SHARP HEALTH PLAN

make life better.℠

Sharp Performance Plus

Health Maintenance Organization (HMO)

Combined Evidence of Coverage and Disclosure Form for the Basic Plan

Effective January 1, 2016

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

CalPERS

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 the 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, we capitalized words throughout this Evidence of Coverage to let you know that you can find their meanings in the GLOSSARY beginning on page 53.

Content subject to change pending DMHC review.

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
7:00 a.m. to 8:00 p.m., 7 days a week

sharphealthplan.com/CalPERS

TABLE OF CONTENTS

BENEFITS AND COVERAGE MATRIX....1
Benefit Changes for Current Year....4
Sharp Health Plan Rates for Contracting Agency Employees and Annuitants....5
Sharp Health Plan Rates for State Employees and Annuitants....6

WELCOME TO SHARP HEALTH PLAN....7
Booklets and Information....7

HOW DOES THE PLAN WORK?....8
Choice of Plan Physicians and Plan Providers....8
Call Your PCP When You Need Care....9
Present Your Member ID Card and Pay Copayment....9

HOW DO YOU OBTAIN MEDICAL CARE?....9
Use Your Member ID Card....9
Access Health Care Services Through Your Primary Care Physician (PCP)....9
Obtain Required Authorization....10
Second Medical Opinions....11
Emergency Services and Care....12
Urgent Care Services....13
Language Assistance Services....13
Access for the Vision Impaired....13
Pre-existing Conditions....13
Case Management....13

WHO CAN YOU CALL WITH QUESTIONS?....14
Customer Care....14
Sharp Nurse Connection®....14
Utilization Management....14

WHAT DO YOU PAY?....14
Copayments....14
Annual Out-of-Pocket Maximum....14
What if You Get a Medical Bill?....15

WHAT ARE YOUR RIGHTS AND RESPONSIBILITIES AS A MEMBER?....16
Security of Your Confidential Information (Notice of Privacy Practices)....17

DISPUTE RESOLUTION....19
Pharmacy Grievance Procedures....19
Medical Grievance Procedures....19
Urgent Decision....20
Experimental or Investigational Denials....20
Independent Medical Review Involving a Disputed Health Care Service....21
Department of Managed Health Care....22
Appeal Rights Following Grievance Procedure....23
Mediation....23
Binding Arbitration - Voluntary....24
CalPERS Administrative Review....24
Administrative Hearing....25

Appeal Beyond Administrative Review and Administrative Hearing 25
Summary of Process and Rights of Members Under the Administrative Procedure Act 25
Appeal Chart 26

WHAT ARE YOUR COVERED BENEFITS? 28
Covered Benefits 28
Acupuncture 28
Acute Inpatient Rehabilitation Facility Services 28
Blood Services 28
Bloodless Surgery 28
Chemotherapy 28
Chemical Dependency and Alcoholism Treatment 29
Chiropractic Services 29
Circumcision 29
Clinical Trials 29
Dental Services/Oral Surgical Services 30
Diabetes Treatment 31
Disposable Medical Supplies 31
Durable Medical Equipment 31
Emergency Services 32
Family Planning Services 32
Gender Reassignment Surgery and Services 33
Health Education Services 33
Hearing Services 33
Home Health Services 33
Hospice Services 34
Hospital Facility Inpatient Services 34
Hospital Facility Outpatient Services 35
Infertility Services 35
Infusion Therapy 35
Injectable Drugs 35
Maternity and Pregnancy Services 35
Mental Health Services 36
MinuteClinic® 36
Outpatient Prescription Drugs 37
Outpatient Rehabilitation Therapy Services 37
Paramedic Ambulance and Medical Transportation Services 37
Phenylketonuria (PKU) Treatment 37
Preventive Care Services 38
Professional Services 38
Prosthetic and Orthotic Services 38
Radiation Therapy 39
Radiology Services 39
Reconstructive Surgical Services 39
Skilled Nursing Facility Services 40
Smoking Cessation 40
Sterilization Services 40
Termination of Pregnancy 40
Transplants 40
Urgent Care Services 41
Vision Services 41

WHAT IS NOT COVERED?....41
Exclusions and Limitations....41
Acupuncture....41
Ambulance....42
Chiropractic Services....42
Clinical Trials....42
Cosmetic Surgical Services....42
Custodial Care....42
Dental Services/Oral Surgical Services....42
Disposable Medical Supplies....43
Durable Medical Equipment....43
Emergency Services....43
Experimental or Investigational Services....43
Family Planning Services....43
Foot Care....43
Gender Reassignment Surgery and Services....43
Genetic Testing, Treatment or Counseling....43
Government Services and Treatment....44
Hearing Services....44
Immunizations and Vaccines....44
Infertility Services....44
Hospital Facility Inpatient and Outpatient Services....45
Mental Health Services....45
Non-Preventive Physical or Psychological Examinations....45
Outpatient Prescription Drugs....45
Private-Duty Nursing Services....45
Prosthetic/Orthotic Services....45
Sexual Dysfunction Treatment....46
Vision Services....46
Other....46

ELIGIBILITY AND ENROLLMENT....47
Live/Work....47
What if You Have Other Health Insurance Coverage?....47
What if You Are Eligible for Medicare?....48
What if You Are Injured at Work?....48
What if You Are Injured by Another Person?....48

INDIVIDUAL CONTINUATION OF BENEFITS....48
Total Disability Continuation Coverage....48
COBRA Continuation Coverage....48
Cal-COBRA Continuation Coverage....49
What Can You Do if You Believe Your Coverage Was Terminated Unfairly?....50
What are Your Rights for Coverage After Disenrolling From Sharp Health Plan?....50

OTHER INFORMATION....51
When Do You Qualify for Continuity of Care?....51
What Is the Relationship Between the Plan and Its Providers?....52
How Can You Participate in Plan Policy?....52
What Happens if You Enter Into a Surrogacy Arrangement?....52

GLOSSARY....53

BENEFITS AND COVERAGE MATRIX

CalPERS Sharp Performance Plus HMO 15/15/0-L

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.

Covered Benefits	Copayments
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[1] / $3,000[1]
Lifetime Maximum	
There are no lifetime maximums for this plan	$0
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	
Online 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, treatments, diagnostic testing, etc.	$15 / visit
Specialist Physician office visit for consultation, treatments, diagnostic testing, etc.	$15 / visit
Laboratory services	$0
Radiology services (X-rays)	$0
Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	$0 / procedure
Allergy testing	$0 / visit
Allergy injections	$0 / visit
Hearing Exam	$0
Audiological Exam	$0

Covered Benefits	Copayments
Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)	
Outpatient surgery	$0 / procedure
Infusion therapy (including but not limited to chemotherapy)	Variable[3]
Dialysis	$0
Physical, occupational and speech therapy	$15 / visit
Radiation therapy	Variable[3]
Hospitalization	
Inpatient services	$0 / admission
Organ transplant	$0 / admission
Inpatient rehabilitation	$0 / admission
Emergency and Urgent Care Services	
Emergency room services (waived if admitted to the hospital)	$50 / visit
Ambulance in connection with hospital admission or emergency services	$0
Urgent care services	$15 / visit
Maternity Care	
Prenatal and postpartum office visits	$0 / visit
Hospitalization	$0 / admission
Breastfeeding support, supplies and counseling	$0
Family Planning Services	
Injectable contraceptives (including but not limited to Depo Provera)	$0
Voluntary sterilization – women	$0
Voluntary sterilization – men	Variable[3]
Interruption of pregnancy	Variable[3]
Infertility services (diagnosis and treatment of underlying condition)	50% coinsurance[4]
Durable Medical Equipment and Other Supplies	
Durable medical equipment	0% coinsurance
Diabetic supplies	0% coinsurance
Prosthetics and orthotics	$15 / visit
Mental Health Services	
Diagnosis and treatment of Severe Mental Illnesses for all members, Serious Emotional Disturbances for children, and other mental health conditions are covered with the Copayments listed below.[5]	
Inpatient	$0 / admission
Office visits	$15 / visit
Home-based applied behavioral analysis for treatment of autism	$0 / visit
Chemical Dependency Services	
Emergency services for acute alcohol or drug detoxification	$50 / visit
Inpatient	$0 / admission
Office visits	$15 / visit

Covered Benefits	Copayments
Skilled Nursing, Home Health and Hospice Services	
Skilled nursing facility services (maximum of 100 days per calendar year)	$0 /admission
Home health services (maximum of 100 visits per calendar year)	$0 / visit
Hospice care – inpatient	$0 / visit
Hospice care – outpatient	$0 / visit
Prescription Drug Coverage[1] (More information about prescription drug coverage is available at www.Caremark.com/CalPERS)	
Generic Formulary/Brand Formulary/Non-Formulary medications up to 30 day supply	$5 / $20 / $50
Generic Formulary/Brand Formulary/Non-Formulary medications up to 90 day supply by mail order (for maintenance medications only)	$10 / $40 / $100
Generic Formulary and prescribed over-the-counter contraceptives for women	$0
Supplemental Benefits[1]	
Acupuncture/Chiropractic services (20 combined visits 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)	Variable[6]
Vision services (once every 12 months/exam only)	$0 / visit
Eyeglasses or contact lenses (following cataract surgery)	$0

Notes

[1] Copayments for supplemental benefits (Acupuncture/Chiropractic Services, Artificial Insemination, Hearing Aids, Outpatient Prescription Drugs and Vision) 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] Copayment depends on type and location of service.

[4] Of contracted rates.

[5] Severe Mental Illnesses include: schizophrenia, schizoaffective disorder, bi-polar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia nervosa and bulimia nervosa.

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

BENEFIT CHANGES FOR CURRENT YEAR

The following is a summary of the most important coverage changes and clarifications made to the Sharp Performance Plus 2016 Evidence of Coverage for the Basic Plan.

Please read this Evidence of Coverage for the complete text of these changes, as well as changes not listed in the summary below. Please refer to the Health Plan Benefits and Coverage Matrix on page 1 for benefit details and the amount Members must pay for covered benefits. Please refer to the Sharp Health Plan Rates on pages 5 and 6 for information about 2016 rates. Benefits are also subject to the "Exclusions and Limitations" section of this Evidence of Coverage.

Artificial Insemination

We have clarified that there is no lifetime maximum on artificial insemination services.

Sharp Health Plan Rates for Contracting Agency Employees and Annuitants		
2016		
Single	2-Party	Family
$561.34	$1,122.68	$1,459.48

Sharp Health Plan Rates for State Employees and Annuitants		
2016		
Single	2-Party	Family
$574.73	$1,149.46	$1,494.30

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 most important to us. We encourage you to let us know how we may serve you better by calling us toll-free at 1-855-995-5004.

Our Customer Care Representatives are available seven days a week from 7:00 a.m. to 8:00 p.m. to answer any questions you may have. Additionally, after 5:00 p.m. weekdays and all day on weekends, you have access to a specially trained registered nurse for immediate medical advice by calling the same Customer Care phone number.

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

Booklets and Information

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

Evidence of Coverage

The Evidence of Coverage explains your health plan membership, how to use the Plan, and who to call if you need assistance. This Evidence of Coverage is very important because it describes your health plan benefits and explains how your health plan works. It also provides information about the Copayments that apply to your benefit plan. For easier reading, we capitalized words throughout this Evidence of Coverage to let you know that you can find their meanings in the GLOSSARY beginning on page 53.

Provider Directory

As a CalPERS member enrolled in the Performance Plus plan, you have access to providers in the Performance Plan Network. This directory is a listing of Plan Physicians, Plan Hospitals and other Plan Providers in the Performance Plan Network. This directory is very important because it lists the Plan Providers from whom you obtain all non-Emergency Services. The Performance Plan Network is printed on your Member identification card.
It's very important to use the correct Plan Network. Use the correct directory to choose your Primary Care Physician (PCP), who will be responsible for providing or coordinating all your health care needs. The directories are available online at sharphealthplan.com/CalPERS. You may also request a directory by calling Customer Care.

Member Newsletter

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

HOW DOES THE PLAN WORK?

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

Please read this Evidence of Coverage carefully to understand how to maximize your Plan Covered 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 Directory lists the addresses and phone numbers of Plan Providers, including PCPs, hospitals and other facilities.

- The Plan has several physician groups (called Plan Medical Groups or PMGs) from which you choose your Primary Care Physician (PCP) and through which you receive specialty physician care or access to hospitals and other facilities.
- 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 doctor or select a new one if the 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, except as described below. 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 assign your newborn to a different PCP or PMG following the birth month by calling Customer Care.
- Write your PCP selection on your enrollment form and give it to your Employer.
- If you are unable to select a doctor at the time of enrollment, we will select one for you so that you have access to care immediately. If you would like to change your PCP, just call Customer Care. We recognize that the choice of a doctor is a personal one, and encourage you to select a PCP who best meets your needs.
- You and your Dependents obtain Covered Benefits through your PCP and from the Plan Providers who are affiliated with your PMG. If you need to be hospitalized, your doctor will generally direct your care to the Plan Hospital or other Plan facility where your doctor has admitting privileges. Since doctors do not usually maintain privileges at all facilities, you may want to check with your doctor to see where he/she admits patients. If you would like assistance with this information, please call Customer Care.
- 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.

If you have questions about the covered service area and provider availability, call us toll-free at 1-855-995-5004, or email us at customer.service@sharp.com.

Call Your PCP When You Need Care

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

Present Your Member ID Card and Pay Copayment

- Always present your Member ID Card to Plan Providers. If you have a new ID card because you changed PCPs or PMGs, be sure to show your provider your new card.
- When you receive care, you pay the provider any Copayment specified on the Health Plan Benefits and Coverage Matrix on page 1. 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.

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

Call Your PCP for all Your Health Care Needs

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

If you fail to obtain Authorization from your PCP, care you receive may not be covered by the Plan and you may be responsible 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.

Use Sharp Health Plan Providers

You receive Covered Benefits 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 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. You are responsible to pay for any care not provided by Plan Providers affiliated with your PMG, unless your PMG has prior-Authorized the service or unless it is an emergency.

Schedule Appointments

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

Referrals to Non-Plan Providers

Sharp Health Plan has an extensive network of high quality Plan Providers throughout 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. You should make sure that these services are Authorized in advance. If the services are Authorized, you pay only the Copayments you would pay if the services were provided by a Plan Provider.

Use Sharp Health Plan Hospitals

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

Changing Your PCP

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

Obtain Required Authorization

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

1. Prior to receiving care, contact your PCP or other approved Plan Provider to discuss your treatment plan.
2. Request prior Authorization for the Covered Benefits that have been ordered by your doctor. Your PCP or other Plan Provider is responsible for requesting Authorization from Sharp Health Plan or your 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.

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

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

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

If we do not receive enough information to make a decision regarding the Authorization request, we will send you a letter within five days to let you know what additional information is needed. We will give you or your provider at least 45 days to provide the additional information. (For urgent Authorization requests, we will notify you and your provider by phone within 72 hours and give you or your provider at least 48 hours to provide the additional information.)

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

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

Second Medical Opinions

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

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

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

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

Emergency Services and Care

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

Emergency Services means those Covered Benefits, including Emergency Services and Care, provided inside or outside the Service Area, which are medically required on an immediate basis for treatment of an Emergency Medical Condition. Sharp Health Plan covers twenty-four hour emergency care. An Emergency Medical Condition is a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable lay person could reasonably expect the absence of immediate attention to result in:

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

Emergency Services and Care means:

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

What To Do When You Require Emergency Services

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

Urgent Care Services

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

What To Do When You Require Urgent Care Services

- Your PCP must Authorize Urgent Care Services if you are in the Plan's Service Area. If you need Urgent Care Services and are in the Plan's Service Area, you must call your PCP first.
- Out-of-Area Urgent Care Services are considered Emergency Services and do not require an Authorization from your PCP. If you are outside Plan's Service Area and need Urgent Care Services, you should still call your PCP. Your PCP may want to see you when you return in order to follow up with your care.
- If for any reason, you are unable to reach your PCP, please call Customer Care. You have access to a nurse evenings and weekends for immediate medical advice by calling our toll-free Customer Care telephone number at 1-855-995-5004.

Language Assistance Services

Sharp Health Plan provides free interpreter and language translation services for all Members. If you need language interpreter services to help you talk to your doctor or health plan or to assist you in obtaining care, please call Customer Care. Let us know your preferred language when you call. Customer Care has representatives who speak English and Spanish. We also have access to interpreting services in over 100 languages. If you need someone to explain medical information while you are at your doctor's office, ask them to call us. You may also be able to get materials written in your language. For free language assistance, please call us toll-free at 1-855-995-5004. We'll be glad to help. The hearing and speech impaired may dial "711" or use the California Relay Service's toll-free telephone numbers to contact us:

- 1-800-735-2929 TTY
- 1-800-735-2922 Voice
- 1-800-855-3000 Spanish Voz 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.

Pre-existing Conditions

Pre-existing conditions, including pregnancy, are covered with no waiting period or particular coverage limitations or exclusions. Upon the effective date of your enrollment, you and your Dependents are immediately covered for any pre-existing conditions.

Case Management

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

WHO CAN YOU CALL WITH QUESTIONS?

Customer Care

From questions about your benefits, to inquiries about your doctor or filling a prescription, we are here to ensure that you have the best health care experience possible. You can reach us by phone toll-free at 1-855-995-5004 or via email at customer.service@sharp.com. Our dedicated San Diego-based Customer Care team is available to support you from 7:00 a.m. to 8:00 p.m., seven days a week.

Sharp Nurse Connection®

After regular business hours, you can contact Sharp Nurse Connection directly at 1-800-767-4277 or by calling Customer Care and selecting the appropriate prompt. This after-hours telephone service will put you in touch with registered nurses who can provide medical advice and direction regarding health care questions or concerns. They are available to assist you 5:00 p.m. to 8:00 a.m., Monday to Friday and 24 hours a day on weekends.

Utilization Management

Our medical practitioners make Utilization Management decisions based only on appropriateness of care and service (after confirming benefit coverage). Medical practitioners and individuals who conduct utilization reviews are not rewarded for denials of coverage for care and service. There are no incentives for Utilization Management decision-makers that encourage decisions resulting in underutilization of health care services. Appropriate staff is available from 8:00 a.m. to 5:00 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 is identified by name, title and organization name.

WHAT DO YOU PAY?

Copayments

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

You are responsible to pay applicable Copayments for any Covered Benefit you receive. Copayment amounts vary depending on the type of care you receive. Copayments may be either a set dollar amount, such as $15 for a primary care office visit, or a percentage of the cost Sharp Health Plan pays for the care, such as 50 percent of contracted rates for infertility services. These specific Copayments can be found in the Health Plan Benefits and Coverage Matrix on page 1. For your convenience, Copayments for the most commonly used benefits are also shown on your Member ID Card.

Annual Out-of-Pocket Maximum

There is a maximum total amount of Copayments you pay each year for Covered Benefits, excluding Supplemental Benefits. The annual Out-of-Pocket Maximum amount is listed on the Health Plan Benefits and Coverage Matrix on page 1 and is renewed at the beginning of each calendar year. Copayments for Supplemental Benefits (acupuncture/chiropractic services, Artificial Insemination services, hearing services, outpatient prescription drugs and vision services) do not apply to the annual Out-of-Pocket Maximum.

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

- If a Member pays amounts for Covered Benefits that equal the Individual Out-of-Pocket Maximum, no further Copayments are required for that Member for Covered Benefits (excluding Supplemental Benefits) for the remainder of the year. Premium contributions are still required.
- Once a Member in a family satisfies the Individual Out-of-Pocket Maximum, the remaining enrolled Dependents must continue to pay applicable Copayments until either (a) the sum of the Copayments paid by the family reaches the Family Out-of-Pocket Maximum or (b) each enrolled Dependent meets his/her Individual Out-of-Pocket Maximum, whichever occurs first.
- When the sum of the Copayments paid for all enrolled Members equals the Family Out-of-Pocket Maximum, no further Copayments are required from any enrolled Member of that family for the remainder of the calendar year.
- Only amounts that are applied to the Individual Out-of-Pocket Maximum may be applied to the Family Out-of-Pocket Maximum. Any amount you pay for Covered Benefits for yourself that would otherwise apply to your Individual Out-of-Pocket Maximum but which exceeds the Individual Out-of-Pocket Maximum will be refunded to you, and will not apply toward your Family Out-of-Pocket Maximum. Individual Members cannot contribute more than their Individual Out-of-Pocket Maximum amount to the Family Out-of-Pocket Maximum.

Exceptions to the Annual Out-of-Pocket Maximum

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

- Payments for services or supplies that the Plan does not cover, e.g., cosmetic surgery, unauthorized non-Emergency Services. (See the section titled "WHAT IS NOT COVERED?" on page 41 for additional exclusions.)
- Copayments made for outpatient prescription drugs. However, Copayments for peak flow meters and inhaler spacers used for the treatment of asthma and dispensed through a participating Plan Pharmacy will be applied to the annual Out-of-Pocket Maximum.
- Copayments for Supplemental Benefits such as Artificial Insemination services, hearing services, outpatient prescription drugs and vision services.

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

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

Sharp Health Plan will also keep track of payments you have made towards your annual Out-of Pocket Maximums. You can also call Customer Care to obtain your most recent Out-of-Pocket totals.

What if You Get a Medical Bill?

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

Some doctors and hospitals that are not contracted with Sharp Health Plan (for example, emergency departments outside San Diego County) may require you to pay at the time you receive care. If you pay for Covered Benefits, you can request reimbursement from Sharp Health Plan.

Go to sharphealthplan.com/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.

WHAT ARE YOUR RIGHTS AND RESPONSIBILITIES AS A MEMBER?

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

You have the right to:

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

You have the responsibility to:

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

Security of Your Confidential Information (Notice of Privacy Practices)

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

PLEASE REVIEW IT CAREFULLY.

Sharp Health Plan provides health care coverage to you. We are required by state and federal law to protect your health information. We have internal processes to protect your oral, written and electronic protected health information (PHI). And we must give you this Notice that tells how we may use and share your information and what your rights are. We have the right to change the privacy practices described in this Notice. If we do make changes, we will post the revised Notice on our sharphealthplan.com website and will provide you with the revised notice, or information about the change and how to obtain the revised notice, in our next annual member mailing.

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

A. HOW WE MAY USE AND SHARE INFORMATION ABOUT YOU

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

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

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

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

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

B. OTHER USES FOR YOUR HEALTH INFORMATION

1. Sometimes a court will order us to give out your health information. We also will give information to a court, investigator or lawyer under certain circumstances. This may involve fraud or actions to recover money from others.
2. You or your doctor, hospital and other health care providers may Appeal decisions made about claims for your health care. Your health information may be used to make these Appeal decisions.
3. We also may share your health information with agencies and organizations that check how our health plan is providing services.
4. We must share your health information with the federal government when it is checking on how we are meeting privacy rules.
5. We may share your information with researchers when an Institutional Review Board (IRB) has reviewed and approved the reason for the research, and has established appropriate protocols to ensure the privacy of the information.
6. We may disclose health information, when necessary, to prevent a serious threat to your health or safety or the health and safety of another person or the public. Such disclosures would be made only to someone able to help prevent the threat.

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

C. WHEN WRITTEN PERMISSION IS NEEDED

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

D. WHAT ARE YOUR PRIVACY RIGHTS?

- You have the right to ask us not to use or share your personal health care information in the ways described in this notice. We may not be able to agree to your request.
- 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 notices, or if we intend to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.
- You have 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.
- 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:

Privacy Officer
Sharp Health Plan
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 complaint (or Grievance) by contacting:

- **Sharp Health Plan** by sending a letter to the address shown in section "E. HOW DO YOU CONTACT US TO USE YOUR RIGHTS?" or by calling toll-free at 1-855-995-5004.
- **U.S. Department of Health and Human Services Office for Civil Rights** by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, by calling 1-877-696-6775, or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

DISPUTE RESOLUTION

Pharmacy Grievance Procedures

All pharmacy benefits are managed by CVS/caremark. Please refer to your CVS Outpatient Prescription Drug Plan Evidence of Coverage booklet for Pharmacy Grievance procedures or you may contact CVS/caremark's Customer Care at 1-877-542-0284 or 1-800-863-5488 [TTY].

Medical Grievance Procedures

You, an Authorized Representative, or a provider on behalf of you, may request a Grievance within one hundred and eighty (180) days of the Adverse Benefit Determination (ABD) or other event that resulted in the Grievance, and must be submitted in one of the following ways:

- Call Customer Care at 1-855-995-5004; or
- Fill out a Member Grievance Form on the Sharp Health Plan website at sharphealthplan.com/CalPERS; or
- In writing by sending information to:

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

The Grievance must clearly state the issue, such as the reasons for disagreement with the ABD or dissatisfaction with the Services received. Include the identification number listed on the Sharp Health Plan Identification 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 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. All information provided will be taken into account without regard to whether such information was submitted or considered in the initial ABD.

Sharp Health Plan will acknowledge receipt of your request within five (5) calendar days. Standard Grievances are resolved within 30 calendar days.

You have the right to review any new information that we have regarding your Grievance. 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 Independent External Review process described below;
- For FABDs involving benefit, 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 section.

Urgent Decision

An urgent Grievance is resolved within 72 hours upon receipt of the request, but only if Sharp Health Plan determines the Grievance 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 Sharp Health Plan determines the Grievance request does not meet one of these criteria, the Grievance 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-HMO-2219 (TDD 1-877-688-9891), without first filing an appeal with us.

Experimental or Investigational Denials

Sharp Health Plan does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if Sharp Health Plan denies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational and you meet the eligibility criteria set out below, you may request an IMR of Sharp Health Plan's decision from the DMHC.

Note: DMHC does not require you to exhaust Sharp Health Plan's appeal process before requesting an IMR of ABD's based on Experimental or Investigational Services. In such cases, you may immediately contact 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 us regarding the disputed health care service.

We 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
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. The condition meets either or both of the following descriptions:

  1. A life threatening condition or a disease is one where the likelihood of death is high unless the course of the disease is interrupted. A life threatening condition or disease can also be one with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.

  2. A seriously debilitating condition or disease is one that causes major irreversible morbidity.

- 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 this 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 ask for this review within six (6) months of the date you receive a denial notice from us in response to your Grievance, or from the end of the 30 day or 72 hour Grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

Within three business days of receiving notice from the DMHC of your request for review we 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 we 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.

Independent Medical Review Involving a Disputed Health Care Service

You or an authorized representative may request an IMR of Disputed Health Care Services from the DMHC if you believe that Health Care Services eligible for coverage and payment under your Sharp Health Plan have been improperly denied, modified or delayed, in whole or in part, by Sharp Health Plan or one of its providers because the service is deemed not Medically Necessary.

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 had urgent care or emergency services that a provider determined was 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 us or your medical group, 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 complaint with us or your medical group and the disputed decision is upheld or the complaint is not resolved after 30 days. If your complaint requires urgent review you need not participate in our complaint process for more than 72 hours. The DMHC may waive the requirement that you follow our complaint process in extraordinary and compelling cases.

You must ask for this review within six (6) months of the date you receive a denial notice from us in response to your Grievance, or from the end of the 30 day or 72 hour Grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

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.

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 toll free at **1-855-995-5004 (TTY users call 711)** 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 an appeal involving an emergency, a Grievance that has not been satisfactorily resolved by your health plan, or a Grievance that has remained unresolved for more than 30 days, you may call the department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and online instructions.

In the event that Sharp Health Plan should cancel or refuse to renew enrollment for you or your dependents and you feel that such action was due to health or utilization of benefits, you or your dependents may request a review by the DMHC Director.

Appeal Rights Following Grievance Procedure

If you do not achieve resolution of your complaint through the Grievance process described under the sections, Grievance Procedures, Experimental or Investigational Denials, Independent Medical Review Involving a Disputed Health Care Service, and Department of Managed Health Care, you have additional dispute resolution options, as follows below:

1. ELIGIBILITY ISSUES

Issues of eligibility must be referred directly to CalPERS at:

CalPERS Member Account Management Division
Attn: Enrollment Administration
P.O. Box 942714
Sacramento, CA 94229-2714

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 EOC booklet. It does not include a 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 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 medication services does not exclude you from the right to submit a Grievance to the department upon completion of mediation. Expenses for mediation are shared equally between you and the Plan.

Binding Arbitration – Voluntary

If you have exhausted the Plan's Appeal process and are still unsatisfied, you have a right to resolve your Grievance through voluntary binding arbitration. Any compliant which may arise, with the exception of medical malpractice, 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 issues are not subject to the arbitration process.

You may begin the arbitration process by submitting a demand for arbitration to Sharp Health Plan. Sharp Health Plan will utilize a neutral arbiter from an appropriate entity. Arbitration will be conducted in accordance with the rules and regulations of the arbitration entity.

Upon receipt of your request, we will forward to you a complete copy of the Arbitration Rules from the arbitration entity and a confirmation that we have submitted a request to the arbitration entity for a list of arbitrators.

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 thirty (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.

The request must be mailed to:

CalPERS Health Plan Administration Division
Health 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 30 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 (3) 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 or issue 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

↙ ↘

Standard Process
180 days to file Appeal.

↓

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

↓

Request for DMHC Review
Member must request DMHC Review **within six (6) 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 30 days**.

Urgent Process
180 days to file Appeal.

↓

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

↓

Request for DMHC Review
Member should submit request for Urgent DMHC Review as soon as possible, but in no event longer than **six (6) months** of FABD.*

↓

DMHC Review
FABD must be reviewed within reasonable timeframes given medical condition but generally completed **within three (3) days** from receipt of request (**seven (7) days** for an experimental/investigational service).

↓

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 (3) business days** of receipt of all pertinent information.

↘ ↙

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

↓

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

↓

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

↓

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

↓

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

↓

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

The Covered Benefits described in this Evidence of Coverage do not include dental services (except as specifically described under Dental Services/Oral Surgical Services). 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. Copayments 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. Outpatient prescription drug benefits are instead covered and administered by CVS/caremark. Members should review the CVS Outpatient Prescription Drug Plan Evidence of Coverage booklet for details regarding the Outpatient Prescription Drug Program.

The Member's Health Plan Benefits and Coverage Matrix on page 1 details applicable Copayments that the Member pays for Covered Benefits, and also includes the Member's annual Out-of-Pocket Maximum amount.

Important exclusions and limitations are described in the section of this Evidence of Coverage entitled "WHAT IS NOT COVERED?" beginning on page 41.

Acupuncture

Acupuncture and chiropractic services are covered for up to a combined maximum of 20 visits per calendar year when provided by a Plan Provider. Copayments made for acupuncture do not apply toward the annual Out-of-Pocket Maximum.

Acute Inpatient Rehabilitation Facility Services

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

Blood Services

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

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

Bloodless Surgery

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

Chemotherapy

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

Chemical Dependency and Alcoholism Treatment

Chemical dependency and alcoholism treatment services are covered, including inpatient hospital services, partial hospital services and outpatient services when ordered and performed by a participating behavioral health professional. Members have direct access to Plan Providers of behavioral health services without obtaining a PCP referral. Covered Benefits must be obtained through Plan Providers. Chemical dependency and alcoholism treatment services that are not provided by Plan Providers are not covered, and you will be responsible to pay for those services. Please call Psychiatric Centers at San Diego toll-free at 1-877-257-7273 whenever you need chemical dependency services. All calls are confidential.

Chiropractic Services

Acupuncture and chiropractic services are covered for up to a combined maximum of 20 visits 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 a Member's participation in an eligible clinical trial are covered. To be eligible for coverage, the Member must meet the following requirements:

1. The Member is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition. The term "life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

2. Either:
   a) the referring health care professional is a Plan Provider and has concluded that the Member's participation in such trial would be appropriate based upon the Member meeting the conditions of the clinical trial; or
   b) the Member provides medical and scientific information establishing that the Member's participation in the clinical trial would be appropriate based upon the Member meeting the conditions of the clinical trial.

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

(A) The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

(i) The National Institutes of Health
(ii) The Centers for Disease Control and Prevention
(iii) The Agency for Health Care Research and Quality
(iv) The Centers for Medicare & Medicaid Services
(v) A cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs.
(vi) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
(vii) Any of the following if the conditions described in paragraph (B) are met:

(a) The Department of Veterans Affairs
(b) The Department of Defense
(c) The Department of Energy

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

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

Covered Benefits for clinical trials include the following:

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

Any clinical trial must be pre-Authorized by Sharp Health Plan.

The following are not covered:

- The provision of non FDA approved drugs or devices that are the subject of the trial.
- Services other than health care services, such as for travel, housing, and other non clinical expenses that the Member may incur due to participation in the trial.
- Any items or services that are provided solely to satisfy data collection and/or analysis needs and that are not used in the clinical management of the Member.
- Health care services that are otherwise excluded from coverage (other than those that are excluded on the basis that they are experimental or investigational).
- Health care services that are customarily provided by the research sponsors free of charge for enrollees in the trial.
- The investigational item, device, or service itself.
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

Dental Services/Oral Surgical Services

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 treatment provided within 48 hours of injury or as soon as the Member is medically stable.
- Services required for the diagnostic testing and specifically approved medical treatment of medically indicated temporomandibular joint (TMJ) disease.

Oral surgical services are covered only as described below:

- Reduction or manipulation of fractures of facial bones.
- Excision of lesions of the mandible, mouth, lip or tongue.
- Incision of accessory sinuses, mouth, salivary glands or ducts.
- Reconstruction or repair of the mouth or lip necessary to correct anatomical functional impairment caused by congenital defect or accidental injury.
- 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 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 (e.g., radical neck or removal of mandibular bone for cancer or tumor).
- Ridge augmentation or alveoplasty when consistent with medical policies for reconstructive surgery or cleft palate policies.
- Tooth extraction prior to a major organ transplant or radiation therapy of neoplastic disease to the head or neck.
- Treatment of maxillofacial cysts, including extraction and biopsy.
- Custom-fitted and prefabricated oral appliances for obstructive sleep apnea patients who have mild sleep apnea and meet the criteria for coverage of continuous positive airway pressure (CPAP), but who are intolerant to CPAP.

General anesthesia services and supplies, associated facility charges, rendered in a hospital or surgery center setting, as outlined in sections titled "Hospital Facility Inpatient Services" (page 34) and "Professional Services" (page 38), are covered for dental and oral surgical services only for Members who meet the following criteria:

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

Diabetes Treatment

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

- Blood glucose monitors and testing strips.
- Blood glucose monitors designed for the visually impaired.
- Insulin pumps and all related necessary supplies.
- Ketone urine testing strips.
- Lancets and lancet puncture devices.
- Pen delivery systems for the administration of insulin, if 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.

Sharp Health Plan does not provide coverage for insulin, prescription medications for the treatment of diabetes, and glucagon, as Covered Benefits. Those 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/caremark. Please refer to your CVS Outpatient Prescription Drug Plan Evidence of Coverage booklet for additional details.

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 Professional Services.

Durable Medical Equipment

Durable Medical Equipment (DME) is covered. DME is a physical accessory designed to serve a repeated medical purpose and appropriate for use in the Member's home.

DME does not include equipment that basically serves comfort or convenience functions (e.g., physical fitness equipment, trays, backpacks, wheelchair racing equipment). DME that is primarily for the convenience of the Member or caretaker is not considered Medically Necessary.

DME is limited to equipment and devices that are:

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

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 his/ her license, and when not caused by misuse or loss. Applicable Copayments apply for authorized DME replacement. No additional Copayments are required for repair of DME.

Emergency Services

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

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

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

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

Family Planning Services

The following family planning services are covered:

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

The Copayments for family planning services are determined based on the type and location of the service. For example, a service that takes place at an outpatient facility will result in an outpatient facility Copayment. Please see the Health Plan Benefits and Coverage Matrix on page 1.

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

Gender Reassignment Surgery and Services

Gender reassignment surgery is one treatment option for Gender Identity Disorder (GID). Gender reassignment surgery and associated services are covered when Medically Necessary. Covered Benefits include clinically appropriate services for the complete treatment of GID including medical, psychiatric, hormonal, and surgical treatments according to the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) Version 7.

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 an audiologist, when authorized by the Plan.
- Hearing aids or ear molds when authorized by the Plan and necessary to provide functional improvement according to professionally accepted standards of practice.

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

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 his/her license. This includes visits by registered nurses, licensed vocational nurses and home health aides for physical, occupational, speech and respiratory therapy when prescribed by a Plan Provider acting within the scope of his/her licensure. Visits on a short-term, intermittent basis are covered for the usual and customary time required to perform the particular skilled service(s), including diagnosis and treatment, for the following services:

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

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

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

1. Is confined to the home (home is wherever the Member makes his or her home but does not

include acute care, rehabilitation or Skilled Nursing Facilities);

2. Needs Medically Necessary skilled nursing visits or needs physical, speech or occupational therapy; and
3. The home health care visits are provided under a plan of care established and periodically reviewed and ordered by a Plan Provider.

Hospice Services

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

Covered Benefits include:

- Nursing care.
- Medical social services.
- Home health aide services, skilled nursing services and homemaker services under the supervision of a qualified registered nurse.
- Physician services.
- Drugs.
- Pharmaceuticals, medical equipment and supplies.
- Counseling and social services with medical social services provided by a qualified social worker. Dietary counseling by a qualified provider shall also be provided when needed.
- Bereavement services.
- Physical, occupational and speech therapy as described in this section for short-term inpatient care for pain control and symptom management or to enable the enrollee 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 enrollees 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 an enrollee at home. Hospitalization is covered when the interdisciplinary team makes the determination that inpatient skilled nursing care is required at a level that cannot be provided in the home. Either homemaker or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis, but the care provided during these periods must be predominantly nursing care. A period of crisis is a period in which the Member requires continuous care to achieve palliation or management of acute medical symptoms.
- Respite Care: Respite care is short-term inpatient care provided to the Member only when necessary to relieve the family members or other persons caring for the Member. Coverage for respite care is limited to an occasional basis and to no more than five consecutive days at a time.

Hospital Facility Inpatient Services

Hospital facility inpatient services are covered. The Member pays an applicable Copayment to the hospital for each hospitalization.

Hospital inpatient services may include:

- A hospital room of two or more beds, including meals, services of a dietitian and general nursing care.
- Intensive care services.
- Operating and special treatment rooms.
- Surgical, anesthesia and oxygen supplies.
- Administration of blood and blood products.

- Ancillary services, including laboratory, pathology and radiology.
- Administered drugs.
- Other diagnostic, therapeutic and rehabilitative services as appropriate.
- Coordinated discharge planning including planning of continuing care, as necessary.

Hospital Facility Outpatient Services

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

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

Infertility Services

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

Infusion Therapy

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

The Copayments for infusion therapy services are determined based on the type and location of the service. For example, if this service is provided during an office visit, then the office visit Copayment will be charged. Please see the Health Plan Benefits and Coverage Matrix on page 1.

Injectable Drugs

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

Sharp Health Plan does not provide coverage for insulin as a Covered Benefit. Insulin is covered under the Outpatient Prescription Drug Program.

The Outpatient Prescription Drug Program is administered by CVS/caremark. Please refer to your CVS Outpatient Prescription Drug Plan Evidence of Coverage booklet for additional details.

Maternity and Pregnancy Services

The following maternity and pregnancy services are covered:

- Prenatal and postnatal services, including but not limited to Plan Physician visits.

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

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

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

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

Mental Health Services

Sharp Health Plan provides coverage for the diagnosis and treatment of Severe Mental Illnesses in Members of any age and Serious Emotional Disturbances in children, including Behavioral Health Treatment for pervasive developmental disorders or autism. Members also have coverage for treatment of other mental health conditions.

Mental health benefits include inpatient hospital services, partial hospital services and outpatient services (including Behavioral Health Treatment delivered in the home or other non-institutional setting) when ordered and performed by a participating mental health professional. Members have direct access to Plan Providers of mental health services without obtaining a PCP referral. Covered mental health benefits must be obtained through Plan Providers. Mental health services that are not provided by Plan Providers are not covered, and you will be responsible to pay for those services. Please call Psychiatric Centers at San Diego toll-free at 1-877-257-7273 whenever you need mental health services. All calls are confidential.

MinuteClinic®

As a Sharp Health Plan Member, you may receive the covered services listed below at any MinuteClinic® location. These services are not an alternative to emergency services or ongoing care. These services are provided in addition to the urgent care services available to you as a Sharp Health Plan member. MinuteClinic is the walk-in medical clinic located inside select CVS/pharmacy® stores. MinuteClinic provides convenient access to basic care. It is staffed with certified family nurse practitioners and physician assistants and is the largest provider of retail health care in the United States. In addition, it is the only retail health care provider to receive three consecutive accreditations from The Joint Commission, the national evaluation and certifying agency for nearly 15,000 health care organizations and programs in the United States.

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

- Diagnosis and treatment for common family illnesses such as strep throat, allergy

symptoms, pink eye and infections of the ears, nose and throat.

- Flu vaccinations.
- Treatment of minor wounds, abrasions and minor burns.
- Treatment for skin conditions such as poison ivy, ringworm and acne.

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

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

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

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. Outpatient prescription drug benefits are instead covered and administered by CVS/caremark. Members should review the CVS Outpatient Prescription Drug Plan Evidence of Coverage booklet for details regarding the Outpatient Prescription Drug Program.
Members may contact CVS/caremark's Customer Care at 1-877-542-0284 or 1-800-863-5488 [TTY] 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. The Member pays an applicable Copayment to the Plan Physician or other health professional for each visit. Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, Skilled Nursing Facility or home.
The goal of rehabilitation therapy is to assist Members to become as independent as possible, using appropriate adaptations if needed to achieve basic Activities of Daily Living including bathing, dressing, feeding, toileting and transferring (e.g., moving from the bed to a chair). Speech therapy is covered when there is a delay in obtaining services through the school system and when additional services are determined to be Medically Necessary, i.e., where injury, illness or congenital defect is documented (e.g., hearing loss, chronic otitis media, brain tumor, cerebral palsy, cleft palate, head trauma). Sharp Health Plan will require periodic evaluations of any therapy to assess ongoing medical necessity.

Paramedic 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.

Phenylketonuria (PKU) 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 doctor who specializes in the treatment of metabolic diseases.

Preventive Care Services

The following preventive care services are covered:

- Well child physical examinations (including vision and hearing screening in the PCP's office) and all periodic immunizations and related laboratory services in accordance with the current recommendations from the American Academy of Pediatrics, US Preventive Services Task Force, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the Health Resources and Services Administration and the American Academy of Family Physicians.
- Well adult physical examinations, episodic immunizations and related laboratory services in accordance with the current recommendations from the US Preventive Services Task Force, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, the Health Resources and Services Administration and Sharp Health Plan medical policies.
- Routine gynecological examinations, mammograms and cervical cancer screening tests, in accordance with the guidelines of the American College of Obstetrics and Gynecology and the Health Resources and Services Administration. Members may directly access OB/GYN care within their PMG without a referral from their PCP.
- All generally accepted cancer screening tests, as determined by the US Preventive Services Task Force and approved by the Food and Drug Administration, including the conventional Pap test, any cervical cancer screening test and human papillomavirus screening test and prostate cancer screening.
- Other preventive diagnostic tests that may be delivered in an outpatient surgical facility, including but not limited to colonoscopy and endoscopy.

Professional Services

The following Professional Services (provided by a Plan Physician or other licensed health professional) are covered. The Copayments for Professional Services are determined based on the type and location of the service. Please see the Health Plan Benefits and Coverage Matrix on page 1.

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

Prosthetic and Orthotic Services

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

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.
- A prosthetic shoe that is an integral part of a prosthesis.
- Special footwear needed by persons who suffer from foot disfigurement including disfigurement from cerebral palsy, arthritis, polio, spinabifida, diabetes and foot disfigurement caused by accident or developmental disability.

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

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

Repair or replacement of prosthetics and orthotics are covered when prescribed by a Plan Physician or ordered by a licensed health care provider acting within the scope of his/her license, and when not caused by misuse or loss. The applicable Copayment per the Health Plan Benefits and Coverage Matrix on page 1 applies for both repair and replacement.

Radiation Therapy

Radiation therapy (standard and complex) is covered.

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

Radiology Services

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

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

Reconstructive Surgical Services

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

- Reconstructive surgical services following a mastectomy or lymph node dissection are covered. The length of a hospital stay associated with a mastectomy or lymph node dissection is determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes. There is no prior Authorization required in determining the length of hospital stay following these procedures. Members who elect to have breast reconstruction after a mastectomy are covered for all complications of the mastectomy and reconstructive surgery, prostheses for and reconstruction of the affected breast and reconstructive surgery on the other breast as may be needed to produce a symmetrical appearance.
- Reconstructive surgical services performed on abnormal structures of the body caused by congenital defects, developmental

anomalies, trauma, infection, tumors, disease or Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures are covered when performed to improve function or create a normal appearance, to the extent possible.

The Copayments for reconstructive surgical services are determined based on the type and location of the service. Please see the Health Plan Benefits and Coverage Matrix on page 1.

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:

- Skilled nursing on a 24 hour basis.
- Bed and board.
- X-ray and laboratory procedures.
- Respiratory therapy.
- Short term physical, occupational and speech therapy.
- Medical social services.
- Prescribed drugs and medications.
- 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. Reversal of sterilization services is not covered.

Termination of Pregnancy

Interruption of pregnancy (abortion) services are covered. The Copayments for termination of pregnancy services are determined based on the type and location of the service. Please see the health Plan Benefits and Coverage Matrix on page 1.

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 experimental or investigational, are covered. Anti-rejection drugs may also be covered under the Outpatient Prescription

Drug Program. The Outpatient Prescription Drug Program is administered by CVS/caremark. Please refer to your CVS Outpatient Prescription Drug Plan Evidence of Coverage booklet for additional details.

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

Urgent Care Services

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

Vision Sevices

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 Benefit.

Copayments made for vision services do not apply toward the annual Out-of-Pocket Maximum.

WHAT IS NOT COVERED?

Exclusions and Limitations

The services and supplies listed below are exclusions (not Covered Benefits) or are covered with limitations (Covered Benefits only in specific instances) in addition to those already described in this Evidence of Coverage. Additional limitations may be specified in the Health Plan Benefits and Coverage Matrix on page 1.

Exclusions include any services or supplies that are:

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

Acupuncture

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

Ambulance

Ambulance service is not covered when used only for the Member's convenience or when another available form of transportation (e.g., a private vehicle or taxi fare) would be more appropriate. Wheelchair transportation service is also not covered.

Chiropractic Services

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

Clinical Trials

The following are not Covered Benefits:

- The provision of non FDA approved drugs or devices that are the subject of the trial.
- Services other than health care services, such as for travel, housing and other non-clinical expenses that the Member may incur due to participation in the trial.
- Any items or services that are provided solely to satisfy data collection and/or analysis needs and that are not used in the clinical management of the Member.
- Health care services that are otherwise excluded from coverage (other than those that are excluded on the basis that they are experimental or investigational).
- Health care services that are customarily provided by the research sponsors free of charge for enrollees in the trial.
- The investigational item, device or service itself.
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Cosmetic Surgical Services

The following are not Covered Benefits:

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

Custodial Care

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

Dental Services/Oral Surgical Services

The following dental services are not Covered Benefits. Dental services are defined as all services required for treatment of the teeth or gums.

- Oral exams, X-rays, routine fluoride treatment, plaque removal and extractions.
- Treatment of tooth decay, periodontal disease, dental cysts, dental abscess, granuloma or inflamed tissue.
- Crowns, fillings, inlays or onlays, bridgework, dentures, caps, restorative or mechanical devices applied to the teeth and orthodontic procedures.
- Restorative or mechanical devices, dental splints or orthotics (whether custom fit or not) or other dental appliances and related surgeries to treat dental conditions, except as specifically described under Covered Benefits.
- Dental implants (materials implanted into or on bone or soft tissue) and any surgery to prepare the jaw for implants or other dental services associated with surgery on the jawbone.

- Follow-up treatment of an injury to sound natural teeth as a result of an accidental injury regardless of reason for such services.
- Oral surgical services not specifically listed as covered in this Evidence of Coverage.
- Dental treatment anesthesia provided or administered in a dentist's office or dental clinic.

Disposable Medical Supplies

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

Durable Medical Equipment

Comfort or convenience items are not covered. Exercise and hygiene equipment, experimental or research equipment, devices not medical in nature such as sauna baths and elevators or modifications to the home or automobile, deluxe equipment or more than one piece of equipment that serve the same function are excluded. Replacement of lost or stolen Durable Medical Equipment is not covered.

Emergency Services

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

Experimental or Investigational Services

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

a) Experimental or investigational or not recognized in accordance with generally accepted standards as being safe and effective for the use in question; or

b) Outmoded or not efficacious, such as those defined by the federal Medicare and state Medicaid programs or drugs or devices that are not approved by the Food and Drug Administration.

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

Please see the section titled "Clinical Trials" on page 29 for information about coverage of experimental or investigational treatments that are part of an eligible cancer clinical trial.

Family Planning Services

The following services are not Covered Benefits:

- Reversal of voluntary sterilization.
- Nonprescription contraceptive supplies.

Foot Care

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

Gender Reassignment Surgery and Services

The following procedures, when used to improve the gender specific appearance of an individual undergoing or planning gender reassignment surgery, are considered cosmetic and therefore are not Covered Benefits:

- Abdominoplasty.
- Breast augmentation.
- Blepharoplasty.
- Face-lift.
- Facial bone reduction.
- Hair transplantation.
- Liposuction.
- Reduction thyroid chondroplasty.
- Rhinoplasty.
- Voice modification surgery.

Genetic Testing, Treatment or Counseling

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

- Individuals who are not Members of Sharp Health Plan.

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

Government Services and Treatment

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

Services required for injuries or illnesses experienced while under arrest, detained, imprisoned, incarcerated or confined pursuant to federal, state or local law are not covered. However, the Plan will reimburse Members their out-of-pocket expenses for services received while confined/incarcerated or, if a juvenile, while detained in any Facility, if the service were provided or authorized by the Member's PCP or PMG in accordance with the terms of the Plan or were Emergency Services or Urgent Care Services. This exclusion does not restrict the Plan's liability with respect to expenses for Covered Benefits solely because the expenses were incurred in a state or county Hospital; however, the Plan's liability with respect to expenses for Covered Benefits provided in a state or county Hospital is limited to the reimbursement that the Plan would pay for those Covered Benefits if provided by a Plan Hospital.

Hearing Services

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.

Coverage expenses related to hearing aids are limited to the usual and customary charge of a basic hearing aid to provide functional improvement.

Immunizations and Vaccines

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

Infertility Services

The following services are not Covered Benefits:

- Assisted Reproductive Technologies (ART) procedures, otherwise known as conception by artificial means (except Artificial Insemination), including but not limited to in vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), multi-cell embryo transfer (TET), intracytoplasmic sperm injections (ICSI), blastocyst transfer, assisted hatching and any other procedures that may be employed to bring about conception without sexual intercourse.
- Any service, procedure or process which prepares the Member for noncovered ART procedures.
- Collection, preservation or purchase of sperm, ova or embryos.

- Reversal of voluntary sterilization.
- Testing, services or supplies for conception by a surrogate who is not enrolled in Sharp Health Plan. If the surrogate is enrolled in Sharp Health Plan, medical expenses related to the pregnancy will be covered by the Plan, subject to the lien described on page 52 in the "What Happens if You Enter Into a Surrogacy Arrangement?" section of this Handbook.
- Devices and procedures to determine the sex of a fetus.
- Elective home deliveries.

Hospital Facility Inpatient and Outpatient Services

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

Mental Health Services

The following services are not Covered Benefits:

- Any service covered under the Member's Employee Assistance Program (EAP).
- Any court ordered treatment or therapy or any treatment or therapy ordered as a condition of parole, probation, custody or visitation.
- Diagnosis and treatment of developmental disorders, developmental reading disorder, developmental arithmetic disorder, developmental language disorder or developmental articulation disorder.*
- Diagnosis and treatment for learning disorders or those services primarily oriented toward treatment of social or learning disorders.*
- Counseling for activities of an educational nature.*
- Counseling for borderline intellectual functioning.
- Counseling for occupational problems.
- Counseling related to consciousness raising.
- Vocational or religious counseling.
- Counseling for marital problems.
- I.Q. testing.
- Psychological testing on children required as a condition of enrollment in school. *

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

Non-Preventive Physical or Psychological Examinations

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

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. Outpatient prescription drug benefits are instead covered and administered by CVS/caremark. Members should review the CVS Outpatient Prescription Drug Plan Evidence of Coverage booklet for details regarding the Outpatient Prescription Drug Program. Members may contact CVS/caremark's Customer Care at 1-877-542-0284 or 1-800-863-5488 [TTY] with questions or to request a copy of the booklet.

Private-Duty Nursing Services

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

Prosthetic/Orthotic Services

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

under the following conditions:

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

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

Special footwear needed by persons who suffer from foot disfigurement is not covered except as specifically described as covered in this Evidence of Coverage.

Sexual Dysfunction Treatment

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

Vision Services

Vision services are not covered unless specifically listed as covered in this Evidence of Coverage. Copayments made for vision services do not apply toward the annual Out-of-Pocket Maximum.

Vision services that are not covered include, but are not limited to:

- Eye surgery for the sole purpose of correcting refractive error (e.g., radial keratotomy).
- Orthoptic services (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- Eyeglasses or contact lenses for circumstances other than following cataract surgery.

Other

- Any services received prior to the Member's effective date of coverage or after the termination date of coverage are not covered.
- Any services or supplies covered under any workers' compensation benefit plan are not covered.
- Any services requested or ordered by a court of law, Employer or school are not covered.
- In the event of any major disaster, act of war or epidemic, Sharp Health Plan and Plan Providers shall provide Covered Benefits to Members to the extent Sharp Health Plan and Plan Providers deem reasonable and practical given the facilities and personnel then available. Under such circumstances, Sharp Health Plan shall use all Plan Providers available to provide Covered Benefits, regardless of whether the particular Members in question had previously selected, been assigned to or received Covered Benefits from those particular Plan Providers.

However, neither Sharp Health Plan nor any Plan Provider shall have any liability to Members for any delay in providing or failure to provide Covered Benefits under such conditions to the extent that Plan Providers are not available to provide such Covered Benefits.

- The frequency of routine health examinations will not be increased for reasons unrelated to the medical needs of the Member. This includes the Member's desire or request for physical examinations and reports or related services for the purpose of obtaining or continuing employment, licenses, insurance or school sports clearance, travel licensure, camp, school admissions, recreational sports, premarital or pre-adoptive purposes, by court order or for other reasons not Medically Necessary.
- Benefits for services or expenses directly related to any condition that caused a Member's Total Disability are excluded when such Member is Totally Disabled on the date of discontinuance of a prior carrier's policy and the Member is entitled to an extension of benefits for Total Disability from that prior carrier.

ELIGIBILITY AND ENROLLMENT

Information pertaining to eligibility, enrollment and termination of coverage can be obtained through the CalPERS website at 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 Member Account Management Division at:

CalPERS
Member Account Management Division
P.O. Box 942714
Sacramento, CA 94229-2714

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 and urgent care) within the health plan's Service Area, even if they do not reside in that area.

What if You Have Other Health Insurance Coverage?

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

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

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

What if You Are Eligible for Medicare?

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

What if You Are Injured at Work?

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

What if You Are Injured by Another Person?

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

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, the Member is covered during this 90-day period.

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

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

COBRA Continuation Coverage

If your Employer has 20 or more employees, and you or your Dependents would otherwise lose coverage for benefits, you may be able to continue uninterrupted coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 and its amendments (referred to as COBRA), subject to your continuing eligibility and your payment of Premiums. COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependent could become qualified beneficiaries if coverage under the group plan is lost because of the qualifying event. Please contact your 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 as described below.

Cal-COBRA Continuation Coverage

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

Qualifying Events

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

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

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

How to Elect Cal-COBRA Coverage

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

Adding Dependents to Cal-COBRA

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

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

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

Premiums for Cal-COBRA Coverage

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

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

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

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

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

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

Certificate of Creditable Coverage

As a service to your Employer, Sharp Health Plan will provide you with a Certificate of Creditable Coverage when the Subscriber or Dependent ceases to be eligible for benefits under the Employer's health benefit plan.

We will also provide a Certificate of Creditable Coverage upon request. This certificate documents your enrollment in Sharp Health Plan and is used to prove prior creditable coverage when a terminated Member seeks new coverage. A Certificate of Creditable Coverage may be used to reduce or eliminate a pre-existing condition exclusion period proposed by a subsequent health plan. If your coverage with Sharp Health Plan ends, please retain a copy of the Certificate for your records.

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?

New Members of Sharp Health Plan

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

Existing Members of Sharp Health Plan

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

eligible to complete your care under certain circumstances that are explained below.

Conditions for Eligibility

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

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

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

What Is the Relationship Between the Plan and Its Providers?

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

How Can You Participate in Plan Policy?

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

What Happens if You Enter Into a Surrogacy Arrangement?

A surrogacy arrangement is one in which you agree to become pregnant and to surrender the baby to another person or persons who intend to raise the child. You must pay us for any amounts paid by the Plan for Covered Benefits you receive related to

conception, pregnancy, delivery or newborn care in connection with a surrogacy arrangement ("Surrogacy Health Services"). Your obligation to pay us for Surrogacy Health Services is limited to the compensation you are entitled to receive under the surrogacy arrangement.

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

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

Sharp Health Plan
Customer Care
Attention: Third Party Liability
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 are reasonably necessary for us to determine the existence of any rights we may have under this "What Happens if You Enter Into a Surrogacy Arrangement?" section and to satisfy those rights. You must not take any action prejudicial to our rights.

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

GLOSSARY

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

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

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

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

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

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

Artificial Insemination is the depositing of sperm by syringe into the vagina near the cervix or directly into the uterus. This technique is used to overcome sexual performance problems, to circumvent sperm-mucus interaction problems, to maximize the potential for poor semen and for using donor sperm.

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

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

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

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

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

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

Dependent means an Enrolled Employee's legally married Spouse, Domestic Partner or child (including an adopted child or stepchild), who meets the eligibility requirements set forth by CalPERS, who is enrolled in the Plan, and for whom the Plan receives Premiums.

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

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

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

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

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

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

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

Emergency Services and Care means:

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

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

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

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

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

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

Health Plan Benefits and Coverage Matrix is a list of the most commonly used Covered Benefits and applicable Copayments for the specific benefit plan purchased by CalPERS. The Health Plan Benefits and Coverage Matrix can be found on page 1 of this Evidence of Coverage.

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

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

Life-Threatening Condition means a disease or condition where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival.

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

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

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

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

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

Outpatient Prescription Drug Program means the program administered by CVS/caremark to provide coverage for certain outpatient prescription drugs. Outpatient prescription drugs are self-administered drugs approved by the Federal Food and Drug Administration (FDA) for sale to the public through retail or mail-order pharmacies and require prescriptions and are not provided for use on an inpatient basis. Please refer to the CVS 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 the Plan and that is included in the Member's Plan Network.

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

Plan Network means that network of providers selected by CalPERS or the Member, as indicated on the Member Identification Card. Members enrolled in the Performance Plus plan have access to the Performance Plan Network.

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

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

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

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

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

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

Professional Services means those professional diagnostic and treatment services which are listed in the 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 the Member's Plan Network, which is updated periodically.

Serious Emotional Disturbance (SED) means one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, to include Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and other pervasive developmental disorders no otherwise specified (including Atypical Autism), in accordance with diagnostic and statistical manual for Mental Disorders–IV-Text revisions (June 2000), other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. One or more of the following must also be true:

1. as a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either of the following occur: a) the child is at risk of removal from the home or has already been removed from the home; or

b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year if not treated; or

2. the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or

3. the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

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

Service Area means all of the ZIP codes in the geographic area of San Diego County, California.

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

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

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

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

Supplemental Benefits means benefits for Artificial Insemination services, hearing services, outpatient prescription drugs and vision services. Copayments for Supplemental Benefits do not apply to the annual Out-of-Pocket Maximum.

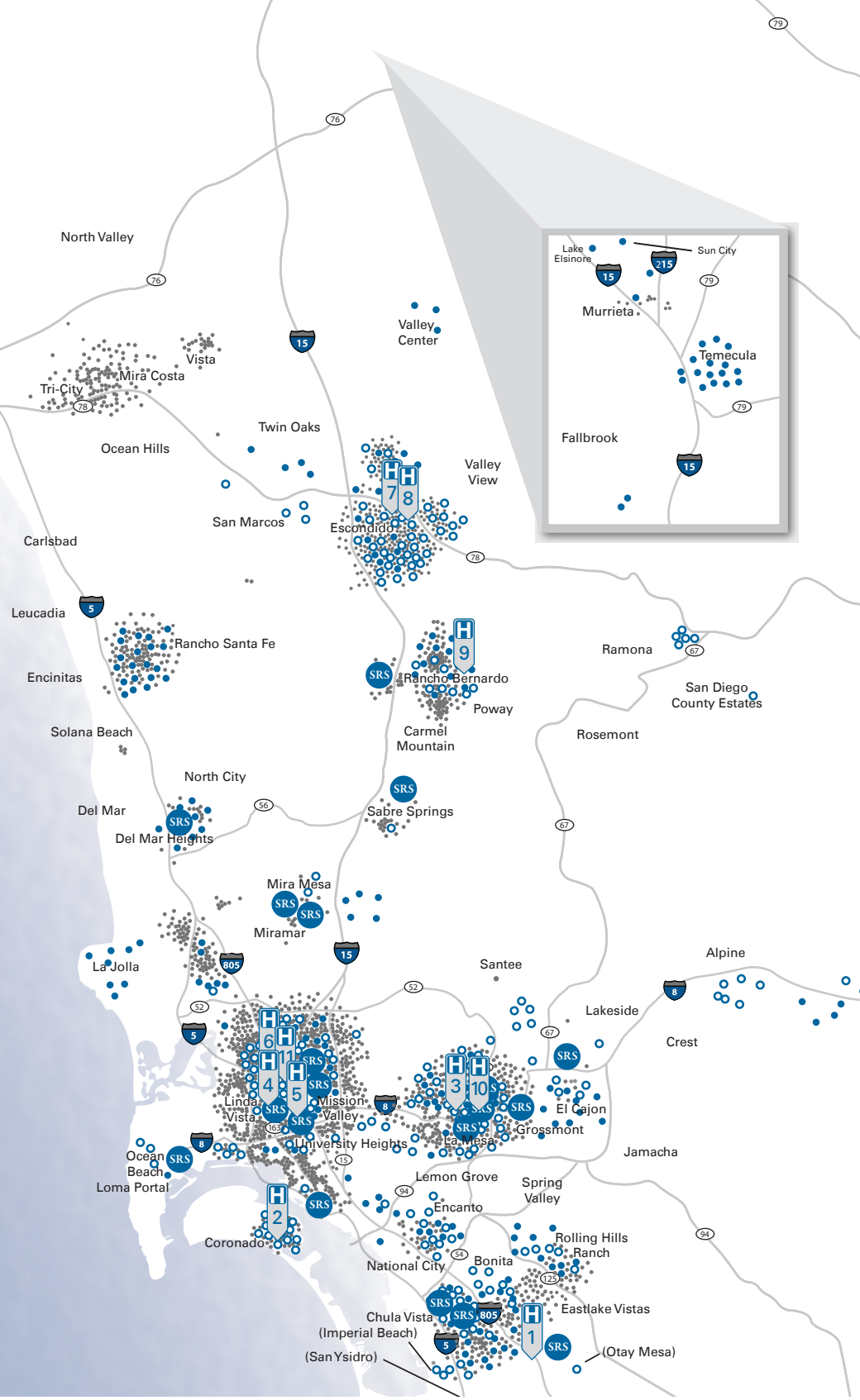
Totally Disabled means a Member who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition and is chiefly dependent upon the Subscriber for support and maintenance. The determination as to whether a Member is Totally Disabled will be made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

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

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

Our Network of Medical Groups

- SRS — Sharp Rees-Stealy Medical Group (SRS)
- Sharp Community Medical Group (SCMG)
- Rady Children's Health Network/CPMG
- Medical Group Specialists
- H — Hospitals



If you have questions about the covered service area and provider availability, call us toll-free at 1-855-995-5004, or email us at customer.service@sharp.com.

SHARP HEALTH PLAN
make life better.™

8520 Tech Way, Ste. 200
San Diego, CA 92123-1450
1-855-995-5004
sharphealthplan.com/CalPERS

Published July 2015
SHPA219.07.15 © 2015 SHC