary Care Dentist on Sharp Health Plan's enrollment application.

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

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

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

Scheduling Appointments

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

ADP who will arrange for such care.

Primary Care Dentists are required to provide Covered Services to Members during normal working hours and during such other hours as may be necessary to keep Member's appointment schedules on a current basis. Appointments for routine, preventive care and specialist consultation shall not exceed four weeks from the date of the request for an appointment.
Wait time in the Primary Care Dentist's office shall not exceed 30 minutes.

Changing Your Provider

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

Continuity of Care for New Members

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

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

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

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

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

Continuity of Care for Termination of Provider

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

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

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

Continuity of care will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity. You must be under the care of the Participating Provider at the time of ADP's termination of the provider's participation. The terminated provider must agree in writing to provide

services to you in accordance with the terms and conditions, including reimbursement rates, of his or her agreement with ADP prior to termination. If the provider does not agree with these contractual terms and conditions and reimbursement rates, ADP is not required to continue the provider's services beyond the contract termination date.

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

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

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

Prior Authorization for Services

Your Primary Care Dentist will coordinate your dental care needs and, when necessary, arrange

Specialty Services for you. In some cases, ADP must authorize certain services and/or Specialty Services 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 shall be communicated to you in writing within two (2) days of the decision. ADP reserves the right to determine the facility and Plan provider from which Covered Services requiring specialty care are obtained.

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

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

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

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

Obtaining a Second Opinion

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

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

within an appropriate period of time.

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

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

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

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

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

Getting Urgent Care

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

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

To obtain Urgent Care when you are **outside** Sharp Health Plan's Service Area, the Member should seek care from any Non-Plan Provider. Services that do not meet the definition of Urgent Care will not be covered if treatment was provided by a Non-Plan Provider. Non-Plan Providers may require the Member to make immediate full payment for services or may allow the Member to pay any applicable Copayments and bill ADP for the unpaid balance. If the Member has to pay any portion of the bill, ADP will reimburse the Member for services that meet the definition of Emergency Care or Urgent Care as defined above. If the Member pays a bill, a copy of the bill or invoice from the dentist who provided the care and a brief explanation of the circumstances that gave rise to the needed dental care should be submitted to the following address: Access Dental Plan**, Attention: Claims Department, P.O. Box: 659005, Sacramento, CA 95865-9005.**

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

Getting Emergency Services

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

If you need Emergency Care during regular Provider office hours, Members may obtain care by contacting a Primary Care Dentist or any available dentist for Emergency Care. After business hours, Members should first attempt to contact his or her Primary Care Dentist if the Member requires Emergency Care or Urgent Care services. If a Member's Primary Care Dentist is unavailable, the Member may contact ADP's twenty-four (24)

hour answering service at 1-866- 650-3660. The on-call operator will obtain information from the Member regarding the Emergency Care and relay the information to a dental provider. This provider will then telephone the Member as soon as possible but not to exceed one (1) hour from the time of the Members call to the answering service. ADP provider will assess the Emergency and take the appropriate action.

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

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

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

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

Non-Covered Services

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

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

Follow-Up Care

After receiving any Emergency or Urgent Care services, you will need to call your

Primary Care Dentist for follow-up care.

Copayments

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

Member Liabilities

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

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

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

Grievances and Appeals Process

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

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

Grievances

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

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

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

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

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

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

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

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

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

Independent Medical Review

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

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

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

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

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If 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 (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms and instructions online.

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

Coordination of Benefits

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

Determination of primary coverage is as follows:

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

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

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

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

- When Access Dental is primary, Access Dental will pay the maximum amount

required by its contract or policy with the Member when coordinating benefits with a secondary dental benefit plan.

- When Access Dental is secondary, Access dental will pay the lesser of either the amount that we would have paid in the absence of any other dental benefit coverage or the Member's total out-of-pocket cost payable under the primary dental benefit plan for benefits covered under the secondary dental benefit plan.

Access Dental will not coordinate nor pay for the following:

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

DEFINITIONS

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

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

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

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

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

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

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

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

Access Dental Plan 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.

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THIS BENEFIT DESCRIPTION SECTION SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PROGRAM BENEFITS AND LIMITATIONS. SEE ALSO, EXCLUDED BENEFITS AND THE SCHEDULE OF BENEFITS.

Child-ONLY*	Copay
Diagnostic and Preventive Oral Exam, Preventive Cleaning, Topical Fluoride Application, Sealants per Tooth, Preventive - X-rays and Space maintainers - Fixed	$0
Basic Services Restorative Procedures, Periodontal Maintenance Services, Adult Periodontics (other than maintenance) Adult Endodontics (Group Dental Plans only)	$0-$25
Major Services Crowns & Casts, Prosthodontics, Endodontics, Periodontics (other than maintenance), and Oral Surgery	$0-$350
Orthodontia (Only for pre-authorized Medically Necessary Orthodontia)	$0-$1000
Individual Deductible (Waived for Diagnostic and Preventive)	$0
Family Deductible (two or more children) (Waived for Diagnostic and Preventive)	$0
Out of Pocket Maximum (OOP) (per person)	$350
Out of Pocket Maximum (OOP) (two or more children)	$700
Annual Maximum	None
Ortho Lifetime Maximum	None
Office Visit (Per Visit)	$0
Waiting Period	None

** Benefits are available for individuals up to*

age 19.

**Please see Schedule of Benefits for a listing of all benefits and Exclusions and Limitations.

Each individual procedure listed within each category above that is covered under the Plan has a specific Copayment, which is shown in the Schedule of Benefits along with a benefit description and limitations. The Exclusions are also listed in the Schedule of Benefits.

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.

ADA Code	ADA Code Description	In-network Member Cost Share
(D0100-D999)	**Diagnostic**	
D0120	Periodic oral evaluation - established patient	No Charge
D0140	Limited oral evaluation – problem focused	No Charge
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No Charge
D0150	Comprehensive oral evaluation – new or established patient	No Charge
D0160	Detailed and extensive oral evaluation – problem focused, by report	No Charge
D0170	Re-evaluation - limited, problem focused (established patient not post-operative visit)	No Charge
D0180	Comprehensive periodontal evaluation – new or established patient	No Charge
D0190	Screening of a patient	Not Covered
D0191	Assessment of a patient	Not Covered
D0210	Intraoral - complete series of radiographic images	No Charge
D0220	Intraoral - periapical first radiographic image	No Charge
D0230	Intraoral - periapical each additional radiographic image	No Charge
D0240	Intraoral - occlusal radiographic image	No Charge
D0250	Extraoral - first radiographic image	No Charge
D0270	Bitewing - single radiographic image	No Charge
D0272	Bitewings - two radiographic images	No Charge
D0273	Bitewings - three radiographic images	No Charge
D0274	Bitewings - four radiographic images	No Charge
D0277	Vertical bitewings – 7 to 8 radiographic images	No Charge
D0290	Posterior – anterior or lateral skull and facial bone survey radiographic image	No Charge
D0310	Sialography	No Charge
D0320	Temporomandibular joint arthrogram, including injection	No Charge
D0322	Tomographic survey	No Charge
D0330	Panoramic film	No Charge
D0340	Cephalometric radiographic image	No Charge
D0350	Oral/Facial photographic images	No Charge
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Not Covered
D0460	Pulp vitality tests	No Charge
D0470	Diagnostic casts	No Charge
D0502	Other oral pathology procedures, by report	No Charge
D0601	caries risk assessment and documentation, with a finding of low risk	No Charge
D0602	caries risk assessment and documentation, with a finding of moderate risk	No Charge
D0603	caries risk assessment and documentation, with a finding of high risk	No Charge
D0999	Unspecified diagnostic procedure, by report	No Charge
(D1000-D1999)	**Preventive**	
D1110	Prophylaxis – adult	No Charge
D1120	Prophylaxis – child	No Charge
D1206	Topical application of fluoride varnish - child 0 to 5	No Charge
D1208	Topical application of flouride varnish - child 6 to 20	No Charge
D1310	Nutritional counseling for control of dental disease	No Charge
D1320	Tobacco counseling for the control and prevention of oral disease	No Charge
D1330	Oral hygiene instructions	No Charge
D1351	Sealant - per tooth	No Charge
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No Charge
D1510	Space maintainer - fixed – unilateral	No Charge
D1515	Space maintainer - fixed – bilateral	No Charge
D1520	Space maintainer - removable - unilateral	No Charge
D1525	Space maintainer - removable - bilateral	No Charge

D1550	Recementation of space maintainer	No Charge
D1555	Removal of fixed space maintainer	No Charge
(D2000-D2999)	**Restorative**	
D2140	Amalgam - one surface, primary or permanent	$25
D2150	Amalgam - two surfaces, primary or permanent	$30
D2160	Amalgam - three surfaces, primary or permanent	$40
D2161	Amalgam - four or more surfaces, primary or permanent	$45
D2330	Resin-based composite - one surface, anterior	$30
D2331	Resin-based composite - two surfaces, anterior	$45
D2332	Resin-based composite - three surfaces, anterior	$55
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$60
D2390	Resin-based composite crown, anterior	$50
D2391	Resin-based composite – one surface, posterior	$30
D2392	Resin-based composite – two surfaces, posterior	$40
D2393	Resin-based composite – three surfaces, posterior	$50
D2394	Resin-based composite – four or more surfaces, posterior	$70
D2542	Onlay – metallic - two surfaces	Not Covered
D2543	Onlay - metallic – three surfaces	Not Covered
D2544	Onlay – metallic – four or more surfaces	Not Covered
D2642	Onlay – porcelain/ceramic – two surfaces	Not Covered
D2643	Onlay – porcelain/ceramic – three surfaces	Not Covered
D2644	Onlay – porcelain/ceramic – four or more surfaces	Not Covered
D2662	Onlay - resin-based composite - two surfaces	Not Covered
D2663	Onlay - resin-based composite - three surfaces	Not Covered
D2664	Onlay - resin-based composite - four or more surfaces	Not Covered
D2710	Crown – resin-based composite (indirect)	$140
D2712	Crown - 3/4 resin-based composite (indirect)	$190
D2720	Crown – resin with high noble metal	Not Covered
D2721	Crown – resin with predominantly base metal	$300
D2722	Crown – resin with noble metal	Not Covered
D2740	Crown – porcelain/ceramic substrate	$300
D2750	Crown - porcelain fused to high noble metal	Not Covered
D2751	Crown - porcelain fused to predominantly base metal	$300
D2752	Crown - porcelain fused to noble metal	Not Covered
D2780	Crown - 3/4 cast high noble metal	Not Covered
D2781	Crown - 3/4 cast predominantly base metal	$300
D2782	Crown - 3/4 cast noble metal	Not Covered
D2783	Crown – ¾ porcelain/ceramic	$310
D2790	Crown - full cast high noble metal	Not Covered
D2791	Crown - full cast predominantly base metal	$300
D2792	Crown - full cast noble metal	Not Covered
D2910	Recement inlay, onlay, or partial coverage restoration	$25
D2915	Recement cast or prefabricated post and core	$25
D2920	Recement crown	$25
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95
D2930	Prefabricated stainless steel crown - primary tooth	$65
D2931	Prefabricated stainless steel crown - permanent tooth	$75
D2932	Prefabricated resin crown	$75
D2933	Prefabricated stainless steel crown with resin window	$80
D2940	protective restoration	$25
D2950	Core buildup, involving any pins	$20
D2951	Pin retention - per tooth, in addition to restoration	$25

D2952	Post and core in addition to crown, indirectly fabricated	$100
D2953	Each additional indirectly fabricated post, same tooth	$30
D2954	Prefabricated post and core in addition to crown	$90
D2955	Post removal	$60
D2957	Each additional prefabricated post – same tooth	$35
D2971	Additional procedures to construct new crown under existing partial denture framework	$35
D2980	Crown repair, by report	$50
D2999	Unspecified restorative procedure, by report	$40
(D3000-D3999)	**Endodontics**	
D3110	Pulp cap - direct (excluding final restoration)	$20
D3120	Pulp cap – indirect (excluding final restoration)	$25
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction application of medicament	$40
D3221	Pulpal debridement, primary and permanent teeth	$40
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	$55
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	$55
D3310	Root canal therapy Anterior (excluding final restoration)	$195
D3320	Root canal therapy, Bicuspid tooth(excluding final restoration)	$235
D3330	Root canal therapy, Molar (excluding final restoration)	$300
D3331	Treatment of root canal obstruction; non-surgical access	$50
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$45
D3333	Internal root repair of perforation defects	$80
D3346	Retreatment of previous root canal therapy – anterior	$240
D3347	Retreatment of previous root canal therapy – bicuspid	$295
D3348	Retreatment of previous root canal therapy - molar	$365
D3351	Apexification/recalcificaion – initial visit	$85
D3352	Apexification/recalcification – interim	$45
D3353	Apexification/recalcification – final visit	Not Covered
D3410	Apicoectomy/periradicular surgery – anterior	$240
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	$250
D3425	Apicoectomy/periradicular surgery – molar (first root)	$275
D3426	Apicoectomy/periradicular surgery molar (each additional root)	$110
D3430	Retrograde filling – per root	$90
D3450	Root amputation – per root	Not Covered
D3910	Surgical procedure for isolation of tooth with rubber dam	$30
D3920	Hemisection (including any root removal; not including root canal therapy)	Not Covered
D3950	Canal prepartion and fitting of preformed dowel or post	Not Covered
D3999	Unspecified endodontic procedure, by report	$100
(D4000-D4999)	**Periodontics**	
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bound spaces per quadrant	$150
D4211	gingivectomy or gingivoplasty – one to three contiguous teeth or tooth bounded spaces per tooth	$50
D4240	Gingival flap procedure including root planing four or more teeth per quadrant	Not Covered
D4241	Gingival flap procedure including root planing one to three teeth per quadrant	Not Covered
D4249	Clinical crown lengthening – hard tissue	$165
D4260	Osseous – muco- gingival surgery per quadrant	$265
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	$140

D4263	Bone replacement graft - first site in quadrant	Not Covered
D4264	Bone replacement graft - each additional site in quadrant	Not Covered
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80
D4266	Guided tissue regeneration - resorbable barrier - per site	Not Covered
D4267	Guided tissue regeneration - non-resorbable barrier - per site (includes membrane removal)	Not Covered
D4270	Pedicle soft tissue graft procedure	Not Covered
D4273	Subepithelial connective tissue graft procedure - per tooth	Not Covered
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$55
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	$30
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$10
D4910	Periodontal maintenance	$30
D4920	Unscheduled dressing change (by someone other than treating dentist)	$15
D4999	Unspecified periodontal procedure, by report	$350
(D5000-D5899)	**Removable Prosthodontics**	
D5110	Complete denture –maxillary	$300
D5120	Complete denture – mandibular	$300
D5130	Immediate denture – maxillary	$300
D5140	Immediate denture – mandibular	$300
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$300
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$300
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including. any conventional clasps, rests and teeth)	$335
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$335
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	Not Covered
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	Not Covered
D5281	Removable unilateral partial denture – one piece cast metal (including clasps and teeth)	Not Covered
D5410	Adjust complete denture – maxillary	$20
D5411	Adjust complete denture – mandibular	$20
D5421	Adjust partial denture – maxillary	$20
D5422	Adjust partial denture – mandibular	$20
D5510	Repair broken complete denture base	$40
D5520	Replace missing or broken teeth - complete denture (each tooth)	$40
D5610	Repair resin denture base	$40
D5620	Repair cast framework	$40
D5630	Repair or replace broken clasp	$50
D5640	Replace broken teeth - per tooth	$35
D5650	Add tooth to existing partial denture	$35
D5660	Add clasp to existing partial denture	$60
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	Not Covered
D5671	Replace all teeth an acrylic on cast metal framework (mandibular)	Not Covered
D5710	Rebase complete maxillary denture	Not Covered
D5711	Rebase complete mandibular denture	Not Covered
D5720	Rebase maxillary partial denture	Not Covered
D5721	Rebase mandibular partial denture	Not Covered
D5730	Reline complete maxillary denture (chairside)	$60
D5731	Reline complete mandibular denture (chairside)	$60
D5740	Reline maxillary partial denture (chairside)	$60

D5741	Reline mandibular partial denture (chairside)	$60
D5750	Reline complete maxillary denture (laboratory)	$90
D5751	Reline complete mandibular denture (laboratory)	$90
D5760	Reline maxillary partial denture (laboratory)	$80
D5761	Reline mandibular partial denture (laboratory)	$80
D5850	Tissue conditioning, maxillary	$30
D5851	Tissue conditioning, mandibular	$30
D5862	Precision attachment, by report	$90
D5863	Overdenture – complete maxillary	$300
D5865	Overdenture – complete mandibular	$300
D5899	Unspecified removable prosthodontic procedure, by report	$350
D5911	Facial moulage (sectional)	$285
D5912	Facial moulage (complete)	$350
D5913	Nasal prosthesis	$350
D5914	Auricular prosthesis	$350
D5915	Orbital prosthesis	$350
D5916	Ocular prosthesis	$350
D5919	Facial prosthesis	$350
D5922	Nasal septal prosthesis	$350
D5923	Ocular prosthesis, interim	$350
D5924	Cranial prosthesis	$350
D5925	Facial augmentation implant prosthesis	$200
D5926	Nasal prosthesis, replacement	$200
D5927	Auricular prosthesis, replacement	$200
D5928	Orbital prosthesis, replacement	$200
D5929	Facial prosthesis, replacement	$200
D5931	Obturator prosthesis, surgical	$350
D5932	Obturator prosthesis, definitive	$350
D5933	Obturator prosthesis, modification	$150
D5934	Mandibular resection prosthesis with guide flange	$350
D5935	Mandibular resection prosthesis without guide flange	$350
D5936	Obturator prosthesis, interim	$350
D5937	Trismus appliance (not for TMD treatment)	$85
D5951	Feeding aid	$135
D5952	Speech aid prosthesis, pediatric	$350
D5953	Speech aid prosthesis, adult	$350
D5954	Palatal augmentation prosthesis	$135
D5955	Palatal lift prosthesis, definitive	$350
D5958	Palatal lift prosthesis, interim	$350
D5959	Palatal lift prosthesis, modification	$145
D5960	Speech aid prosthesis, modification	$145
D5982	Surgical stent	$70
D5983	Radiation carrier	$55
D5984	Radiation shield	$85
D5985	Radiation cone locator	$135
D5986	Fluoride gel carrier	$35
D5987	Commissure splint	$85
D5988	Surgical splint	$95
D5991	Topical Medicament Carrier	$70
D5999	Unspecified maxillofacial prosthesis, by report	$350
(D6000-D6199)	**Implant Services**	
D6010	Surgical placement of implant body: endosteal implant	$350
D6040	Surgical placement: eposteal implant	$350

D6050	Surgical placement: transosteal implant	$350
D6055	Connecting bar - implant supported or abutment supported	$350
D6056	Prefabricated abutment - includes modification and placement	$135
D6057	Custom fabricated abutment - includes placement	$180
D6058	Abutment supported porcelain/ceramic crown	$320
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300
D6062	Abutment supported cast metal crown (high noble metal)	$315
D6063	Abutment supported cast metal crown (predominantly base metal)	$300
D6064	Abutment supported cast metal crown (noble metal)	$315
D6065	Implant supported porcelain/ceramic crown	$340
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	$335
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$340
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320
D6075	Implant supported retainer for ceramic FPD	$335
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$330
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$350
D6080	Implant maintenance procedures, including removal of prosthesis, cleansing of prosthesis and abutments and reinsertion of prosthesis	$30
D6090	Repair implant supported prosthesis, by report	$65
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40
D6092	Recement implant/abutment supported crown	$25
D6093	Recement implant/abutment supported fixed partial denture	$35
D6094	Abutment supported crown (titanium)	$295
D6095	Repair implant abutment, by report	$65
D6100	Implant removal, by report	$110
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	$350
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	$350
D6112	Implant/abutment supported removable denture for partically edentulous arch - maxillary	$350
D6113	Implant/abutment supported removable denture for partically edentulous arch - mandibular	$350
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	$350
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	$350
D6116	Implant/abutment supported fixed denture for partically edentulous arch - maxillary	$350
D6117	Implant/abutment supported fixed denture for partically edentulous arch - mandibular	$350
D6190	Radiographic/Surgical implant index, by report	$75
D6194	Abutment supported retainer crown for FPD (titanium)	$265
D6199	Unspecified implant procedure, by report	$350
(D6200-D6999)	**Fixed Prosthodontics**	
D6205	Pontic - indirect resin based composite	Not Covered

D6210	Pontic - cast high noble metal	Not Covered
D6211	Pontic - cast predominantly base metal	$300
D6212	Pontic - cast noble metal	Not Covered
D6214	Pontic - cast titanium metal	Not Covered
D6240	Pontic - porcelain fused to high noble metal	Not Covered
D6241	Pontic - porcelain fused to predominantly base metal	$300
D6242	Pontic - porcelain fused to noble metal	Not Covered
D6245	Pontic - porcelain/ceramic	$300
D6250	Pontic – resin with high noble metal	Not Covered
D6251	Pontic – resin with predominantly base metal	$300
D6252	Pontic – resin with noble metal	Not Covered
D6545	Retainer - cast metal for resin bonded fixed prosthesis	Not Covered
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	Not Covered
D6608	Onlay - porcelain/ceramic - two surfaces	Not Covered
D6609	Onlay - porcelain/ceramic - three or more surfaces	Not Covered
D6610	Onlay - cast high noble metal - two surfaces	Not Covered
D6611	Onlay - cast high noble metal - three or more surfaces	Not Covered
D6612	Onlay - cast predominantly base metal - two surfaces	Not Covered
D6613	Onlay - cast predominantly base metal - three or more surfaces	Not Covered
D6614	Onlay - cast noble metal- two surfaces	Not Covered
D6615	Onlay - cast noble metal - three or more surfaces	Not Covered
D6634	Onlay – titanium	Not Covered
D6710	Crown - indirect resin based composite	Not Covered
D6720	Crown – resin with high noble metal	Not Covered
D6721	Crown – resin with predominantly base metal	$300
D6722	Crown – resin with noble metal	Not Covered
D6740	crown - porcelain/ceramic	$300
D6751	Crown – porcelain fused to predominantly base metal	$300
D6781	crown - 3/4 cast predominantly base metal	$300
D6782	crown - 3/4 cast noble metal	Not Covered
D6783	crown - 3/4 porcelain/ceramic	$300
D6791	Crown – full cast predominantly base metal	$300
D6930	Re-cement or re-bond fixed partial denture	$40
D6980	Fixed partial denture repair necessitated by restorative material failure	$95
D6999	Unspecified fixed prosthodontic procedure, by report	$350
(D7000-D7999)	**Oral and Maxillofacial Surgery**	
D7111	Extraction, coronal remnants – deciduous tooth	$40
D7140	Extraction, erupted tooth or exposed root	$65
D7210	Surgical removal of erupted tooth requiring elevation of mucoperisteal flap and removal of bone and/or section of tooth	$120
D7220	Removal of impacted tooth - soft tissue	$95
D7230	Removal of impacted tooth - partially bony	$145
D7240	Removal of impacted tooth - completely bony	$160
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175
D7250	Surgical removal of residual tooth roots (cutting procedure)	$80
D7260	Oral Antral Fistula closure	$280
D7261	Primary closure of a sinus perforation	$285
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$185
D7280	Surgical access of an unerupted tooth	$220
D7283	Placement of device to facilitate eruption of impacted tooth	$85
D7285	Biopsy of oral tissue – hard (bone, tooth)	$180
D7286	Biopsy of oral tissue – soft	$110

D7287	Exfoliative cytological sample collection	Not Covered
D7288	Brush biopsy transepithelial sample collection	Not Covered
D7290	Surgical repositioning of teeth	$185
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80
D7310	Alveoloplasty in conjunction with extractions – per quadrant	$85
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	$120
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	$65
D7340	Vestibuloplasty – ridge extension (secondary epithelialization)	$350
D7350	Vestibuloplasty – ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	$350
D7410	Excision of benign lesion up to 1.25 cm	$75
D7411	Excision of benign lesion greater than 1.25 cm	$115
D7412	Excision of benign lesion, complicated	$175
D7413	Excision of malignant lesion up to 1.25 cm	$95
D7414	Excision of malignant lesion greater than 1.25 cm	$120
D7415	Excision of malignant lesion, complicated	$255
D7440	Excision of malignant tumor – lesion diameter up to 1.25 cm	$105
D7441	Excision of malignant tumor – lesion diameter greater than 1.25 cm	$185
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40
D7471	Removal of lateral exostosis (maxilla or mandible)	$140
D7472	Removal of torus palatinus	$145
D7473	Removal of torus mandibularis	$140
D7485	Surgical reduction of osseous tuberosity	$105
D7490	Radical resection of maxilla or mandible	$350
D7510	Incision and drainage of abscess – intraoral soft tissue	$70
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated	$70
D7520	incision and drainage of abscess - extraoral soft tissue	$70
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple facial spaces)	$80
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75
D7550	Partial ostectomy /sequestrectomy for removal of non-vital bone	$125
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235
D7610	Maxilla – open reduction (teeth immobilized, if present)	$140

D7620	Maxilla – closed reduction (teeth immobilized, if present)	$250
D7630	Mandible – open reduction (teeth immobilized, if present)	$350
D7640	Mandible – closed reduction (teeth immobilized, if present)	$350
D7650	Malar and/or zygomatic arch – open reduction	$350
D7660	Malar and/or zygomatic arch – closed reduction	$350
D7670	Alveolus – closed reduction, may include stabilization of teeth	$170
D7671	Alveolus – open reduction, may include stabilization of teeth	$230
D7680	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350
D7710	Maxilla – open reduction	$110
D7720	Maxilla – closed reduction	$180
D7730	Mandible – open reduction	$350
D7740	Mandible – closed reduction	$290
D7750	Malar and/or zygomatic arch – open reduction	$220
D7760	Malar and/or zygomatic arch – closed reduction	$350
D7770	Alveolus – open reduction stabilization of teeth	$135
D7771	Alveolus, closed reduction stabilization of teeth	$160
D7780	Facial bones – complicated reduction with fixation and multiple surgical approaches	$350
D7810	Open reduction of dislocation	$350
D7820	Closed reduction of dislocation	$80
D7830	Manipulation under anesthesia	$85
D7840	Condylectomy	$350
D7850	Surgical discectomy, with/without implant	$350
D7852	Disc repair	$350
D7854	Synovectomy	$350
D7856	Myotomy	$350
D7858	Joint reconstruction	$350
D7860	Arthrostomy	$350
D7865	Arthroplasty	$350
D7870	Arthrocentesis	$90
D7871	Non-arthroscopic lysis and lavage	$150
D7872	Arthroscopy – diagnosis, with or without biopsy	$350
D7873	Arthroscopy – surgical: lavage and lysis of adhesions	$350
D7874	Arthroscopy – surgical: disc repositioning and stabilization	$350
D7875	Arthroscopy – surgical: synovectomy	$350
D7876	Arthroscopy – surgical: discectomy	$350
D7877	Arthroscopy – surgical: debridement	$350
D7880	Occlusal orthotic device, by report	$120
D7899	Unspecified TMD therapy, by report	$350
D7910	Suture of recent small wounds up to 5 cm	$35
D7911	Complicated suture – up to 5 cm	$55
D7912	Complicated suture – greater than 5 cm	$130

D7920	Skin graft (identify defect covered, location and type of graft)	$120
D7940	Osteoplasty – for orthognathic deformities	$160
D7941	Osteotomy – mandibular rami	$350
D7943	Osteotomy – mandibular rami with bone graft; includes obtaining the graft	$350
D7944	Osteotomy – segmented or subapical	$275
D7945	Osteotomy – body of mandible	$350
D7946	LeFort I (maxilla – total)	$350
D7947	LeFort I (maxilla – segmented)	$350
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) – without bone graft	$350
D7949	LeFort II or LeFort III – with bone graft	$350
D7950	Osseous, osteoperiosteal, or cartilage graft of mandible or facial bones – autogenous or nonautogenous, by report	$190
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290
D7952	Sinus augmentation with bone or bone substitute via a vertical approach	$175
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200
D7960	Frenulectomy – also known as frenectomy or frenotomy – separate procedure	$120
D7963	Frenuloplasty	$120
D7970	Excision of hyperplastic tissue - per arch	$175
D7971	Excision of pericoronal gingival	$80
D7972	Surgical reduction of fibrous tuberosity	$100
D7980	Sialolithotomy	$155
D7981	Excision of salivary gland, by report	$120
D7982	Sialodochoplasty	$215
D7983	Closure of salivary fistula	$140
D7990	Emergency tracheotomy	$350
D7991	Coronoidectomy	$345
D7995	Synthetic graft – mandible or facial bones, by report	$150
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60
D7999	Unspecified oral surgery procedure, by report	$350
(D8000-D8999)	**Orthodontics**	
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1000
D8210	Removable appliance therapy	
D8220	Fixed appliance therapy	
D8660	Pre-orthodontic treatment visit	
D8670	Periodic orthodontic treatment visit (as part of contract)	
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	
D8691	Repair of orthodontic appliance	
D8692	Replacement of lost or broken retainer	
D8693	Rebonding or recementing: and/or repair, as required, of fixed retainers	
D8999	Unspecified orthodontic procedure, by report	
(D9000-D9999)	**Adjunctive General Services**	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$30

D9120	Fixed partial denture sectioning	$95
D9210	Local anesthesia not in conjunction with outpatient surgical procedures	$10
D9211	Regional block anesthesia	$20
D9212	Trigeminal division block anesthesia	$60
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15
D9223	Deep sedation/general anesthesia - each 15 minute increment	$45
D9230	Analgesia, anxiolysis, inhalation of nitrous oxide	$15
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	$165
D9243	Intraveneous conscious sedation/analgesia - each 15 minute increment	$60
D9248	Non-intravenous conscious sedation	$65
D9310	Consultation **- (**diagnostic service provided by dentist or physician other than requesting dentist or physician)	$50
D9410	House/Extended care facility call	$50
D9420	Hospital or ambulatory surgical center call	$135
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	$20
D9440	Office visit - after regularly scheduled hours	$45
D9450	Case presentation, detailed and extensive treatment planning	Not Covered
D9610	Therapeutic parenteral drug, single administration	$30
D9612	Therapeutic parenteral drug, two or more administrations, different medications	$40
D9910	Application of desensitizing medicament	$20
D9930	treatment of complications (post-surgical) - unusual circumstances, by report	$35
D9940	Occlusal guards, by report	Not Covered
D9942	Repair and/or reline of occlusal guard	Not Covered
D9950	Occlusion analysis – mounted case	$120
D9951	Occlusal adjustment - limited	$45
D9952	Occlusal adjustment - complete	$210
D9999	unspecified adjunctive procedure, by report	$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.

You may be charged for missed appointments if you do not give the dental office 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

Diagnostic General Policies (D0100-D0999)

1. **Radiographs (D0210-D0340):**
   - **a)** According to accepted standards of dental practice, the lowest number of radiographs needed to provide the diagnosis shall be taken.
   - b) Original radiographs shall be a part of the patient's clinical record and shall be retained by the provider at all times.
   - c) Radiographs shall be considered current as follows:
     - i) radiographs for treatment of primary teeth within the last eight months.
     - ii) radiographs for treatment of permanent teeth (as well as over-retained primary teeth where the permanent tooth is congenitally missing or impacted) within the last 14 months.
     - iii) radiographs to establish arch integrity within the last 36 months.
   - d) All treatment and post treatment radiographs are included in the fee for the associated procedure and are not payable separately.
2. **Photographs (D0350):**
   - a) Photographs are a part of the patient's clinical record and the provider shall retain original photographs at all times.
   - b) Photographs shall be made available for review upon the request.
3. **Prior authorization is not required for examinations, radiographs or photographs.**

Diagnostic Procedures (D0100-D0999)

PROCEDURE D0120
PERIODIC ORAL EVALUATION - ESTABLISHED PATIENT

A benefit:

a. for patients under the age of 19.

b. once every six months, per provider.

PROCEDURE D0140
LIMITED ORAL EVALUATION - PROBLEM FOCUSED

A benefit:

a. for patients under the age of 19.

b. once per patient per provider.

PROCEDURE D0145
ORAL EVALUATION FOR A PATIENT UNDER THREE YEARS OF AGE AND COUNSELING WITH PRIMARY CAREGIVER

PROCEDURE D0150
COMPREHENSIVE ORAL EVALUATION - NEW OR ESTABLISHED PATIENT

1. A benefit once per patient per provider for the initial evaluation.

2. This procedure is not a benefit when provided on the same date of service with procedures:

   a. limited oral evaluation (D0140),

   b. detailed and extensive oral evaluation- problem focused, by report (D0160),

   c. re-evaluation-limited, problem focused (established patient; not post-operative visit) (D0170).

3. The following procedures are not a benefit when provided on the same date of service with D0150:

   a. periodic oral evaluation (D0120),

   b. office visit for observation (during regularly scheduled hours)-no other services performed (D9430).

PROCEDURE D0160
DETAILED AND EXTENSIVE ORAL EVALUATION - PROBLEM FOCUSED, BY REPORT

A benefit once per patient per provider.

a. The following procedures are not a benefit when provided on the same date of service with D0160: periodic oral evaluation(D0120),

b. limited oral evaluation-problem focused (D0140),

c. comprehensive oral evaluation- new or established patient (D0150),

d. re-evaluation-limited, problem focused (established patient; not post- operative visit) (D0170), office visit for observation (during regularly scheduled hours-no other services performed (D9430)**.**

PROCEDURE D0170
RE-EVALUATION – LIMITED, PROBLEM FOCUSED (ESTABLISHED PATIENT; NOT POST-OPERATIVE VISIT)

A benefit for the ongoing symptomatic care of temporomandibular joint dysfunction:

a. up to six times in a three month period.

b. up to a maximum of 12 in a 12-month period.

PROCEDURE D0180
COMPREHENSIVE PERIODONTAL EVALUATION - NEW OR ESTABLISHED PATIENT

PROCEDURE D0210
INTRAORAL - COMPLETE SERIES OF RADIOGRAPHIC IMAGES

A benefit once per provider every 36 months.

PROCEDURE D0220
INTRAORAL - PERIAPICAL FIRST RADIOGRAPHIC IMAGE

PROCEDURE D0230
PROCEDURE INTRAORAL - PERIAPICAL EACH ADDITIONAL RADIOGRAPHIC IMAGE

A benefit to a maximum of 20 periapicals in a 12- month period to the same provider, in any combination of the following: intraoral- periapical first radiographic image (D0220) and intraoral- periapical each additional radiographic image (D0230). Periapicals taken as part of an intraoral complete series of radiographic images (D0210) are not considered against the maximum of 20 periapical films in a 12 month period.

PROCEDURE D0240
INTRAORAL - OCCLUSAL RADIOGRAPHIC IMAGE

A benefit up to a maximum of two in a six-month period per provider.

PROCEDURE D0250 EXTRAORAL - FIRST RADIOGRAPHIC IMAGE

A benefit once per date of service.

PROCEDURE D0270 BITEWING - SINGLE RADIOGRAPHIC IMAGE

1. A benefit once per date of service.
2. Not a benefit for a totally edentulous area.

PROCEDURE D0272 BITEWINGS - TWO RADIOGRAPHIC IMAGES

1. A benefit once every six months per provider.
2. Not a benefit:
   a. within six months of intraoral-complete series of radiographic images (D0210), same provider.
   b. for a totally edentulous area.

PROCEDURE D0273 BITEWINGS - THREE RADIOGRAPHIC IMAGES

PROCEDURE D0274 BITEWINGS - FOUR RADIOGRAPHIC IMAGES

1. A benefit once every six months per provider.
2. Not a benefit:
   a. within six months of intraoral-complete series of radiographic images (D0210), same provider.
   b. for patients under the age of 10
   c. for a totally edentulous area.

PROCEDURE D0277

VERTICAL BITEWINGS - 7 TO 8 RADIOGRAPHIC IMAGES

This procedure can only be billed as bitewings-four radiographic images (D0274). The maximum payment is for four bitewings.

PROCEDURE D0290 POSTERIOR - ANTERIOR OR LATERAL SKULL AND FACIAL BONE SURVEY RADIOGRAPHIC IMAGE

A benefit:

a. for the survey of trauma or pathology.

b. for a maximum of three per date of service.

PROCEDURE D0310 SIALOGRAPHY

PROCEDURE D0320 TEMPOROMANDIBULAR JOINT ARTHROGRAM, INCLUDING INJECTION

A benefit:

a. for the survey of trauma or pathology.

b. for a maximum of three per date of service.

PROCEDURE D0322 TOMOGRAPHIC SURVEY

A benefit twice in a 12 month period per provider.

PROCEDURE D0330 PANORAMIC RADIOGRAPHIC IMAGE

1. A benefit once in a 36-month period per provider, except when documented as essential for a follow-up/ post-operative exam (such as after oral surgery).
2. Not a benefit, for the same provider, on the same date of service as an intraoral- complete series of radiographic images (D0210).
3. This procedure shall be considered part of an intraoral- complete series of radiographic images (D0210) when taken on the same date of service with bitewings (D0272 or D0274) and a minimum of two (2) intraoral-periapicals each additional radiographic image (D0230).

PROCEDURE D0340 CEPHALOMETRIC RADIOGRAPHIC IMAGE

A benefit twice in a 12-month period per provider.

PROCEDURE D0350 ORAL/FACIAL PHOTOGRAPHIC IMAGES

A benefit up to a maximum of four per date of service.

PROCEDURE D0460 PULP VITALITY TESTS

PROCEDURE D0470 DIAGNOSTIC CASTS

1. Diagnostic casts are for the evaluation of orthodontic benefits only.
2. Diagnostic casts are required to be submitted for orthodontic evaluation and are payable only upon authorized orthodontic treatment. Do not send original casts, as casts will not be returned.
3. A benefit:
   a. once per provider unless special circumstances are

documented (such as trauma or pathology which has affected the course of orthodontic treatment).

b. for patients under the age of 19.

c. for permanent dentition (unless over the age of 13 with primary teeth still present or has a cleft palate or craniofacial anomaly).

d. only when provided by a Specialty Care orthodontist.

PROCEDURE D0502 OTHER ORAL PATHOLOGY PROCEDURES BY REPORT

PROCEDURE D0601 CARIES RISK ASSESSMENT AND DOCUMENTATION< WITH A FINDING OF LOW RISK

PROCEDURE D0602 CARIES RISK ASSESSMENT AND DOCUMENTATION< WITH A FINDING OF MODERATE RISK

PROCEDURE D0603 CARIES RISK ASSESSMENT AND DOCUMENTATION< WITH A FINDING OF HIGH RISK

PROCEDURE D0999 UNSPECIFIED DIAGNOSTIC PROCEDURE, BY REPORT

Preventive General Policies (D1000-D1999)

1. **Dental Prophylaxis and Fluoride Treatment (D1110-D1208):**

   a. Dental prophylaxis (D1110 and D1120) is defined as the preventive dental procedure of coronal scaling and polishing which includes the complete removal of calculus, soft deposits, plaque, stains and smoothing of unattached tooth surfaces.

   b. Fluoride treatment (D1206 and D1208) is a benefit only for prescription strength fluoride products.

   c. Fluoride treatments do not include treatments that incorporate fluoride with prophylaxis paste, topical application of fluoride to the prepared portion of a tooth prior to restoration and applications of aqueous sodium fluoride.

   d. The application of fluoride is only a benefit for caries control and as a full mouth treatment regardless of the number of teeth treated.

   e. Prophylaxis and fluoride procedures (D1120, D1206 and D1208) are a benefit once in a six-month period without prior authorization under the age of 19

   f. Prophylaxis and fluoride procedures (D1110, D1206 and D1208) are a benefit once in a 12-month period without prior authorization for age 19 or older.

   g. Additional requests, beyond the stated frequency limitations, for prophylaxis and fluoride procedures (D1110, D1120, D1206 and D1208) shall be considered for prior authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.

Preventive Procedures (D1000-D1999)

PROCEDURE D1110
PROPHYLAXIS - ADULT

A benefit once in a 12-month period for patients age 19 or older. Frequency limitations shall apply toward prophylaxis procedure D1120.

PROCEDURE D1120
PROPHYLAXIS - CHILD

A benefit once in a six- month period for patients under the age of 19.

PROCEDURE D1206
TOPICAL APPLICATION OF FLUORIDE VARNISH

A benefit:

a. once in a six month period for patients under the age of 19. Frequency limitations shall apply toward topical application of fluoride(D1208).

b. once in a 12 month period for patients age 19 or older. Frequency limitations shall apply toward topical application of fluoride(D1208).

PROCEDURE D1208
TOPICAL APPLICATION OF FLUORIDE

A benefit:

a. once in a six month period for patients under the age of 19. Frequency limitations shall apply toward topical application of fluoride varnish (D1206).

b. once in a 12 month period for patients age 19 or older. Frequency limitations shall apply toward topical application of fluoride varnish (D1206).

PROCEDURE D1310
NUTRITIONAL COUNSELING FOR CONTROL OF DENTAL DISEASE

PROCEDURE D1320
TOBACCO COUNSELING FOR THE CONTROL AND PREVENTION OF ORAL DISEASE

PROCEDURE D1330
ORAL HYGIENE INSTRUCTIONS

PROCEDURE D1351
SEALANT - PER TOOTH

A benefit:

a. for first, second and third permanent molars that occupy the second molar position.

b. only on the occlusal surfaces that are free of decay and/or restorations.

c. for patients under the age of 19.

d. once per tooth every 36 months per provider regardless of surfaces sealed.

PROCEDURE D1352
PREVENTIVE RESIN RESTORATIONIN A MODERATE TO HIGH CARIES RISK PATIENT-PERMANENT TOOTH

A benefit:

a. for first, second and third permanent molars that occupy the second molar position.

b. only for an active cavitated lesion in a pit or fissure that does not cross the DEJ.

c. for patients under the age of 19.

d. once per tooth every 36 months per provider regardless of surfaces sealed.

2. **PROCEDURE D1510**
3. **SPACE MAINTAINER - FIXED UNILATERAL**

1. A benefit:

a. once per quadrant per patient.

b. for patients under the age of 18.

c. only to maintain the space for a single tooth.

2. Not a benefit:

a. when the permanent tooth is near eruption or is missing.

b. for upper and lower anterior teeth.

c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.

PROCEDURE D1515
SPACE MAINTAINER - FIXED - BILATERAL

1. A benefit:

once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant for patients under the age of 18.

2. Not a benefit:

a. when the permanent tooth is near eruption or is missing.

b. for upper and lower anterior teeth.

c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.

PROCEDURE D1520
SPACE MAINTAINER - REMOVABLE - UNILATERAL

1. A benefit:

   a. once per quadrant per patient.

   b. for patients under the age of 18.

   c. only to maintain the space for a single tooth.

2. Not a benefit:

   a. when the permanent tooth is near eruption or is missing.

   b. for upper and lower anterior teeth.

   c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.

PROCEDURE D1525
SPACE MAINTAINER - REMOVABLE - BILATERAL

1. A benefit:

   a. once per arch when there is a missing primary molar in both quadrants or when there are two missing primary molars in the same quadrant.

   b. for patients under the age of 18.

2. Not a benefit:

   a. when the permanent tooth is near eruption or is missing.

   b. for upper and lower anterior teeth.

   c. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.

PROCEDURE D1550
RECEMENTATION OF SPACE MAINTAINER

A benefit:

a. once per provider, per applicable quadrant or arch.

b. for patients under the age of 18.

PROCEDURE D1555
REMOVAL OF FIXED SPACE MAINTAINER

Restorative General Policies (D2000-D2999)

1. **Amalgam and Resin-Based Composite Restorations (D2140-D2394):**

   a) Restorative services shall be a benefit when medically necessary, when carious activity or fractures have extended through the dentinoenamel junction (DEJ) and when the tooth demonstrates a reasonable longevity.

   b) Anterior proximal restorations (amalgam/composite) submitted as a two or three surface restoration shall be clearly demonstrated on radiographs that the tooth structure is involved to a point one-third the mesial–distal width of the tooth.

   c) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.

   d) Restorative services are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

   e) Restorations for primary teeth near exfoliation are not a benefit.

   f) The five valid tooth surface classifications are mesial, distal, occlusal/incisal, lingual and facial (including buccal and labial).

   g) Each separate non-connecting restoration on the same tooth for the same date of service shall be submitted on separate Claim Service Lines (CSLs). All surfaces on a single tooth restored with the same restorative material shall be considered connected, for payment purposes, if performed on the same date of service.

   h) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, bonding agents, lining agents, occlusal adjustments (D9951), polishing, local anesthesia and any other associated procedures are included in the fee for a completed restorative service.

   i) The original provider is responsible for any replacement restorations necessary in primary teeth within the first 12 months and permanent teeth within the first 36 months, except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits).

   j) Replacement of otherwise satisfactory amalgam restorations with resin-based composite restorations is not a benefit unless a specific allergy has been documented by a medical specialist (allergist) on their professional letterhead or prescription and submitted for payment.

2. **Prefabricated Crowns (D2929-D2933):**

   A) Primary Teeth:

      a) Prefabricated crowns (D2929, D2930, D2932 and D2933) are a benefit only once in a 12-month period.

      b) Primary teeth do not require prior authorization. At least one of the following criteria shall be met for coverage:

         i. decay, fracture or other damage involving three or more tooth surfaces,

         ii. decay, fracture or other damage involving one interproximal surface when the damage has extended extensively buccolingually or mesiodistally,

      c) Prefabricated crowns for primary teeth near exfoliation are not a benefit.

   B) Permanent Teeth:

      a) Prefabricated crowns (D2931, D2932 and D2933) are a benefit only once in a 36-month period.

b) Permanent teeth do not require prior authorization. At least one of the following criteria shall be met for coverage:

i. Anterior teeth shall show traumatic or pathological destruction of the crown of the tooth which involves four or more tooth surfaces including at least the loss of one incisal angle,

ii. bicuspids (premolars) shall show traumatic or pathological destruction of the crown of the tooth which involves three or more tooth surfaces including at least one cusp,

iii. molars shall show traumatic or pathological destruction of the crown of the tooth which involves four or more tooth surfaces including at least two cusps,

iv. the prefabricated crown shall restore an endodontically treated bicuspid or molar tooth.

v. Arch integrity and the overall condition of the mouth, including the patient's ability to maintain oral health, shall be considered based upon a supportable 36-month prognosis for the permanent tooth to be crowned.

vi. Indirectly fabricated or prefabricated posts (D2952 and D2954) are benefits when medically necessary for the retention of prefabricated crowns on root canal treated permanent teeth.

vii. Prefabricated crowns on root canal treated teeth shall be considered for payment only after satisfactory completion of root canal therapy.

viii. Prefabricated crowns are not a benefit for abutment teeth for cast metal framework partial dentures (D5213 and D5214).

C) Primary and Permanent Teeth:

i. Prefabricated crowns provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.

ii. Prefabricated crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

iii. Prefabricated crowns are not a benefit when a tooth can be restored with an amalgam or resin-based composite restoration.

iv. Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, occlusal adjustments (D9951), local anesthesia (D9210) and any other associated procedures are included in the fee for a prefabricated crown.

3. Laboratory Processed Crowns (D2710-D2792):

a) Laboratory processed crowns on permanent teeth (or over-retained primary teeth with no permanent successor) are a benefit only once in a 5 year period except when failure or breakage results from circumstances beyond the control of the provider (such as due to a patient's oral habits).

b) A benefit for patients age 13 or older when a lesser service will not suffice because of extensive coronal destruction.

i) Anterior teeth shall show traumatic or pathological destruction to the crown of the tooth, which involves at least one of the following:

a. the involvement of four or more surfaces including at least one incisal angle. The facial or lingual surface shall not be considered involved for a mesial or proximal restoration unless the proximal restoration wraps around the tooth to at least the midline,

b. the loss of an incisal angle which involves a minimum area of both half the incisal width and half the height of the anatomical crown,

c. an incisal angle is not involved but more than 50% of the anatomical crown is involved

ii) Bicuspids (premolars) shall show traumatic or pathological destruction of the crown of the tooth, which involves three or more tooth surfaces including one cusp.

iii) Molars shall show traumatic or pathological destruction of the crown of the tooth, which involves four or more tooth surfaces including two or more cusps.

iv) Posterior crowns for patients age 19 or older are a benefit only when they act as an abutment for a removable partial denture with cast clasps or rests (D5213 and D5214) or for a fixed partial denture which meets current criteria.

c) Restorative services provided solely to replace tooth structure lost due to attrition, abrasion, erosion or for cosmetic purposes are not a benefit.

d) Laboratory crowns are not a benefit when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

e) Laboratory processed crowns are not a benefit when the tooth can be restored with an amalgam or resin-based composite.

f) Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, lining agents, impressions, temporary crowns, occlusal adjustments (D9951), polishing, local anesthesia (D9210) and any other associated procedures are included in the fee for a completed laboratory processed crown.

g) Indirectly fabricated or prefabricated posts (D2952 and D2954) are a benefit when medically necessary for the retention of allowable laboratory processed crowns on root canal treated permanent teeth.

h) Partial payment will not be made for an undelivered laboratory processed crown. Payment shall be made only upon final cementation

Restorative Procedures (D2000-D2999)

PROCEDURE D2140 AMALGAM - ONE SURFACE, PRIMARY OR PERMANENT

Primary teeth:

A benefit once in a 12- month period.

Permanent teeth:

A benefit once in a 36- month period.

PROCEDURE D2150 AMALGAM - TWO SURFACES, PRIMARY OR PERMANENT

See the criteria under Procedure D2140.

PROCEDURE D2160 AMALGAM - THREE SURFACES, PRIMARY OR PERMANENT

See the criteria under Procedure D2140.

PROCEDURE D2161 AMALGAM - FOUR OR MORE SURFACES, PRIMARY OR PERMANENT

See the criteria under Procedure D2140

PROCEDURE D2330 RESIN-BASED COMPOSITE - ONE SURFACE, ANTERIOR

Primary teeth:
A benefit once in a 12-month period.

Permanent teeth:
A benefit once in a 36-month period.

PROCEDURE D2331 RESIN-BASED COMPOSITE - TWO SURFACES, ANTERIOR

Primary teeth:

A benefit once in a 12- month period.

Permanent teeth:

A benefit once in a 36-month period

PROCEDURE D2332 RESIN-BASED COMPOSITE - THREE SURFACES, ANTERIOR

See the criteria under Procedure D2331.

PROCEDURE D2335 RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES OR INVOLVING INCISAL ANGLE (ANTERIOR)

See the criteria under Procedure D2331.

PROCEDURE D2390 RESIN-BASED COMPOSITE CROWN, ANTERIOR

Primary teeth:

A benefit once in a 12- month period.

Permanent teeth:

A benefit once in a 36 month period.

PROCEDURE D2391 RESIN-BASED COMPOSITE - ONE SURFACE, POSTERIOR

Primary teeth:

1. A benefit once in a 12- month period.

Permanent teeth:

2. A benefit once in a 36- month period.

PROCEDURE D2392 RESIN-BASED COMPOSITE - TWO SURFACES, POSTERIOR

See the criteria under Procedure D2391.

PROCEDURE D2393 RESIN-BASED COMPOSITE - THREE SURFACES, POSTERIOR

See the criteria under Procedure D2391.

A benefit once in a 36-month period.

PROCEDURE D2394 RESIN-BASED COMPOSITE - FOUR OR MORE SURFACES, POSTERIOR

See the criteria under Procedure D2391.

PROCEDURE D2710 CROWN – RESIN– BASED COMPOSITE (INDIRECT)

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 19):

1. A benefit:
   a. once in a five-year period.
   b. for any resin based composite crown that is indirectly fabricated.
2. Not a benefit:
   a. for patients under the age of 13.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
3. for use as a temporary crown.

Permanent posterior teeth (age 19 or older):

A benefit:

a. once in a five-year period.

b. for any resin based

composite crown that is indirectly fabricated.

c. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

d. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214).

Not a benefit:

e. for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

f. for use as a temporary crown.

PROCEDURE D2712 CROWN – 3/4 RESIN- BASED COMPOSITE (INDIRECT)

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 19):

1. A benefit:
   a. once in a five-year period.
   b. for any resin based composite crown that is indirectly fabricated.
2. Not a benefit:
   a. for patients under the age of 13.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.
   c. for use as a temporary crown.

Permanent posterior teeth (age 19 or older):

1. A benefit:
   a. once in a five-year period.
   b. for any resin based composite crown that is indirectly fabricated.
   c. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
2. Not a benefit:
   a. for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.
   b. for use as a temporary crown.

PROCEDURE D2721 CROWN - RESIN WITH PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 19):

1. A benefit once in a five- year period.
2. Not a benefit:
   a. for patients under the age of 13.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 21 or older):

1. A benefit:
   a. once in a five-year period.
   b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or
2. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2740 CROWN - PORCELAIN/CERAMIC SUBSTRATE

Permanent anterior teeth

(age 13 or older) and permanent posterior teeth

(ages 13 through 19):

1. A benefit once in a five- year period.
2. Not a benefit:
   a. for patients under the age of 13.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 19 or older):

1. A benefit:

a. once in a five-year period.

b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

2. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2751 CROWN - PORCELAIN FUSED TO PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 19):

1. A benefit once in a five- year period.
2. Not a benefit:

a. for beneficiaries under the age of 13.

b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 19 or older):

1. A benefit:

a. once in a five-year period.

b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

c. when the treatment plan includes an abutment crown and removable partial denture (D5213 or D5214).

2. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2781 CROWN - 3/4 CAST PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 19):

1. A benefit once in a five- year period.
2. Not a benefit:

a. for patients under the age of 13.

b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 21 or older):

1. A benefit:

a. once in a five- year period.

b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

2. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2783 CROWN - 3/4 PORCELAIN / CERAMIC

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 19):

1. A benefit once in a five-year period.
2. Not a benefit:

a. for patients under the age of 13.

b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 19 or older):

1. A benefit:

a. once in a five- year period.

b. only for the treatment of posterior teeth acting as an abutment for an existing removable partial denture with cast clasps or rests (D5213 and D5214), or

2. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable

partial denture with cast clasps or rests.

PROCEDURE D2791 CROWN - FULL CAST PREDOMINANTLY BASE METAL

Permanent anterior teeth (age 13 or older) and permanent posterior teeth (ages 13 through 19):

1. A benefit once in a five- year period.
2. Not a benefit:
   a. for patients under the age of 13.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing removable partial denture with cast clasps or rests.

Permanent posterior teeth (age 19 or older):

1. A benefit:
   a. once in a five-year period.
2. Not a benefit for 3rd molars, unless the 3rd molar is an abutment for an existing removable partial denture with cast clasps or rests.

PROCEDURE D2910 RECEMENT INLAY, ONLAY, OR PARTIAL COVERAGE RESTORATION

1. A benefit once in a 12-month period, per provider.

PROCEDURE D2915 RECEMENT CAST OR PREFABRICATED POST AND CORE

PROCEDURE D2920 RECEMENT CROWN

Not a benefit within 12 months of a previous re-cementation by the same provider.

PROCEDURE D2929 PREFABRICATED PORCELAIN/ CERAMIC CROWN - PRIMARY TOOTH

A benefit once in a 12- month period.

PROCEDURE D2930 PREFABRICATED STAINLESS STEEL CROWN - PRIMARY TOOTH

A benefit once in a 12- month period.

PROCEDURE D2931 PREFABRICATED STAINLESS STEEL CROWN - PERMANENT TOOTH

1. A benefit once in a 36-month period.
2. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D2932 PREFABRICATED RESIN CROWN

Primary teeth:

1. A benefit once in a 12- month period.

Permanent teeth:

2. A benefit once in a 36- month period.
3. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D2933 PREFABRICATED STAINLESS STEEL CROWN WITH RESIN WINDOW

Primary teeth:

1. A benefit once in a 12-month period.
2. This procedure includes the placement of a resin-based composite.

Permanent teeth:

1. A benefit once in a 36-month period.
2. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position.
3. This procedure includes the placement of a resin-based composite.

PROCEDURE D2940 PROTECTIVE RESTORATION

1. A benefit once per tooth in a six-month period, per provider.
2. Not a benefit:
   a. when performed on the same date of service with a permanent restoration or crown, for same tooth.
   b. on root canal treated teeth.

PROCEDURE D2950 CORE BUILDUP, INCLUDING ANY PINS

This procedure is included in the fee for restorative procedures and is not payable separately.

PROCEDURE D2951 PIN RETENTION - PER TOOTH, IN ADDITION TO RESTORATION

A benefit:

a. for permanent teeth only.
b. when billed with an amalgam or composite

restoration on the same date of service.

c. once per tooth regardless of the number of pins placed.

d. for a posterior restoration when the destruction involves three or more connected surfaces and at least one cusp, or

e. for an anterior restoration when extensive coronal destruction involves the incisal angle.

PROCEDURE D2952 POST AND CORE IN ADDITION TO CROWN, INDIRECTLY FABRICATED

A benefit:

a. once per tooth regardless of number of posts placed.

b. only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.

PROCEDURE D2953 EACH ADDITIONAL INDIRECTLY FABRICATED POST - SAME TOOTH

This procedure is to be performed in conjunction with D2952

PROCEDURE D2954 PREFABRICATED POST AND CORE IN ADDITION TO CROWN

A benefit:

a. once per tooth regardless of number of posts placed.

b. only in conjunction with allowable crowns (prefabricated or laboratory processed) on root canal treated permanent teeth.

PROCEDURE D2955 POST REMOVAL

This procedure is included in the fee for endodontic and restorative procedures and is not payable separately.

PROCEDURE D2957 EACH ADDITIONAL PREFABRICATED POST - SAME TOOTH

This procedure is to be performed in conjunction with D2954 and is not payable separately.

PROCEDURE D2971 ADDITIONAL PROCEDURES TO CONSTRUCT NEW CROWN UNDER EXISTING PARTIAL DENTURE FRAMEWORK

This procedure is included in the fee for laboratory processed crowns and is not payable separately.

PROCEDURE D2980 CROWN REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE

Not a benefit within 12 months of initial crown placement or previous repair for the same provider.

PROCEDURE D2999 UNSPECIFIED RESTORATIVE PROCEDURE, BY REPORT

1. This procedure does not require prior authorization.
2. Procedure D2999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Endodontic General Policies (D3000-D3999)

a) Prior authorization with current periapical radiographs is required for initial root canal therapy (D3310, D3320 and D3330), root canal retreatment (D3346, D3347 and D3348), partial pulpotomy for apexogenesis (D3222), apexification/recalcification (D3351) and apicoectomy/periradicular surgery (D3410, D3421, D3425 and D3426) on permanent teeth.

b) Root canal therapy (D3310, D3320, D3330, D3346, D3347 and D3348) is a benefit for permanent teeth and over-retained primary teeth with no permanent successor, if medically necessary. It is medically necessary when the tooth is non-vital (due to necrosis, gangrene or death of the pulp) or if the pulp has been compromised by caries, trauma or accident that may lead to the death of the pulp.

c) Endodontic procedures are not a benefit when the prognosis of the tooth is questionable (due to non- restorability or periodontal involvement).

d) Endodontic procedures are not a benefit when extraction is appropriate for a tooth due to non-restorability, periodontal involvement or for a tooth that is easily replaced by an addition to an existing or proposed prosthesis in the same arch.

e) Endodontic procedures are not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar positions or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

f) The fee for endodontic procedures includes all treatment and post treatment radiographs, any temporary restorations and/or occlusal seals, medicated treatments, bacteriologic studies, pulp vitality tests, removal of root canal obstructions (such as posts, silver points, old root canal filling material, broken root canal files and broaches and calcifications), internal root repairs of perforation defects and routine postoperative care within 30 days.

g) Endodontic procedures shall be completed prior to payment. The date of service on the payment request shall reflect the final treatment date.

h) Satisfactory completion of endodontic procedures is required prior to requesting the final restoration.

Endodontic Procedures (D3000-D3999)

PROCEDURE D3110 PULP CAP - DIRECT (EXCLUDING FINAL RESTORATION)

PROCEDURE D3120 PULP CAP - INDIRECT (EXCLUDING FINAL RESTORATION)

PROCEDURE D3220 THERAPEUTIC PULPOTOMY (EXCLUDING FINAL RESTORATION) - REMOVAL OF PULP CORONAL TO THE DENTINOCEMENTAL JUNCTION AND APPLICATION OF MEDICAMENT

1. A benefit once per primary tooth.
2. Not a benefit:
   a. for a primary tooth near exfoliation.
   b. for a primary tooth with a necrotic pulp or a periapical lesion.
   c. for a primary tooth that is non-restorable.
   d. for a permanent tooth.

PROCEDURE D3221 PULPAL DEBRIDEMENT, PRIMARY AND PERMANENT TEETH

A benefit:

a. for permanent teeth.
b. for over-retained primary teeth with no permanent successor.
c. once per tooth.

PROCEDURED3222 PARTIAL PULPOTOMY FOR APEXOGENESIS- PERMANENT TOOTH WITH INCOMPLETE ROOT DEVELOPMENT

1. A benefit:
   a. once per permanent tooth.
   b. for patients under the age of 19.
2. Not a benefit:
   a. for primary teeth.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

PROCEDURE D3230 PULPAL THERAPY (RESORBABLE FILLING) - ANTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)

1. A benefit once per primary tooth.
2. Not a benefit:
   a. for a primary tooth near exfoliation.
   b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth.
   c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.

PROCEDURE D3240 PULPAL THERAPY (RESORBABLE FILLING) - POSTERIOR, PRIMARY TOOTH (EXCLUDING FINAL RESTORATION)

1. A benefit once per primary tooth.
2. Not a benefit:
   a. for a primary tooth near exfoliation.
   b. with a therapeutic pulpotomy (excluding final restoration) (D3220), same date of service, same tooth.
   c. with pulpal debridement, primary and permanent teeth (D3221), same date of service, same tooth.

PROCEDURE D3310 ENDODONTIC THERAPY, ANTERIOR TOOTH (EXCLUDING FINAL RESTORATION)

1. A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-anterior (D3346).
2. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3320 ENDODONTIC THERAPY, BICUSPID TOOTH (EXCLUDING FINAL RESTORATION)

A benefit once per tooth for initial root canal therapy treatment. For root canal therapy retreatment use retreatment of previous root canal therapy-bicuspid

(D3347).

The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3330 ENDODONTIC THERAPY, MOLAR TOOTH (EXCLUDING FINAL RESTORATION)

1. A benefit once per tooth for initial root canal therapy treatment.
2. Not a benefit for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
3. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3331 TREATMENT OF ROOT CANAL OBSTRUCTION; NON-SURGICAL ACCESS

This procedure is to be performed in conjunction with endodontic procedures and is not payable separately.

PROCEDURE D3332 INCOMPLETE ENDODONTIC THERAPY; INOPERABLE, UNRESTORABLE OR FRACTURED TOOTH

Endodontic treatment is only payable upon successful completion of endodontic therapy.

PROCEDURE D3333 INTERNAL ROOT REPAIR OF PERFORATION DEFECTS

This procedure is to be performed in conjunction with endodontic procedures and is not payable separately.

PROCEDURE D3346 RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - ANTERIOR

1. Not a benefit to the original provider within 12 months of initial treatment.
2. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3347 RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - BICUSPID

1. Not a benefit to the original provider within 12 months of initial treatment.
2. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3348 RETREATMENT OF PREVIOUS ROOT CANAL THERAPY - MOLAR

1. Not a benefit:
   a. to the original provider within 12 months of initial treatment.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
2. The fee for this procedure includes all treatment and post treatment radiographs, any temporary restoration and/or occlusal seal.

PROCEDURE D3351 APEXIFICATION/ RECALCIFICATION/PULPAL REGENERATION - INITIAL VISIT (APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, PULP SPACE DISINFECTION ETC.)

1. A benefit:
   a. once per permanent tooth.
   b. for patients under the age of 19.
2. Not a benefit:
   a. for primary teeth.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
   c. on the same date of service as any other endodontic procedures for the same tooth.
3. This procedure includes initial opening of the

tooth, performing a pulpectomy, preparation of canal spaces, placement of medications and all treatment and post treatment radiographs.

PROCEDURE D3352 APEXIFICATION/ RECALCIFICATION/PULPAL REGENERATION - INTERIM MEDICATION REPLACEMENT

1. A benefit:
   a. only following apexification/ recalcification- initial visit (apical closure/ calcific repair of perforations, root resorption, etc.) (D3351).
   b. once per permanent tooth.
   c. for patients under the age of 19.
2. Not a benefit:
   a. for primary teeth.
   b. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
   c. on the same date of service as any other endodontic procedures for the same tooth.
3. This procedure includes reopening the tooth, placement of medications and all treatment and post treatment radiographs.

PROCEDURE D3353 APEXIFICATION/ RECALCIFICATION - FINAL VISIT (INCLUDES COMPLETED ROOT CANAL THERAPY - APICAL CLOSURE/CALCIFIC REPAIR OF PERFORATIONS, ROOT RESORPTION, ETC.)

This procedure is not a benefit.

PROCEDURE D3410 APICOECTOMY/ PERIRADICULAR SURGERY - ANTERIOR

1. A benefit for permanent anterior teeth only.
2. Not a benefit:
   a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
   b. to the original provider within 24 months of a prior apicoectomy/ periradicular surgery.

PROCEDURE D3421 APICOECTOMY/ PERIRADICULAR SURGERY - BICUSPID (FIRST ROOT)

1. A benefit for permanent bicuspid teeth only.
2. Not a benefit:
   a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
   b. to the original provider within 24 months of a prior apicoectomy/ periradicular surgery, same root.

PROCEDURE D3425 APICOECTOMY/ PERIRADICULAR SURGERY - MOLAR (FIRST ROOT)

1. Requires a tooth code.
2. A benefit for permanent 1st and 2nd molar teeth only.
3. Not a benefit:
   a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
   b. to the original provider within 24 months of a prior apicoectomy/ periradicular surgery, same root.
   c. for 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

PROCEDURE D3426 APICOECTOMY/ PERIRADICULAR SURGERY (EACH ADDITIONAL ROOT)

1. A benefit for permanent teeth only.
2. Not a benefit:
   a. to the original provider within 90 days of root canal therapy except when a medical necessity is documented.
   b. to the original provider within 24 months of a prior apicoectomy/ periradicular surgery, same root.
   c. for 3rd molars, unless the 3rd molar occupies the

1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.

PROCEDURE D3430 RETROGRADE FILLING - PER ROOT

This procedure is to be performed in conjunction with endodontic procedures and is not payable separately.

PROCEDURE D3910 ISOLATION OF TOOTH WITH RUBBER DAM

This procedure is included in the fees for restorative and endodontic procedures and is not payable separately.

PROCEDURE D3999 UNSPECIFIED ENDODONTIC PROCEDURE, BY REPORT

Procedure D3999 shall be used:

a. for a procedure which is not adequately described by a CDT code, or
b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Periodontal General Policies (D4000-D4999)

a. Periodontal procedures shall be a benefit for patients age 13 or older. Periodontal procedures shall be considered for patients under the age of 13 when unusual circumstances exist such as aggressive periodontitis and drug-induced hyperplasia and the medical necessity has been fully documented.

b. Prior authorization is required for all periodontal procedures except for unscheduled dressing change (by someone other than the treating dentist) (D4290) and periodontal maintenance (D4910).

c. Only teeth that qualify as diseased are to be considered in the count for the number of teeth to be treated in a particular quadrant. A qualifying tooth shall have a significant amount of bone loss, presence of calculus deposits, be restorable and have arch integrity. Qualifying teeth include implants. Teeth shall not be counted as qualifying when they are indicated to be extracted. Full or partial quadrants are defined as follows:

   i) a full quadrant is considered to have four or more qualifying diseased teeth,

   ii) a partial quadrant is considered to have one, two, or three diseased teeth,

   iii) third molars shall not be counted unless the third molar occupies the first or second molar position or is an abutment for an existing fixed or removable partial denture with cast clasps or rests.

d. Tooth bounded spaces shall only be counted in conjunction with osseous surgeries (D4260 and D4261) that require a surgical flap. Each tooth bounded space shall only count as one tooth space regardless of the number of missing natural teeth in the space.

e. Scaling and root planing (D4341 and D4342) are a benefit once per quadrant in a 24 month period. Patients shall exhibit connective tissue attachment loss and radiographic evidence of bone loss and/or subgingival calculus deposits on root surfaces.

f. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) are a benefit once per quadrant in a 36 month period and shall not be authorized until 30 days following scaling and root planing (D4341 and D4342) in the same quadrant. Patients shall exhibit radiographic evidence of moderate to severe bone loss to qualify for osseous surgery.

g. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes three months of post-operative care and any surgical re-entry for 36 months. Documentation of extraordinary circumstances and/or medical conditions will be given consideration on a case-by- case basis.

h. Scaling and root planing (D4341 and D4342) can be authorized in conjunction with prophylaxis procedures (D1110 and D1120). However, payment shall not be made for any prophylaxis procedure if the prophylaxis is performed on the same date of service as the scaling and root planing.

i. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) includes frenulectomy (frenectomy or frenotomy) (D7960), frenuloplasty (D7963) and/or distal wedge performed in the same area on the same date of service.

j. Procedures involved in acquiring graft tissues (hard or soft) from extra-oral donor sites are considered part of the fee for osseous surgery (D4260 and D4261) and are not payable separately.

k. Gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261) performed in conjunction with a laboratory crown, prefabricated crown, amalgam or resin- based composite restoration or endodontic therapy is included in the fee for the final restoration or endodontic therapy and is not payable separately.

Periodontal Procedures (D4000-D4999)

PROCEDURE D4210 GINGIVECTOMY OR GINGIVOPLASTY- FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

1. If three or fewer diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4211).
2. A benefit:
   a. for patients age 13 or older.
   b. once per quadrant every 36 months.

PROCEDURE D4211 GINGIVECTOMY OR GINGIVOPLASTY - ONE TO THREE CONTIGUOUS TEETH, OR TOOTH BOUNDED SPACES PER QUADRANT

1. If four or more diseased teeth are present in the quadrant, use gingivectomy or gingivoplasty (D4210).
2. A benefit:
   a. for patients age 13 or older.
   b. once per quadrant every 36 months.

PROCEDURE D4249 CLINICAL CROWN LENGTHENING – HARD TISSUE

This procedure is included in the fee for a completed restorative service.

PROCEDURE D4260 OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE)- FOUR OR MORE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES PER QUADRANT

1. Prior authorization is required.
2. Requires a quadrant code.
3. If three or fewer diseased teeth are present in the quadrant, use osseous surgery (D4261).
4. A benefit:
   a. for patients age 13 or older.
   b. once per quadrant every 36 months.

PROCEDURE D4261 OSSEOUS SURGERY (INCLUDING FLAP ENTRY AND CLOSURE) - ONE TO THREE CONTIGUOUS TEETH OR TOOTH BOUNDED SPACES, PER QUADRANT

1. Prior authorization is required.
2. Requires a quadrant code.
3. If four or more diseased teeth are present in the quadrant, use osseous surgery (D4260).
4. A benefit:
   a. for patients age 13 or older.
   b. once per quadrant every 36 months.

PROCEDURE D4265 BIOLOGIC MATERIALS TO AID IN SOFT AND OSSEOUS TISSUE REGENERATION

This procedure is included in the fees for other periodontal procedures and is not payable separately.

PROCEDURE D4341 PERIODONTAL SCALING AND ROOT PLANING - FOUR OR MORE TEETH PER QUADRANT

A benefit:

a. for patients age 13 or older.
b. once per quadrant every 24 months.

PROCEDURE D4342 PERIODONTAL SCALING AND ROOT PLANING - ONE TO THREE TEETH PER QUADRANT

A benefit:

a. for patients age 13 or older.
b. once per quadrant every 24 months.

PROCEDURE D4355 FULL MOUTH DEBRIDEMENT TO ENABLE COMPREHENSIVE EVALUATION AND DIAGNOSIS

This procedure is included in the fees for other periodontal procedures and is not payable separately.

PROCEDURE D4381 LOCALIZED DELIVERY OF ANTIMICROBIAL AGENTS VIA A CONTROLLED RELEASE VEHICLE INTO DISEASED CREVICULAR TISSUE, PER TOOTH

This procedure is included in the fees for other periodontal procedures and is not payable separately.

PROCEDURE D4910 PERIODONTAL MAINTENANCE

1. This procedure does not require prior authorization.
2. A benefit:
   a. only for patients residing in a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF).
   b. only when preceded by a periodontal scaling and root planing (D4341-D4342).
   c. only after completion of all necessary scaling and root planings.
   d. once in a calendar quarter.
   e. only in the 24 month period following the last scaling and root planing.
3. This procedure is considered a full mouth treatment.

PROCEDURE D4920 UNSCHEDULED DRESSING CHANGE (BY SOMEONE OTHER THAN TREATING DENTIST)

1. This procedure cannot be prior authorized.
2. A benefit:
   a. for patients age 13 or older.
   b. once per patient per provider.
   c. within 30 days of the date of service of gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).
3. Unscheduled dressing changes by the same provider are considered part of, and included in the fee for gingivectomy or gingivoplasty (D4210 and D4211) and osseous surgery (D4260 and D4261).

PROCEDURE D4999 UNSPECIFIED PERIODONTAL PROCEDURE, BY REPORT

1. A benefit for patients age 13 or older.
2. Procedure D4999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an condition to justify the medical necessity. Documentation shall include the exceptional medical medical condition and the specific CDT code associated with the treatment.

Prosthodontics (Removable) General Policies (D5000-D5899)

1. **Complete and Partial Dentures (D5110-D5214 and D5860):**

   a) Prior authorization is required for removable prostheses except for immediate dentures (D5130 and D5140).

   b) Prior authorization shall be considered for a new prosthesis only when it is clearly evident that the existing prosthesis cannot be made serviceable by repair, replacement of broken and missing teeth or reline.

   c) Complete and partial dentures are prior authorized only as full treatment plans. Payment shall be made only when the full treatment has been completed.

   d) New complete or partial dentures shall not be prior authorized when it would be highly improbable for a patient to utilize, care for or adapt to a new prosthesis due to psychological and/or motor deficiencies as determined by a clinical screening dentist (see "g" below).

   e) All endodontic, restorative and surgical procedures for teeth that impact the design of a removable partial denture (D5211, D5212, D5213 and D5214) shall be addressed before prior authorization is considered.

   f) The need for new or replacement prosthesis may be evaluated by a clinical screening dentist.

   g) A removable prosthesis is a benefit only once in a five year period. When adequately documented, the following exceptions shall apply:

      i) Catastrophic loss beyond the control of the patient. Documentation must include a copy of the official public service agency report (fire or police), or

      ii) A need for a new prosthesis due to surgical or traumatic loss of oral-facial anatomic structure, or

      iii) The removable prosthesis is no longer serviceable as determined by a clinical screening dentist.

   h) Prosthodontic services provided solely for cosmetic purposes are not a benefit.

   i) Temporary or interim dentures to be used while a permanent denture is being constructed are not a benefit.

   j) Spare or backup dentures are not a benefit.

   k) Evaluation of a denture on a maintenance basis is not a benefit.

   l) The fee for any removable prosthesis, reline, tissue conditioning or repair includes all adjustments necessary for six months after the date of service by the same provider.

   m) Immediate dentures should only be considered for a patient when one or more of the following conditions exist:

      i) extensive or rampant caries are exhibited in the radiographs,

      ii) severe periodontal involvement is indicated in the radiographs,

      iii) numerous teeth are missing resulting in diminished masticating ability adversely affecting the patient's health.

   n) There is no insertion fee payable to an oral surgeon who seats an immediate denture.

   o) Preventative, endodontic or restorative procedures are not a benefit for teeth to be retained for overdentures. Only extractions for the retained teeth will be a benefit.

   p) Partial dentures are not a benefit to replace missing 3rd molars.

2. Relines and Tissue Conditioning (D5730-D5761, D5850 and D5851):

a) Laboratory relines (D5750, D5751, D5760 and D5761) are a benefit six months after the date of service for immediate dentures (D5130 and D5140), an immediate overdenture (D5860) and cast metal partial dentures (D5213 and D5214) that required extractions.

b) Laboratory relines (D5750, D5751, D5760 and D5761) are a benefit 12 months after the date of service for complete (remote) dentures (D5110 and D5120), a complete (remote) overdenture (D5860) and cast metal partial dentures (D5213 and D5214) that did not require extractions.

c) Laboratory relines (D5760 and D5761) are not a benefit for resin based partial dentures (D5211and D5212).

d) Laboratory relines (D5750, D5751, D5760 and D5761) are not a benefit within 12 months of chairside relines (D5730, D5731, D5740 and D5741).

e) Chairside relines (D5730, D5731, D5740 and D5741) are a benefit six months after the date of service for immediate dentures (D5130 and D5140), an immediate overdenture (D5860), resin based partial dentures (D5211 and D5212) and cast metal partial dentures (D5213 and D5214) that required extractions.

f) Chairside relines (D5730, D5731, D5740 and D5741) are a benefit 12 months after the date of service for complete (remote) dentures (D5110 and D5120), a complete (remote) overdenture (D5860), resin based partial dentures (D5211 and D5212) and cast metal partial dentures (D5213 and D5214) that did not require extractions.

g) Chairside relines (D5730, D5731, D5740 and D5741) are not a benefit within 12 months of laboratory relines (D5750, D5751, D5760 and D5761).

h) Tissue conditioning (D5850 and D5851) is only a benefit to heal unhealthy ridges prior to a definitive prosthodontic treatment.

i) Tissue conditioning (D5850 and D5851) is a benefit the same date of service as an immediate prosthesis that required extractions.

Prosthodontic (Removable) Procedures (D5000-D5899)

PROCEDURE D5110 COMPLETE DENTURE – MAXILLARY

1. Prior authorization is required.
2. A benefit once in a five year period from a previous complete, immediate or overdenture-complete denture.
3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
4. A laboratory reline (D5750) or chairside reline (D5730) is a benefit 12 months after the date of service for this procedure.

PROCEDURE D5120 COMPLETE DENTURE – MANDIBULAR

1. Prior authorization is required.

   A benefit once in a five year period from a previous complete, immediate or overdenture-complete denture.
2. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
3. A laboratory reline (D5751) or chairside reline (D5731) is a benefit 12 months after the date of service for this procedure.

PROCEDURE D5130 IMMEDIATE DENTURE – MAXILLARY

1. A benefit once per patient.
2. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
4. A laboratory reline (D5750) or chairside reline (D5730) is a benefit six months after the date of service for this procedure.

PROCEDURE D5140 IMMEDIATE DENTURE – MANDIBULAR

1. A benefit once per patient.
2. Not a benefit as a temporary denture. Subsequent complete dentures are not a benefit within a five-year period of an immediate denture.
3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
4. A laboratory reline (D5751) or chairside reline (D5731) is a benefit six months after the date of service for this procedure.

PROCEDURE D5211 MAXILLARY PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. A benefit once in a five-year period.
3. A benefit when replacing a permanent anterior tooth/teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
   a. five posterior permanent teeth are missing, (excluding 3rd molars), or
   b. all four 1st and 2nd permanent molars are missing, or
   c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
4. Not a benefit for replacing missing 3rd molars.
5. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
6. Laboratory reline (D5760) is not a benefit for this procedure.
7. Chairside reline (D5740) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a partial denture that required

extractions, or

c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5212 MANDIBULAR PARTIAL DENTURE – RESIN BASE (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. A benefit once in a five-year period.
3. A benefit when replacing a permanent anterior tooth/ teeth and/or the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
   a. five posterior permanent teeth are missing, (excluding 3rd molars), or
   b. all four 1st and 2nd permanent molars are missing, or
   c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
4. Not a benefit for replacing missing 3rd molars.
5. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
6. Laboratory reline (D5761) is not a benefit for this procedure.
7. Chairside reline (D5741) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a partial denture that required extractions, or
   c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5213 MAXILLARY PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. A benefit once in a five- year period.
3. A benefit when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
   a. five posterior permanent teeth are missing, (excluding 3rd molars), or
   b. all four 1st and 2nd permanent molars are missing, or
   c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
4. Not a benefit for replacing missing 3rd molars.
5. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
6. Laboratory reline (D5760) is a benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a cast partial denture that required extractions, or
   c. 12 months after the date of service for a cast partial denture that did not require extractions.
7. Chairside reline (D5740) is a benefit:
   a. once in a 12 month period.
   b. six months after the date of service for a partial denture that required extractions, or
   c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5214 MANDIBULAR PARTIAL DENTURE – CAST METAL FRAMEWORK WITH RESIN DENTURE BASES (INCLUDING ANY CONVENTIONAL CLASPS, RESTS AND TEETH)

1. Prior authorization is required.
2. A benefit once in a five- year period.
3. A benefit when opposing a full denture and the arch lacks posterior balanced occlusion. Lack of posterior balanced occlusion is defined as follows:
    a. five posterior permanent teeth are missing, (excluding 3rd molars), or
    b. all four 1st and 2nd permanent molars are missing, or
    c. the 1st and 2nd permanent molars and 2nd bicuspid are missing on the same side.
4. Not a benefit for replacing missing 3rd molars.
5. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
6. Laboratory reline (D5761) is a benefit:
    a. once in a 12-month period.
    b. six months after the date of service for a cast partial denture that required extractions, or
    c. 12 months after the date of service for a cast partial denture that did not require extractions.
7. Chairside reline (D5741) is a benefit:
    a. once in a 12-month period.
    b. six months after the date of service for a partial denture that required extractions, or
    c. 12 months after the date of service for a partial denture that did not require extractions.

PROCEDURE D5410 ADJUST COMPLETE DENTURE - MAXILLARY

1. A benefit:
    a. once per date of service per provider.
    b. twice in a 12-month period per provider.
2. Not a benefit:
    a. same date of service or within six months of the date of service of a complete denture-maxillary (D5110), immediate denture- maxillary (D5130)or overdenture-complete (D5860).
    b. same date of service or within six months of the date of service of a reline complete maxillary denture (chairside) (D5730), reline complete maxillary denture (laboratory) (D5750) and tissue conditioning, maxillary (D5850).
    c. same date of service or within six months of the date of service of repair broken complete denture base (D5510) and replace missing or broken teeth-complete denture (D5520).

PROCEDURE D5411 ADJUST COMPLETE DENTURE – MANDIBULAR

1. A benefit:
    a. once per date of service per provider.
    b. twice in a 12-month period per provider.
2. Not a benefit:
    a. same date of service or within six months of the date of service of a complete denture-mandibular (D5120), immediate denture-

mandibular (D5140) or overdenture-complete (D5860).

b. same date of service or within six months of the date of service of a reline complete mandibular denture (chairside) (D5731), reline complete mandibular denture (laboratory) (D5751) and tissue conditioning, mandibular (D5851).

c. same date of service or within six months of the date of service of repair broken complete denture base (D5510) and replace missing or broken teeth-complete denture (D5520).

PROCEDURE D5421 ADJUST PARTIAL DENTURE MAXILLARY

1. A benefit:

   a. once per date of service per provider.

   b. twice in a 12-month period per provider.

2. Not a benefit:

   a. same date of service or within six months of the date of service of a maxillary partial- resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213).

   b. same date of service or within six months of the date of service of a reline maxillary partial denture (chairside) (D5740), reline maxillary partial denture (laboratory) (D5760) and tissue conditioning, maxillary (D5850).

   c. same date of service or within six months of the date of service of repair resin denture base (D5610), repair cast framework (D5620), repair or replace broken clasp (D5630), replace broken teeth- per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).

PROCEDURE D5422 ADJUST PARTIAL DENTURE - MANDIBULAR

1. A benefit:

   a. once per date of service per provider.

   b. twice in a 12 month period per provider.

2. Not a benefit:

   a. same date of service or within six months of the date of service of a mandibular partial- resin base (D5212) or mandibular partial denture- cast metal framework with resin denture bases (D5214).

   b. same date of service or within six months of the date of service of a reline mandibular partial denture (chairside) (D5741), reline mandibular partial denture (laboratory) (D5761) and tissue conditioning, mandibular (D5851).

   c. same date of service or within six months of the date of service of repair resin denture base (D5610), repair cast framework (D5620), repair or replace broken clasp (D5630), replace broken teeth- per tooth (D5640), add tooth to existing partial denture (D5650) and add clasp to existing partial denture (D5660).

PROCEDURE D5510 REPAIR BROKEN COMPLETE DENTURE BASE

1. A benefit:

   a. once per arch, per date of service per provider.

   b. twice in a 12-month period per provider.

2. Not a benefit on the same date of service as reline complete maxillary denture (chairside) (D5730), reline complete mandibular denture (chairside) (D5731), reline complete maxillary denture (laboratory) (D5750) and reline complete mandibular denture (laboratory) (D5751).

3. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this

procedure.

PROCEDURE D5520 REPLACE MISSING OR BROKEN TEETH – COMPLETE DENTURE (EACH TOOTH)

1. A benefit:
   a. up to a maximum of four, per arch, per date of service per provider.
   b. twice per arch, in a12- month period per provider.
2. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5610 REPAIR RESIN DENTURE BASE

1. A benefit:
   a. once per arch, per date of service per provider.
   b. twice per arch, in a 12-month period per provider.
   c. for partial dentures only.
2. Not a benefit same date of service as reline maxillary partial denture (chairside) (D5740), reline mandibular partial denture (chairside) (D5741), reline maxillary partial denture (laboratory) (D5760) and reline mandibular partial denture (laboratory) (D5761).
3. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5620 REPAIR CAST FRAMEWORK

1. A benefit:
   a. once per arch, per date of service per provider.
   b. twice per arch, in a 12-month period per provider.
2. All adjustments made for six months after the date of

repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5630 REPAIR OR REPLACE BROKEN CLASP

1. A benefit:
   a. up to a maximum of three, per date of service per provider.
   b. twice per arch, in a 12- month period per provider.
2. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5640 REPLACE BROKEN TEETH – PER TOOTH

1. A benefit:
   a. up to a maximum of four, per arch, per date of service per provider.
   b. twice per arch, in a 12- month period per provider.
   c. for partial dentures only.
2. All adjustments made for

   six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5650 ADD TOOTH TO EXISTING PARTIAL DENTURE

1. A benefit:
   a. for up to a maximum of three, per date of service per provider.
   b. once per tooth.
2. Not a benefit for adding 3rd molars.
3. All adjustments made for six months after the date of repair, by the same provider and same arch, are included in the fee for this procedure.

PROCEDURE D5660 ADD CLASP TO EXISTING PARTIAL DENTURE

1. A benefit:
   a. for up to a maximum of three, per date of service per provider.
   b. twice per arch, in a 12-month period per provider.
2. All adjustments made for six months after the date of repair, by the same provider

   and same arch, are included in the fee for this procedure.

PROCEDURE D5730 RELINE COMPLETE MAXILLARY DENTURE (CHAIRSIDE)

1. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a immediate denture-maxillary (D5130) or immediate overdenture-complete (D5860) that required extractions, or
   c. 12 months after the date of service for a complete (remote) denture-maxillary (D5110) or overdenture(remote)-complete (D5860) that did not require extractions.
2. Not a benefit within 12 months of a reline complete maxillary denture (laboratory) (D5750).
3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5731 RELINE COMPLETE MANDIBULAR DENTURE (CHAIRSIDE)

1. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a immediate denture-mandibular (D5140) or immediate overdenture-complete (D5860) that required extractions, or
   c. 12 months after the date of service for a complete (remote) denture-mandibular (D5120) or overdenture (remote)- complete (D5860) that did not require extractions.
2. Not a benefit within 12 months of a reline complete mandibular denture (laboratory) (D5751).
3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5740 RELINE MAXILLARY PARTIAL DENTURE (CHAIRSIDE)

1. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for maxillary partial denture-resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213) that required extractions, or
   c. 12 months after the date of service for maxillary partial denture-resin base (D5211) or maxillary partial denture- cast metal framework with resin denture bases (D5213) that did not require extractions.
2. Not a benefit within 12 months of a reline maxillary partial denture (laboratory) (D5760).
3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5741 RELINE MANDIBULAR PARTIAL DENTURE (CHAIRSIDE)

1. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for mandibular partial denture-resin base (D5212) or mandibular partial denture-cast metal framework with resin denture bases (D5214) that required extractions, or
   c. 12 months after the date of service for mandibular partial denture-resin base (D5212) or mandibular partial denture-cast metal framework with resin denture bases (D5214) that did not require extractions.
2. Not a benefit within 12 months of a reline mandibular partial denture (laboratory) (D5761).

3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5750 RELINE COMPLETE MAXILLARY DENTURE (LABORATORY)

1. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a immediate denture-maxillary (D5130) or immediate overdenture-complete (D5860) that required extractions, or
   c. 12 months after the date of service for a complete (remote) denture- maxillary (D5110) or overdenture(remote)-complete (D5860) that did not require extractions.
2. Not a benefit within 12 months of a reline complete maxillary denture (chairside) (D5730).
3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5751 RELINE COMPLETE MANDIBULAR DENTURE (LABORATORY)

1. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for a immediate denture-mandibular (D5140) or immediate overdenture-complete (D5860) that required extractions, or
   c. 12 months after the date of service for a complete (remote) denture - mandibular (D5120) or overdenture (remote) - complete (D5860) that did not require extractions.
2. Not a benefit within 12 months of a reline complete mandibular denture (chairside) (D5731).
3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5760 RELINE MAXILLARY PARTIAL DENTURE (LABORATORY)

1. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for maxillary partial denture- cast metal framework with resin denture bases (D5213) that required extractions, or
   c. 12 months after the date of service for maxillary partial denture- cast metal framework with resin denture bases (D5213) that did not require extractions.
2. Not a benefit:
   a. within 12 months of a reline maxillary partial denture (chairside) (D5740).
   b. for a maxillary partial denture-resin base (D5211).
3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5761 RELINE MANDIBULAR PARTIAL DENTURE (LABORATORY)

1. A benefit:
   a. once in a 12-month period.
   b. six months after the date of service for mandibular partial denture-cast metal framework with resin denture bases (D5214) that required extractions, or
   c. 12 months after the date of service for mandibular partial denture-cast metal framework with resin denture bases (D5214) that did not require extractions.
2. Not a benefit:
   d. within 12 months of a reline mandibular partial denture (chairside) (D5741).
   e. for a mandibular partial denture-resin base (D5212).
3. All adjustments made for six months after the

date of service, by the same provider, are included in the fee for this procedure.

PROCEDURE D5850 TISSUE CONDITIONING, MAXILLARY

1. A benefit twice per prosthesis in a 36-month period.
2. Not a benefit:

a. same date of service as reline complete maxillary denture (chairside) (D5730), reline maxillary partial denture (chairside) (D5740), reline complete maxillary denture (laboratory) (D5750) and reline maxillary partial denture (laboratory) (D5760).

b. same date of service as a prosthesis that did not require extractions.

3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
4. Tissue conditioning is designed to heal unhealthy ridges prior to a more definitive treatment.

PROCEDURE D5851 TISSUE CONDITIONING, MANDIBULAR

1. A benefit twice per prosthesis in a 36-month period.
2. Not a benefit:

a. same date of service as reline complete mandibular denture (chairside) (D5731), reline mandibular partial denture (chairside) (D5741), reline complete mandibular denture (laboratory) (D5751) and reline mandibular partial denture (laboratory) (D5761).

b. same date of service as a prosthesis that did not require extractions.

3. All adjustments made for six months after the date of service, by the same provider, are included in the fee for this procedure.
4. Tissue conditioning is designed to heal unhealthy ridges prior to a more definitive treatment.

PROCEDURE D5862 PRECISION ATTACHMENT, BY REPORT

This procedure is included in the fee for prosthetic and restorative procedures and is not payable separately.

PROCEDURE D5899 UNSPECIFIED REMOVABLE PROSTHODONTIC PROCEDURE, BY REPORT

Procedure D5899 shall be used:

a. for a procedure which is not adequately described by a CDT code, or

b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Maxillofacial Prosthetics General Policies (D5900-D5999)

a. Maxillofacial prosthetic services are for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.

b. Prior authorization is required for the following procedures:

   i) trismus appliance (D5937),

   ii) palatal lift prosthesis, interim (D5958),

   iii) fluoride gel carrier (D5986),

   iv) surgical splint (D5988).

c. All maxillofacial prosthetic procedures include routine postoperative care, revisions and adjustments for 90 days after the date of delivery.

Maxillofacial Prosthetic Procedures (D5900-D5999)

PROCEDURE D5911
FACIAL MOULAGE (SECTIONAL)

PROCEDURE D5912
FACIAL MOULAGE (COMPLETE)

PROCEDURE D5913
NASAL PROSTHESIS

PROCEDURE D5914
AURICULAR PROSTHESIS

PROCEDURE D5915
ORBITAL PROSTHESIS

PROCEDURE D5916
OCULAR PROSTHESIS

Not a benefit on the same date of service as ocular prosthesis, interim (D5923).

PROCEDURE D5919
FACIAL PROSTHESIS

PROCEDURE D5922
NASAL SEPTAL PROSTHESIS

PROCEDURE D5923
OCULAR PROSTHESIS, INTERIM

Not a benefit on the same date of service with an ocular prosthesis (D5916).

PROCEDURE D5924
CRANIAL PROSTHESIS

PROCEDURE D5925
FACIAL AUGMENTATION IMPLANT PROSTHESIS

PROCEDURE D5926
NASAL PROSTHESIS, REPLACEMENT

PROCEDURE D5927
AURICULAR PROSTHESIS, REPLACEMENT

PROCEDURE D5928
ORBITAL PROSTHESIS, REPLACEMENT

PROCEDURE D5929
FACIAL PROSTHESIS, REPLACEMENT

PROCEDURE D5931
OBTURATOR PROSTHESIS, SURGICAL

Not a benefit on the same date of service as obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).

1. **PROCEDURED5932**
2. **OBTURATOR PROSTHESIS, DEFINITIVE**

Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, interim (D5936).

PROCEDURE D5933
OBTURATOR PROSTHESIS, MODIFICATION

1. A benefit twice in a 12 month period.
2. Not a benefit on the same date of service as obturator prosthesis, surgical (D5931), obturator prosthesis, definitive (D5932) and obturator prosthesis, interim (D5936).

PROCEDURE D5934

MANDIBULAR RESECTION PROSTHESIS WITH GUIDE FLANGE

PROCEDURE D5935
MANDIBULAR RESECTION PROSTHESIS WITHOUT GUIDE FLANGE

PROCEDURE D5936
OBTURATOR PROSTHESIS, INTERIM

Not a benefit on the same date of service as obturator prosthesis, surgical (D5931) and obturator prosthesis, definitive (D5932).

PROCEDURE D5937
TRISMUS APPLIANCE (NOT FOR TMD TREATMENT)

PROCEDURE D5951
FEEDING AID

A benefit for patients under the age of 18.

PROCEDURE D5952
SPEECH AID PROSTHESIS, PEDIATRIC

A benefit for patients under the age of 18.

PROCEDURE D5953
SPEECH AID PROSTHESIS, ADULT

A benefit for patients age 18 or older.

PROCEDURE D5954
PALATAL AUGMENTATION PROSTHESIS

PROCEDURE D5955
PALATAL LIFT PROSTHESIS, DEFINITIVE

Not a benefit on the same date of service as palatal lift prosthesis, interim (D5958).'

PROCEDURE D5958
PALATAL LIFT PROSTHESIS, INTERIM

Not a benefit on the same date of service with palatal lift prosthesis, definitive (D5955).

PROCEDURE D5959
PALATAL LIFT PROSTHESIS, MODIFICATION

1. A benefit twice in a 12- month period.

2. Not a benefit on the same date of service as palatal lift prosthesis, definitive (D5955) and palatal lift prosthesis, interim (D5958).

PROCEDURE D5960 SPEECH AID PROSTHESIS, MODIFICATION

1. A benefit twice in a 12- month period.
2. Not a benefit on the same date of service as speech aid prosthesis, pediatric (D5952) and speech aid prosthesis, adult (D5953).

PROCEDURE D5982 SURGICAL STENT

PROCEDURE D5983 RADIATION CARRIER

PROCEDURE D5984 RADIATION SHIELD

PROCEDURE D5985 RADIATION CONE LOCATOR

PROCEDURE D5986 FLUORIDE GEL CARRIER

A benefit only in conjunction with radiation therapy directed at the teeth, jaws or salivary glands.

PROCEDURE D5987 COMMISSURE SPLINT

PROCEDURE D5988 SURGICAL SPLINT

PROCEDURE D5991 TOPICAL MEDICAMENT CARRIER

PROCEDURE D5992 ADJUST MAXILLOFACIAL PROSTHETIC APPLIANCE, BY REPORT

This procedure is not a benefit.

PROCEDURE D5993 MAINTENANCE AND CLEANING OF A MAXILLOFACIAL PROSTHESIS (EXTRA OR INTRAORAL) OTHER THAN REQUIRED ADJUSTMENTS, BY REPORT

This procedure is not a benefit.

PROCEDURE D5999 UNSPECIFIED MAXILLOFACIAL PROSTHESIS, BY REPORT

Procedure D5999 shall be used:

a. for a procedure which is not adequately described by a CDT code, or
b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Implant Services General Policies (D6000-D6199)

a. Implant services are a benefit only when exceptional medical conditions. Exceptional medical conditions include, but are not limited to:

   i) cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prostheses.

   ii) severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the patient is unable to function with conventional prostheses.

   iii) skeletal deformities that preclude the use of conventional prostheses (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).

   iv) traumatic destruction of jaw, face or head where the remaining osseous structures are unable to support conventional dental prostheses.

b) Providers shall submit complete case documentation (such as radiographs, scans, operative reports, craniofacial panel reports, diagnostic casts, intraoral/extraoral photographs and tracings) necessary to demonstrate the medical necessity of the requested implant services.

c) Single tooth implants are not a benefit of the plan.

d) Implant removal, by report (D6100) is a benefit. Refer to the procedure for specific requirements.

Implant Service Procedures (D6000-D6199)

PROCEDURE D6010 SURGICAL PLACEMENT OF IMPLANT BODY: ENDOSTEAL IMPLANT

Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Refer to Implant Services General policies for specific requirements.

PROCEDURE D6040 SURGICAL PLACEMENT: EPOSTEAL IMPLANT

See the criteria for Procedure D6010.

PROCEDURE D6050 SURGICAL PLACEMENT: TRANSOSTEAL IMPLANT

See the criteria for Procedure D6010.

PROCEDURE D6051 INTERIM ABUTMENT

This procedure is not a benefit.

PROCEDURE D6055 CONNECTING BAR – IMPLANT SUPPORTED OR ABUTMENT SUPPORTED

See the criteria for Procedure D6010.

PROCEDURE D6056 PREFABRICATED ABUTMENT - INCLUDES MODIFICATION AND PLACEMENT

See the criteria for Procedure D6010.

PROCEDURE D6057 CUSTOM FABRICATED ABUTMENT - INCLUDES PLACEMENT

See the criteria for Procedure D6010.

PROCEDURE D6058 ABUTMENT SUPPORTED PORCELAIN/CERAMIC CROWN

See the criteria for Procedure D6010.

PROCEDURE D6059 ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6060 ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (PREDOMINANTLY BASE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6061 ABUTMENT SUPPORTED PORCELAIN FUSED TO METAL CROWN (NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6062 ABUTMENT SUPPORTED CAST METAL CROWN (HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6063 ABUTMENT SUPPORTED CAST METAL CROWN (PREDOMINANTLY BASE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6064 ABUTMENT SUPPORTED CAST METAL CROWN (NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6065 IMPLANT SUPPORTED PORCELAIN/CERAMIC CROWN

See the criteria for Procedure D6010.

PROCEDURE D6066 IMPLANT SUPPORTED PORCELAIN FUSED TO METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6067 IMPLANT SUPPORTED METAL CROWN (TITANIUM, TITANIUM ALLOY, HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6068 ABUTMENT SUPPORTED RETAINER FOR PORCELAIN/ CERAMIC FPD

See the criteria for Procedure D6010.

PROCEDURE D6069 ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6070 ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (PREDOMINANTLY BASE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6071 ABUTMENT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6072 ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6073 ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (PREDOMINANTLY BASE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6074 ABUTMENT SUPPORTED RETAINER FOR CAST METAL FPD (NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6075 IMPLANT SUPPORTED RETAINER FOR CERAMIC FPD

See the criteria for Procedure D6010.

PROCEDURE D6076 IMPLANT SUPPORTED RETAINER FOR PORCELAIN FUSED TO METAL FPD (TITANIUM, TITANIUM ALLOY, OR HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6077 IMPLANT SUPPORTED RETAINER FOR CAST METAL FPD (TITANIUM, TITANIUM ALLOY, OR HIGH NOBLE METAL)

See the criteria for Procedure D6010.

PROCEDURE D6080 IMPLANT MAINTENANCE PROCEDURES, INCLUDING REMOVAL OF PROSTHESIS, CLEANSING OF PROSTHESIS AND ABUTMENTS AND REINSERTION OF PROSTHESIS

See the criteria for Procedure D6010.

PROCEDURE D6090 REPAIR IMPLANT SUPPORTED PROSTHESIS, BY REPORT

See the criteria for Procedure D6010.

PROCEDURE D6091 REPLACEMENT OF SEMI-PRECISION OR PRECISION ATTACHMENT (MALE OR FEMALE COMPONENT) OF IMPLANT/ABUTMENT SUPPORTED PROSTHESIS, PER ATTACHMENT

See the criteria for Procedure D6010.

PROCEDURE D6092 RECEMENT IMPLANT/ ABUTMENT SUPPORTED CROWN

Not a benefit within 12 months of a previous re-cementation by the same provider.

PROCEDURE D6093 RECEMENT IMPLANT/ ABUTMENT SUPPORTED FIXED PARTIAL DENTURE

Not a benefit within 12 months of a previous re-cementation by the same provider.

PROCEDURE D6094 ABUTMENT SUPPORTED CROWN (TITANIUM)

See the criteria for Procedure D6010.

PROCEDURE D6095 REPAIR IMPLANT ABUTMENT, BY REPORT

See the criteria for Procedure D6010.

PROCEDURE D6100 IMPLANT REMOVAL, BY REPORT

PROCEDURE D6101 DEBRIDEMENT OF A PERIIMPLANT DEFECT AND SURFACE CLEANING OF EXPOSED IMPLANT SERVICES, INCLUDING FLAP ENTRY AND CLOSURE

This procedure is not a benefit.

PROCEDURE D6102 DEBRIDEMENT AND OSSEOUS CONTOURING OF A PERIIMPLANT DEFECT; INCLUDES SURFACE CLEANING OF EXPOSED IMPLANT SURFACES AND FLAP ENTRY AND CLOSURE

This procedure is not a benefit.

PROCEDURE D6103 BONE GRAFT FOR REPAIR OF PERIIMPLANT DEFECT - NOT INCLUDING FLAP ENTRY AND CLOSURE OR, WHEN INDICATED, PLACEMENT OF A BARRIER MEMBRANE OR BIOLOGIC MATERIALS TO AID IN OSSEOUS REGENERATION

This procedure is not a benefit.

PROCEDURE D6104 BONE GRAFT AT TIME OF IMPLANT PLACEMENT

This procedure is not a benefit.

PROCEDURE D6190 RADIOGRAPHIC/SURGICAL IMPLANT INDEX, BY REPORT

This procedure is included in the fee for surgical placement of implant body: endosteal implant (D6010).

PROCEDURE D6194 ABUTMENT SUPPORTED RETAINER CROWN FOR FPD (TITANIUM)

See the criteria for Procedure D6010.

PROCEDURE D6199 UNSPECIFIED IMPLANT PROCEDURE, BY REPORT

1. Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity.
2. radiographs.

Fixed Prosthodontic General Policies (D6200-D6999)

a. Fixed partial dentures (bridgework) are considered beyond the scope of the plan. However, the fabrication of a fixed partial denture shall be considered for prior authorization only when medical conditions or employment preclude the use of a removable partial denture. Most importantly, the patient shall first meet the criteria for a removable partial denture before a fixed partial denture will be considered.

b. Medical conditions, which preclude the use of a removable partial denture, include:

   i) the epileptic patient where a removable partial denture could be injurious to their health during an uncontrolled seizure,

   ii) the paraplegia patient who utilizes a mouth wand to function to any degree and where a mouth wand is inoperative because of missing natural teeth,

   iii) patients with neurological disorders whose manual dexterity precludes proper care and maintenance of a removable partial denture.

c. Fixed partial dentures are a benefit once in a five-year period only on permanent teeth when the above criteria are met.

d. Fixed partial dentures are not a benefit when the prognosis of the retainer (abutment) teeth is questionable due to non-restorability or periodontal involvement.

e. Posterior fixed partial dentures are not a benefit when the number of missing teeth requested to be replaced in the quadrant does not significantly impact the patient's masticatory ability.

f. Tooth and soft tissue preparation, crown lengthening, cement bases, direct and indirect pulp capping, amalgam or acrylic buildups, pins (D2951), bonding agents, lining agents, impressions, temporary crowns, adjustments (D9951), polishing, local anesthesia (D9210) and any other associated procedures are included in the fee for a completed fixed partial denture.

g. Fixed partial denture inlay/onlay retainers (abutments) (D6545-D6634) are not a benefit.

h. Cast resin bonded fixed partial dentures (Maryland Bridges) are not a benefit.

Fixed Prosthodontic Procedures (D6200-D6999)

PROCEDURE D6211 PONTIC – CAST PREDOMINANTLY BASE METAL

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
   c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6241 PONTIC – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
   c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6242 PONTIC – PORCELAIN FUSED TO NOBLE METAL

This procedure is not a benefit.

PROCEDURE D6245 PONTIC – PORCELAIN/CERAMIC

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
   c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6251 PONTIC – RESIN WITH PREDOMINANTLY BASE METAL

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
   c. only when billed on the same date of service with fixed partial denture retainers (abutments) (D6721, D6740, D6751, D6781, D6783 and D6791).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6721 CROWN – RESIN WITH PREDOMINANTLY BASE METAL

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6740 CROWN – PORCELAIN/CERAMIC

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6751 CROWN – PORCELAIN FUSED TO PREDOMINANTLY BASE METAL

1. A benefit:
   a. once in a five year period.
   a. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6781 CROWN – ¾ CAST PREDOMINANTLY BASE METAL

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6783 CROWN – ¾ PORCELAIN/ CERAMIC

1. Requires a tooth code.
2. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
3. Not a benefit for patients under the age of 13.

PROCEDURE D6791 CROWN – FULL CAST PREDOMINANTLY BASE METAL

1. A benefit:
   a. once in a five year period.
   b. only when the criteria are met for a resin partial denture or cast partial denture (D5211, D5212, D5213 and D5214).
2. Not a benefit for patients under the age of 13.

PROCEDURE D6930 RECEMENT FIXED PARTIAL DENTURE

The original provider is responsible for all re-cementations.

PROCEDURE D6980 FIXED PARTIAL DENTURE REPAIR NECESSITATED BY RESTORATIVE MATERIAL FAILURE

Not a benefit within 12 months of initial placement or previous repair, same provider.

PROCEDURE D6999 UNSPECIFIED, FIXED PROSTHODONTIC PROCEDURE, BY REPORT

1. Not a benefit within 12 months of initial placement, same provider.
2. Procedure D6999 shall be used:

a. for a procedure which is not adequately described by a CDT code, or

b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Oral and Maxillofacial Surgery General Policies (D7000-D7999)

a) Local anesthetic, sutures and routine postoperative care within 30 days following an extraction procedure (D7111-D7250) are considered part of, and included in, the fee for the procedure. All other oral and maxillofacial surgery procedures include routine postoperative care for 90 days.

b) The level of payment for multiple surgical procedures performed on the same date of service shall be modified to the most inclusive procedure.

1. Extractions (D7111-D7250):

a) The following conditions shall be considered medically necessary and shall be a benefit:

i) full bony impacted supernumerary teeth or mesiodens that interfere with the alignment of other teeth,

ii) teeth which are involved with a cyst, tumor or other neoplasm,

iii) unerupted teeth which are severely distorting the normal alignment of erupted teeth or causing the resorption of the roots of other teeth,

iv) the extraction of all remaining teeth in preparation for a full prosthesis,

v) extraction of third molars that are causing repeated or chronic pericoronitis

vi) extraction of primary teeth required to minimize malocclusion or malalignment when there is adequate space to allow normal eruption of succedaneous teeth,

vii) perceptible radiologic pathology that fails to elicit symptoms,

viii) extractions that are required to complete orthodontic dental services excluding prophylactic removal of third molars,

ix) when the prognosis of the tooth is questionable due to non-restorability or periodontal involvement.

b. The prophylactic extraction of 3rd molars is not a benefit.

c) The fee for surgical extractions includes the removal of bone and/or sectioning of tooth, and elevation of mucoperiosteal flap, if indicated.

d) Classification of surgical extractions and impactions shall be based on the anatomical position of the tooth rather than the surgical technique employed in the removal.

2. Fractures (D7610-D7780):

a) The placement and removal of wires, bands or splints is included in the fee for the associated procedure.

b) Routine postoperative care within 90 days is included in the fee for the associated procedure.

c) When extensive multiple or bilateral procedures are performed at the same operative session, each procedure shall be valued as follows:

i) 100% (full value) for the first or major procedure, and

ii) 50% for the second procedure, and

iii) 25% for the third procedure, and

iv) 10% for the fourth procedure, and

v) 5% for the fifth procedure, and

vi) over five procedures, by report.

3. **Temporomandibular Joint Dysfunctions (D7810-D7899):**

   a) TMJ dysfunction procedures are limited to differential diagnosis and symptomatic care. Not included as a benefit are those TMJ treatment modalities that involve prosthodontia, orthodontia and full or partial occlusal rehabilitation.

   b) Most TMJ dysfunction procedures require prior authorization. Submission of sufficient diagnostic information to establish the presence of the dysfunction is required. Refer to the individual procedures for specific submission requirements.

   c) TMJ dysfunction procedures solely for the treatment of bruxism is not a benefit.

4. **Repair Procedures (D7910-D7998):**

   Suture procedures (D7910, D7911 and D7912) are not a benefit for the closure of surgical incisions.

Oral and Maxillofacial Surgery Procedures (D7000-D7999)

PROCEDURE D7111
EXTRACTION, CORONAL REMNANTS – DECIDUOUS TOOTH

Not a benefit for asymptomatic teeth.

PROCEDURE D7140
EXTRACTION, ERUPTED TOOTH OR EXPOSED ROOT (ELEVATION AND/OR FORCEPS REMOVAL)

Not a benefit to the same provider who performed the initial tooth extraction.

PROCEDURE D7210
SURGICAL REMOVAL OF ERUPTED TOOTH REQUIRING REMOVAL OF BONE AND/OR SECTIONING OF TOOTH, AND INCLUDING ELEVATION OF MUCOPERIOSTEAL FLAP IF INDICATED

A benefit when the removal of any erupted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone or sectioning of the tooth.

PROCEDURE D7220
REMOVAL OF IMPACTED TOOTH
- SOFT TISSUE

A benefit when the major portion or the entire occlusal surface is covered by mucogingival soft tissue.

PROCEDURE D7230
REMOVAL OF IMPACTED TOOTH
- PARTIALLY BONY

A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone. One of the proximal heights of contour of the crown shall be covered by bone.

PROCEDURE D7240
REMOVAL OF IMPACTED TOOTH
- COMPLETELY BONY

A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown.

PROCEDURE D7241
REMOVAL OF IMPACTED TOOTH
– COMPLETELY BONY, WITH UNUSUAL SURGICAL COMPLICATIONS

A benefit when the removal of any impacted tooth requires the elevation of a mucoperiosteal flap and the removal of substantial alveolar bone covering most or all of the crown. Difficulty or complication shall be due to factors such as nerve dissection or aberrant tooth position.

PROCEDURE D7250
SURGICAL REMOVAL OF RESIDUAL TOOTH ROOTS (CUTTING PROCEDURE)

A benefit when the root is completely covered by alveolar bone.

Not a benefit to the same provider who performed the initial tooth extraction.

PROCEDURE D7251
CORONECTOMY- INTENTIONAL PARTIAL TOOTH REMOVAL

This procedure is not a benefit.

PROCEDURE D7260
ORAL ANTRAL FISTULA CLOSURE

1. A benefit for the excision of a fistulous tract between the maxillary sinus and oral cavity.
2. Not a benefit in conjunction with extraction procedures (D7111 – D7250).

PROCEDURE D7261
PRIMARY CLOSURE OF A SINUS PERFORATION

A benefit in the absence of a fistulous tract requiring the repair or immediate closure of the oroantral or oralnasal communication, subsequent to the removal of a tooth.

PROCEDURE D7270
TOOTH REIMPLANTATION AND/ OR STABILIZATION OF ACCIDENTALLY EVULSED OR DISPLACED TOOTH

1. A benefit:
   a. once per arch regardless of the number of teeth involved, and
   b. for permanent anterior teeth only.

2. The procedure includes splinting and/or stabilization, postoperative care and the removal of the splint or stabilization, by the same provider.

PROCEDURE D7272 TOOTH TRANSPLANTATION (INCLUDES REIMPLANTATION FROM ONE SITE TO ANOTHER AND SPLINTING AND/OR STABILIZATION)

This procedure is not a benefit.

PROCEDURE D7280 SURGICAL ACCESS OF AN UNERUPTED TOOTH

1. Requires a tooth code.
2. Not a benefit:
   a. for patients age 19 or older.
   b. for 3rd molars.

PROCEDURE D7282 MOBILIZATION OF ERUPTED OR MALPOSITIONED TOOTH TO AID ERUPTION

This procedure is not a benefit.

PROCEDURE D7283 PLACEMENT OF DEVICE TO FACILITATE ERUPTION OF IMPACTED TOOTH

1. A benefit only for patients in active orthodontic treatment.
2. Not a benefit:
   a. for patients age 19 years or older.
   b. for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D7285 BIOPSY OF ORAL TISSUE – HARD (BONE, TOOTH)

1. A benefit:
   a. for the removal of the specimen only.
   b. once per arch, per date of service regardless of the areas involved.
2. Not a benefit with an apicoectomy/periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseous lesions (D7410-D7461) in the same area or region on the same date of service.

PROCEDURE D7286 BIOPSY OF ORAL TISSUE – SOFT

1. A benefit:
   a. for the removal of the specimen only.
   b. up to a maximum of three per date of service.
2. Not a benefit with an apicoectomy/periradicular surgery (D3410-D3426), an extraction (D7111-D7250) and an excision of any soft tissues or intraosseouslesions (D7410-D7461) in the same area or region on the same date of service.

PROCEDURE D7290 SURGICAL REPOSITIONING OF TEETH

1. Requires an arch code.
2. A benefit:
   a. for permanent teeth only.
   b. once per arch.
   c. only for patients in active orthodontic treatment.
3. Not a benefit:
   a. for patients age 19 years or older.
   b. for 3rd molars unless the 3rd molar occupies the 1st or 2nd molar position.

PROCEDURE D7291 TRANSSEPTAL FIBEROTOMY/ SUPRA CRESTAL FIBEROTOMY, BY REPORT

1. A benefit:
   a. once per arch.
   b. only for patients in active orthodontic treatment.
2. Not a benefit for patients age 19 or older.

PROCEDURE D7310 ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT

1. A benefit on the same date of service with two or more extractions (D7140-D7250) in the same quadrant.
2. Not a benefit when only one tooth is extracted in the same quadrant on the same date of service.

PROCEDURE D7311 ALVEOLOPLASTY IN CONJUNCTION WITH EXTRACTIONS – ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT

This procedure can only in conjunction with extractions-four or more teeth or tooth spaces, per quadrant (D7310).

PROCEDURE D7320 ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS – FOUR OR MORE TEETH OR TOOTH SPACES, PER QUADRANT

1. A benefit regardless of the number of teeth or tooth spaces.
2. Not a benefit within six months following extractions (D7140-D7250) in the same quadrant, for the same provider.

PROCEDURE D7321 ALVEOLOPLASTY NOT IN CONJUNCTION WITH EXTRACTIONS – ONE TO THREE TEETH OR TOOTH SPACES, PER QUADRANT

This procedure can only be billed as alveoloplasty not in conjunction with extractions- four or more teeth or tooth spaces, per quadrant (D7320).

PROCEDURE D7340 VESTIBULOPLASTY-RIDGE EXTENSION (SECONDARY EPITHELIALIZATION)

1. A benefit once in a five year period per arch.
2. Not a benefit:
   a. on the same date of service with a vestibuloplasty – ridge extension (D7350) same arch.
   b. on the same date of service with extractions (D7111-D7250) same arch.

PROCEDURE D7350 VESTIBULOPLASTY – RIDGE EXTENSION (INCLUDING SOFT TISSUE GRAFTS, MUSCLE REATTACHMENT, REVISION OF SOFT TISSUE ATTACHMENT AND MANAGEMENT OF HYPERTROPHIED AND HYPERPLASTIC TISSUE)

1. A benefit once per arch.
2. Not a benefit:
   a. on the same date of service with a vestibuloplasty – ridge extension (D7340) same arch.
   b. on the same date of service with extractions (D7111-D7250) same arch.

PROCEDURE D7410 EXCISION OF BENIGN LESION UP TO 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7411 EXCISION OF BENIGN LESION GREATER THAN 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7412 EXCISION OF BENIGN LESION, COMPLICATED

1. A pathology report from a certified pathology laboratory is required.
2. A benefit when there is extensive undermining with advancement or rotational flap closure.

PROCEDURE D7413 EXCISION OF MALIGNANT LESION UP TO 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7414 EXCISION OF MALIGNANT LESION GREATER THAN 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7415 EXCISION OF MALIGNANT LESION, COMPLICATED

1. A pathology report from a certified pathology laboratory is required.
2. A benefit when there is extensive undermining with advancement or rotational flap closure.

PROCEDURE D7440 EXCISION OF MALIGNANT TUMOR – LESION DIAMETER UP TO 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7441 EXCISION OF MALIGNANT TUMOR – LESION DIAMETER GREATER THAN 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7450 REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIAMETER UP TO 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7451 REMOVAL OF BENIGN ODONTOGENIC CYST OR TUMOR – LESION DIAMETER GREATER THAN 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7460 REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR – LESION DIAMETER UP TO 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7461 REMOVAL OF BENIGN NONODONTOGENIC CYST OR TUMOR – LESION DIAMETER GREATER THAN 1.25 CM

A pathology report from a certified pathology laboratory is required.

PROCEDURE D7465 DESTRUCTION OF LESION(S) BY PHYSICAL OR CHEMICAL METHOD, BY REPORT

PROCEDURE D7471 REMOVAL OF LATERAL EXOSTOSIS (MAXILLA OR MANDIBLE)

A benefit:

a. once per quadrant.

b. for the removal of buccal or facial exostosis only.

PROCEDURE D7472 REMOVAL OF TORUS PALATINUS

A benefit once in the patient's lifetime.

PROCEDURE D7473 REMOVAL OF TORUS MANDIBULARIS

A benefit once per quadrant.

PROCEDURE D7485 SURGICAL REDUCTION OF OSSEOUS TUBEROSITY

A benefit once per quadrant.

PROCEDURE D7490 RADICAL RESECTION OF MAXILLA OR MANDIBLE

PROCEDURE D7510 INCISION AND DRAINAGE OF ABSCESS – INTRAORAL SOFT TISSUE

1. A benefit once per quadrant, same date of service.
2. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.

This procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7511 INCISION AND DRAINAGE OF ABSCESS – INTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)

1. A benefit once per quadrant, same date of service.
2. Not a benefit when any other definitive treatment is performed in the same quadrant on the same date of service, except necessary radiographs and/or photographs.
3. This procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7520 INCISION AND DRAINAGE OF ABSCESS – EXTRAORAL SOFT TISSUE

This procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7521 INCISION AND DRAINAGE OF ABSCESS – EXTRAORAL SOFT TISSUE - COMPLICATED (INCLUDES DRAINAGE OF MULTIPLE FASCIAL SPACES)

This procedure includes the incision, placement and removal of a surgical draining device.

PROCEDURE D7530 REMOVAL OF FOREIGN BODY FROM MUCOSA, SKIN, OR SUBCUTANEOUS ALVEOLAR TISSUE

1. A benefit once per date of service.
2. Not a benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).

PROCEDURE D7540 REMOVAL OF REACTION PRODUCING FOREIGN BODIES, MUSCULOSKELETAL SYSTEM

1. A benefit once per date of service.
2. Not a benefit when associated with the removal of a tumor, cyst (D7440- D7461) or tooth (D7111- D7250).

PROCEDURE D7550 PARTIAL OSTECTOMY/ SEQUESTRECTOMY FOR REMOVAL OF NON-VITAL BONE

1. A benefit:
   a. once per quadrant per date of service.
   b. only for the removal of loose or sloughed off dead bone caused by infection or reduced blood supply.
2. Not a benefit within 30 days of an associated extraction (D7111-D7250).

PROCEDURE D7560 MAXILLARY SINUSOTOMY FOR REMOVAL OF TOOTH FRAGMENT

OR FOREIGN BODY

Not a benefit when a tooth fragment or foreign body is retrieved from the tooth socket.

PROCEDURE D7610 MAXILLA – OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit when necessary for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7620 MAXILLA – CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit when necessary for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7630 MANDIBLE – OPEN REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7640 MANDIBLE – CLOSED REDUCTION (TEETH IMMOBILIZED, IF PRESENT)

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7650 MALAR AND/OR ZYGOMATIC ARCH – OPEN REDUCTION

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7660 MALAR AND/OR ZYGOMATIC ARCH – CLOSED REDUCTION

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7670 ALVEOLUS – CLOSED REDUCTION, MAY INCLUDE STABILIZATION OF TEETH

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7671 ALVEOLUS – OPEN REDUCTION, MAY INCLUDE STABILIZATION OF TEETH

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7680 FACIAL BONES – COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES

1. A benefit for the treatment of simple fractures.
2. This procedure includes the placement andremoval of wires, bands, splints and arch bars.
3. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7710 MAXILLA – OPEN REDUCTION

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7720 MAXILLA – CLOSED REDUCTION

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7730 MANDIBLE – OPEN REDUCTION

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7740 MANDIBLE – CLOSED REDUCTION

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7750 MALAR AND/OR ZYGOMATIC ARCH – OPEN REDUCTION

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7760 MALAR AND/OR ZYGOMATIC ARCH – CLOSED REDUCTION

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7770 ALVEOLUS – OPEN REDUCTION STABILIZATION OF TEETH

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7771 ALVEOLUS – CLOSED REDUCTION STABILIZATION OF TEETH

1. This procedure includes the placement and removal of wires, bands, splints and arch bars.
2. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7780 FACIAL BONES – COMPLICATED REDUCTION WITH FIXATION AND MULTIPLE SURGICAL APPROACHES

1. A benefit for the treatment of compound fractures.
2. This procedure includes the placement and removal of wires, bands, splints and arch bars.
3. Anesthesia procedure (D9248) is a separate benefit, when necessary, for the surgical removal of wires, bands, splints or arch bars.

PROCEDURE D7810 OPEN REDUCTION OF DISLOCATION

PROCEDURE D7820 CLOSED REDUCTION OF DISLOCATION

PROCEDURE D7830 MANIPULATION UNDER ANESTHESIA

Anesthesia procedure (D9248) is a separate benefit, when necessary.

PROCEDURE D7840 CONDYLECTOMY

PROCEDURE D7850

SURGICAL DISCECTOMY, WITH/ WITHOUT IMPLANT

PROCEDURE D7852 DISC REPAIR

PROCEDURE D7854 SYNOVECTOMY

PROCEDURE D7856 MYOTOMY

PROCEDURE D7858 JOINT RECONSTRUCTION

PROCEDURE D7860 ARTHROTOMY

PROCEDURE D7865 ARTHROPLASTY

PROCEDURE D7870 ARTHROCENTESIS

PROCEDURE D7871 NON-ARTHROSCOPIC LYSIS AND LAVAGE

This procedure is included in the fee for other procedures and is not payable separately.

PROCEDURE D7872 ARTHROSCOPY – DIAGNOSIS, WITH OR WITHOUT BIOPSY

PROCEDURE D7873 ARTHROSCOPY – SURGICAL: LAVAGE AND LYSIS OF ADHESIONS

PROCEDURE D7874 ARTHROSCOPY – SURGICAL: DISC REPOSITIONING AND STABILIZATION

PROCEDURE D7875 ARTHROSCOPY – SURGICAL: SYNOVECTOMY

PROCEDURE D7876 ARTHROSCOPY – SURGICAL: DISCECTOMY

PROCEDURE D7877 ARTHROSCOPY – SURGICAL: DEBRIDEMENT

PROCEDURE D7880 OCCLUSAL ORTHOTIC DEVICE, BY REPORT

1. A benefit for diagnosed TMJ dysfunction.
2. Not a benefit for the treatment of bruxism.

PROCEDURE D7899 UNSPECIFIED TMD THERAPY, BY REPORT

Not a benefit for procedures such as acupuncture, acupressure, biofeedback and hypnosis.

PROCEDURE D7910 SUTURE OF RECENT SMALL WOUNDS UP TO 5 CM

Not a benefit for the closure of surgical incisions.

PROCEDURE D7911 COMPLICATED SUTURE – UP TO 5 CM

Not a benefit for the closure of surgical incisions.

PROCEDURE D7912 COMPLICATED SUTURE – GREATER THAN 5 CM

Not a benefit for the closure of surgical incisions.

PROCEDURE D7920 SKIN GRAFT (IDENTIFY DEFECT COVERED, LOCATION AND TYPE OF GRAFT)

Not a benefit for periodontal grafting.

PROCEDURE D7940 OSTEOPLASTY – FOR ORTHOGNATHIC DEFORMITIES

PROCEDURE D7941 OSTEOTOMY – MANDIBULAR RAMI

PROCEDURE D7943 OSTEOTOMY – MANDIBULAR RAMI WITH BONE GRAFT; INCLUDES OBTAINING THE GRAFT

PROCEDURE D7944 OSTEOTOMY – SEGMENTED OR SUBAPICAL

PROCEDURE D7945 OSTEOTOMY – BODY OF MANDIBLE

PROCEDURE D7946 LEFORT I (MAXILLA – TOTAL)

PROCEDURE D7947 LEFORT I (MAXILLA – SEGMENTED)

PROCEDURE D7948 LEFORT II OR LEFORT III (OSTEOPLASTY OF FACIAL BONES FOR MIDFACE HYPOPLASIA OR RETRUSION) – WITHOUT BONE GRAFT

PROCEDURE D7949 LEFORT II OR LEFORT III – WITH BONE GRAFT

PROCEDURE D7950 OSSEOUS, OSTEOPERIOSTEAL, OR CARTILAGE GRAFT OF THE MANDIBLE OR FACIAL BONES – AUTOGENOUS OR NONAUTOGENOUS, BY REPORT

Not a benefit for periodontal grafting.

PROCEDURE D7951 SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTES VIA A LATERAL OPEN APPROACH

A benefit only for patients with authorized implant services.

PROCEDURE D7952 SINUS AUGMENTATION WITH BONE OR BONE SUBSTITUTE VIA A VERTICAL APPROACH

A benefit only for patients with authorized implant services.

PROCEDURE D7953 BONE REPLACEMENT GRAFT FOR RIDGE PRESERVATION- PER SITE

This procedure is not a benefit.

PROCEDURE D7955 REPAIR OF MAXILLOFACIAL SOFT AND/OR HARD TISSUE DEFECT

Not a benefit for periodontal grafting.

PROCEDURE D7960 FRENULECTOMY ALSO KNOWN AS FRENECTOMY OR FRENOTOMY – SEPARATE PROCEDURE NOT IDENTICAL TO ANOTHER

A benefit

a. once per arch per date of service

b. only when the permanent incisors and cuspids have erupted.

PROCEDURE D7963 FRENULOPLASTY

A benefit

a. once per arch per date of service.

only when the permanent incisors and cuspids have erupted.

PROCEDURE D7970 EXCISION OF HYPERPLASTIC TISSUE – PER ARCH

1. A benefit once per arch per date of service.
2. Not a benefit for drug induced hyperplasia or where removal of tissue requires extensive gingival recontouring.
3. This procedure is included in the fees for other surgical procedures that are performed in the same area on the same date of service.

PROCEDURE D7971 EXCISION OF PERICORONAL GINGIVA

This procedure is included in the fee for other associated procedures that are performed on the same tooth on the same date of service.

PROCEDURE D7972 SURGICAL REDUCTION OF FIBROUS TUBEROSITY

1. A benefit once per quadrant per date of service.
2. This procedure is included in the fees for other surgical procedures that are performed in the same quadrant on the same date of service.

PROCEDURE D7980 SIALOLITHOTOMY

PROCEDURE D7981 EXCISION OF SALIVARY GLAND, BY REPORT

PROCEDURE D7982 SIALODOCHOPLASTY

PROCEDURE D7983 CLOSURE OF SALIVARY FISTULA

PROCEDURE D7990 EMERGENCY TRACHEOTOMY

PROCEDURE D7991 CORONOIDECTOMY

PROCEDURE D7995 SYNTHETIC GRAFT – MANDIBLE OR FACIAL BONES, BY REPORT

Not a benefit for periodontal grafting.

PROCEDURE D7996 IMPLANT – MANDIBLE FOR AUGMENTATION PURPOSES (EXCLUDING ALVEOLAR RIDGE), BY REPORT

This procedure is not a benefit.

PROCEDURE D7997 APPLIANCE REMOVAL (NOT BY DENTIST WHO PLACED APPLIANCE), INCLUDES REMOVAL OF ARCH BAR

1. A benefit:
   a. once per arch per date of service.
   b. for the removal of appliances related to surgical procedures only.
2. Not a benefit for the removal of orthodontic appliances and space maintainers.

PROCEDURE D7998 INTRAORAL PLACEMENT OF A FIXATION DEVICE NOT IN CONJUNCTION WITH A FRACTURE

This procedure is not a benefit.

PROCEDURE D7999 UNSPECIFIED ORAL SURGERY PROCEDURE, BY REPORT

1. Procedure D7999 shall be

used:

a. for a procedure which is not adequately described by a CDT code, or

b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Orthodontic General Policies (D8000-D8999)

1. **Orthodontic Procedures (D8080, D8660, D8670 and D8680)**
   a. Orthodontic procedures shall only be performed by dentists who qualify as orthodontists under the California Code of Regulations, Title 22, Section 51223(c).
   b. Orthodontic procedures are benefits for medically necessary handicapping malocclusion, cleft palate and facial growth management cases for patients under the age of 19 and shall be prior authorized.
   c. Only those cases with permanent dentition shall be considered for medically necessary handicapping malocclusion, unless the patient is age 13 or older with primary teeth remaining. Cleft palate and craniofacial anomaly cases are a benefit for primary, mixed and permanent dentitions. Craniofacial anomalies are treated using facial growth management.
   d. All necessary procedures that may affect orthodontic treatment shall be completed before orthodontic treatment is considered.
   e. Orthodontic procedures are a benefit only when the diagnostic casts verify a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09) or one of the six automatic qualifying conditions below exist or when there is written documentation of a craniofacial anomaly from a credentialed specialist on their professional letterhead.
   f. The automatic qualifying conditions are:
      i) cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
      ii) craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
      iii) a deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
      iv) a crossbite of individual anterior teeth causing destruction of soft tissue,
      v) an overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
      vi) a severe traumatic deviation (such as loss of a premaxilla segment by burns, accident or osteomyelitis or other gross pathology). Written documentation of the trauma or pathology shall be submitted with the prior authorization request.
   g. When a patient transfers from one orthodontist to another orthodontist, prior authorization shall be submitted:
      i) when the patient has already qualified and has been receiving treatment, the balance of the originally authorized treatment shall be authorized to the new orthodontist to complete the case. Diagnostic casts, Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09), and photographs are not required for a transfer case that has already been approved, or
      ii) when a patient has been receiving orthodontic treatment that has not been previously approved, pre-treatment diagnostic casts and current photographs are required. If pre-treatment diagnostic casts are not available then current diagnostic casts shall be submitted. Prior authorization for the balance of the orthodontic treatment shall be allowed or denied based on plan's evaluation of the diagnostic casts and photographs.

h. When additional periodic orthodontic treatment visit(s) (D8670) are necessary beyond the maximum allowed to complete the case, prior authorization is required. Current photographs are required to justify the medical necessity.

i. If the patient's orthodontic treatment extends beyond the month of their 19th birthday or they become ineligible during treatment, then it is the patient's responsibility to pay for their continued treatment.

j. If the patient's orthodontic treatment is interrupted and orthodontic bands are prematurely removed, then the patient no longer qualifies for continued orthodontic treatment.

k. If the patient's orthodontic bands have to be temporarily removed and then replaced due to a medical necessity, a claim for comprehensive orthodontic treatment of the adolescent dentition (D8080) for rebanding shall be submitted along with a letter from the treating physician or radiologist, on their professional letterhead, stating the reason why the bands needed to be temporarily removed.

Orthodontic Procedures (D8000-D8999)

PROCEDURE D8080
COMPREHENSIVE ORTHODONTIC TREATMENT OF THE ADOLESCENT DENTITION

1. Prior authorization is required. The following shall be submitted together for prior authorization:
   a. comprehensive orthodontic treatment of the adolescent dentition (D8080), and
   b. periodic orthodontic treatment visit(s) (D8670), and
   c. orthodontic retention (D8680), and
   d. the diagnostic casts (D0470), and
   e. a completed Handicapping Labio- Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09).
2. No treatment will be authorized after the month of the patient's 19th birthday.
3. Written documentation for prior authorization for cleft palate and facial growth management cases shall be submitted:
   a. cleft palate cases require documentation from a credentialed specialist, on their professional letterhead, if the cleft palate is not visible on the diagnostic casts, or facial growth management cases require documentation from a credentialed specialist, on their professional letterhead, of the craniofacial anomaly.
4. A benefit:
   a. for handicapping malocclusion, cleft palate and facial growth management cases.
   b. for patients under the age of 19.
   c. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
   d. once per patient per phase of treatment.
5. All appliances (such as bands, arch wires, headgear and palatal expanders) are included in the fee for this procedure. No additional charge to the patient is permitted.
6. This procedure includes the replacement, repair and removal of brackets, bands and arch wires by the original provider.

PROCEDURE D8210
REMOVABLE APPLIANCE THERAPY

1. Prior authorization is required.
2. Radiographs for prior authorization–submit current periapical radiographs of the maxillary anterior teeth.
3. Written documentation for prior authorization–shall justify the medical necessity for the appliance and the presence of a harmful oral habit such as thumb sucking and/or tongue thrusting.
4. A benefit:
   a. for patients ages 6 through 12.
   b. once per patient.
5. Not a benefit:
   a. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.
   b. for space maintainers in the upper or lower anterior region.
6. This procedure includes all adjustments to the appliance.

PROCEDURE D8220
FIXED APPLIANCE THERAPY

1. Prior authorization is required.
2. Radiographs for prior authorization–submit current periapical radiographs of the maxillary anterior teeth.

3. Written documentation for prior authorization – shall justify the medical necessity for the appliance and the presence of a

harmful oral habit such as thumb sucking and/or tongue thrusting.

4. A benefit:

   a. for patients ages 6 through 12.

   b. once per patient.

5. Not a benefit:

   a. for orthodontic appliances, tooth guidance appliances, minor tooth movement, or activating wires.

   b. for space maintainers in the upper or lower anterior region.

6. This procedure includes all adjustments to the appliance.

PROCEDURE D8660 PRE-ORTHODONTIC TREATMENT VISIT

1. This procedure is for the observation of the patient's oral and/or facial growth for craniofacial anomalies prior to starting orthodontic treatment for facial growth management cases.

2. Prior authorization is required. The following shall be submitted together for authorization:

   a. comprehensive orthodontic treatment of the adolescent dentition (D8080), and

   b. pre-orthodontic treatment visit(s) (D8660) indicating the quantity of treatment visits required up to a maximum of six during the patient's lifetime, and

   c. periodic orthodontic treatment visit(s) (D8670), and

orthodontic retention (D8680), and

   d. a completed Handicapping Labio- Lingual Deviation (HLD) Index California Modification Score Sheet Form, DC016 (06/09).

3. Written documentation for prior authorization- shall include a letter from a credentialed specialist, on their professional letterhead, confirming a craniofacial anomaly.

4. A benefit:

   a. prior to comprehensive orthodontic treatment of the adolescent dentition (D8080) for the initial treatment phase for facial growth management cases regardless of how many dentition phases are required.

   b. once every three months.

   c. for patients under the age of 19.

   d. for a maximum of six.

PROCEDURE D8670 PERIODIC ORTHODONTIC TREATMENT VISIT (AS PART OF CONTRACT)

1. Prior authorization is required. Refer to Orthodontic General Policies for specific authorization requirements.

2. The start of payments for this procedure shall be the next calendar month following the date of service for comprehensive orthodontic treatment of the adolescent dentition (D8080).

3. A benefit:

   a. for patients under the age of 19.

   b. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).

   c. once per calendar quarter.

4. The maximum quantity of monthly treatment visits for the following phases are:

   a. Malocclusion- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or

   b. Cleft Palate:

      i) Primary dentition – up to a maximum of 4 quarterly visits. (2 additional

quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

ii) Mixed dentition - up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

iii) Permanent dentition- up to a maximum of 10 quarterly visits. (5 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity), or

c. Facial Growth Management:

i) Primary dentition- up to a maximum of 4 quarterly visits. (2 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

ii) Mixed dentition- up to a maximum of 5 quarterly visits. (3 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

iii) Permanent dentition- up to a maximum of 8 quarterly visits. (4 additional quarterly visits shall be authorized when documentation and photographs justify the medical necessity).

PROCEDURE D8680 ORTHODONTIC RETENTION (REMOVAL OF APPLIANCES, CONSTRUCTION AND PLACEMENT OF RETAINER(S))

1. Prior authorization is required. Refer to Orthodontic General Policies for specific authorization requirements.
2. This procedure shall be paid only following the completion of periodic orthodontic treatment visit(s) (D8670) which is considered to be the active phase of orthodontic treatment.
3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 19.
   b. for permanent dentition (unless the patient is age 13 or older with primary teeth still present or has a cleft palate or craniofacial anomaly).
   c. once per arch for each authorized phase of orthodontic treatment.
5. Not a benefit until the active phase of orthodontic treatment (D8670) is completed. If fewer than the authorized number of periodic orthodontic treatment visit(s) (D8670) are necessary because the active phase of treatment has been completed early, then this shall be documented on the claim for orthodontic retention (D8680).
6. The removal of appliances, construction and placement of retainers, all observations and necessary adjustments are included in the fee for this procedure.

PROCEDURE D8691 REPAIR OF ORTHODONTIC APPLIANCE

1. This procedure does not require prior authorization.
2. Written documentation for payment – indicate the type of orthodontic appliance and a description of the repair.
3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 19.
   b. once per appliance.
5. Not a benefit to the original provider for the replacement and/or repair of brackets, bands, or arch wires.

PROCEDURE D8692 REPLACEMENT OF LOST OR BROKEN RETAINER

1. This procedure does not require prior authorization.
2. Written documentation for payment – indicate how the retainer was lost or why it is no

longer serviceable.

3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 19.
   b. once per arch.
   c. only within 24 months following the date ofservice of orthodontic retention (D8680).
5. This procedure is only payable when orthodontic retention (D8680) has been previously paid by the program.

PROCEDURE D8693 REBONDING OR RECEMENTING: AND/OR REPAIR, AS REQUIRED, OF FIXED RETAINERS

1. This procedure does not require prior authorization.
2. Submission of radiographs, photographs or written documentation demonstrating medical necessity is not required for payment.
3. Requires an arch code.
4. A benefit:
   a. for patients under the age of 19.
   b. once per provider.
5. Additional requests beyond the stated frequency limitations shall be considered for payment when the medical necessity is documented and identifies an unusual condition (such as displacement due to a sticky food item).

PROCEDURE D8999 UNSPECIFIED ORTHODONTIC PROCEDURE, BY REPORT

1. Prior authorization is required for non-emergency procedures.
2. Radiographs for prior authorization - submit radiographs if applicable for the type of procedure.
3. Photographs for prior authorization - submit photographs if applicable for the type of procedure.
4. Written documentation for prior authorization or payment – describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed or actual treatment.
5. A benefit for patients under the age of 19.
6. Not a benefit to the original provider for the adjustment, repair, replacement or removal of brackets, bands or arch wires.
7. Procedure D8999 shall be used:
   a. for a procedure which is not adequately described by a CDT code, or
   b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Adjunctive General Policies (D9000-D9999)

Anesthesia (D9210-D9248)

a) General anesthesia (D9223) is defined as a controlled state of unconsciousness, accompanied by a partial or complete loss of protective reflexes, including the loss of the ability to independently maintain an airway and respond purposefully to physical stimulation or verbal command, produced by a pharmacologic or non-pharmacologic method or combination thereof.

b) Intravenous sedation/analgesia (D9241 and D9243) is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes intravenous (IV) administration of sedative and/or analgesic agent(s) and appropriate monitoring.

c) Non-intravenous conscious sedation (D9248) is a medically controlled state of depressed consciousness while maintaining the patient's airway, protective reflexes and the ability to respond to stimulation or verbal commands. It includes administration of sedative and/or analgesic agent(s) by a route other than IV (oral, patch, intramuscular or subcutaneous) and appropriate monitoring.

d) Deep sedation/general anesthesia (D9223) and intravenous conscious sedation/ analgesia (D9241 and D9243) shall be considered for payment when it is documented why local anesthesia is contraindicated. Such contraindications shall include the following:

   i) a severe mental or physical handicap,

   ii) extensive surgical procedures,

   iii) an uncooperative child,

   iv) an acute infection at an injection site,

   v) a failure of a local anesthetic to control pain.

e) The administration of deep sedation/general anesthesia (D9223), nitrous oxide (D9230), intravenous conscious sedation/analgesia (D9241 and D9243) and therapeutic parenteral drug (D9610) is a benefit in conjunction with payable associated procedures.

f) Only one anesthesia procedure is payable per date of service regardless of the methods of administration or drugs used. When one or more anesthesia procedures are performed only the most profound procedure will be allowed. The following anesthesia procedures are listed in order from most profound to least profound:

   i) Procedure D9221 (Deep Sedation/General Anesthesia),

   ii) Procedure D9241/D9242 (Intravenous Conscious Sedation/Analgesia),

   iii) Procedure D9248 (Non-Intravenous Conscious Sedation),

   iv) Procedure D9230 (Inhalation Of Nitrous Oxide/Analgesia, Anxiolysis).

g) Providers who administer general anesthesia (D9223) and/or intravenous conscious sedation/analgesia (D9241 and D9243) shall have valid anesthesia permits with the California Dental Board.

h) The cost of analgesic and anesthetic agents and supplies are included in the fee for the analgesic/ anesthetic procedure.

I) Anesthesia time for general anesthesia and intravenous conscious sedation is defined as the period between the beginning of the administration of the anesthetic agent and the time that the anesthetist is no longer in personal attendance.

J) Sedation is a benefit in conjunction with the surgical removal of wires, bands, splints and arch bars.

Adjunctive Service Procedures (D9000-D9999)

PROCEDURE D9110 PALLIATIVE (EMERGENCY) TREATMENT OF DENTAL PAIN – MINOR

1. A benefit once per date of service per provider regardless of the number of teeth and/or areas treated.
2. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.

PROCEDURE D9120 FIXED PARTIAL DENTURE SECTIONING

1. Requires a tooth code for the retained tooth.
2. A benefit when at least one of the abutment teeth is to be retained.

PROCEDURE D9210 LOCAL ANESTHESIA NOT IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES

1. A benefit:
   a. once per date of service per provider.
   b. only for use in order to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state.
2. Not a benefit when any other treatment is performed on the same date of service, except when radiographs/ photographs are needed of the affected area to diagnose and document the emergency condition.

PROCEDURE D9211 REGIONAL BLOCK ANESTHESIA

This procedure is included in the fee for other procedures and is not payable separately.

PROCEDURE D9212 TRIGEMINAL DIVISION BLOCK ANESTHESIA

This procedure is included in the fee for other procedures and is not payable separately.

PROCEDURE D9215 LOCAL ANESTHESIA IN CONJUNCTION WITH OPERATIVE OR SURGICAL PROCEDURES

This procedure is included in the fee for other procedures and is not payable separately.

PROCEDURE D9230 INHALATION OF NITROUS OXIDE/ANXIOLYSIS, ANALGESIA

1. Written documentation for patients age 13 or older- shall indicate the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
2. A benefit:
   a. for uncooperative patients under the age of 13, or
   b. for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
3. Not a benefit:
   a. on the same date of service as deep sedation/general anesthesia (D9223), intravenous conscious sedation/ analgesia (D9241 and D9243) or non-intravenous conscious sedation (D9248).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9241 INTRAVENOUS CONSCIOUS SEDATION/ANALGESIA – FIRST 30 MINUTES

1. Written documentation–shall justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthetic agent.
2. Not a benefit:
   on the same date of service as deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or non- intravenous conscious sedation (D9248).
   a. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9248 NON-INTRAVENOUS CONSCIOUS SEDATION

1. Written documentation for patients age 13 or older- shall indicate the physical,

behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.

2. A benefit:
   a. for uncooperative patients under the age of 13, or
   b. for patients age 13 or older when documentation specifically identifies the physical, behavioral, developmental or emotional condition that prohibits the patient from responding to the provider's attempts to perform treatment.
   c. for oral, patch, intramuscular or subcutaneous routes of administration.
   d. once per date of service.
3. Not a benefit:
   on the same date of service as deep sedation/general anesthesia (), analgesia, anxiolysis, inhalation of nitrous oxide (D9230) or intravenous conscious sedation/ analgesia (D9241 and D924).
   a. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9310 CONSULTATION - (DIAGNOSTIC SERVICE PROVIDED BY DENTIST OR PHYSICIAN OTHER THAN REQUESTING DENTIST OR PHYSICIAN

PROCEDURE D9410 HOUSE/EXTENDED CARE FACILITY CALL

A benefit:

a. once per patient per date of service.

only in conjunction with procedures that are payable.

PROCEDURE D9420 HOSPITAL OR AMBULATORY SURGICAL CENTER CALL

Not a benefit:

a. for an assistant surgeon.
b. for time spent compiling the patient history, writing reports or for post- operative or follow up visits.

PROCEDURE D9430 OFFICE VISIT FOR OBSERVATION (DURING REGULARLY SCHEDULED HOURS) – NO OTHER SERVICES PERFORMED

Not a benefit:

a. when procedures other than necessary radiographs and/or photographs are provided on the same date of service.
b. for visits to patients residing in a house/ extended care facility.

PROCEDURE D9440 OFFICE VISIT – AFTER REGULARLY SCHEDULED HOURS

1. A benefit
   a. once per date of service per provider.
   b. only with treatment that is a benefit.
2. This procedure is to compensate providers for travel time back to the office for emergencies outside of regular office hours.

PROCEDURE D9610 THERAPEUTIC PARENTERAL DRUG, SINGLE ADMINISTRATION

1. A benefit for up to a maximum of four injections per date of service.
2. Not a benefit:
   a. for the administration of an analgesic or sedative when used in conjunction with deep sedation/general anesthesia (D9223), analgesia, anxiolysis, inhalation of nitrous oxide (D9230), intravenous conscious sedation/ analgesia (D9241 and D9243) or non- intravenous conscious sedation (D9248).
   b. when all associated procedures on the same date of service by the same provider are denied.

PROCEDURE D9612 THERAPEUTIC PARENTERAL DRUG, TWO OR MORE ADMINISTRATIONS, DIFFERENT MEDICATIONS

PROCEDURE D9910 APPLICATION OF DESENSITIZING MEDICAMENT

1. A benefit:
   a. once in a 12-month period per provider.
   b. for permanent teeth only.
2. Not a benefit:
   a. when used as a base, liner or adhesive under a restoration.
   b. the same date of service as fluoride (D1206 and

D1208).

PROCEDURE D9930 TREATMENT OF COMPLICATIONS (POST-SURGICAL) – UNUSUAL CIRCUMSTANCES, BY REPORT

1. A benefit:
   a. once per date of service per provider.
   b. for the treatment of a dry socket or excessive bleeding within 30 days of the date of service of an extraction.
   c. for the removal of bony fragments within 30 days of the date of service of an extraction.
2. Not a benefit:
   a. for the removal of bony fragments on the same date of service as an extraction.
   b. for routine post-operative visits.

PROCEDURE D9950 OCCLUSION ANALYSIS – MOUNTED CASE

1. A benefit:
   a. once in a 12-month period.
   b. for patients age 13 or older.
   c. for diagnosed TMJ dysfunction only.
   d. for permanent dentition.
2. Not a benefit for bruxism only.

PROCEDURE D9951 PROCEDURE OCCLUSAL ADJUSTMENT - LIMITED

1. A benefit:
   a. once in a 12-month period per quadrant per provider.
   b. for patients age 13 or older.
   c. for natural teeth only.
2. Not a benefit within 30 days following definitive restorative, endodontic, removable and fixed prosthodontic treatment in the same or opposing quadrant.

PROCEDURE D9952 OCCLUSAL ADJUSTMENT - COMPLETE

1. A benefit:
   a. once in a 12-month period following occlusion analysis-mounted case (D9950).
   b. for patients age 13 or older.
   c. for diagnosed TMJ dysfunction only.
   d. for permanent dentition.
2. Not a benefit in conjunction with an occlusal orthotic device (D7880).

PROCEDURE D9999 UNSPECIFIED ADJUNCTIVE PROCEDURE, BY REPORT

Procedure D9999 shall be used:

a. for a procedure which is not adequately described by a CDT code, or
b. for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the medical condition and the specific CDT code associated with the treatment.

Endnotes to 2017 Dental Standard Benefit Plan Designs Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan, Family Dental Plan or Group Dental Plan)

1) Deductible is waived for Diagnostic and Preventive Services.
2) Cost sharing payments made by each individual child for in-network covered services accrue to the child's out-of-pocket maximum. Once the child's individual out of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family out-of-pocket maximum.
4) In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of-pocket maximum.
5) Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
6) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.
7) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.

Supplemental Benefit Plan

Assisted Reproductive Technologies (ART) C

General Information

Sharp Health Plan provides the following supplemental evidence of covered benefits for *Infertility* treatment in addition to the coverage's described in your Member Handbook. Under this supplemental benefit plan, you are entitled to receive the benefits described below, subject to all the terms, conditions, exclusions and limitations described in the Member Handbook. The glossary on the reverse of this handout defines the italicized words used throughout.

How Does This Plan Work for Me?

- You have direct access to OB/GYNs in your Plan Medical Group for diagnosis and treatment of *Infertility* (your OB/GYN will refer you to an *Infertility* specialist if needed).
- You must obtain covered benefits from Plan Providers.
- The Plan does not cover services that are not obtained from a Plan Provider, and you must pay for those services yourself.
- Always present your Sharp Health Plan Member ID card to Plan Providers, and ask them to inform you if something will not be covered.
- You pay the Copayments for the covered benefits listed below.

What Are My Covered Benefits and Copayments?

Treatment for Infertility is a covered benefit. "*Treatment for Infertility*" means procedures consistent with established medical practices in the treatment of *Infertility* by licensed physicians and surgeons including, but not limited to, diagnosis, diagnostic tests, medication, surgery, and *Gamete Intrafallopian Transfer*.

For diagnosed *Infertility*, the following are covered benefits:

- *Artificial Insemination* services up to a *Lifetime* maximum of three inseminations
- *Assisted Reproductive Technologies (ART)* procedures up to a combined *Lifetime* maximum of three cycles for any combination of procedures
- Covered *ART* procedures are limited to *Gamete Intrafallopian Transfer (GIFT)*

The Member pays Copayments equal to **50 percent** of the Plan's scheduled or contracted rate of payment, whichever is less, to each Plan Provider of services for all covered *Infertility* services.

What Is Not Covered?

The Plan excludes or limits the services and supplies listed below:

- The collection, preservation or purchase of sperm, ova or embryos
- Any services relating to cryopreservation including, but not limited to, collection, storage, thawing, or procedures employing sperm, ova, or embryos that have been cryopreserved
- Reversal of voluntary sterilization
- Surrogacy services or supplies
- *Assisted Reproductive Technologies (ART)* procedures other than *GIFT*
- Procedures that are not covered include, but are not limited to, *Assisted Hatching,* blastocyst transfer*, Intracytoplasmic Sperm Injections (ICSI),* multi-cell embryo transfer *(TET), Zygote Intrafallopian Transfer (ZIFT),* and any other procedures that may be employed to bring about conception without sexual intercourse
- Any service, procedure or process that prepares the member for non-covered *ART* procedures

SHARP HEALTH PLAN
Welcome home.

Assisted Reproductive Technologies (ART) C (continued)

Glossary

We have italicized the following words throughout the handout to let you know they are defined in this glossary. These words pertain only to the covered benefits for the treatment of *Infertility* described in this handout.

Artificial Insemination is the depositing of sperm by syringe into the vagina near the cervix or directly into the uterus. This technique is used to overcome sexual performance problems, to circumvent sperm-mucus interaction problems, to maximize the potential for poor semen and for using donor sperm.

Assisted Hatching is a procedure whereby a small hole is dissolved into the zona pellucida, the soft shell surrounding the embryo that protects it during early development, to allow the embryo to hatch out and implant into the uterine wall.

Assisted Reproductive Technologies (ART) are a set of several procedures that may be employed to bring about conception without sexual intercourse.

Gamete Intrafallopian Transfer (GIFT) is a procedure whereby unfertilized ovum are removed from the female and inserted along with sperm into the fallopian tube for the purpose of enhancing the chance of conception.

Intracytoplasmic Sperm Injection (ICSI) is a procedure whereby a single active sperm is injected into the egg outside the body and inserted into the fallopian tube for the purpose of enhancing the chance of conception.

In Vitro Fertilization (IVF) is a procedure whereby unfertilized ovum are removed from the female, fertilized with a donor's sperm outside the body, and implanted directly into the uterus in an attempt to achieve pregnancy.

Infertility is the diminished or absent ability to conceive and subsequently produce offspring after unprotected sexual relations on a regular basis in excess of a period of 12 months; or the presence of a demonstrated condition recognized by a licensed physician or surgeon as a cause of infertility.

Lifetime means any attempts or treatments rendered during the Member's coverage under the Plan at anytime during the Member's lifetime.

Treatment for Infertility means procedures consistent with established medical practices in the treatment of *Infertility* by licensed physicians and surgeons including, but not limited to, diagnosis, diagnostic tests, medication, surgery, and *Gamete Intrafallopian Transfer*.

Zygote Intrafallopian Transfer (ZIFT) is a procedure whereby unfertilized ovum are removed from the female and fertilized with a donor's sperm outside the body. The pronuclear stage embryo is then inserted into the fallopian tube in an attempt to achieve pregnancy.

If you have questions regarding your coverage under this supplemental benefit plan, please contact Sharp Health Plan Customer Care at (858) 499-8300 or 1-800-359-2002, or visit www.SharpHealthPlan.com.

English

If you, or someone who you are helping, has questions about Sharp Health Plan, you have the right to obtain help and information in your language without any cost to you. To speak with an interpreter, call (800) 359-2002.

Español (Spanish)

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Sharp Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 800-359-2002.

繁體中文 (Chinese)

如果您，或是您正在協助的對象，有關Sharp Health Plan代碼及範圍方面有疑問，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 (800) 359-2002。

Tiếng Việt (Vietnamese)

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Sharp Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (800) 359-2002.

Tagalog (Tagalog – Filipino)

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Sharp Health Plan, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa (800) 359-2002.

한국어**(Korean)**

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Sharp Health Plan에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 (800) 359-2002로 전화하십시오.

Հայերեն (Armenian)

Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Sharp Health Plan մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք (800) 359-2002:

Persian

اگر شما، یا کسی که شما به او کمک میکنید ، در مورد سوال Sharp Health Plan ، کمک که دارید را این حق باشید داشته نمایید دریافت رایگان طور به را خود زبان به اطلاعات و (800) 359-2002. نمایید حاصل تماس .

Русский (Russian)

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Sharp Health Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (800) 359-2002.

日本語 (Japanese)

ご本人様、またはお客様の身の回りの方でも、Sharp Health Planについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(800) 359-2002までお電話ください。

العربية **(Arabic)**

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Sharp Health Plan ، فلديك الحق في الحصول على المساعدة والمعلومات المساعدة بلغتك الضرورية. ب اتصل مترجم مع للتحدث (800) 359-2002) تكلفة اية دون من

ਪੰਜਾਬੀ (Punjabi)

ਜੇ ਤੁਹਾਨੂੰ , ਜਾਂ ਤੁਸੀ ਜਿਸ ਦੀ ਮਦਦ ਕਰ ਰਹੇ ਹੋ , Sharp Health Plan ਕੋਈ ਸਵਾਲ ਹੈ ਤਾਂ, ਤੁਹਾਨੂੰ ਬਿਨਾ ਕਿਸੇ ਕੀਮਤ 'ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ . ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (800) 359-2002 ਤੇ ਕਾਲ ਕਰੋ .

ខ្មែរ (Mon Khmer, Cambodian)

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងដែលជួយ ម្នាក់ Sharp Health Plan លេ, អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មាន លៅកនុងភាសា អស់អ្នក លោយមិនអ្ប៉ូប្ចាក់ ។ ដើមបីនិយាយជាមួយអ្នកកដ្ប្ រ សូម (800) 359-2002 ។

Hmoob (Hmong)

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Sharp Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau (800) 359-2002.

हिंदी (Hindi)

यदि आपके ,या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के Sharp Health Plan के बारे में प्रश्न हैं , तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुभाषिए से बात करने के लिए , (800) 359-2002 पर कॉल करें।

ภาษาไทย (Thai)

หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคาถามเกี่ยวกับ Sharp Health Plan คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร (800) 359-2002

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

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (such as large print, audio, accessible electronic formats, or other formats)

- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Jamie Ryan, Director of Operations at (858) 499-8275.

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Sharp Health Plan
Appeal/Grievance Department
Attn: Jamie Ryan, Director of Operations
8520 Tech Way, Suite 200
San Diego, CA 92123-1450
Toll-free: 1-800-359-2002
1-800-735-2929 TTY
Fax: (619) 740-8572

You can file a grievance in person or by mail, fax, or you can also complete the online Grievance/Appeal form on the Plan's website sharphealthplan.com. If you need help filing a grievance, Jamie Ryan, Director of Operations is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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