Evidence of Coverage and Disclosure Form

Effective January 1, 2026

Sharp Performance Plus HMO Basic Plan

Health Maintenance Organization (HMO)

SHARP Health Plan

Contracted by the CalPERS Board of Administration Under the Public Employees' Medical & Hospital Care Act (PEMHCA)

CalPERS

Pending DMHC Approval

This booklet is your **Combined Evidence of Coverage and Disclosure Form** that discloses the terms and conditions of coverage. Applicants have the right to view this Evidence of Coverage prior to enrollment. This Evidence of Coverage is only a summary of Covered Benefits available to you as a Sharp Health Plan Member.

The Group Agreement and this Evidence of Coverage may be amended at any time. In the case of a conflict between the Group Agreement and this Evidence of Coverage, the provisions of this Evidence of Coverage shall be binding upon Sharp Health Plan notwithstanding any provisions in the Group Agreement that may be less favorable to Members.

THERE IS NO VESTED RIGHT TO RECEIVE ANY PARTICULAR BENEFIT SET FORTH IN THE PLAN. PLAN BENEFITS MAY BE MODIFIED. ANY MODIFIED BENEFIT (SUCH AS THE ELIMINATION OF A PARTICULAR BENEFIT OR AN INCREASE IN THE MEMBER'S COPAYMENT) APPLIES TO SERVICES OR SUPPLIES FURNISHED ON OR AFTER THE EFFECTIVE DATE OF THE MODIFICATION.

This Evidence of Coverage provides you with information on how to obtain Covered Benefits and the circumstances under which these benefits will be provided to you. We recommend you read this Evidence of Coverage 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 and to better understand your coverage, we have capitalized words throughout this Evidence of Coverage. Please refer to the **Glossary** section for detailed definitions.

Please contact us with questions about this Evidence of Coverage.

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

Email: customer.service@sharp.com
Call toll-free: 1-855-995-5004
7 a.m. to 8 p.m., 7 days a week

SHARP Health Plan

sharphealthplan.com/CalPERS

Table of Contents

Summary of Benefits

CalPERS Sharp Performance Plus HMO

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. PLEASE CONTACT YOUR EMPLOYER FOR SPECIFIC INFORMATION ON YOUR COVERAGE OR VISIT SHARPHEALTHPLAN.COM/CALPERS TO VIEW THE MEMBER HANDBOOK.

Covered Benefits	Cost Share
Annual Deductible and Out-of-Pocket Maximum	
There are no deductibles for the medical benefits under this plan	$0
Annual out of pocket maximum (per individual/per family)[1]	$1,500 / $3,000
Lifetime Maximum	
There are no lifetime maximums for this plan	Unlimited
Preventive Care[2]	
Well-baby and well-child (to age 18) physical exams, immunizations and related laboratory services	$0
Routine adult physical exams, immunizations and related laboratory services	$0
Laboratory, radiology and other services for the early detection of disease when ordered by a Physician	$0
Routine gynecological exams, immunizations and related laboratory services	$0
Mammography	$0
Prostate cancer screening	$0
Colorectal cancer screenings including sigmoidoscopy and colonoscopy	$0
Best Health℠ Wellness Services	
On-line health education and wellness workshops and other wellness tools	$0
Telephonic health coaching (weight management, tobacco cessation, stress management, physical activity, nutrition)	$0
Professional Services	
Primary Care Physician office visit for consultation, treatment, diagnostic testing, etc.	$15 / visit
Specialist Physician office visit for consultation, treatment, diagnostic testing, etc.	$15 / visit
Laboratory tests and services	$0
Radiology services (X-rays and diagnostic imaging)	$0
Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	$0 / visit
Allergy testing	$0
Allergy injections	$0
Hearing exam	$0
Audiological exam	$0

Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)	
Outpatient facility fee	$0 / visit
Outpatient Physician/Surgeon fee	$0
Infusion therapy (including but not limited to chemotherapy)	variable[3]
Dialysis	$0
Rehabilitation services: physical, occupational and speech therapy	$15 / visit
Habilitation services	$15 / visit
Radiation therapy	variable[3]
Hospitalization (Including but not limited to inpatient services, organ transplant, and inpatient rehabilitation)	
Facility fee	$0 / admission
Physician/surgeon fee	$0
Emergency and Urgent Care Services	
Emergency room services facility fee (waived if admitted to the hospital)	$50 / visit
Emergency room services physician fee (waived if admitted to the hospital)	$0
Urgent care services	$15 / visit
Medical Transportation	
Emergency medical transportation	$0
Non-emergency medical transportation	$0
Maternity Care	
Prenatal and postpartum office visits	$0
Delivery and all inpatient services – Hospital	$0 / admission
Delivery and all inpatient services – Professional	$0
Breastfeeding support, supplies and counseling	$0
Family Planning Services	
Contraceptives (including but not limited to all FDA-approved drugs, supplies, devices, implants, injections, and other products	$0
Voluntary sterilization – women	$0
Voluntary sterilization – men	$0
Interruption of pregnancy (including but not limited to office visits, outpatient surgery, and inpatient services)	$0
Infertility services (diagnosis and treatment of underlying condition)	50% coinsurance[4]
Doula Services[8]	
Prenatal and postpartum visits (Doula services are covered with no charge to the member up to the allowable visit limits)	$0
Durable Medical Equipment and Other Supplies	
Durable medical equipment	$0
Diabetic supplies	$0
Prosthetics and orthotics	$15 / visit

Mental Health Services[5]	
Office visits	$15 / visit
Group therapy	$15 / visit
Other outpatient items and services (including but not limited to Home-based applied behavioral analysis for treatment of autism)	$0 / visit
Inpatient facility fee	$0 / admission
Inpatient physician fee	$0
Emergency services facility fee (waived if admitted)	$50 / visit
Emergency services physician fee (waived if admitted)	$0
Emergency psychiatric transportation	$0
Non-emergency psychiatric transportation	$0
Urgent care services	$15 / visit
Substance Use Disorder Services[5]	
Office visits	$15 / visit
Group therapy	$7 / visit
Other outpatient items and services	$0 / visit
Inpatient facility fee	$0 / admission
Inpatient physician fee	$0
Emergency services facility fee for alcohol or drug detoxification (waived if admitted)	$50 / visit
Emergency services physician fee for alcohol or drug detoxification (waived if admitted)	$0
Emergency substance use disorder transportation	$0
Non-emergency substance use disorder transportation	$0
Urgent care services	$15 / visit
Skilled Nursing, Home Health and Hospice Services	
Skilled nursing facility services (maximum of 100 days per calendar year)	$0 / admission
Home health services (cost share per visit - maximum of 100 visits per calendar year)	$0
Hospice care – inpatient	$0
Hospice care – outpatient	$0
Prescription Drug Coverage[6] (More information about prescription drug coverage is available at www.caremark.com/calpers)	
Preferred Generic/Preferred Brand/Non-preferred medications up to 30-day supply	$5 / $20 / $50
Preferred Generic/Preferred Brand/Non-preferred medications for a 90-day supply by mail order (for maintenance medications only)	$10 / $40 / $100
Preventive prescription drugs including Preferred Generic and over-the-counter contraceptives	$0
Supplemental Benefits[1]	
Acupuncture/Chiropractic services (maximum of 20 visits combined per calendar year)	$15 / visit
Artificial Insemination (no lifetime maximum)	50% coinsurance[4]

Hearing aids or ear molds (maximum up to $1,000 every 36 months). Hearing aids are covered at 100% in both ears every 36 months when medically necessary to prevent or treat speech and language development delay due to hearing loss. (100% = total cost of hearing aid which may exceed the $1,000 standard allowance)	variable[7]
Vision services (once every 12 months / Exam only)	$0
Eyeglasses or contact lenses (following cataract surgery)	$0

Notes

[1] In a family plan, an individual is responsible only for the single out-of-pocket maximum amount. Cost sharing payments (copayments and coinsurance, but not premiums) made by each individual in a family contribute to the family out-of-pocket maximum. Once the family out-of-pocket maximum is reached, the plan pays all costs for covered services for all family members. Cost sharing payments for all covered benefits accumulate toward the out-of-pocket maximum. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Vision, etc.) do not apply to the annual out of pocket maximum.

[2] Includes preventive services with a rating of A or B from the US Preventive Services Task Force; immunizations for children, adolescents and adults recommended by the Centers of Disease Control; and preventive care and screenings supported by the Health Resources and Services Administration for infants, children, adolescents and women. If preventive care is received at the time of other services, the applicable copayment for such services other than preventive care may apply.

[3] Out of pocket cost is based on type and location of service (e.g. outpatient surgery cost-share for outpatient surgery or specialist office visit cost-share for a service received during a specialist office visit).

[4] Of contracted rates

[5] All medically necessary treatment of mental health and substance use disorders is covered under this plan.

[6] Member cost-share will not exceed $250 per individual prescription of up to a 30-day supply of a covered oral anti-cancer drug. 90-day supply cost share applies to maintenance medications filled by mail order only.

[7] Maximum benefit of $1,000. Member is responsible for any charges over $1,000.

[8] This program is designed to assist mothers (prenatal, postpartum, and interpregnancy) with needs, such as understanding health care benefits, making appointments, and providing health plan and community resources. The Plan offers case management services to members who qualify, which includes members with a maternal mental health condition. Referrals are accepted from any source, including, but not limited to, treating providers (OB/GYN, PCP), members, and/or a facility utilization reviewer/case manager.

Note: Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).

Note: For “Mental Health Services”, “Office Visits” cost-share applies to outpatient office visits, psychological testing, and outpatient monitoring of drug therapy. “Group Therapy” cost-share applies to group mental health evaluation and treatment and group therapy sessions. “Other Outpatient Items and Services” cost-share applies to multidisciplinary treatment in an intensive outpatient psychiatric treatment program, partial hospitalization, and home-based behavioral health treatment for autism spectrum disorder. “Inpatient” cost-share applies to inpatient facility and physician services, mental health psychiatric observation and mental health crisis residential treatment.

Notes, continued

Note: For "Substance Use Disorder Services", "Office Visits" cost-share applies to outpatient office visits, medication treatment for withdrawal, and individual evaluation. "Group Therapy" cost-share applies to substance use disorder group evaluation and group therapy sessions. "Other Outpatient Items and Services" cost-share applies to day treatment programs, intensive outpatient programs, and partial hospitalization. "Inpatient" cost-share applies to the inpatient facility and physician services and substance use disorder transitional residential recovery services in a non-medical residential setting.

Note: The cost of developing an evaluation and the provisions of all health care services required or recommended pursuant to a Community Assistance, Recovery and Empowerment (CARE) Agreement or CARE Plan are covered whether the service is provided by a Plan provider or non-Plan provider. All services are covered without prior authorization and Cost Sharing, except prescription drugs.

Note: Medically Necessary treatment of a Mental Health or Substance Use Disorder including but not limited to, Behavioral Health Crisis Services provided by a 988 center, or mobile crisis team or other provider of Behavioral Health Crisis Services can be provided by Plan providers or non-Plan providers. You will only pay the in-network cost sharing amount for any out-of-network Medically Necessary treatment of a Mental Health or Substance Use Disorder, provided by a 988 center, mobile crisis team or other provider of Behavioral Health Crisis Services.

Benefit Changes for Current Year

For 2026, your Sharp Health Plan benefits will now include Habilitative Services, with a $15 cost share per visit. Please refer to the Summary of Benefits beginning on page 1 for benefit details and the amount Members must pay for Covered Benefits. Please refer to the Sharp Health Plan Rates on page 6 for information about 2026 rates. Benefits are also subject to the "Exclusions and Limitations" section of this Evidence of Coverage. Copayments, Coinsurance, and Deductibles will not change during the Calendar Year.

Rate Tables

Sharp Health Plan Rates for Contracting Agency Employees and Annuitants		
2026		
Single	2-Party	Family
$916.20	$1,832.40	$2,382.12

Sharp Health Plan Rates for State Employees and Annuitants		
2026		
Single	2-Party	Family
$916.20	$1,832.40	$2,382.12

Welcome to Sharp Health Plan

Thank you for selecting Sharp Health Plan's Performance Plus plan for your health plan benefits! Your health and satisfaction with our service are very important to us. If you have any questions about your Evidence of Coverage or your Sharp Health Plan benefits, please visit sharphealthplan.com/CalPERS or email customer.service@sharp.com. You can also call us toll-free at 1-855-995-5004.

Our Customer Care team is available to assist you seven days a week from 7 a.m. to 8 p.m. Additionally, after hours and on weekends, you have access to speak with a specially trained registered nurse for medical advice by calling the same Customer Care phone number.

Sharp Health Plan is a locally based, nonprofit health plan that has been serving San Diegans for over 30 years. Sharp Health Plan continues to be recognized in California and nationally for our affordable, high-quality health care and service for San Diegans of all ages. Visit sharphealthplan.com/honors to learn more.

Important Health Plan Information

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

Evidence of Coverage

This Evidence of Coverage explains your health plan membership, how to use your benefit plan and access care, and who to call if you have questions. This Evidence of Coverage also describes your Covered Benefits and any exclusions or limitations.

In this Evidence of Coverage, "you" or "your" means any Member (Subscriber or Dependent), who has enrolled in the Plan under the provisions of the Group Agreement and for whom the applicable Premiums have been paid.

For easier reading, we have capitalized words throughout this Evidence of Coverage. Please refer to the **Glossary** section for detailed definitions. To access this Evidence of Coverage online, log in to your Sharp Health Plan online account at sharphealthplan.com/CalPERS.

Health Plan Summary of Benefits

Your Health Plan Summary of Benefits outlines the applicable Deductible(s), Coinsurances, Copayments and Out-of-Pocket Maximum that apply to the benefit plan you purchased. The Health Plan Summary of Benefits is considered part of this Evidence of Coverage.

Provider Directories

As a CalPERS Member enrolled in the Performance Plus plan, you have access to providers in the Performance Plan Network. The Provider Directories list Plan Physicians, Plan Hospitals and other Plan Providers in the Performance Plan Network. When selecting your Primary Care Physician (PCP) who will coordinate all your care, you must choose a provider who is in your Plan Network. You will receive all non-emergency Covered Benefits from the Plan Providers in your Plan Network. For your convenience, your Plan Network is listed on your Sharp Health Plan Member identification card.

Our Provider Directories listing the Plan Providers in your Plan Network, including providers in American Specialty Health Plans (acupuncture and chiropractic services), are available online at sharphealthplan.com/CalPERS. Provider directories for Vision Service Plan (vision services) are also available if your benefit plan includes coverage for vision services.

For Mental Health and Substance Use Disorder services, you have direct access to providers in the Magellan provider network. The

Provider Directory can be accessed online at sharphealthplan.com/findadoctor. You can also contact Magellan at 1-844-483-9013 to request a printed directory or if you need assistance with finding a provider.

Member Resource Guide

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

How Does the Plan Work

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

Please read this Evidence of Coverage carefully to understand how to get the most out of your health plan benefits. After you have read the Evidence of Coverage, we encourage you to call Customer Care with any questions. To begin, here are the basics that explain how to make the Plan work best for you.

Choice of Plan Physicians and Plan Providers

Sharp Health Plan Providers are located throughout San Diego County. The Provider Directories list addresses, phone numbers and other information for Plan Providers, including PCPs, hospitals and other facilities.

- The Plan has several physician groups (called Plan Medical Groups or PMGs) from which you select your PCP and through which you receive specialty physician care or access to hospitals and other facilities.
- You select a PCP for yourself and one for each of your Dependents. Look in the Provider Directory for the Performance Plan Network to find your current PCP or select a new one if your doctor is not listed. Dependents who are eligible to enroll in the Performance Plus plan may select different PCPs and PMGs to meet their individual needs. 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 or discharge from the hospital, whichever is later 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 PCP at the time of enrollment, we will select one for you so that you have access to care immediately. If you would like to change your PCP, just call Customer Care. We recognize that the choice of a PCP 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 they have admitting privileges. Since doctors do not usually maintain privileges at all facilities, you may want to check with your doctor to see where they admit patients. If you would like assistance with this information, please call Customer Care.
- For Mental Health and Substance Use Disorder services, you have direct access to providers in the Human Affairs International of California ("Magellan") provider network, as described

under **Mental Health Services** and **Substance Use Disorder Treatment**.

- If the relationship between you and a Plan Physician is unsatisfactory, then you may submit the matter to the Plan and request a change of Plan Physician.
- 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 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 for triage and screening services to assess your health concerns and symptoms. If your PCP is not available or if it is after regular office hours, a message will be taken. Your call will be returned by a qualified health professional within 30 minutes.
- If you are unable to reach your PCP, please call Customer Care. You have access to our nurse advice line evenings and weekends for medical advice.
- If you have an Emergency Medical Condition, call "911" or go to the nearest hospital emergency room.
- All Members have direct and unlimited access to OB/GYN Plan Physicians as well as PCPs (family practice, internal medicine, etc.) in their PCP's PMG for obstetric and gynecologic services.
- All Members have direct access to providers in the Magellan provider network for Mental Health and Substance Use Disorder services, as described under **Mental Health Services** and **Substance Use Disorder Treatment**.

Present Your Member ID Card and Pay Copayment

- Always present your Member ID card when you receive health care services. If you are a new Member, you will receive your ID card within 7-10 business days of your effective date. If you are an existing Member, you will receive a new ID card within 7-10 business days of any applicable changes in your benefits or your PCP. You can also print a temporary ID card by logging into your account online at sharphealthplan.com.
- If you have a new ID card because you changed PCPs or PMGs, be sure to show your provider your new card.
- When you receive care, you pay the provider the applicable Copayment specified on the Health Plan Summary of Benefits. For convenience, some Copayments are also shown on your Member ID card.

Call us with questions toll-free at 1-855-995-5004, 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/CalPERS by logging in to your Sharp Health Plan account.

Access Health Care Services Through Your Primary Care Physician (PCP)

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

If you fail to obtain Authorization from your PCP, care you receive may not be covered by the Plan and you may be responsible to pay 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 PCP's PMG for obstetric and gynecologic services. You will not be required to obtain prior Authorization for sexual and reproductive health services in your Plan Medical Group.

For Mental Health and Substance Use Disorder services, you have direct access to providers in the Magellan provider network, as described under **Mental Health Services** and **Substance Use Disorder Treatment**. Authorization from Magellan may be required for certain services.

Use Sharp Health Plan Providers

You receive Covered Benefits (except those listed below) from Plan Providers who are affiliated with your PMG and who are part of the Performance Plan Network. To find out which Plan Providers are affiliated with your PMG, refer to the Performance Network Provider Directory or call Customer Care. If Covered Benefits are not available from Plan Providers affiliated with your PMG, you will be referred to another Plan Provider to receive such Covered Benefits. Availability of Plan Providers will be assessed based on your specific medical needs, provider expertise, geographical access, and appointment availability. You are responsible to pay for any care not provided by Plan Providers affiliated with your PMG, unless your PMG has Authorized the service in advance or it is an Emergency Service. In some cases, a non-Plan Provider may provide Covered Benefits at an in-network facility where we have Authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the Covered Benefits you receive at in-network facilities or at facilities where we have Authorized you to receive care.

The following services are available from Plan Providers who are not part of your PMG. You do not need a referral from your PCP to access Covered Benefits with these providers:

- Mental Health and Substance Use Disorder services – Magellan contracted providers
- Acupuncture and chiropractic services – American Specialty Health Plans contracted providers
- Outpatient prescription drugs – CVS Caremark contracted pharmacies

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 the Performance Plan Network. If the hospital services you need are not available at a Plan Hospital affiliated with your PMG, you will be referred to another Plan Hospital to receive such hospital services. To find out which

Plan Hospitals are affiliated with your PMG, please check the Performance Network Provider Directory online at sharphealthplan.com/CalPERS, or call Customer Care. You are responsible to pay for any care that is not provided by Plan Hospitals affiliated with your PMG, unless your PMG has Authorized the service in advance or it is an Emergency Service.

Schedule Appointments

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

Timely Access to Care

Making sure you have timely access to care is extremely important to us. Check out the charts below to plan ahead for services.

Appointment Wait Times

Urgent Appointments	Maximum Wait Time After Request
No prior Authorization required	48 hours
Prior Authorization required	96 hours

Non-Urgent Appointments	Maximum Wait Time After Request
PCP (Excludes preventive care appointments)	10 business days
Non-physician mental health care or Substance Use Disorder provider (e.g., psychologist or therapist) (Includes follow-up appointments)	10 business days
Specialist (Excludes follow-up appointments)	15 business days
Ancillary services (e.g., X-rays, lab tests, etc. for the diagnosis and treatment of injury, illness, or other health conditions)	15 business days

Rescheduling Appointments

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

Extended Appointment Scheduling Times

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

Advance Scheduling

Your appointments for preventive and periodic follow up care services (e.g., standing referrals to specialists for chronic conditions, periodic visits to monitor and treat pregnancy, cardiac, or Mental Health or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease) may be scheduled in advance, consistent with professionally recognized standards of practice, and exceed the listed wait times.

Timely Access to Mental Health and Substance Use Disorder Services

If covered Mental Health or Substance Use Disorder services are not available in accordance with required geographic and timely access standards, Magellan shall provide and arrange coverage for Medically Necessary Mental Health and Substance Use Disorder services from an out-of-network provider or providers. Magellan will schedule the appointment

for the Member or arrange for the admission of the Member if inpatient or residential services are Medically Necessary and when accepted by the Member. The offered appointment or admission will be scheduled as follows:

a. No more than ten (10) business days after the initial request for non-urgent services.

b. Within 15 business days of a request for specialist physician Mental Health or Substance Use Disorder services.

c. Within 48 hours of the initial request for Urgent Mental Health or Substance Use Disorder Services when Magellan does not require prior Authorization.

d. Within 96 hours of the initial request for Urgent Mental Health and Substance Use Disorder Services if Magellan requires prior Authorization.

If the Member is unable to attend the appointment offered by Magellan, Magellan will continue to arrange and schedule a new appointment with the same out-of-network provider or a different out-of-network provider to ensure the delivery of Medically Necessary Mental Health or Substance Use Disorder services.

The timeframes noted above may be extended if either of the following is true:

a. The referring or treating licensed Health Care Provider, or the health professional providing triage or screening services, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the Member.

b. The requested services are preventive care services or periodic follow-up care, including periodic office visits to monitor and treat Mental Health or Substance Use Disorder conditions and laboratory and radiological monitoring for recurrence of disease. Such services may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed Health Care Provider acting within the scope of their practice.

Telephone Wait Times

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

After-Hours Triage Services

Your PCP, mental health providers, and Substance Use Disorder providers are required to have an answering service or a telephone answering machine during nonbusiness hours. These services must provide direction telling you how to obtain urgent or emergency care and, if applicable, how you can contact an on-call provider for screening or urgent or emergency care as appropriate.

In addition, after hours and on weekends, registered nurses are available through Sharp Nurse Connection™. They can talk with you about an illness or injury, help you decide where to seek care and provide advice on any of your health concerns. Call 1-800-359-2002 and select the appropriate prompt, 5 p.m. to 8 a.m., Monday to Friday and 24 hours on weekends and holidays.

Interpreter Services at Scheduled Appointments

Sharp Heath Plan provides free interpreter services at scheduled appointments. Interpreter services may be in-person, via video chat, or by telephone, based on the capabilities of your provider and the interpreter. For language interpreter services, please call Customer Care: 1-855-995-5004. The hearing and speech impaired may dial "711" or use California's Relay Service's toll-free numbers to contact us:

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

Members must make requests for interpreting services at scheduled appointments at least five (5) business days prior to the appointment date to allow sufficient time for scheduling an interpreter.

Referrals to Non-Plan Providers

Sharp Health Plan has an extensive network of high-quality Plan Providers throughout San Diego County. Occasionally, however, our Plan Providers may not be able to provide the services you need that are covered by the Plan. If this occurs, your PCP will refer you to a provider where the services you need are available and meet geographic and timely access standards set by law. Sharp Health Plan or PMG will Authorize Medically Necessary out-of-network services when the services are not available in network. You will pay in-network Cost Sharing for out-of-network services Authorized by the Plan, PMG or Magellan. 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.

If Magellan fails to arrange coverage for a Member as set forth in Timely Access to Mental Health and Substance Use Disorder Services, all the following shall apply:

a. The Member or the Member's representative may arrange for the Member to obtain Medically Necessary care from any appropriately licensed provider(s), regardless of whether the provider contracts with Magellan, so long as the Member's first appointment with the provider or admission to the provider occurs no more than 90 calendar days after the date the Member, the Member's representative, or the Member's provider initially submitted a request for covered Mental Health or Substance Use Disorder services to Magellan. If an appointment or admission to a provider is not available within 90 calendar days of initially submitting a request, the Member may arrange an appointment or admission for the earliest possible date outside the 90-day window so long as the appointment or admission was confirmed within 90 days.

b. If the Member receives covered Medically Necessary Mental Health or Substance Use services pursuant to paragraph (a) above from an out-of-network provider, Magellan shall reimburse all claims from the provider(s) for Medically Necessary Mental Health or Substance Use Disorder service(s) delivered to the Member by the provider(s), and shall ensure the Member pays no more than the same Cost Sharing that the Member would pay for the Mental Health or Substance Use Disorder services if the services had been delivered by an in-network provider.

Changing Your Primary Care Physician

It is a good idea to stay with a PCP so they can get to know your health needs and medical history. However, you have the option to change your PCP to a different doctor in the Performance Plan Network for any reason. If you select a PCP in a different PMG, you will have access to a different group of specialists, hospitals, and other providers. Your new PCP may also need to submit Authorization requests for any specialty care, Durable Medical Equipment or other Covered Benefits you need. The Authorizations from your previous PMG will no longer be valid. Be sure to contact your new PCP promptly if you need Authorization for a specialist or other Covered Benefits. See the section below titled **Obtain Required Authorization** for more information.

If you wish to change your PCP, please call or email Customer Care. One of our Customer Care Representatives will help you choose a new doctor. In general, the change will be effective on the first day of the month following your call or email.

Obtain Required Authorization

In most instances you are responsible for obtaining valid Authorization before you receive Covered Benefits.

You do not have to obtain Authorization for:

- PCP services
- Obstetric and gynecologic services, including abortion and abortion-related services, including preabortion and follow-up services

- Vasectomy services and procedures
- Biomarker testing for Members with advanced or metastatic stage 3 or 4 cancer
- Outpatient Mental Health or Substance Use Disorder office visits
- Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other providers of Behavioral Health Crisis Services, including Behavioral Health Crisis Stabilization Services
- Services other than Prescription Drugs provided under a Community Assistance, Recovery, and Empowerment (CARE) Plan or CARE Agreement approved by a court
- MinuteClinic services
- Emergency Services

There are other services listed throughout this document that do not require Authorization; those benefits have specific language stating Authorization is not required. For services not listed above, 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 PMG.
3. If Authorization is approved, obtain the expiration date for the Authorization. You must access care before the expiration date with the Plan Provider identified in the approved Authorization.

A decision will be made on the Authorization request 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 in a timely fashion based on the nature of your medical condition, but no later than 72 hours after receipt of the Authorization request.

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

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

The Plan uses evidence-based guidelines for Authorization, modification or denial of services as well as Utilization Management, prospective, concurrent and retrospective review. Plan specific guidelines are developed and reviewed on an ongoing basis by the Plan Medical Director, Utilization Management Committee and appropriate physicians to assist in determination of community standards of care. A description of the medical review process or the guidelines used in the process, including any nonprofit professional association clinical review criteria, education program and training materials for Mental Health or Substance Use Disorders, will be provided upon request at no cost.

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

Second Opinions

When a medical or surgical procedure or course of treatment (including Mental Health or Substance Use Disorder treatment) is recommended, and either you or the Plan Physician requests, a second opinion may be obtained. You may request a second opinion for any reason, including the following:

- You question the reasonableness or necessity of recommended surgical procedures.
- 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.
- 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.
- 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.
- 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.
- 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 of the same specialty within the Plan Network. If there is no qualified provider within the Plan's network, you may request Authorization for a second opinion from a provider of the same specialty outside the Plan's network. A second opinion is for a consultation only, which may be conducted in person, virtually, by telephone, or through telehealth services. If a Provider outside the Plan's network provides a second opinion, that Provider should not perform, assist, or provide care, including ordering tests such as laboratory studies or X-rays, as the Plan does not provide reimbursement for such care.

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

Telehealth Services

Telehealth is a way of delivering health care services via phone or video to facilitate diagnosis, consultation, treatment and other services. Telehealth services are intended to make it more convenient for you to receive health care services. You may receive Covered Benefits via Telehealth when available, determined by your Plan Provider to be medically appropriate, and provided by a Plan Provider. Medically Necessary health care services appropriately delivered via Telehealth are covered on the same basis and to the same extent as coverage for the same services received through in-person visits. This means you have the same Cost Share and Out-of-Pocket Maximum for in-person and Telehealth services. The same Authorization rules also apply. Coverage is not limited to services delivered by third-party Telehealth providers.

Magellan offers Telehealth services for Mental Health Disorders and Substance Use Disorders through third-party providers. This means the provider does not have a physical office location. You are not required to receive services from a third-party Telehealth provider and can continue seeing a specialist or other individual health professional, clinic or facility in person or request to see that provider, clinic, or facility in person, if preferred. All services provided through a specialist or other individual health professional, clinic or facility must be consistent with timely access standards set by law or regulation. If you decide to obtain services from a third-party Telehealth provider, you will be required to consent verbally or in writing to receive the service via Telehealth. The Telehealth provider will ask for your consent prior to receiving Telehealth services. You have the right to request your medical records from a third-party Telehealth provider. Your records will be shared

with your PCP unless you object. You can object to your records being shared with your PCP by indicating your preference in the intake process, prior to your first appointment. All services rendered through a third-party Telehealth provider will be available at your in-network Cost Sharing and will apply to your Deductible and Out-of-Pocket Maximum, if applicable.

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, which are medically required on an immediate basis for treatment of an Emergency Medical Condition. Sharp Health Plan covers 24-hour emergency care. An Emergency Medical Condition is a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

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

Emergency Services and Care means:

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

If you are a victim of rape or sexual assault, you do not have to pay a cost share for Emergency Services. This includes up to nine months of follow-up medical care, after the initial Emergency Services are received. You are not required to file a police report, press charges or participate in any legal proceedings, and the assailant does not need to be convicted of an offense to qualify for the waived Cost Share. Follow-up medical care includes medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault.

Your Copayment for emergency room services will not apply if you are admitted as an inpatient directly to the hospital from the emergency room or kept for observation.

What To Do When You Require Emergency Services

- If you have an Emergency Medical Condition, call "911" or go to the nearest hospital emergency room. It is not necessary to contact your PCP before calling "911" or going to a hospital if you believe you have an Emergency Medical Condition.
- If you are unsure whether your condition requires Emergency Services, call your PCP (even after normal business hours). Your PCP can help decide the best way to get treatment and can arrange for prompt emergency 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 reasonably believe you are having 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 San Diego County, your Plan Physician and the Plan may arrange for your transfer to a Plan Hospital if your medical condition is sufficiently stable for you to be transferred.

- Paramedic ambulance services are covered when provided in conjunction with Emergency Services.
- Some non-Plan Providers may require that you pay for Emergency Services and seek reimbursement from the Plan. On these occasions, obtain a complete bill of all services rendered and a copy of the emergency medical report, and forward them to the Plan right away for reimbursement. Reimbursement request forms are available online at sharphealthplan.com/CalPERS.
- 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 Summary of Benefits.

Urgent Care Services

Urgent Care Services means those services performed, inside or outside the Plan's Service Area, that are medically required within a short timeframe, usually within 24 hours, in order to prevent a serious deterioration of a Member's health due to an illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgent conditions are not emergencies, but may need prompt medical attention. Urgent Care Services are not a substitute for seeing your PCP. They are intended to provide urgently needed care in a timely manner when you or your PCP has determined that you require these services or you are outside the Plan's Service Area and require Urgent Care Services.

What To Do When You Require Urgent Care Services

If you need Urgent Care Services and are in the Plan's Service Area, you must use an urgent care facility within your PMG network. Some network urgent care centers offer virtual visits. If you have a question regarding where to go for urgent care, please call your PCP, PMG or Sharp Health Plan prior to going out of network. You also have access to a registered nurse evenings and weekends for medical advice by calling our toll-free Customer Care number at 1-855-995-5004. They can talk with you about an illness or injury, help you decide where to seek care and provide advice on any of your health concerns.

Out-of-Area Urgent Care Services are considered Emergency Services and do not require an Authorization from your PCP. If you are outside the Plan's Service Area and need Urgent Care Services, you should call your PCP, who may want to see you when you return in order to follow up with your care.

Language Assistance Services

Sharp Health Plan provides free interpreter and language translation services for all Members. If you need language interpreter services to help you talk to your doctor or health plan or to assist you in obtaining care, please call Customer Care. Let us know your preferred language when you call. Customer Care has representatives who speak English and Spanish. We also have access to interpreting services in more than 100 languages. If you need someone to explain medical information while you are at your doctor's office, ask them to call us. You may also be able to get materials that are written in your preferred language. For free language assistance, please call us toll-free at 1-855-995-5004. We will 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 Voz en español y TTY (teléfono de texto)

Access for the Vision Impaired

This Evidence of Coverage 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 Evidence of Coverage or other materials, please call Customer Care.

Case Management

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

Who Can You Call With Questions?

Customer Care

From questions about your benefits, to inquiries about your doctor, we are here to ensure that you have the best health care experience possible. For questions about Mental Health and Substance Use Disorder services, you may contact Magellan's Customer Service Center at 1-844-483-9013. For all other questions, you can call Customer Care toll free at 1-855-995-5004 or email customer.service@sharp.com. Our dedicated Customer Care team is available to support you from 7 a.m. to 8 p.m., seven days a week.

After-Hours Nurse Advice

After hours and on weekends, registered nurses are available through Sharp Nurse Connection™. They can talk with you about an illness or injury, help you decide where to seek care and provide advice on any of your health concerns. Call 1-855-995-5004 and select the appropriate prompt, 5 p.m. to 8 a.m., Monday to Friday and 24 hours on weekends and holidays.

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 Saturday, except Contractor holidays, to answer questions from providers and Members regarding Utilization Management. After business hours Members have the option of leaving a voicemail for a return call by the next business day. When returning calls, our staff will identify themselves by name, title and organization name.

What Do You Pay?

Copayments

A Copayment, sometimes referred to as a "Copay", is a specific dollar amount (for example, $20) you pay for a particular Covered Benefit. If the contracted rate for a Covered Benefit is less than the Copayment, you pay only the contracted rate.

You are responsible to pay applicable Copayments for any Covered Benefit you receive. Copayments are due at the time of service. Sharp Health Plan is not responsible for the coordination and collection of Copayments. The provider is responsible for the collection of Copayments. Copayment amounts may vary depending on the type of care you receive. Copayment amounts are listed on your Health Plan Summary of Benefits. For your convenience, Copayments for the most commonly used benefits are also shown on your Member ID card. Copayments will not change during the Benefit Year. The Copayments listed on the Summary of Benefits apply to each Member (including eligible newborn Dependents).

Coinsurance

Coinsurance is the percentage of costs you pay (for example, 20%) for a Covered Benefit. The following example illustrates how Coinsurance is applied: If Sharp Health Plan's contracted rate for a specialist office visit is $100 and your Coinsurance is 20%, you pay $20 (20% of $100). Sharp Health Plan would cover the remaining $80.

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

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

Annual Out-of-Pocket Maximum

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

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

- Premium contributions,
- Charges for services not covered under the benefit plan (see the section titled **What Is Not Covered?** for a list of exclusions and limitations),
- Charges for services that exceed specific treatment limitations explained in this Evidence of Coverage or noted in the Health Plan Summary of Benefits,
- Copayments, Deductibles and Coinsurance for Supplemental Benefits (e.g., acupuncture and chiropractic services), and
- Cost Shares for Outpatient Prescription Drugs, dispensed through a plan pharmacy.

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

All Copayments you pay for Covered Benefits, except Supplemental Benefits, count toward the Out-of-Pocket Maximum. If your total payments for Covered Benefits, excluding Supplemental Benefits, reach the Individual Out-of-Pocket Maximum amount, no further Copayments are required from you for Covered Benefits (excluding Supplemental Benefits) for the remainder of the Calendar Year. Premium contributions are still required.

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

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

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

The maximum amount that any one covered family member can contribute toward the Family Out-of-Pocket Maximum is the amount applied toward the Individual Out-of-Pocket Maximum. Any amount you pay for Covered Benefits (excluding Supplemental Benefits) for yourself that would otherwise apply to your Individual Out-of-Pocket Maximum, but which exceeds the Individual Out-of-Pocket Maximum, will be refunded to you and will not apply toward your Family Out-of-Pocket Maximum.

Annual Deductible and Out-of-Pocket Maximum Balances

We will provide you with your annual Deductible and annual Out-of-Pocket Maximum balances each month you use benefits by mailing you an Explanation of Benefits (EOB) until the accrual balance equals the full Deductible and the full Out-of-Pocket Maximum. You can opt out of mailed notices by logging in to your Sharp Health Plan online account and visiting the Claims page. If you're on the mobile app, tap the Medical button. Copies of your EOB and your Deductible and Out-of-Pocket Maximum balances are available online at sharphealthplan.com/login. Additionally, you may request your balances from us by contacting Customer Care. The annual Deductible and annual Out-of-Pocket Maximum balances sent will be the most up-to-date information available. Sharp Health Plan defines "most up-to-date information available" to be all received and processed claims from the month in question. In instances where a provider submits a claim for services rendered during a prior month, that claim will be included on the EOB for the month in which it was processed by Sharp Health Plan.

What if You Get a Medical Bill?

You are only responsible for paying your contributions to the monthly Premium and any required 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 may require you to pay at the time you receive care. These include, but are not limited to, emergency departments outside San Diego County, Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other providers of Behavioral Health Crisis Services (including Behavioral Health Crisis Stabilization Services), and services provided under a Community Assistance, Recovery, and Empowerment (CARE) Plan or CARE Agreement approved by a court).

If you pay for Covered Benefits, you can request reimbursement from Sharp Health Plan. Go to sharphealthplan.com/CalPERS or call Customer Care to request a Member reimbursement form. You will also need to send written evidence of the care you received and the amount you paid (itemized bill, receipt, medical records). We will reimburse you for Covered Benefits within 30 calendar days of receiving your complete information. You must send your request for

reimbursement to Sharp Health Plan within 180 calendar days of the date you received care. If you are unable to submit your request within 180 calendar days from the date you received care, please provide documentation showing why it was not reasonably possible to submit the information within 180 days.

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

In some cases, a non-Plan Provider may provide Covered Benefits at an in-network facility where we have Authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the Covered Benefits you receive at in-network facilities where we have Authorized you to receive care.

Members' Rights and Responsibilities

As a Member, you have a right to:

- Receive information about your rights and responsibilities.
- Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the Plan's Member rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
- Know the costs for your care, and whether your Deductible or Out-of-Pocket Maximum have been met.
- Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in your Plan's network, including one with a specialist.
- Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.
- Certain accommodations for your disability, including:
    - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
    - Full and equal access, as other members of the public, to medical facilities.
    - Extra time for visits if you need it.
    - Taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
    - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
    - To be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition,

treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.

- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a Co-pay, Co-insurance, or Deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible Dependent(s) on your Plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.
- Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan Member.
- Have an Advanced Health Care Directive.
- Be fully informed about your Plan's Grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, Grievance, or Appeal in your preferred language about:
    - Your Plan or Health Care Provider.
    - Any care you receive, or access to care you seek.
    - Any covered service or benefit decision that your Plan makes.
    - Any improper charges or bills for care.
    - Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
    - Not meeting your language needs.
- Know why your Plan denies a service or treatment.
- Contact the Department of Managed Health

Care if you are having difficulty accessing health care services or have questions about your Plan.

- To ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

As a Plan Member, you have the responsibility to:

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

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 will give out your health information when ordered by a court, unless the order conflicts with California law. 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.
- **You have the right to receive Sensitive Services or to submit a claim for Sensitive Services if you have the right to consent to care.**
- **You have the right, without the authorization of the Subscriber or another policyholder, to have communications containing medical information related to Sensitive Services communicated to you at an alternative mail or email address or telephone number. You can update your contact information in your Sharp Health Plan account or by contacting Customer Care at 1-855-995-5004.**
- **If you have not designated an alternative mailing address, email address, or telephone number, we will send or make all communications related to your receipt of Sensitive Services in your name at the address or telephone number on file. Such communications include written, verbal, or electronic communications, including:**
  - **Bills and attempts to collect payment.**
  - **A notice of adverse benefits determinations.**
  - **An explanation of benefits notice.**
  - **A health care service plan's request for additional information regarding a claim.**
  - **A notice of a contested claim.**
  - **The name and address of a provider, description of services provided, and other information related to a visit.**
  - **Any written, oral, or electronic communication from a health care service plan that contains protected health information.**
- **We will not disclose medical information related to your receipt of Sensitive Services to the policyholder, primary Subscriber, or any Members, absent your express written authorization.**

- **You have the right to request confidential communication in a certain form and format if it is readily producible in the requested form and format, or at alternative locations. The confidential communication request shall be valid until you submit a revocation of the request or a new confidential communication request is submitted.**
- 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 the right to receive written notification if we discover a breach of your unsecured PHI, and determine through a risk assessment that notification is required.
- You have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing, for most uses or disclosures of psychotherapy notes, or if we intend to sell your PHI.
- You may revoke an authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.
- You have the right to request a copy of this Notice of Privacy Practices. You also can find this Notice on our website at: sharphealthplan.com/CalPERS/disclosures.
- You have the right to complain about any aspect of our health information practices, per section F. COMPLAINTS.

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

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

Sharp Health Plan Privacy Officer
8520 Tech Way, Suite 200
San Diego, CA 92123
Toll-free at 1-855-995-5004

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 health information privacy complaint by contacting Sharp Health Plan or the U.S. Department of Health & Human Services' Office for Civil Rights (OCR) within 180 days of when you knew that the privacy incident

occurred. Sharp Health Plan or the OCR may extend the 180-day period if you can show good cause.

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

- Complete the Member Grievance form on our website at: sharphealthplan.com.
- Call toll free at 1-855-995-5004.
- Mail a letter to Sharp Health Plan:
  Attn: Appeal/Grievance Department
  8520 Tech Way, Suite 200
  San Diego, CA 92123-1450
- Fax a letter or your completed Member Grievance form to: 1-619-740-8572.

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

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

What Is the Grievance or Appeal Process?

Pharmacy Grievance Procedures

All pharmacy benefits are managed by CVS Pharmacy. Please refer to your CVS Pharmacy Outpatient Prescription Drug Plan Evidence of Coverage booklet for pharmacy Grievance and Appeal procedures, or you may contact CVS Pharmacy's Customer Care at 1-833-291-3649 (TTY users call 711).

Medical Grievance Procedures

You, an Authorized Representative, or a provider on behalf of you, may file a Grievance or Appeal within 180 calendar days of an Adverse Benefit Determination (ABD) or other incident that is subject to your dissatisfaction. You can obtain a copy of Sharp Health Plan's Grievance and Appeal Policy and Procedure from your Plan Provider or by calling Customer Care. To begin the Appeal or Grievance process, you or your Authorized Representative can call, write or fax Sharp Health Plan or Magellan to the correct organization listed below. You can also file a Grievance online at sharphealthplan.com and we will forward it to the correct organization for you.

Please note that Sharp Health Plan does not make decisions about eligibility for enrollment, effective date, termination date or your Premium amount. For concerns regarding these issues, contact your Employer.

For Appeals involving Mental Health or Substance Use Disorder treatment:

Magellan Health
P.O. Box 710430
San Diego, CA 92171
Toll-free: 1-866-512-6190
Fax: 1-888-656-5366

For all other Appeals or to file a Grievance:

Sharp Health Plan
Attn: Appeal/Grievance Department
8520 Tech Way, Suite 200
San Diego, CA 92123-1450
Toll-free: 1-855-995-5004
Fax: 1-619-740-8572

If you prefer to send a written Grievance or Appeal, please send a detailed letter describing your concern, or complete the Member Grievance & Appeal Form that you can get from any Plan Provider or directly from a Plan representative. You can also complete the form online through the Plan's website, sharphealthplan.com/CalPERS. Include the Member identification number listed on your Sharp Health Plan ID card and any information that clarifies or supports your position. For pre-service requests, include any additional medical information or scientific studies that support the Medical Necessity of the service. If you would like us to consider your

Grievance or Appeal on an urgent basis, please write "urgent" on your request and provide your rationale. You may submit written comments, documents, records, scientific studies and other information related to the claim that resulted in the ABD in support of the Grievance or Appeal. All information provided will be taken into account without regard to whether such information was submitted or considered in the initial ABD. Please call Customer Care if you need any assistance with submitting your Grievance or Appeal.

Sharp Health Plan will acknowledge receipt of your Grievance or Appeal within five calendar days and will send you a decision letter within 30 calendar days.

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.

You have the right to review any new information that we have regarding your Grievance or Appeal. Upon request and free of charge, this information will be provided to you, including copies of all relevant documents, records, and other information. To make a request, contact Customer Care at 1-855-995-5004.

If Sharp Health Plan upholds the ABD, that decision becomes the Final Adverse Benefit Decision (FABD).

Upon receipt of an FABD, the following options are available to you:

- For FABDs involving medical judgment, you may pursue the external Independent Medical Review (IMR) process described below.
- For FABDs involving benefits, you may pursue the Department of Managed Health Care's process as described in the "Department of Managed Health Care" section, or you may initiate voluntary mediation or voluntary binding arbitration, as described in the "Mediation" or "Binding Arbitration –Voluntary" sections.

Urgent Decision

An urgent Grievance or Appeal is resolved within 72 hours upon receipt of the request, but only if Sharp Health Plan determines the Grievance or Appeal involves imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function. If the Grievance or Appeal involves Sharp Health Plan's cancellation, Rescission, or nonrenewal of your coverage, we will provide you with a decision within 72 hours. If Sharp Health Plan determines the Grievance or Appeal does not meet one of these criteria, the Grievance or Appeal will be processed as a standard request.

> **Note:** If you believe your condition meets the criteria above, you have the right to contact the California Department of Managed Health Care (DMHC) at any time to request an IMR or other review, at 1-888-466-2219 (TDD 1-877-688-9891), without first filing an Appeal with us.

Independent Medical Reviews (IMR)

If care that is requested for you is denied, delayed or modified, in whole or in part, by Sharp Health Plan, Magellan or a Plan Medical Group, you may be eligible for an Independent Medical Review (IMR). You or an Authorized Representative may request an IMR from the DMHC. If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to medical necessity or 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 IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for this review.

You have the right to provide information in support of the request for an IMR. Sharp Health Plan must provide you with an IMR application form and Sharp Health Plan FABD letter that states its position on the Disputed Health Care Service. A decision not to participate in the IMR process

may cause you to forfeit any statutory right to pursue legal action against Sharp Health Plan regarding the Disputed Health Care Service.

Eligibility: The DMHC will look at your application for IMR to confirm that:

1. One or more of the following conditions have been met:
   (a) Your provider has recommended a health care service as Medically Necessary, or
   (b) You have received Urgent Care Services or Emergency Services that a provider determined were Medically Necessary, or
   (c) You have been seen by a Sharp Health Plan provider for the diagnosis or treatment of the medical condition for which you want an IMR;

2. The Disputed Health Care Service has been denied, changed, or delayed by Sharp Health Plan, Magellan or your PMG, based in whole or in part on a decision that the health care service is deemed not Medically Necessary; **and**

3. You have filed a Grievance with Sharp Health Plan and the disputed decision is upheld or the Grievance is not resolved within 30 days. If your Grievance requires urgent review, you are not required to participate in the Sharp Health Plan Grievance process for more than 72 hours. The DMHC may waive the requirement that you follow the Sharp Health Plan Grievance process in extraordinary and compelling cases.

You must apply to the DMHC for an IMR within six months of the date you receive a denial notice from Sharp Health Plan in response to your Grievance, or from the end of the Grievance period, whichever occurs first. This application deadline may be extended by the DMHC if the DMHC determines that the circumstances of your case warrant an extension.

If your case is eligible for an IMR, the dispute will be submitted to an Independent Medical Review Organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of Sharp Health Plan. The IRO will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of medical professionals knowledgeable in the treatment of your condition, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither you nor Sharp Health Plan will control the choice of expert reviewers.

The IRO will render its analysis and recommendations on your IMR case in writing, and in layperson's terms to the maximum extent practical. For standard reviews, the IRO must provide its determination and the supporting documents within 30 days of receipt of the application for review. For urgent cases, utilizing the same criteria as in the Appeal and Grievance procedures section above, the IRO must provide its determination within 72 hours.

If the IRO upholds Sharp Health Plan's FABD, you may have additional review rights under the CalPERS Administrative Review section.

For more information regarding the IMR process or to request an application form, please call Customer Care at 1-855-995-5004.

Experimental or Investigational Denials

Sharp Health Plan does not cover Experimental or Investigational Services, drugs, devices or procedures. However, if Sharp Health Plan, Magellan or your PMG denies or delays a therapy or medical service that would otherwise be covered on the basis that it is experimental or investigational, and you meet the eligibility criteria set out below, you may request an Independent Medical Review (IMR) of Sharp Health Plan, Magellan or your PMG's decision from the DMHC.

> **Note:** DMHC does not require you to exhaust Sharp Health Plan or Magellan's Appeal process before requesting an IMR of an ABD based on experimental or investigational services. In such cases, you may immediately contact the DMHC to request an IMR.

You pay no application or processing fees of any kind for this review. If you decide not to participate in the DMHC review process, you may be giving up any statutory right to pursue legal action against Sharp Health Plan regarding the Disputed Health Care Service.

Sharp Health Plan will send you an application form and an addressed envelope for you to request this review with any Grievance disposition letter denying coverage. You may also request an application form by calling us at 1-855-995-5004 or write to us at:

Sharp Health Plan
Attn: Appeal and Grievance Department
8520 Tech Way, Suite 200
San Diego, CA 92123

To qualify for this review, all of the following conditions must be met:

- You have a Life-Threatening or Seriously Debilitating Condition.
- Your Plan Physician must certify that you have a condition described above for which either:

  (a) standard treatment has not been effective in improving your condition,

  (b) standard treatment is not medically appropriate, or

  (c) there is no standard treatment option covered by Sharp Health Plan that is more beneficial than the proposed treatment.

- The proposed treatment must either be:

  1. Recommended by a Sharp Health Plan provider who certifies in writing that the treatment is likely to be more beneficial than standard treatments, or

  2. Requested by you or by a licensed board certified or board eligible doctor qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:

     - Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards;

     - Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR);

     - Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;

     - Either of the following:
       (i) The American Hospital Formulary Service's Drug Information, or
       (ii) the American Dental Association Accepted Dental Therapeutics;

     - Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
       (i) the Elsevier Gold Standard's Clinical Pharmacology,
       (ii) the National Comprehensive Cancer Network Drug and Biologics Compendium, or
       (iii) the Thomson Micromedex DrugDex;

     - Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and

     - Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You must apply to the DMHC for an IMR within six (6) months of the date you receive a denial notice from Sharp Health Plan in response to your Grievance, or from the end of the 30-day or

72-hour Grievance period, whichever occurs first. This application deadline may be extended by the DMHC if the DMHC determines that the circumstances of your case warrant an extension.

Within five business days of receiving notice from the DMHC of your request for review, Sharp Health Plan will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your doctor. Any newly developed or discovered relevant medical records that Sharp Health Plan or a Sharp Health Plan provider identifies after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request (or within seven days if your doctor determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three days for any delay in receiving necessary records.

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

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

If you believe that your health care coverage or your Dependent's health coverage was, or will be, improperly cancelled, Rescinded, or not renewed, you have the right to file a Grievance with the Department of Managed Health Care. You may submit a Grievance to the Department of Managed Health Care online at **www.healthhelp.ca.gov** or by calling the toll-free telephone number provided above. You may also mail your written Grievance to:

HELP CENTER
DEPARTMENT OF MANAGED HEALTH CARE
980 NINTH STREET, SUITE 500
SACRAMENTO, CALIFORNIA 95814-2725

Appeal Rights Following Grievance Procedure

If you do not achieve resolution of your complaint through the Sharp Health Plan Grievance process or IMR process described above, you have additional dispute resolution options, as follows:

1. ELIGIBILITY ISSUES

Issues of eligibility must be referred directly to CalPERS at:

CalPERS Health Account Management Division
Attn: Enrollment Administration
P.O. Box 942715, Sacramento, CA 94229-2715

888 CalPERS (or 888-225-7377)
CalPERS Customer Service and Outreach Division toll free telephone number

1-916-795-1277 fax number

2. COVERAGE ISSUES

A coverage issue concerns the denial or approval of health care services substantially based on a finding that the provision of a particular service is included or excluded as a Covered Benefit under this Evidence of Coverage. It does not include a Sharp Health Plan or contracting provider decision regarding a Disputed Health Care Service.

If you are dissatisfied with the outcome of Sharp Health Plan's internal Appeal or Grievance process, or if you have been in the process for 30 days or more, you may request review by the DMHC, proceed to court, or initiate voluntary mediation or voluntary binding arbitration. If you initiate voluntary mediation and are not successful in resolving your dispute, you may request review by the DMHC. Upon exhaustion of the DMHC review process, you may then request a CalPERS Administrative Review. You may **not** request a CalPERS Administrative Review if you decide to proceed to court or initiate binding arbitration.

3. MALPRACTICE AND BAD FAITH

You must proceed directly to court.

4. DISPUTED HEALTH CARE SERVICE ISSUE

A decision regarding a Disputed Health Care Service relates to the practice of medicine and is not a coverage issue, and includes decisions as to whether a particular service is not Medically Necessary, or Experimental or Investigational.

If you are dissatisfied with the outcome of Sharp Health Plan's internal Grievance process or if you have been in the process for 30 days or more, you may request an IMR from the DMHC.

If you are dissatisfied with the IMR determination, you may request a CalPERS Administrative Review within 30 days of the IMR determination, or you may proceed to court. If you choose to proceed to court, you may **not** request a CalPERS Administrative Review.

Mediation

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

Binding Arbitration – Voluntary

If you have exhausted the Plan's Appeal process and are still unsatisfied, you have a right to resolve your Grievance regarding coverage disputes through voluntary binding arbitration. Only coverage disputes (that is, a denial based on the Plan's finding that the requested service, drug, or supply is not a Covered Benefit) may be resolved through binding arbitration rather than a lawsuit. Binding arbitration means you agree to waive your rights to a jury trial. Medical malpractice, medical necessity, and quality of care issues are not subject to the arbitration process.

You may begin the arbitration process by submitting a written demand for arbitration to Sharp Health Plan, including the following information:

- Member name
- Contact name (if someone other than the Member is requesting arbitration, for example a parent on behalf of a child)
- Member ID number
- Address
- Telephone number
- Name and contact information for your attorney, if any
- Description of the services you are requesting (including provider name, date of service, type of

service received) and the dollar amount that is being requested

- The specific reasons why you disagree with Sharp Health Plan's decision not to cover the requested services

Send your written demand for arbitration to:

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

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 identification of the arbitration entity, 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.

The fees and expenses of the neutral arbiter 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. Except as mandated by law, you will be responsible for your own attorneys' fees, your witness fees, and any other expenses you incur during the arbitration process regardless of the outcome of the arbitration.

CalPERS Administrative Review

If you remain dissatisfied with the DMHC's determination or the IMR's determination, you may request an Administrative Review. You must exhaust Sharp Health Plan's internal Grievance process, the DMHC's process and the IMR process, when applicable, prior to submitting a request for CalPERS Administrative Review.

The request for an Administrative Review must be submitted in writing to CalPERS within 30 days from the date of the DMHC's determination or, the IMR determination letter, in cases involving a Disputed Health Care Service, or Experimental or Investigational determination. Upon satisfactory showing of good cause, CalPERS may grant additional time to file a request for an Administrative Review, not to exceed 30 days.

The request must be mailed to:

CalPERS Health Benefit Compliance and Appeals Unit
Att: Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

If you are planning to submit information Sharp Health Plan may have regarding your dispute with your request for Administrative Review, please note that Sharp Health Plan may require you to sign an authorization form to release this information. In addition, if CalPERS determines that additional information is needed after Sharp Health Plan submits the information it has regarding your dispute, CalPERS may ask you to sign an Authorization to Release Health Information (ARHI) form.

If you have additional medical records from Providers or scientific studies that you believe are relevant to CalPERS review, those records should be included with the written request. You should send **copies** of documents, not originals, as CalPERS will retain the documents for its files. You are responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims of medical malpractice, i.e. quality of care, or quality of service disputes.

CalPERS will attempt to provide a written determination within 60 days from the date all pertinent information is received by CalPERS. For claims involving urgent care, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than three business days from the date all pertinent information is received by CalPERS.

> **Note:** In urgent situations, if you request an IMR at the same time you submit a request

for CalPERS Administrative Review, but before a determination has been made by the IMR, CalPERS will not begin its review orcissue its determination until the IMR determination is issued.

Administrative Hearing

You must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving Covered Benefits are eligible for an Administrative Hearing.

You must request an Administrative Hearing in writing within 30 days of the date of the Administrative Review determination. Upon satisfactorily showing good cause, CalPERS may grant additional time to file a request for an Administrative Hearing, not to exceed 30 days.

The request for an Administrative Hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to a Member's case not previously submitted for Administrative Review, DMHC and IMR.

If CalPERS accepts the request for an Administrative Hearing, it shall be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.). An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); you may, but are not required to, be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open (public) meeting. The Board's final decision will be provided in writing to you within two weeks of the Board's open meeting.

Appeal Beyond Administrative Review and Administrative Hearing

If you are still dissatisfied with the Board's decision, you may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

A Member may not begin civil legal remedies until after exhausting these administrative procedures.

Summary of Process and Rights of Members Under the Administrative Procedure Act

- Right to records, generally. You may, at his or her own expense, obtain copies of all non-medical and non-privileged medical records from the administrator and/or CalPERS, as applicable.
- Records subject to attorney-client privilege. Communication between an attorney and a client, whether oral or in writing, will not be disclosed under any circumstances.
- Attorney Representation. At any stage of the appeal proceedings, you may be represented by an attorney. If you choose to be represented by an attorney, you must do so at your own expense. Neither CalPERS nor the administrator will provide an attorney or reimburse you for the cost of an attorney even if you prevail on appeal.
- Right to experts and consultants. At any stage of the proceedings, you may present information through the opinion of an expert, such as a physician. If you choose to retain an expert to assist in presentation of a claim, it must be at your own expense. Neither CalPERS nor the administrator will reimburse you for the costs of experts, consultants or evaluations.

Appeal Chart

Adverse Benefit Determination (ABD)

Appeals Process Member Receives ABD

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Standard Process
180 days to file Appeal.

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Internal Review
Final Adverse Benefit Determination (FABD) issued **within 30 days** from receipt of request.

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Request for DMHC Review
Member must request DMHC Review **within six months** of FABD.*

↓

DMHC Review
FABD must be reviewed **within 30 days** from date DMHC Review requested.

↓

CalPERS Administrative Review (AR)
Member must file within 30 days of DMHC determination for benefit decisions, or IMR decision for cases involving Medical Judgment. CalPERS will attempt to notify Member of determination **within 60 days**.

Urgent Process
180 days to file Appeal.

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Internal Review
Final Adverse Benefit Determination (FABD) issued within reasonable timeframes given medical condition but in no event longer than **72 hours.**

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Request for DMHC Review
Member should submit request for Urgent DMHC Review as soon as possible, but in no event longer than **six months** of FABD.*

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DMHC Review
FABD must be reviewed within reasonable timeframes given medical condition but generally completed **within three days** from receipt of request (**seven days** for an experimental/investigational service).

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CalPERS Administrative Review (AR)
Member should file as soon as possible, but in no event longer than **30 days** of IMR decision. CalPERS will notify Member of AR determination **within three business days** of receipt of all pertinent information.

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Process continued on following page

*For FABDs that involve "Medical Judgment," the Member must request IMR from DMHC prior to submitting a CalPERS Administrative Review.

Administrative Hearing Process

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Request for Administrative Hearing
Member may request Administrative Hearing **within 30 days** of CalPERS AR determination.

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Administrative Hearing
CalPERS submits a statement of issues to Administrative Law Judge. Member has right to attorney, to present witnesses and evidence.

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Proposed Decision
After hearing, ALJ issues a proposed decision pursuant to California Administrative Procedures Act.

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CalPERS Board of Administration
Adopts, rejects or returns proposed decision for additional evidence. If adopts, decision becomes final decision.

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Member May Request
Reconsideration by Board or appeal final decision to Superior Court by Writ of Mandate.

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 Evidence of Coverage. Covered Benefits are described below and must be:

1. Medically Necessary;
2. Described in this Evidence of Coverage or as otherwise required by law;
3. Provided by Plan Providers; unless services are for Emergency or Out-of-Area Urgent Care or services have been prior Authorized by the Plan to be received by non-Plan Providers;
4. Prescribed by a Plan Physician, except when coverage is required for treatment of an Emergency Medical Condition or services are prescribed as part of a treatment plan prior Authorized by the Plan with a non-Plan provider;
5. If required, Authorized in advance by your PCP, your PMG, Magellan or Sharp Health Plan; and
6. Part of a treatment plan for Covered Benefits or required to treat medical conditions that are direct and predictable complications or consequences of Covered Benefits.

The Covered Benefits described in this Evidence of Coverage do not include dental services (except as specifically described under the **Dental Services/ Oral Surgical Services** benefit category of this section). The Covered Benefits described in this Evidence of Coverage for acupuncture/chiropractic services, Artificial Insemination services, hearing services, Outpatient Prescription Drugs and vision services are considered Supplemental Benefits. Cost Share payments made for Supplemental Benefits do not apply toward the annual Out-of-Pocket Maximum. Sharp Health Plan does not provide Outpatient Prescription Drug coverage as a Covered Benefit, except for limited classes of Prescription Drugs that are integral to treatments covered as basic health care services and subject to the medical benefit. Outpatient Prescription Drug benefits are instead covered and administered by CVS Pharmacy. Members should review the CVS Pharmacy Outpatient Prescription Drug Plan Evidence of Coverage booklet for details regarding the Outpatient Prescription Drug Program.

Your Health Plan Summary of Benefits details applicable Copayments.

Important exclusions and limitations are described in the section of this Evidence of Coverage titled **What Is Not Covered?**

Acupuncture Services

Acupuncture and chiropractic services are covered for up to a combined maximum of 20 visits per Calendar Year when provided by a American Specialty Health Plans of California, Inc. (ASH Plans) participating provider.

New patient examinations for acupuncture are limited to one every three years. Subsequent examinations are limited to periodic examination necessary to re-evaluate clinical necessity of ongoing treatments.

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 the highest level of functional ability.

Ambulance and Medical Transportation Services

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

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

licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from Covered Benefits.

The covered medical transportation services described above include services received from an air or ground ambulance provider, whether contracted or not contracted with Sharp Health Plan. If you receive covered services from a non-contracting air or ground ambulance provider, your Copayment will be the same as the Cost Share you would pay for covered services received from a contracting air or ground ambulance provider. The Copayment you pay will count toward the Out-of-Pocket Maximum set forth in the Summary of Benefits. You will not be responsible for any additional costs above the amount of your Copayment.

Biomarker Testing

Medically Necessary biomarker testing, as determined by the Plan's clinical guidelines, is covered and may be subject to prior Authorization.

Blood Services

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

Bloodless Surgery

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

Chemotherapy

Chemotherapy as part of a comprehensive treatment plan is covered when provided as part of an inpatient, hospital administered, or provider administered service. Outpatient self-administered chemotherapy is not covered. If you are admitted for inpatient chemotherapy, the applicable inpatient services Copayment applies.

Chiropractic Services

Manipulation of the spine to correct a subluxation, when provided by an American Specialty Health Plans of California, Inc. (ASH Plans) participating provider. Services provided by non-participating providers will not be covered except for Emergency Services.

New patient examinations for chiropractic services are limited to one every three years. Subsequent examinations are limited to periodic examination necessary to re-evaluate clinical necessity of ongoing treatments.

Acupuncture and chiropractic services are covered for up to a combined maximum of 20 visits per Calendar Year. Chiropractic appliances are limited to $50 per Calendar Year. Copayments made for chiropractic services do not apply toward the annual Out-of-Pocket Maximum.

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 your participation in an Approved Clinical Trial are covered. To be eligible for coverage, you must meet the following requirements:

1. You are eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening disease or condition. The term "Life-Threatening disease or condition" means a disease or condition from which the likelihood of death is probable, unless the course of the disease or condition is interrupted.

2. Either:

a) the referring health care professional is a Plan Provider and has concluded that your participation in such trial would be appropriate based upon you meeting the conditions of the clinical trial; or
b) you provide medical and scientific information establishing that your participation in the clinical trial would be appropriate based upon you meeting the conditions of the clinical trial.

The clinical trial must meet the following requirements:

The clinical trial must be a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life-Threatening disease or condition that meets at least one of the following:

1. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
   a. The National Institutes of Health
   b. The Centers for Disease Control and Prevention
   c. The Agency for Healthcare Research and Quality
   d. The Centers for Medicare & Medicaid Services
   e. A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
   f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
   g. The Department of Veterans Affairs*
   h. The Department of Defense*
   i. The Department of Energy*

   *For those approved or funded by the Department of Veterans Affairs, the Department of Defense, or the Department of Energy, the study or investigation must have been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.
2. The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
3. The study or investigation is a drug trial that is exempt from having an investigational new drug application reviewed by the United States Food and Drug Administration.

Covered Benefits for an Approved Clinical Trial include the following, with the exception of outpatient self-administered medication:

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

Prior Authorization by Sharp Health Plan is required for any clinical trial in order for the services described above to be covered by Sharp Health Plan. Cost Sharing for routine health care costs for items and services furnished in connection with an Approved Clinical Trial will be the same as Cost Sharing applied to the same services not delivered in a clinical trial.

If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider, unless the clinical trial is outside the state where you live. Sharp Health Plan may limit coverage to an Approved Clinical Trial in California, unless the clinical trial is not offered or available through a Plan Provider in California. In the case of covered health care services associated with an Approved Clinical Trial that are provided by a doctor who does not participate in your Plan Network, Sharp Health Plan's payment will be limited to the negotiated rate otherwise paid to Plan Providers for the same services, less any applicable Cost Share.

Community Paramedicine, Triage to Alternate Destination and Mobile Integrated Health Programs

Services received from a community paramedicine program, triage to alternate destination program and mobile integrated health program are covered. If you receive services from a non-contracting community paramedicine program, triage to alternate designation program or mobile integrated health program, your Cost Share will be the same as the Cost Share you would pay for covered services received from a contracting community paramedicine program, triage to alternate destination program or mobile integrated health program. The Cost Share you pay will count toward the Out-of-Pocket Maximum and Deductible (if applicable) set forth in the Summary of Benefits. You will not be responsible for any additional costs above the amount of your Cost Share.

Dental Services/Oral Surgical Services

Dental services are covered only as described below:

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

Oral surgical services are covered only as described below:

- Reduction or manipulation of fractures of facial bones.
- Excision of lesions of the mandible, mouth, lip or tongue.
- Incision of accessory sinuses, mouth, salivary glands or ducts.
- Reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect or accidental injury.
- Biopsy of gums or soft palate.
- Oral or dental examinations performed on an inpatient or outpatient basis as part of a comprehensive workup prior to transplantation surgery.
- Preventive fluoride treatment administered in a dental office prior to an aggressive chemotherapeutic or radiation therapy protocol.
- Fluoride trays and/or bite guards used to protect the teeth from caries and possible infection during radiation therapy.
- Reconstruction of a ridge that is performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes).
- Reconstruction of the jaw when Medically Necessary (e.g., radical neck or removal of mandibular bone for cancer or tumor).
- Ridge augmentation or alveoplasty when consistent with medical policies for reconstructive surgery or cleft palate.
- Tooth extraction prior to a major organ transplant or radiation therapy of neoplastic disease to the head or neck.
- Treatment of maxillofacial cysts, including extraction and biopsy.
- Custom-fitted and prefabricated oral appliances for obstructive sleep apnea patients who have mild sleep apnea and meet the criteria for coverage of continuous positive airway pressure (CPAP), but who are intolerant to CPAP.

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

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

Diabetes Treatment

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

- Blood glucose monitors and testing strips.
- Blood glucose monitors designed for the visually impaired.
- Insulin pumps and all related necessary supplies.
- Ketone urine testing strips.
- Lancets and lancet puncture devices.
- Pen delivery systems for the administration of insulin, if Medically Necessary.
- 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.
- Annual comprehensive foot evaluation to identify risk factors for ulcers and amputations.
- Routine foot care if Medically Necessary for diabetics with certain conditions such as neuropathy, pre-ulcerative calluses, foot deformity, poor circulation, previous ulceration or amputation, or impaired vision.

Sharp Health Plan does not provide coverage for insulin, glucagon and other Prescription Drugs for the treatment of diabetes. These medications are covered under the Outpatient Prescription Drug Program. Insulin pens and insulin syringes are also covered under the Outpatient Prescription Drug Program. The Outpatient Prescription Drug Program is administered by CVS Pharmacy. Please refer to your CVS Pharmacy Outpatient Prescription Drug Plan Evidence of Coverage booklet for additional details.

Diabetic supplies used with a diabetic Durable Medical Equipment (DME) are subject to the DME Cost Share (e.g., Omnipods).

Disposable Medical Supplies

Disposable Medical Supplies are medical supplies that are consumable or expendable in nature and cannot withstand repeated use or use by more than one individual, such as bandages, support hose and garments, elastic bandages and incontinence pads. Disposable Medical Supplies are only covered when provided in a hospital or doctor office or by a home health professional as set forth under the **Professional Services** benefit category of this section. For information about coverage for ostomy and urological supplies please see the section titled **Ostomy and Urological Services.**

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

Durable Medical Equipment

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

DME is limited to equipment and devices that are:

1. Intended for repeated use over a prolonged period;
2. Ordered by a licensed Health Care Provider acting within the scope of their license;

3. Intended for your exclusive use;
4. Not duplicative of the function of another piece of equipment or device already covered for you;
5. Generally not useful to a person in the absence of illness or injury;
6. Primarily serving a medical purpose;
7. Appropriate for use in the home; and
8. Lowest cost item necessary to meet your needs.

Sharp Health Plan reserves the right to determine if covered DME will be purchased or rented. Medically Necessary repair or replacement of DME is covered when prescribed by a Plan Physician or ordered by a licensed Health Care Provider acting within the scope of their license, and when not caused by misuse or loss. Applicable Cost Share apply for Authorized DME replacement. No additional Cost Share are required for repair of DME.

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.

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

Emergency Services

Hospital emergency room services provided inside or outside the Service Area that are Medically Necessary for treatment of an Emergency Medical Condition are covered. Emergency services copayment does not apply if Member is admitted directly to hospital as an inpatient from emergency room or kept for observation and hospital bills for an emergency room observation visit. An Emergency Medical Condition means a medical condition, manifesting itself by symptoms of sufficient severity, including severe pain, which, in the absence of immediate medical attention, could reasonably be expected to result in:

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

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

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

If you are a victim of rape or sexual assault, you do not have to pay a cost share for Emergency Services. This includes up to nine months of follow-up medical care, after the initial Emergency Services are received. You are not required to file a police report, press charges or participate in any legal proceedings, and the assailant does not need to be convicted of an offense to qualify for the waived Cost Share. Follow-up medical care includes medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault.

Experimental or Investigational Services

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

1. The Member has been diagnosed with a Life-Threatening Condition or Seriously Debilitating Condition.
2. The Member's Plan Physician certifies that the Member has a Life-Threatening Condition or Seriously Debilitating Condition for which standard therapies have not been effective in

improving the Member's condition, for which standard therapies would not be medically appropriate for the Member, or for which there is no more beneficial standard therapy covered by Sharp Health Plan than the therapy proposed.

3. One of the following is true:
   - The Member's Plan Physician has recommended a drug, device, procedure or other therapy that the doctor certifies, in writing, is likely to be more beneficial for the Member than any available standard therapies or,
   - The Member, or the Member's physician who is a licensed, board-certified or board-eligible physician qualified to treat the Member's condition, has requested an Experimental or Investigational Treatment that, based on documentation from the medical and scientific evidence, is likely to be more beneficial for the Member than any available standard therapy. The physician certification must include a statement of the evidence relied upon by the physician in certifying his or her recommendation.
4. The specific drug, device, procedure, or other therapy recommended is otherwise a Covered Benefit according to the terms of this Evidence of Coverage.

Family Planning Services

The following family planning services are covered:

- Voluntary sterilization services including tubal ligation, vasectomy services and procedures, and other similar sterilization techniques.
- Interruption of pregnancy (abortion) services. Abortion is covered for all pregnant persons including, but not limited to, transgender individuals.
- FDA-approved emergency contraception when dispensed by a non-contracted provider, in the event of a medical emergency.
- FDA-approved emergency contraception dispensed by a contracting pharmacist is covered under the Outpatient Prescription Drug Program administered by CVS Pharmacy.
- Counseling and education on contraception, in addition to those identified under the Professional Services benefit category of this section.
- Clinical services related to the use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling.
- Follow-up services related to the drugs, devices, products, and procedures covered in this section including, but not limited to, management of side effects, counseling for continued adherence, and device removal.

Please see the Health Plan Summary of Benefits. Members are not required to obtain prior Authorization to access reproductive and sexual health care services within the Plan Medical Group. You may be required to obtain prior Authorization for out-of-network care. Sharp Health Plan will not infringe on your choice of contraceptive drug, device, or product and will not impose any restrictions or delays on Family Planning Services such as prior Authorization, or Utilization Management.

Sharp Health Plan covers all provider administered FDA-approved contraceptive drugs, products, devices, implants, and injections, sterilization procedures and patient education and counseling for women, as recommended by the Health Resources and Services Administration (HRSA) guidelines, except for those contraceptive drugs and products obtained through a pharmacy. These services are covered without any Cost Sharing on the Member's part. Contraceptive drugs and products obtained through a pharmacy are covered under the Outpatient Prescription Drug Program administered by CVS Pharmacy. All FDA-approved contraceptive drugs, devices, and products available over the counter are also covered under the Outpatient Prescription Drug Program administered by CVS Pharmacy. Please refer to your CVS Pharmacy Outpatient Prescription Drug Plan Evidence of Coverage booklet for additional details.

Where the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, Sharp Health Plan is only required to cover at least one therapeutic equivalent

without Cost Sharing. If a covered therapeutic equivalent of a provider administered drug, device, or product is deemed medically inadvisable by your provider, Sharp Health Plan will defer to the determination and judgement of your provider and provide coverage for the alterative prescribed contraceptive drug, device, product or service without Cost Sharing. If there is no therapeutic equivalent generic substitute available, you will be provided coverage for the original, brand name contraceptive, without Cost Sharing. All abortion and abortion related services, including preabortion and follow-up will be covered without Cost Sharing.

Gender-Affirming Care

Gender-affirming care and associated services are covered when Medically Necessary. Covered Benefits include Medically Necessary services for the treatment of Gender Dysphoria, including medical services, psychiatric services (including counseling), hormonal treatments, surgical treatments, hair removal/transplant procedures, and voice therapy/surgery, according to the most recent revisions and updates of the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC).

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.

Hearing Services

The following hearing services are covered:

- An audiometric examination by a Plan Provider.
- Hearing aids or ear molds when Authorized by the Plan and necessary to provide functional improvement according to professionally accepted standards of practice.
- Hearing aids are covered 100% in both ears every 36 months when Medically Necessary to prevent or treat speech and language development delay due to hearing loss.

Cost Shares made for hearing services do not apply toward the annual Out-of-Pocket Maximum.

The following services are not Covered Benefits:

- Replacement of a hearing aid that is lost, broken or stolen within 36 months of receipt
- Repair of the hearing aid and related services.
- Service or supplies for which a Member is entitled to receive reimbursement under any applicable workers' compensation law.
- Services or supplies that are not necessary according to professionally accepted standards of practice.
- An eyeglass-type hearing aid or additional charges for a hearing aid designed specifically for cosmetic purposes.

Home Health Services

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

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

- Skilled nursing services of a registered nurse, public health nurse, licensed vocational nurse, licensed practical nurse under the supervision of a registered nurse, psychiatrically trained nurse, and/or 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 home health agency.

- Medical social services.
- Medical supplies, medicines, laboratory services and Durable Medical Equipment, when provided by a home health agency while the Member is under a home health plan of care.
- 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 all of the following are true:

1. The Member is confined to the home, except for infrequent or relatively short duration absences or when absences are due to the need to receive medical treatment. (Home is wherever the Member makes his or her home but does not include acute care, rehabilitation or Skilled Nursing Facilities.)
2. The Member needs Medically Necessary skilled nursing visits or needs physical, speech or occupational therapy.
3. The home health care visits are provided under a plan of care established and periodically reviewed and ordered by a Plan Provider. For Mental Health and Substance Use Disorders, the plan of care may be reviewed no less frequently than once every 60 days.

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.
- 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. You pay 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.

Iatrogenic Infertility

Iatrogenic Infertility means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. Standard fertility preservation services are covered for Members with Iatrogenic Infertility. Sharp Health Plan covers standard fertility preservation services for Iatrogenic Infertility in the following circumstances:

1. Your provider has recommended you receive a covered medical treatment that may cause infertility, and
2. Your provider recommends you receive such treatment within the next 12 months, and you attest that you plan to undergo such treatment in the next 12 months. Sharp Health Plan will accept an attestation from you or your provider contained in a request for services.

OR

1. You received a covered medical treatment that may cause infertility, and
2. Your medical condition was such that you were either unable to undergo fertility preservation or complete your fertility preservation cycle(s), and
3. You face an ongoing risk for infertility due to reproductive damage caused by those treatments.

Standard fertility preservation services for Members with Iatrogenic Infertility include the following:

- A lifetime limit of two cycles for oocyte (egg) retrieval for Members with ovaries
- A lifetime limit of up to two attempts to collect sperm for Members with testicles

- A lifetime limit of up to two attempts of embryo creation
- A lifetime limit of up to two attempts to retrieve gonadal tissue
- Gonadal shielding or transposition during a procedure or treatment, if not already included in the usual coverage for that procedure or treatment
- Any other standard fertility preservation services consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine

The lifetime limits specified above apply regardless of the number of health plans you enroll in during your lifetime.

Cryopreservation and storage of sperm, oocytes, gonadal tissue and embryos is covered as follows:

- Until you reach the age of 26 if you are under the age of 18 on the date your genetic material is first cryopreserved
- Until you reach the age of 26 or for three years, whichever is longer, if you are 18 years or older but not yet 26 years old on the date your genetic material is first cryopreserved
- For a period of three years if you are 26 or older at the time your genetic material is first cryopreserved

Sharp Health Plan chooses a cryopreservation vendor where your genetic material will be stored. Sharp Health Plan is not required to continue coverage for cryopreservation storage if you are no longer enrolled in coverage. If you change health plans during the covered storage period and your new health plan determines your genetic material should be transferred to a different storage facility, Sharp Health Plan will coordinate with the new health plan to ensure the transfer and transportation of your genetic material is achieved in the most cost-effective manner. Sharp Health Plan will provide the new health plan with information showing the beginning date of any cryopreservation of your genetic material. Your new health plan will be responsible for transportation costs of your genetic material as well as costs to store your genetic material for the remainder of the applicable storage time. Your new health plan must provide you with a notice that the transportation and storage costs will be covered for the remainder of the applicable storage time.

Sharp Health Plan is not permitted to deny a coverage request for Medically Necessary standard fertility preservation services based solely upon:

- A prior diagnosis of infertility, where medical evaluation indicates that you would have a reasonable chance of responding to such services
- Your age, where medical evaluation indicates you would have a reasonable chance of responding to such services
- Your gender
- Your gender identity
- Your sexual orientation
- Your gender expression
- Your marital status
- Your disability status

You have a right to receive standard fertility preservation services for iatrogenic infertility when you meet the requirements in Section 1300.74.551 of Title 28 of the California Code of Regulations. "Iatrogenic infertility" means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. If Sharp Health Plan fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you will pay no more than in-network cost-sharing for the same services.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days for primary care and 15 business days for specialist care from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior

authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. If you are enrolled in preferred provider organization (PPO) coverage, and your health plan can arrange care for you within the timeframes and within geographic standards, your voluntary use of out-of-network benefits may subject you to incur out-of-network charges.

If you have questions about how to obtain standard fertility preservation services for iatrogenic infertility or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on your-health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.DMHC.ca.gov to request assistance in obtaining standard fertility preservation services for iatrogenic infertility.

Infertility Services

Infertility services, including provider administered treatment of the Member's infertility condition, are covered. Infertility is defined as:

(1) a person's inability to conceive a pregnancy or carry a pregnancy to live birth either as an individual or with their partner; or

(2) a licensed physician's determination of infertility, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.

Artificial Insemination is covered.

The Member pays a Cost Share equal to 50% of the Plan's contracted rate of payment to each Plan Provider of services for all covered infertility services.

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 your home, in a physician's office, in a hospital, or in an institution, such as board and care, custodial care, assisted living facility or infusion center, that is not a hospital or institution primarily engaged in providing skilled nursing services or rehabilitation services.

The Cost Shares 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 applicable office visit Cost Share will be charged. If the service is provided in an outpatient hospital facility, the Outpatient Services Cost Share will apply. Please see the Health Plan Summary of Benefits.

Injectable Drugs

Provider administered injectable medications and self-injectable medications are covered under the medical benefit when not otherwise limited or excluded.

Provider administered injectable medications include those drugs or preparations which are not usually self-administered and which are given by the intramuscular or subcutaneous route.

Self-injectable medications are drugs that are injected subcutaneously (under the skin) and are approved by the Food and Drug Administration (FDA) for self-administration and/or are packaged in patient-friendly injection devices along with instructions on how to administer.

Epi-pens, self-injectable insulin and GLP1 agents approved by the Food and Drug Administration (FDA) for the treatment of diabetes are covered under the Outpatient Prescription Drug Program administered by CVS Pharmacy. Please refer to your CVS Pharmacy Outpatient Prescription Drug Plan Evidence of Coverage booklet for additional details.

Long-acting injectable naltrexone being used as medicated-assisted treatment is a type of provider administered injectable medication that is covered

under the medical benefit and does not require Utilization Management, Step Therapy or prior Authorization.

Maternity and Pregnancy Services

The following maternity and pregnancy services are covered:

- Prenatal and postnatal services, including, but not limited to, Plan Physician visits.
- Laboratory services (including the California Department of Health Services' Expanded Alpha Fetoprotein (AFP) Program).
- Radiology services.
- Prenatal diagnosis of genetic disorders of a fetus in high-risk pregnancy cases.
- Breastfeeding services and supplies. A breast pump and supplies required for breastfeeding are covered within 365 days after delivery. (Optional accessories, such as tote bags and nursing bras, are not covered.) A new breast pump and supplies will be provided for subsequent pregnancies, only if a pump previously provided by Sharp Health Plan is no longer covered under warranty.
- Screening and treatment for a Maternal Mental Health Condition for all women during pregnancy and during the postpartum period, that shall consist of at least one maternal mental health screening to be conducted during pregnancy, at least one additional screening to be conducted during the first six weeks of the postpartum period, and additional postpartum screenings, if determined to be Medically Necessary and clinically appropriate in the judgment of the treating provider.
- Doula care including health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum women before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion provided virtually or in person with locations in any setting including, but not limited to homes, office visits, hospitals, or alternative birth centers.
    - Doula services include up to 11 visits with an in-network Doula plus labor and delivery or termination of pregnancy:
        - One initial visit
        - Up to eight prenatal or postpartum visits
        - Support during labor and delivery (including labor and delivery ending in stillbirth, miscarriage, and abortion).
        - Up to two extended three-hour postpartum visits
    - Visits can be in person or virtual.
    - Find an in-network Doula provider at this location: sharphealthplan.com/findadoctor
    - All visits are limited to one per day, per Member.
    - One prenatal visit or one postpartum visit can be provided on the same day as labor and delivery, stillbirth, abortion, or miscarriage support.
- Medically Necessary pasteurized human donor milk.

Prenatal and postnatal care recommended by the U.S. Preventive Services Task Force (USPSTF) with an A or B rating or by the Health Resources and Services Administration (HRSA) is covered under the preventive benefit without Member Cost Share. Such care includes, but is not limited to:

- Routine prenatal and postnatal obstetrical office visits.
- Certain lab services.
- Breastfeeding services and supplies (including counseling, education and breastfeeding equipment and supplies) during the antenatal, perinatal and postpartum periods.
- Depression screening and appropriate follow up.
- Tobacco use cessation counseling.
- Unhealthy alcohol use screening and behavioral counseling.

- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP).
- Gestational diabetes mellitus screening.
- Hepatitis B and human immunodeficiency virus (HIV) infection screening.

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

Prenatal and postnatal office visit Copayments are separate from any hospital Copayments. For delivery, you pay the applicable Copayment to the hospital facility at the time of admission. An additional hospital Copayment applies if the newborn Dependent requires a separate admission from the mother because care is necessary to treat a sick newborn.

Inpatient hospital care is covered for no less than 48 hours following a normal vaginal delivery and 96 hours following a delivery by cesarean section. The mother, in consultation with the treating physician, may decide to be discharged before the 48-hour or 96-hour time period. Extended stays beyond the 48-hour or 96-hour time period must be Authorized. Sharp Health Plan will also cover a follow-up visit within 48 hours of discharge when prescribed by the treating physician. The visit shall include parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments.

The treating physician, in consultation with the mother, will determine whether the post-discharge visit shall occur at the home, at the hospital or at the treating physician's office after assessment of the environmental, social risks, and the transportation needs of the family.

Mental Health Services

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

Outpatient Mental Health Services

- Physician services, including consultation and referral to other Health Care Providers and Prescription Drugs when furnished or administered by a Health Care Provider or facility
- Medication management
- Coordinated specialty care for the treatment of first episode psychosis
- Individual office visits and group Mental Health evaluation and treatment
- Outpatient professional services, including but not limited to individual, group, and family mental health counseling
- Psychological and neuropsychological testing when necessary to evaluate a Mental Health Disorder
- Screening and treatment for a Maternal Mental Health Condition for all women during pregnancy and during the postpartum period
- Outpatient services for the purpose of monitoring drug therapy
- Behavioral Health Treatment for autism spectrum disorder
- Intensive outpatient treatment (programs usually less than five hours per day)
- Partial hospitalization (programs usually more than five hours per day)
- Day treatment

- Transcranial magnetic stimulation
- Case management services
- Intensive community-based treatment, including assertive community treatment and intensive case management
- Electroconvulsive therapy
- Diagnostic laboratory and diagnostic and therapeutic radiologic services
- Polysomnography
- Home health services
- Intensive home-based treatment
- Schoolsite services for a mental health condition that are delivered to a Member at a schoolsite pursuant to Health and Safety Code section 1374.722
- Preventive health services, as described under **Preventive Care Services**
- Medically Necessary treatment of a Mental Health or Substance Use Disorder, including, but not limited to, Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider, including Behavioral Health Crisis Stabilization Services
- The cost of developing an evaluation pursuant to Section 5977.1 of the Welfare and Institutions Code and the provision of all health care services when required or recommended for you as part of a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court. Services provided to you pursuant to a CARE Agreement or a CARE Plan, excluding Prescription Drugs, will be provided with no Cost Sharing regardless of whether the service was provided by a Plan Provider or non-Plan Provider.

Intensive Psychiatric Treatment Programs

Intensive psychiatric treatment programs:

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

Inpatient Mental Health Services

- Inpatient psychiatric hospitalization, including room and board, drugs, supplies, and services of health care professionals
- Treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis and psychiatric observation for an acute psychiatric crisis
- The Member Cost Share for the entire inpatient mental health stay is determined by the benefit plan in effect on the day you were admitted to the hospital

Emergency Health Care Services

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

Services related to preventing, diagnosing, and treating mental conditions as Medically Necessary in accordance with current generally accepted standards of mental health care are also covered. Sharp Health Plan shall not limit Mental Health coverage to short term or acute treatment.

Members have direct access to Health Care Providers of Mental Health services without obtaining a PCP referral. In most cases services must be provided by Plan Providers. Please call Magellan toll-free at 1-844-483-9013 whenever you need mental health services. All calls are confidential. The following exceptions can be provided by Plan Providers or non-Plan Providers: 1) Medically Necessary treatment of a Mental Health or Substance Use Disorder, including but not limited to Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider, and 2) services received under a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court.

If services for the Medically Necessary treatment of a Mental Health Disorder are not available in network within the geographic and timely access standards set by law or regulation, Magellan will Authorize and arrange for Medically Necessary out-of-network services and any Medically Necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. The Member will pay in-network Cost Sharing for out-of-network services Authorized by the Plan and for any out-of-network Medically Necessary treatment of a Mental Health or Substance Use Disorder, including, but not limited to Behavioral Health Crisis Services provided by a 988 center, mobile crisis team or other provider. You will not pay any Cost Sharing for services provided pursuant to a CARE Agreement or CARE Plan, excluding Prescription Drugs, regardless of whether the service was provided by a Plan Provider or non-Plan Provider.

You have a right to receive timely and geographically accessible Mental Health/ Substance Use Disorder (MH/SUD) services when you need them. If Magellan fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have any questions about how to obtain MH/SUD services or are having difficulties obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

MinuteClinic® at CVS®

As a Sharp Health Plan Member, you may receive the Covered Benefits listed below at any MinuteClinic® at CVS® ("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 medical clinic located inside select CVS/ pharmacy® stores. MinuteClinic provides convenient access to basic care. It is staffed with board-certified family nurse practitioners and physician associates and is the largest provider of retail health care in the United States. In addition, it was the first retail Health Care Provider to receive accreditation and the Joint Commission's Gold Seal of Approval® for dedication to delivering the highest possible quality health care to patients. The Joint Commission is the national evaluation and certifying agency for nearly 20,000 health care organizations and programs in the United States.

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

- Diagnosis and treatment for common family illnesses such as strep throat, allergy symptoms, pink eye and infections of the ears, nose and throat

- Seasonal flu, COVID-19, and other non-seasonal vaccinations
- Treatment of minor wounds, abrasions and minor burns
- Treatment for skin conditions such as poison ivy, ringworm and acne

No prior Authorization is necessary to receive Covered Benefits at a MinuteClinic. The MinuteClinic providers may refer you to your Sharp Health Plan PCP if you need services other than those covered at MinuteClinic locations.

For more information about MinuteClinic services, age restrictions, and to schedule an appointment, please visit CVS.com/MinuteClinic. If you receive covered services at a MinuteClinic, your cost is equal to the PCP Copayment, as applicable to your benefit plan. A Deductible may apply. There is no Copayment for flu vaccinations.

You have access to all MinuteClinic locations. Appointments can be scheduled in person, online at CVS.com/MinuteClinic, or through the CVS pharmacy app.

Ostomy and Urological Services

Ostomy and urological supplies prescribed by a Plan Provider are a Covered Benefit. Coverage is limited to the standard supply that adequately meets your medical needs. Sharp Health Plan does not use a soft goods formulary (list of approved ostomy and urological supplies), but supplies may require prior Authorization by the Plan or your Plan Medical Group to determine if they are Medically Necessary. Ostomy and urological supplies must be provided by an approved vendor. For information on approved vendors and prior Authorization you can contact your PCP or Customer Care.

Covered ostomy and urological supplies include:

- 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.

Outpatient Prescription Drugs

Sharp Health Plan does not provide Outpatient Prescription Drug coverage as a Covered Benefit, except for limited classes of Prescription Drugs that are integral to treatments covered as basic health care services and subject to the medical benefit. Outpatient Prescription Drug benefits are instead covered and administered by CVS Pharmacy. Members should review the CVS Pharmacy Outpatient Prescription Drug Plan Evidence of Coverage booklet for details regarding the Outpatient Prescription Drug Program.

Members may contact CVS Pharmacy's Customer Care at 1-833-291-3649 (TTY users call 711) with questions or to request a copy of the booklet.

Outpatient Rehabilitation Therapy Services

Outpatient rehabilitation services, including occupational, physical and speech therapy, are covered. You pay an applicable Copayment to the Plan Physician or other health care professional for

each visit. Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, Skilled Nursing Facility or home.

The goal of rehabilitation therapy is to assist Members to become as independent as possible, using appropriate adaptations if needed to achieve basic Activities of Daily Living including bathing, dressing, feeding, toileting and transferring (e.g., moving from the bed to a chair).

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

Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS)

Medically Necessary services for the prevention, diagnosis and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) are covered. Treatments for PANDAS and PANS include antibiotics, medications and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange and intravenous immunoglobulin therapy.

Phenylketonuria (PKU) Diagnosis and Treatment

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 physician who specializes in the treatment of metabolic diseases.

Preventive Care Services

Covered preventive care services include, but are not limited to, the following. Coverage does not include Outpatient Prescription Drugs. Outpatient Prescription Drugs are administered by CVS Pharmacy. Please refer to your CVS Pharmacy Outpatient Prescription Drug Plan Evidence of Coverage booklet for additional details regarding the Outpatient Prescription Drug Program.

- Well Child physical examinations (including vision and hearing screening in the PCP's office) and all periodic immunizations and related laboratory services and screening for blood lead levels in Children of any age who are at risk for lead poisoning, as determined by a Sharp Health Plan physician and surgeon, if the screening is prescribed by a Sharp Health Plan Health Care Provider, in accordance with the current recommendations from the American Academy of Pediatrics, U.S. Preventive Services Task Force (USPSTF), or the Advisory Committee on Immunization Practices of the CDC.
- Well adult physical examinations, episodic immunizations and related laboratory services in accordance with the current recommendations from the USPSTF, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC), the Health Resources and Services Administration (HRSA) 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 HRSA. 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 USPSTF and approved by the federal Food and Drug Administration, including the conventional Pap test, any cervical cancer screening test, BRCA screening and testing in high-risk women, human papillomavirus screening test, lung cancer screening in certain persons, colorectal cancer screening, and prostate cancer screening.

- 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.
- Home test kits for sexually transmitted disease (including the laboratory costs for processing the kits) that are deemed Medically Necessary or appropriate and ordered directly by a provider or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.
- Hepatitis B and Hepatitis C screenings.
- Depression screening.
- Adverse Childhood Experiences (ACEs) screening
- Screening for tobacco use.
- Behavioral counseling intervention for tobacco smoking cessation
- Exercise interventions to prevent falls in community-dwelling adults 65 years or older who are at increased risk for falls.
- Screening for osteoporosis with bone measurement testing for women 65 or older, or younger than 65 at increased risk.
- Screening, brief intervention and referral to treatment, primary care based interventions, and specialty services for persons with hazardous, at-risk, or harmful substance use who do not meet the diagnostic criteria for a substance use disorder, or persons for whom there is not yet sufficient information to document a substance use or addictive disorder, as described in ASAM level of care 0.5 (3rd edition), or the most recent version of The ASAM Criteria.
- Basic services for prevention and health maintenance, including: screening for mental health and developmental disorders and adverse childhood experiences; multidisciplinary assessments; expert evaluations; referrals; consultations and counseling by mental health clinicians; emergency evaluation, brief intervention and disposition; crisis intervention and stabilization; community outreach prevention and intervention programs; mental health first aid for victims of trauma or disaster; and health maintenance and violence prevention education, as described in LOCUS and CALOCUS-CASII level of care zero (version 2020), or the most recent versions of LOCUS and CALOCUS CASII.

Preventive care services are covered in accordance with the following recommendations and guidelines.

- Recommendations made by the U.S. Preventive Services Task Force (USPSTF) with a rating of "A" or "B", available at www.uspreventiveservicestaskforce.org.
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC), available at www.cdc.gov/vaccines/acip.
- Health Resources and Services Administration (HRSA)-supported women's preventive services guidelines, available at www.hrsa.gov/womens-guidelines.
- Bright Futures guidelines for Children and adolescents, developed by the HRSA with the American Academy of Pediatrics, available at mchb.hrsa.gov/programs-impact/programs/preventive-guidelines-screenings-women-children-youth.

The USPSTF, ACIP or HRSA may update their recommendations and guidelines periodically. Any change in benefits required as a result of a new or updated recommendation or guideline will be effective for the Benefit Year that begins on or after the date that is one year after the date the recommendation or guideline is issued. For example, if your Benefit Year begins January 1 of each year and the USPSTF issues a new recommendation with a rating of "A" on September 1, 2022, the benefit changes required would take effect January 1, 2024 (the start of your Benefit Year that begins one year after the USPSTF issued its recommendation). In the event of a safety recall or otherwise significant safety concern, or if the USPSTF downgrades a particular recommendation to a "D" rating, coverage of the

affected item or service may cease prior to the end of your Benefit Year.

All pharmacy benefits, including coverage for FDA-approved tobacco cessation medications, are managed by CVS Pharmacy. Please refer to your CVS Pharmacy Outpatient Prescription Drug Plan Evidence of Coverage booklet or contact CVS Pharmacy's Customer Care at 1-833-291-3649 (TTY users call 711).

Any item, service or immunization not specifically listed here but that is recommended by the USPSTF with an "A" or "B" rating, recommended by ACIP or supported by HRSA, as described above, will also be covered as preventive. All preventive care services are provided at no Cost Share to Members; however, reasonable medical management techniques may be used to determine the frequency, method, treatment or clinical setting for a recommended preventive service, to the extent not specified in the recommendation or guideline regarding that preventive service.

Professional Services

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

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

Prosthetic and Orthotic Services

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

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

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

The following external prosthetic and orthotic devices are covered:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx. (This coverage does not include electronic voice-producing machines, which are not prosthetic devices.)
- Prostheses needed after a Medically Necessary mastectomy and up to three brassieres required to hold a breast prosthesis every 12 months.
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist.
- Compression burn garments and lymphedema wraps and garments.
- Enteral and parenteral nutrition: enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding

supply kits; enteral nutrition infusion pump; enteral tubing; gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; parenteral nutrition solutions; stomach tube; and supplies for self-administered injections.

- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.

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

- A shoe that is an integral part of a leg brace and included as part of the cost of the brace.
- Therapeutic shoes furnished to selected diabetic Members.
- Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care.
- Prosthetic shoes are an integral part of a prosthesis.
- Special footwear needed by persons who suffer from foot disfigurement including disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes and foot disfigurement caused by accident or developmental disability.

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

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

Repair or replacement of prosthetics and orthotics are covered when prescribed by a Plan Physician or ordered by a licensed Health Care Provider acting within the scope of their license, and when not caused by misuse or loss. The applicable Copayment, per the Health Plan, listed on the Summary of Benefits, applies for both repair and replacement.

Radiation Therapy

Radiation therapy (standard and complex) is covered.

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

Radiology Services

Radiology services provided in the physician's office, outpatient facility or inpatient hospital facility are covered.

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

Reconstructive Surgical Services

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

- Reconstructive surgical services following a mastectomy or lymph node dissection are covered. The length of a hospital stay associated with a mastectomy or lymph node dissection is determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes. There is no prior Authorization required in determining the length of hospital stay following these procedures. Members who elect to have breast reconstruction after a mastectomy are

covered for all complications of the mastectomy and reconstructive surgery, prostheses for and reconstruction of the affected breast and reconstructive surgery on the other breast as may be needed to produce a symmetrical appearance.

- Reconstructive surgical services performed on abnormal structures of the body caused by congenital defects, developmental anomalies, trauma, infection, tumors, 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.
- For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which the Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.

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

Skilled Nursing Facility Services

Skilled Nursing Facility services are covered for up to a maximum of 100 days per Calendar Year in a semi-private room (unless a private room is Medically Necessary). Covered Benefits for skilled nursing care are those services prescribed by a Plan Provider and provided in a qualified licensed Skilled Nursing Facility. Covered Benefits include:

- Physician and Skilled nursing on a 24-hour basis
- Room and board
- X-ray and laboratory procedures
- Respiratory therapy
- Short term physical, occupational and speech therapy
- Medical social services
- Behavioral Health Treatment for autism spectrum disorder
- Blood, blood products and their administration
- Medical Supplies, appliances and equipment normally furnished by the Skilled Nursing Facility

Smoking Cessation

Members who participate and complete a smoking cessation class or program will be reimbursed up to $100 per class or program per Calendar Year. For more information about these classes and programs, please contact Customer Care.

Sterilization Services

Voluntary sterilization services are covered.

Substance Use Disorder Treatment

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

- Physician services, including consultation and referral to other Health Care Providers and Prescription Drugs when furnished or administered by a Health Care Provider or facility
- Outpatient professional services, including but not limited to individual, group and family substance use counseling
- Medication management
- Diagnostic laboratory and diagnostic and therapeutic radiologic services
- Drug testing, both presumptive and definitive, including for initial and ongoing patient assessment during Substance Use Disorder treatment
- Home health services
- Intensive home-based treatment

- Preventive health services, as described under **Preventive Care Services**
- Emergency health care services, including ambulance and ambulance transport services and Out-of-Area coverage, as described under **Emergency Services and Care**
- Inpatient detoxification: Drug or alcohol detoxification is covered as an Emergency Medical Condition. Hospitalization in a Plan Hospital for medical management of withdrawal symptoms, including room and board, Plan Physician services, drugs, dependency recovery services, education, case management, counseling, and aftercare programs.
- Withdrawal management services
- Chemical dependency recovery hospitals
- Transitional residential recovery services: Substance Use Disorder treatment in a nonmedical transitional residential recovery setting if Authorized in advance by Plan. These settings provide counseling and support services in a structured environment.
- Outpatient Substance Use Disorder care: day-treatment programs, intensive outpatient programs (programs usually less than five hours per day), individual and group Substance Use Disorder counseling, medical treatment for withdrawal symptoms, partial hospitalization (programs usually more than five hours per day), and case management services.
- Intensive community-based treatment, including assertive community treatment and intensive case management
- Narcotic (opioid) treatment programs
- Schoolsite services for a Substance Use Disorder that are delivered to a Member at a school site pursuant to Health and Safety Code section 1374.722
- Medically Necessary treatment of a Mental Health or Substance Use Disorder, including but not limited to Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider, including Behavioral Health Crisis Stabilization Services.
- Services received as part of a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court. Services provided to you pursuant to a CARE Agreement or a CARE Plan, excluding Prescription Drugs, will be provided with no Cost Sharing regardless of whether the service was provided by a Plan Provider or non-Plan Provider.

Other services are also covered if Medically Necessary for preventing, diagnosing and treating a Substance Use Disorder, in accordance with current generally accepted standards of Substance Use Disorder care. Sharp Health Plan may not limit Substance Use Disorder coverage to short-term or acute treatment if a higher level of care is Medically Necessary.

Members have direct access to Health Care Providers of Substance Use Disorder treatment without obtaining a PCP referral. In most cases, services must be provided by Plan Providers. Please call Magellan toll-free at 1-844-483-9013 whenever you need Substance Use Disorder treatment. All calls are confidential.

Prior Authorization is not required for outpatient Substance Use Disorder office visits, services received under a CARE Agreement or CARE Plan approved by a court, or Medically Necessary treatment of a Substance Use Disorder, including but not limited to Behavioral Health Crisis Services provided to you by a 988 center, mobile crisis team or other provider of Behavioral Health Crisis Services. In most cases, services must be provided by Plan Providers. The following exceptions can be provided by Plan Providers or non-Plan Providers:

1. Medically Necessary treatment of a Substance Use Disorder, including but not limited to Behavioral Health Crisis Services provided by a 988 center, mobile crisis team or other provider, and
2. Services received under a CARE Agreement or CARE Plan approved by a court.

If services for the Medically Necessary treatment of a Substance Use Disorder are not available in network within the geographic and timely access standards set by law or regulation, Sharp Health Plan will Authorize Medically Necessary out-of-

network services and any Medically Necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. The Member will pay in-network Cost Sharing for out-of-network services Authorized by the Plan and for any out-of-network Medically Necessary treatment of a Substance Use Disorder including, but not limited to, Behavioral Health Crisis Services provided by a 988 center, mobile crisis team or other provider.

You will not pay any Cost Sharing for services provided pursuant to a CARE Agreement or CARE Plan, excluding Prescription Drugs, regardless of whether the service was provided by a Plan Provider or non-Plan Provider.

You have the right to receive timely and geographically accessible Mental Health/ Substance Use Disorder (MH/SUD) services when you need them. If Magellan fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, y ou do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have any questions about how to obtain MH/SUD services or are having difficulties obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Termination of Pregnancy

Interruption of pregnancy (abortion) services, including outpatient surgery, inpatient hospital stays, and specialist visits, are covered with no Cost Share.

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 biological products and procedures that have been established as safe and effective, and no longer determined to be Experimental or Investigational Treatment, are covered. Anti-rejection drugs may also be covered under the Outpatient Prescription Drug Program. The Outpatient Prescription Drug Program is administered by CVS Pharmacy. Please refer to your CVS Pharmacy Outpatient Prescription Drug Plan Evidence of Coverage booklet for additional details.

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

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

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

Travel and Lodging

Specified travel and lodging expenses are covered for Medically Necessary covered services including, but not limited to, the services listed below when they cannot be accessed from Plan Providers within 50 miles from the Member's permanent residence. Prior Authorization is required unless otherwise noted.

- Abortion services (prior Authorization not required)
- Bariatric surgery
- Organ and tissue transplants
- Gender-Affirming Care
- Acute inpatient pediatric care (except direct admission to the neonatal intensive care unit) or specialty inpatient pediatric care (except direct admission to the pediatric intensive care unit)
- Outpatient pediatric hematology and oncology

Coverage is limited to $5,000 per occurrence and includes travel expenses for the Member and one companion. If the patient is under 18, covered companion travel expenses include two parents/guardians. Travel and lodging expenses require prior Authorization by Sharp Health Plan. Covered expenses include:

- Transportation from the Member's permanent address to the Authorized location to receive eligible covered services, as described above.
- Lodging accommodations if one or more overnight stays are required to obtain eligible covered services. Limited to 1 double-occupancy room. Coverage is limited to the room charge only, up to $200 per night. All other hotel expenses are excluded.
- Meals, up to $100 per day, excluding alcohol.
- Expenses are covered for the Member and one companion or two parents/guardians (if the Member is under 18).

For complete details on services covered, the amount of reimbursement, limitations and exclusions, and how to request reimbursement, refer to the Travel and Lodging benefit description online at sharphealthplan.com/CalPERS/TL.

Certain travel expense reimbursements may be tax reportable. When required, we will issue a Form 1099-MISC to you, reporting travel expense reimbursements. We do not provide tax advice. If you have tax questions about travel expense reimbursements, consult with your tax advisor.

Urgent Care Services

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

Vision Care

Routine vision screenings included as part of a preventive care visit are covered. Eye exams for refraction to determine the need for corrective lenses are a covered Supplemental Benefit.

Wigs and 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 you up to $300 per Calendar Year for a wig or hairpiece from a provider of your choice.

What Is Not Covered?

Exclusions and Limitations

The Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this Evidence of Coverage (EOC).

These exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary Treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by the Plan or required by law.

Acupuncture Services

This Plan does not cover acupuncture services, except as described in this EOC in **Acupuncture Services** or as provided by law.

Chiropractic Services

This Plan does not cover chiropractic services, except as described in this EOC in **Chiropractic Services** or as provided by law.

Clinical Trials

This Plan does not cover clinical trials, except Approved Clinical Trials as described in this EOC in Clinical Trials, or as required by law.

Coverage of Approved Clinical Trials does not include the following:

- The investigational drug, item, device, or service itself.
- Drugs, items, devices and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member.
- Drugs, items, devices and services specifically excluded from coverage in this EOC, except for drugs, devices, and services required to be covered pursuant to state and federal law.
- Drugs, items, devices and services customarily provided free of charge to a clinical trial participant by the research sponsor.

This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental Services or Investigational Services independent review process as described in this EOC in **Experimental or Investigational Services**, or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in this EOC in **Independent Medical Reviews (IMR)**.

Cosmetic Services, Supplies, or Surgeries

This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function, except as described in this EOC in **Reconstructive Surgical Services**, or as required by law. This Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in this EOC in **Gender-Affirmative Care**, or as required by law.

This exclusion does not apply to the following:

- Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
- Reconstructive surgery as described in this EOC in **Reconstructive Surgical Services**.
- For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve functions, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this EOC in **Gender-Affirmative Care**.

Custodial or Domiciliary Care

This Plan does not cover custodial care, which involves assistance with Activities of Daily Living, 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, except as described in this EOC in **Hospice Services** and **Skilled Nursing Facility Services** or as required by law.

This exclusion does not apply to the following:

- Assistance with Activities of Daily Living that requires the regular services of or is regularly provided by trained medical or health professionals.
- Assistance with Activities of Daily Living that is provided as part of covered hospice, Skilled Nursing Facility, or inpatient hospital care.
- Custodial care provided in a healthcare facility.

Dental Services

This Plan does not cover dental services or supplies, except as described in this EOC in **Dental Services/ Oral Surgical Services** or as required by law.

Dietary or Nutritional Supplements

This Plan does not cover dietary or nutritional supplements, except as described in this EOC in **Prosthetic and Orthotic Services and Phenylketonuria (PKU)** or as required by law.

Disposable Supplies for Home Use

This Plan does not cover Disposable Supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this EOC in **Ostomy and Urological Services** or as required by law.

Exercise Programs

This Plan does not cover exercise programs, except as required by law.

Experimental or Investigational Services

This Plan does not cover Experimental Services or Investigational Services, except as described in this EOC in **Experimental or Investigational Services**, or as required by law.

Experimental Services means drugs, equipment, or services that are in testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

1. Testing is not complete; and
2. The efficacy and safety of such services in human subjects are not yet established; and
3. The service is not in wide usage.

The determination that a service is an Experimental Service or Investigational Service is based on:

1. Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
2. Consultation with provider organizations, academic and professional specialists pertinent to the specific service;
3. Reference to current medical literature.

However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an external, independent review.

Qualifications

1. You must have a Life-Threatening or Seriously Debilitating condition.
2. Your Health Care Provider must certify to the Plan that you have a Life-Threatening or Seriously Debilitating condition for which

standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.

3. Either (a) your Health Care Provider, who has a contract with or is employed by the Plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.
4. You have been denied coverage by the Plan for the recommended or requested service.
5. If not for the Plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

External, Independent Review Process

If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

DMHC's Independent Medical Review (IMR)

This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in this EOC in **Independent Medical Reviews (IMR)**. In certain circumstances, you do not have to participate in the Plan's grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial. See **Denial of Experimental or Investigational Treatment for Life-Threatening or Seriously Debilitating Conditions.**

Hearing Aids

This Plan does not cover hearing aids, except as described in this EOC in **Hearing Services** and **Prosthetic and Orthotic Services** or as provided by law.

Immunizations

This Plan does not cover non-Medically Necessary or non-preventive immunizations solely for foreign travel or occupational purposes, except as required by law.

Non-licensed or Non-certified Providers

This Plan does not cover treatments or services rendered by a non-licensed or non-certified Health Care Provider, except as required by law. This exclusion does not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.

Personal or Comfort Items

This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.

Prescription Drugs/Outpatient Prescription Drugs

The Plan does not cover Outpatient Prescription Drugs as a Covered Benefit except as required by law. The medical benefit provides coverage of limited classes of Prescription Drugs that are integral to treatments covered as basic health care

services. Members should contact their group for more information about supplemental Outpatient Prescription Drug benefits.

Private Duty Nursing

This Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as required by law.

Reversal of Voluntary Sterilization

This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as required by law.

Routine Physical Examination

The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non-preventive purpose, except as described in this EOC in **What Happens if You Receive Covered Services through a Community Assistance, Recovery and Empowerment (CARE) Program?** or as required by law.

Surrogate Pregnancy

This Plan does not cover testing, services, or supplies for a person who is not covered under this Plan for a surrogate pregnancy, except as described in this EOC in **Infertility Treatment and Fertility Services** or as required by law.

Therapies

This Plan does not cover the following physical and occupational therapies, except as described in this EOC in **Outpatient Rehabilitation Therapy Services** or as required by law:

- Massage therapy, unless it is a component of a treatment plan;
- Training or therapy for the treatment of learning disabilities or behavioral problems;
- Social skills training or therapy; and
- Vocational, educational, recreational, art, dance, music, or reading therapy.

Vision Care

This Plan does not cover vision services, except as described in this EOC in **Vision Care** or as provided by law.

Eligibility and Enrollment

Information pertaining to eligibility, enrollment and termination of coverage can be obtained through the CalPERS website at www.calpers.ca.gov or by calling CalPERS. Also, please refer to the CalPERS Health Program Guide for additional information about eligibility. Your coverage begins on the date established by CalPERS.

It is your responsibility to stay informed about your coverage. For an explanation of specific enrollment and eligibility criteria, please consult your Health Benefits Officer or, if you are retired, the CalPERS Health Account Management Division at:

CalPERS
Health Account Management Division
P.O. Box 942715
Sacramento, CA 94229-2715

Or call:
888 CalPERS (or **888-225-7377**)
(916) 795-3240 (TDD)

Live/Work

If you are an active employee or a working CalPERS retiree, you may enroll in a plan using either your residential or work ZIP code. When you retire from a CalPERS Employer and are no longer working for any Employer, you must select a health plan using your residential ZIP code. If you use your residential ZIP code, all enrolled Dependents must reside in the health plan's Service Area.

When you use your work ZIP code, all enrolled Dependents must receive all Covered Benefits (except Emergency Services and Urgent Care Services) within the health plan's Service Area, even if they do not reside in that area.

What if You Have Other Health Insurance Coverage?

When you are covered by more than one group health plan, payments for Covered Benefits will be coordinated between the two plans, so that benefits paid do not exceed 100% of allowable expenses. The coordination of benefits rules determine which group health plan is primary (pays first) and which is secondary (pays second). Sharp Health Plan follows the rules for coordination of benefits as outlined in the California Code of Regulations, Title 28, Section 1300.67.13. You must give us any information we request to help us coordinate benefits according to these rules.

- When a plan does not have a coordination of benefits provision, that plan pays its benefits first. Otherwise, the group health plan covering you as an Enrolled Employee or Subscriber provides benefits before the plan covering you as a Dependent.
- Sharp Health Plan uses the "Birthday Rule" in coordinating health insurance coverage for Child Dependents when the parents are not divorced or separated. When both parents have different group plans that cover a Child Dependent, the group health plan of the parent whose birthday falls earliest in the Calendar Year will be the primary health plan for the Child Dependent.
- When the parents are divorced or separated, and a court decree states one of the parents is responsible for the health care expenses of the Child, the group health plan of the responsible parent is primary.
- When the parents are divorced or separated, and there is no court decree, and the parent with custody has not remarried, the group health plan of the custodial parent is primary.
- When the parents are divorced or separated, and there is no court decree, and the parent with custody has remarried, the order of payment is (1) the group health plan of the custodial parent; (2) the group health plan of the stepparent; (3) the group health plan of the noncustodial parent.
- If the above rules do not apply, the group health plan that has covered you for the longer period of time is the primary plan.

What if You Are Eligible for Medicare?

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

If you have Medicare coverage, we will coordinate benefits with your Medicare coverage under Medicare rules. Medicare rules determine which coverage is primary (pays first), and which coverage is (pays secondary). You must give us any information we request to help us coordinate benefits according to Medicare rules. If you have questions about Medicare rules for coordinating coverage, please contact Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

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.

Individual Continuation of Benefits

Total Disability Continuation Coverage

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

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

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

COBRA Continuation Coverage

If your Employer has 20 or more employees, and you or your Dependents would otherwise lose coverage for benefits, you may be able to continue uninterrupted coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 and its amendments (referred to as COBRA), subject to your continuing eligibility and your payment of Premiums. COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependents could become qualified beneficiaries if coverage under the group plan is lost because of the qualifying event. Please contact your CalPERS 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 CalPERS or Sharp Health Plan changes benefits, Premiums, etc., your continuation coverage will change accordingly. If the contract between CalPERS and Sharp Health Plan terminates while you are still eligible for COBRA, you may elect to continue COBRA coverage under the subsequent group health plan.

If you are no longer eligible for COBRA continuation coverage and your COBRA coverage was less than 36 months, you may be eligible for Cal-COBRA continuation coverage as described below.

Cal-COBRA Continuation Coverage

If your Employer consists of 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 CalPERS or Sharp Health Plan changes benefits, Premiums, etc., your continuation coverage will change accordingly. If the contract between CalPERS and Sharp Health Plan terminates while you are still eligible for Cal-COBRA, you may elect to continue Cal-COBRA coverage under the 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 their Employer within 60 days of the date of the qualifying event. The notification must be in writing and delivered to the Employer by first class mail or other reliable means of delivery. If you do not notify your Employer within 60 days of the date of the qualifying event, you are not eligible for coverage under Cal-COBRA.

Qualifying Events

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

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

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

How To Elect Cal-COBRA Coverage

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

Adding Dependents to Cal-COBRA

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

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

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

Premiums for Cal-COBRA Coverage

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

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

How To Terminate Cal-COBRA Coverage

If you wish to terminate Cal-COBRA coverage, you must complete and return the Cal-COBRA Termination Form to Sharp Health Plan. The termination request must be done within 30 calendar days of the requested termination date. As Cal-COBRA Coverage is provided on a monthly basis, the termination date will be effective at midnight on the last day of the month.

The Cal-COBRA Termination Form can be found on the Sharp Health Plan website: sharphealthplan.com/members/manage-your-plan/cancel.

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

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

Sharp Health Plan will never terminate your coverage because of your health status or your need for health services. If you believe that your coverage or your Dependent's coverage was, or will be, cancelled, Rescinded, or not renewed due to health status or requirements for health care services, you have a right to submit a Grievance to Sharp Health Plan or to the Director of the Department of Managed Health Care, pursuant to section 1365(b) of the California Health and Safety Code.

For information on submitting a Grievance to Sharp Health Plan, see the section titled **What Is the Grievance or Appeal Process?** in this Evidence of Coverage. Sharp Health Plan will resolve your

Grievance regarding an improper cancellation, Rescission or nonrenewal of coverage, or provide you with a pending status within three calendar days of receiving your Grievance. If you do not receive a response from Sharp Health Plan within three calendar days, or if you are not satisfied in any way with the response, you may submit a Grievance to the Department of Managed Health Care as detailed below.

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

- You may submit a Grievance to the Department of Managed Health Care online at: WWW.HEALTHHELP.CA.GOV
- You may submit a Grievance to the Department of Managed Health Care by mailing your written Grievance to:

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

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

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

What Are Your Rights for Coverage After Disenrolling From Sharp Health Plan?

HIPAA

Federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. California law provides similar and additional protections.

If you lose group health insurance coverage and meet certain criteria, you are entitled to purchase individual health coverage (non-group) from any health plan that sells individual coverage for hospital, medical or surgical benefits. Every health plan that sells individual coverage for these benefits must offer individual coverage to an eligible person under HIPAA. The health plan cannot reject your application if you are an eligible person under HIPAA; you agree to pay the required Premiums; and you live or work inside the Plan's Service Area.

To be considered an eligible person under HIPAA, you must meet the following requirements:

- You have 18 or more months of creditable coverage without a break of 63 calendar days or more between any of the periods of creditable coverage or since your most recent coverage was terminated;
- Your most recent creditable coverage was a group, government or church plan that provided hospital, medical or surgical benefits. (COBRA and Cal-COBRA are considered group coverage);
- You were not terminated from your most recent creditable coverage due to nonpayment of Premiums or fraud;
- You are not eligible for coverage under a group health plan, Medicare or Medicaid (Medi-Cal);
- You have no other health insurance coverage; and
- You have elected and exhausted any continuation coverage you were offered under COBRA or Cal-COBRA.

There are important choices you need to make in a very short time frame regarding the options available to you following termination of your group health care coverage. You should read carefully all available information regarding HIPAA coverage so you can understand fully the special protections of HIPAA coverage and make an informed comparison and choice regarding available coverage. For more information, please call Customer Care. If the Plan is unable to assist or you feel your HIPAA rights have been violated, you may contact the Department of Managed Health Care at 1-888-HMO-2219 or visit the Department's website at www.hmohelp.ca.gov.

Other Information

When Do You Qualify for Continuity of Care?

Continuity of care means continued services, under certain conditions, with your current Health Care Provider until your Health Care Provider completes your care.

As a *newly enrolled* Sharp Health Plan Member, you may receive continuity of care for services otherwise covered in this Evidence of Coverage when:

- You are receiving care from a non-Plan provider for one of the conditions listed below and, at the time your coverage with Sharp Health Plan became effective, were receiving such care from that provider.
- You were not offered an out-of-network option and you were not given the option to continue with your previous health plan or provider.

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

- Your Sharp Health Plan Network has changed; or
- Your Sharp Health Plan Medical Group, Plan Hospital, or other Plan Provider is no longer contracted with Sharp Health Plan.

Continuity of care may be provided for the completion of care when you are in an active course of treatment for one of the following conditions:

Condition	Length of Time for Continuity of Care
Acute Condition	Duration of Acute Condition
Serious Chronic Condition	• Current Member: No more than 12 months from the Health Care Provider's contract termination date • Newly enrolled Member: 12 months from the effective date of coverage
Pregnancy	Duration of the pregnancy, to include the three trimesters of pregnancy and the immediate post-partum period
Maternal Mental Health Condition	12 months from the Maternal Mental Health Condition diagnosis or from the end of pregnancy, whichever occurs later
Terminal Illness	Duration of the Terminal Illness
Pending surgery or other procedure	Must be scheduled within 180 days of the Health Care Provider's contract termination or your enrollment in Sharp Health Plan
Care of newborn Child between birth and age 36 months	No more than 12 months from the Health Care Provider's contract termination date or, if the Child is a newly enrolled Member, 12 months from the Child's effective date of coverage

Continuity of care is limited to Covered Benefits, as described in this Evidence of Coverage, in connection with one or more of the conditions listed above. Your requested Health Care Provider must agree to provide continued services to you, subject to the same contract terms and conditions and similar payment rates to other similar Health Care Providers contracted with Sharp Health Plan.

If your Health Care Provider does not agree, Sharp Health Plan cannot provide continuity of care.

You are not eligible for continuity of care coverage in the following situations:

- You are a newly enrolled Member and had the opportunity to enroll in a health plan with an out-of-network option.

- You are a newly enrolled Member and had the option to continue with your previous health plan or Health Care Provider, but instead voluntarily chose to change health plans.
- Your Health Care Provider's contract with Sharp Health Plan or your PMG has been terminated or not renewed for reasons relating to a medical disciplinary cause or reason, or fraud or other criminal activity.

Please contact Customer Care or go to sharphealthplan.com/CalPERS to request a continuity of care benefits form. You may also request a copy of Sharp Health Plan's medical policy on continuity of care for a detailed explanation of eligibility and applicable limitations.

What Is the Relationship Between the Plan and Its Providers?

- Most of our Plan Medical Groups receive an agreed-upon monthly payment from Sharp Health Plan to provide services to you. This monthly payment is a fixed dollar amount for each Member. The monthly payment typically covers Professional Services directly provided by the medical group, and may also cover certain referral services.
- Some doctors receive a different agreed-upon payment from us to provide services to you. Each time you receive healthcare 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 PMG and some of our contracted hospitals on the monthly payment from Sharp Health Plan for services, including referral services, under the program for any Plan Members treated by the PMG/Hospital.
- If you would like more information, please contact Customer Care. You can also obtain more information from your Plan Provider or the PMG you have selected.

How Can You Participate in Plan Policy?

The Plan has established a Member Advisory Committee (previously called the Public Policy Committee) for Members to participate in making decisions to assure patient comfort, dignity and convenience from the Plan's Providers that provide health care services to you and your family. At least annually, Sharp Health Plan provides Members, through the Member Resource Guide, a description of its system for Member participation in establishing Plan policy and communicates material changes (updates and important information) affecting Plan policy to Members.

What Happens if You Enter Into a Surrogacy Arrangement?

A surrogacy arrangement is one in which you agree to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the baby (or babies) as his/her/their Child (or Children).

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

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

satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

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

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

You must send this information to:

Sharp Health Plan
Attention: Surrogacy Arrangements
8520 Tech Way, Suite 200
San Diego, CA 92123

You must complete and send us all consents, releases, Authorizations, lien forms and other documents that we request or that you believe are reasonably necessary for us to determine the existence of any rights we may have under this section and to satisfy those rights. You must not take any action prejudicial to our rights. You may not agree to waive, release, or reduce our rights under this "Surrogacy Arrangements" section without our prior written consent.

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

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

What Happens if You Receive Covered Services Through a Community Assistance, Recovery and Empowerment (CARE) Program?

If you are under a CARE Agreement or CARE Plan approved by the court in accordance with the court's authority under Welfare and Institutions Code Sections 5977.1, 5977.2, 5977.3, all services are covered without prior Authorization and Cost Sharing. Services received under a CARE Agreement or CARE Plan are covered whether the service is provided by a Plan Provider or a non-Plan Provider. Services include the development of an evaluation and the provision of all health care services when required or recommended for you pursuant to a CARE Agreement or CARE Plan approved by a court. We need to know about your active CARE Agreement or CARE Plan. Please submit CARE documentation to us via email or mail:

Sharp Health Plan
Customer Care
8520 Tech Way, Suite 200
San Diego, CA 92123
Email: customer.service@sharp.com

How Can You Help Us Fight Health Care Fraud?

Health care fraud is an intentional deception or misrepresentation that an individual or entity makes, knowing that the misrepresentation could result in some unauthorized benefit to the individual, the entity or some other party. Recent estimates put the impact of health care fraud in the United States at approximately $60 billion per year. Health care fraud is costly for everyone. It leads to higher Premiums, more uninsured people and fewer dollars available for health care services.

Health care fraud comes in many forms, including:

- Submitting fraudulent claims (e.g., billing for services that were not provided or inappropriately coding claims to result in higher charges)
- Use of health plan ID cards by people who are not entitled to benefits
- Falsification of drug Prescriptions
- Offering free diabetic supplies, medical supplies or genetic tests in exchange for your ID number or other personal information
- Enrolling someone on your plan who is not an authorized family member or keeping someone on your plan after they are no longer eligible (e.g., after a divorce)

Sharp Health Plan is committed to working to reduce fraudulent activity. Here are some things you can do to prevent fraud:

- Do not give your Sharp Health Plan identification (ID) number over the phone or to people you do not know, except for your Health Care Providers or Sharp Health Plan representatives.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using Health Care Providers who say that an item or service is not usually covered, but they know how to bill to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get an item or service paid for.
- If you suspect a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, call the provider and ask for an explanation. There may be an error.
- Do not enroll individuals who are not eligible for coverage as your Spouse or Dependent. (Individuals can enroll in their own plan at sharphealthplan.com or coveredca.com.)

If You Suspect Fraud, Abuse or Waste

What if you suspect fraud? Contact Sharp Health Plan Customer Care at 1-800-359-2002 or customer.service@sharp.com.

Or send a letter to:

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

You do not have to give your name. Just tell us why you think fraud is occurring. Give us the name of the provider or Member and tell us what you are concerned about. We take your questions and input seriously. You can help us stop health care fraud.

If you suspect non-compliance or fraud related to Medicare, you can also contact us anonymously using the Sharp HealthCare dedicated hotline number at 1-800-350-5022.

Glossary

Because we know health plan information can be confusing, we have capitalized these words (and the plural form of these words, when appropriate) throughout this Evidence of Coverage and each of its attachments to let you know that you can find their meanings in this **Glossary**.

Active Labor means a labor at a time at which any of the following would occur:

1. There is inadequate time to effect a safe transfer to another hospital prior to delivery; or
2. A transfer may pose a threat to the health and safety of the patient or the unborn Child.

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

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

Advanced Health Care Directive means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.

Adverse Benefit Determination or ABD means a decision by Sharp Health Plan to deny, reduce, terminate or fail to pay for all or part of a benefit that is based on:

1. Determination of an individual's eligibility to participate in this Sharp Health Plan benefit plan;
2. Determination that a benefit is not covered; or
3. Determination that a benefit is experimental, investigational, or not Medically Necessary or appropriate.

Appeal means a written or oral request, by or on behalf of a Member, to re-evaluate a specific determination regarding a requested service, including a delay, denial or modification of a requested service, made by Sharp Health Plan or any of its delegated entities (e.g., Plan Medical Group, American Specialty Health Plans, Magellan).

Appropriately Qualified Health Care Provider means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

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

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
  - The National Institutes of Health.
  - The federal Centers for Disease Control and Prevention.
  - The Agency for Healthcare Research and Quality.
  - The federal Centers for Medicare and Medicaid Services.
  - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
  - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
  - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that

the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

- The United States Department of Veterans Affairs.
- The United States Department of Defense.
- The United States Department of Energy.

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

Artificial Insemination means 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.

Authorization or **Authorized** means approval by your Plan Medical Group (PMG) or Sharp Health Plan for Covered Benefits. (An Authorization request may also be called a pre-service claim.)

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

Behavioral Health Crisis Services means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a Mental Health or Substance Abuse Disorder crisis that is wellness, resiliency, and recovery oriented. These include but are not limited to, crisis intervention, such as counseling provided by 988 centers, mobile crisis teams, and crisis receiving and stabilization services.

Behavioral Health Crisis Stabilization Services means the services necessary to determine if a behavioral health crisis exists and, if a behavioral health crisis does exist, the care and treatment that is necessary to stabilize the behavioral health crisis within the capability of the 988 center, mobile crisis team, or other provider of Behavioral Health Crisis Services.

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

1. The treatment is prescribed by a licensed Plan Provider;
2. The treatment is provided by a Qualified Autism Service Provider, Qualified Autism Service Professional or Qualified Autism Service Paraprofessional contracted with Sharp Health Plan;
3. The treatment is provided under a treatment plan that has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific patient being treated; and
4. The treatment plan is reviewed at least every six months by a Qualified Autism Service Provider, modified whenever appropriate, and is consistent with the elements required under the law.

Benefit Year means the twelve-month period that begins at 12:01 a.m. on the first day of the month of each year established by CalPERS and Sharp Health Plan.

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

CARE (Community Assistance Recovery and Empowerment) Agreement means a voluntary settlement agreement entered into by the parties. A CARE Agreement includes the same elements as a CARE Plan to support the respondent in accessing community-based services and supports.

CARE Plan means an individualized, appropriate range of community-based services and supports, which include clinically appropriate behavioral health care and stabilization medications, housing, and other supportive services as appropriate.

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

- The naturally born Children, legally adopted Children, or stepchildren of the Enrolled Employee;
- Children for whom the Enrolled Employee has been appointed a legal guardian by a court;
- Children for whom the Enrolled Employee is required to provide health coverage pursuant to a qualified medical support order; and
- Children, not including foster Children, for whom the Enrolled Employee has assumed a parent-child relationship, as indicated by intentional assumption of parental status, or assumption of parental duties, by the Enrolled Employee, and as certified by the Enrolled Employee at the time of enrollment of the Child and annually thereafter.

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

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

Coinsurance means a percentage of the cost of a Covered Benefit (for example, 20%) that a Member pays.

Copayment or **Copay** means a fixed dollar amount (for example, $20) that a Member pays for a Covered Benefit.

Cost Share or **Cost Sharing** means the amount of your financial responsibility as specifically set forth in the Health Plan Summary of Benefits and any Supplemental Benefit rider, if applicable, attached to this Evidence of Coverage. Cost Share may include any combination of Deductibles, Coinsurance and Copayments, up to the Out-of-Pocket Maximum. Cost Sharing for Supplemental Benefits, if applicable, does not count toward your Out-of-Pocket Maximum.

Covered Benefits means those Medically Necessary services and supplies that you are entitled to receive under a Group Agreement and which are described in this Evidence of Coverage or under California health plan law.

Deductible means the amount you pay in a Calendar Year for certain Covered Benefits before Sharp Health Plan will start to pay for those Covered Benefits in that Calendar Year. Members enrolled in the Performance Plus plan do not have a Deductible.

Dependent means an Enrolled Employee's legally married Spouse, Domestic Partner or Child who meets the eligibility requirements set forth by CalPERS, who is enrolled in the benefit plan, and for whom Sharp Health Plan receives Premiums.

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

Disputed Health Care Service means any Health Care Service eligible for coverage and payment under your Sharp Health Plan plan that has been denied, modified or delayed by Sharp Health Plan or one of its contracting providers, in whole or in part because the service is deemed not Medically Necessary.

Domestic Partner means a person who has established eligibility for the Plan by meeting all

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

1. Both persons have chosen to share one another's lives in an intimate and committed relationship of mutual caring.
2. Neither person is married to someone else nor is a member of another domestic partnership that has not been terminated, dissolved, or adjudged a nullity.
3. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
4. Both persons are at least 18 years of age, except as follows:
    a) A person under 18 years of age who, together with the other proposed Domestic Partner, otherwise meets the requirements for a domestic partnership other than the requirements of being at least 18 years of age, may establish a domestic partnership upon obtaining a court order granting permission to the underage person or persons to establish a domestic partnership.
5. Both persons are capable of consenting to the domestic partnership.
6. Both file a Declaration of Domestic Partnership with the Secretary of State.

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

Doula means a nonmedical professional who provides health education, advocacy, and physical, emotional and nonmedical support for pregnant and postpartum women before, during and after childbirth, including support during miscarriage, stillbirth and abortion.

Durable Medical Equipment or **DME** means medical equipment appropriate for use in the home that 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 the period of time specified by the Employer, who is actively engaged in the conduct of the business of the Employer with a normal work week, as specified by 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. A contracted ("1099") employee who meets the criteria outlined in Sharp Health Plan's underwriting guidelines also qualifies as an Eligible Employee.

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

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

Emergency Services and Care means (1) medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or (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.

Evidence of Coverage means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Family Coverage means coverage for an Enrolled Employee and one or more Dependents.

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

Grievance means a written or oral expression of dissatisfaction regarding Sharp Health Plan and/or a provider, including quality of care concerns, complaints, disputes, requests for reconsideration or Appeals made by a Member or a Member's representative.

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

Health Care Provider means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

Health Plan Summary of Benefits means the list of the most commonly used Covered Benefits and applicable Copayments for the specific benefit plan purchased by CalPERS. The Health Plan Summary of Benefits can be found at the beginning of this Evidence of Coverage.

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

Independent Medical Review (IMR) means a review of your Plan's denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to 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. Your Plan must pay for the services if an IMR decides you need it.

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

Infertility means a person's inability to conceive a pregnancy or carry a pregnancy to live birth either as an individual or with their partner; or a licensed physician's determination of infertility, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

1. Testing is not complete; and

2. The efficacy and safety of such services in human subjects are not yet established; and

3. The service is not in wide usage.

Life-Threatening means either or both of the following:

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

Maternal Mental Health Condition means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

Medical Information means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment. Individually identifiable means that the medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, or other information that, alone or in combination with other publicly available information, reveals the identity of the individual.

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

- In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider.

Member means a Subscriber, enrollee, Enrolled Employee, or Dependent of a Subscriber or an Enrolled Employee, who has enrolled in the Plan and for whom coverage is active or live.

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

Out-of-Area means you are temporarily outside your Plan Network Service Area. Out-of-Area coverage includes Urgent Care Services and Emergency Services for the sudden onset of symptoms of sufficient severity to require immediate medical attention to prevent serious deterioration of your health resulting from unforeseen illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until you return to the Service Area. Out-of-Area medical services will be covered to meet your immediate medical needs. Applicable follow-up for the Urgent Care Service or Emergency Services must be Authorized by Sharp Health Plan and will be covered until it is clinically appropriate to transfer your care into the Service Area.

Out-of-Pocket Maximum means the maximum total amount of expenses that a Member will pay for Covered Benefits in a Calendar Year before Sharp Health Plan pays Covered Benefits at 100%. All Copayments for Covered Benefits, excluding Supplemental Benefits, contribute to the Out-of-Pocket Maximum.

Outpatient Prescription Drug means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy,

requires a prescription, and has not been provided for use on an inpatient basis.

Outpatient Prescription Drug Program means the program administered by CVS Pharmacy to provide coverage for certain Outpatient Prescription Drugs. Outpatient Prescription Drugs are self-administered drugs approved by the U.S. Food and Drug Administration (FDA) for sale to the public through retail or mail order pharmacies, require Prescriptions, and are not provided for use on an inpatient basis. Please refer to the CVS Pharmacy Outpatient Prescription Drug Plan Evidence of Coverage booklet for details regarding the Outpatient Prescription Drug Program.

Plan means Sharp Health Plan.

Plan Hospital means an institution licensed by the State of California as an acute care hospital that provides certain Covered Benefits to Members through an agreement with Sharp Health Plan and that is included in your Plan Network. Plan Hospitals are listed in the Provider Directory.

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 your Plan Network.

Plan Network means a discrete set of network Providers, including all of the professional providers and facilities that are in the Sharp Health Plan Network (e.g., American Specialty Health Plans, Vision Service Plan, Magellan), that Sharp Health Plan has designated to deliver all covered services for a specific network Service Area, as defined in this Glossary. Members enrolled in the Performance Plus plan have access to the Performance Plan Network.

Plan Physician means any doctor of medicine, osteopathy, or podiatry licensed by the State of California who has agreed to provide Professional Services to Members, either through an agreement with Sharp Health Plan or as a member of a PMG, and that is included in your Plan Network. Plan Physicians are listed in the Provider Directory.

Plan Provider or **Plan Providers** means the physician(s), hospital(s), Skilled Nursing Facility or Facilities, home health agency or agencies, pharmacy or pharmacies, medical transportation company or companies, laboratory or laboratories, radiology and diagnostic facility or facilities, Durable Medical Equipment supplier(s) and other licensed health care entities or professionals who are part of your Plan Network, or who provide Covered Benefits to Members through an agreement with Sharp Health Plan. Plan Providers also include contracted providers affiliated with American Specialty Health Plan (acupuncture and chiropractic services).

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

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

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

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

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

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

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

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

h. A psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision

(d) of Section 2914 of, the Business and Professions Code.

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

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

Prescription Drug or "drug" means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a Prescription and is not provided for use on an inpatient basis. The term "drug" or "Prescription Drug" includes: (A) disposable devices that are Medically Necessary for the administration of a covered Prescription Drug, such as spacers and inhalers for the administration of aerosol Outpatient Prescription Drugs; (B) syringes for self-injectable Prescription Drugs that are not dispensed in pre-filled syringes; (C) drugs, devices, and FDA-approved products covered under the Prescription Drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and (D) at the option of the health plan, any vaccines or other health care benefits covered under the Plan's Prescription Drug benefit.

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

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

Professional Services means those professional diagnostic and treatment services that are listed in this Evidence of Coverage and provided by Plan Physicians and other health professionals.

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

Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

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

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

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

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

Qualified Autism Service Provider means either of the following:

1. A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for autism spectrum disorder, provided the services are within the experience and competence of the person who is nationally certified.
2. A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist, pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for autism spectrum disorder, provided the services are within the experience and competence of the licensee.

Reproductive or Sexual Health Application Information means information about a consumer's reproductive health, menstrual cycle, fertility, pregnancy, pregnancy outcome, plans to conceive, or type of sexual activity collected by a reproductive or sexual health digital service, including, but not limited to, information from which one can infer someone's pregnancy status, menstrual cycle, fertility, hormone levels, birth control use, sexual activity, or gender identity.

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

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

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

Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

Service Area means the geographic area designated by the plan within which a plan shall provide health care services.

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

Spouse means an Enrolled Employee's legally married husband, wife, or partner. Based on eligibility criteria established by CalPERS, it may also mean an Enrolled Employee's Domestic Partner.

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

Subscriber (also known as "Enrolled Employee") means 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.

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

Supplemental Benefits means benefits for Artificial Insemination services, hearing services, Outpatient Prescription Drugs and vision services. Cost Shares for Supplemental Benefits do not apply to the annual Out-of-Pocket Maximum.

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

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

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

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

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

Trans-Inclusive Health Care means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

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 or sooner if appropriate for your condition, in order to prevent a serious deterioration of a Member's health due to an illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed. Urgently needed services include maternity services necessary to

prevent serious deterioration of the health of the Member or the Member's fetus, based on the Member's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the Member returns to the Service Area.

Urgent Mental Health or **Substance Use Disorder Services** means services to treat when the Member's condition is such that the Member faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for decision-making to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to the Member, would be detrimental to the Member's life or health or could jeopardize the Member's ability to regain maximum function.

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

You or **Your** means the Member (Subscriber), or the Dependent of a Member, who has enrolled in the Plan under the provisions of the Membership Agreement and for whom the applicable Premiums have been paid.

Notice of Nondiscrimination

Sharp Health Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability. A copy of the Nondiscrimination Notice can also be accessed at **sharphealthplan.com/members/notices-and-disclosures**.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters.
- Provides reasonable modifications for individuals with disabilities, and appropriate auxiliary aids and services, including qualified interpreters for individuals with disabilities and information in alternative formats, such as braille or large print, free of charge and in a timely manner, when such modifications, aids, and services are necessary to ensure accessibility and an equal opportunity to participate to individuals with disabilities.
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters and language assistance services, including electronic and written translated documents and oral interpretation, free of charge and in a timely manner, when such services are a reasonable step to provide meaningful access to an individual with limited English proficiency. If you need these services, contact Customer Care at 1-800-359-2002 (TTY 771).

If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability, you can file a grievance with our Civil Rights Coordinator and Section 1557 Nondiscrimination Coordinator at:

- Address: Sharp Health Plan Compliance Department, Attn: Director of Compliance and Regulatory Affairs Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450
- Telephone: 1-800-359-2002 (TTY 711)
- Fax: 1-619-740-8572
- Email: shpcompliance@sharp.com

You can file a grievance in person or by mail or fax, or you can also complete the online

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

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

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

- 1-888-466-2219 Voice
- 1-877-688-9891 TDD

The Department of Managed Health Care's website has complaint forms and instructions online: **www.dmhc.ca.gov**.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Sharp Health Plan right away at 1-858-499-8300 or 1-800-359-2002.

IMPORTANTE: ¿Puede leer esta carta? Si no le es posible, podemos ofrecerle ayuda para que alguien se la lea. Además, usted también puede obtener esta carta en su idioma. Para ayuda gratuita, por favor llame a Sharp Health Plan inmediatamente al 1-858-499-8300 o 1-800-359-2002.

Language Assistance Services

English
ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-855-995-5004 (TTY:711).

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-995-5004 (TTY:711).

繁體中文 **(Chinese)**
注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-995-5004 (TTY:711)。

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-995-5004 (TTY:711).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-995-5004 (TTY:711).

한국어 **(Korean):**
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-995-5004 (TTY:711) 번으로 전화해 주십시오.

Հայերեն **(Armenian):**
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-995-5004 (TTY (հեռատիպ)՝ 711).

فارسی (Farsi):
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-855-995-5004 (TTY:711) تماس بگیرید.

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-995-5004 (телетайп: 711).

日本語 **(Japanese):**
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-995-5004 (TTY:711) まで、お電話にてご連絡ください。

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-995-5004 (رقم هاتف الصم والبكم: 711).

ਪੰਜਾਬੀ (Punjabi):
ਧਿਆਨ ਦਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-855-995-5004 (TTY:711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon Khmer, Cambodian):
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-995-5004 (TTY:711)។

Hmoob (Hmong):
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-995-5004 (TTY:711).

हिंदी (Hindi):
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-995-5004 (TTY:711) पर कॉल करें।

ภาษาไทย **(Thai):**
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-995-5004 (TTY:711).

SHARP Health Plan

Consider us your personal health care assistant®

sharphealthplan.com/CalPERS | customer.service@sharp.com | 1-855-995-5004

Pending DMHC Approval