



2019

Sutter Health Plus

Large Group Evidence of Coverage and Disclosure Form

Plan Name: County of Sacramento \$1350 HDHP HMO

Effective January 1, 2019

If you intend to use this health care plan with a Health Savings Account (HSA) you must open an HSA with a financial institution qualified under applicable federal law and Internal Revenue Service rules, and you should seek professional guidance from a tax or financial planner.

Sutter Health Plus
2480 Natomas Park Drive, Suite 150
Sacramento, CA 95833

Member Services
8 a.m. to 7 p.m.
Monday through Friday
1-855-315-5800 (TTY 1-855-830-3500)
www.sutterhealthplus.org

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SUTTER HEALTH PLUS NONDISCRIMINATION POLICY

Sutter Health Plus complies with applicable Federal and California civil rights laws and does not exclude people or otherwise discriminate against them because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Sutter Health Plus:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, call Sutter Health Plus Member Services at 1-855-315-5800.

If you believe that Sutter Health Plus has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with Sutter Health Plus in person, by mail or fax or online at:

Sutter Health Plus	Telephone:	1-855-315-5800
Attn: Appeals & Grievances	TTY:	1-855-830-3500
P.O. Box 160305	Fax:	1-916-736-5422
Sacramento, CA 95816	Toll-Free Fax:	1-855-759-8755
	Internet Address:	<i>sutterhealthplus.org</i> <i>shplus.org/memberportal</i>

If you need help filing a grievance, call Sutter Health Plus Member Services at 1-855-315-5800.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against Sutter Health Plus, you should first call Sutter Health Plus at **1-855-315-5800 (TTY 1-855-830-3500)** and use the Sutter Health Plus grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an emergency, a grievance not satisfactorily resolved by Sutter Health Plus, or a grievance unresolved for more than 30 days, call the department for assistance. 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 Web site ***hmohelp.ca.gov*** has complaint forms online.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201	Telephone: 1-800-368-1019 TDD: 1-800-537-7697 Complaint Portal: <i>ocrportal.hhs.gov/ocr/portal/lobby.jsf</i> Complaint Forms: <i>hhs.gov/ocr/office/file/index.html</i>
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INTRODUCTION

Welcome to Sutter Health Plus! We are committed to providing you with access to high-quality, personalized care and service. This combined *Evidence of Coverage and Disclosure Form (EOC)* is your roadmap to how, when and where you may access covered health care services. It is your right to view the *EOC* prior to enrollment and we encourage you to carefully read and understand how our plan works.

Throughout this *EOC*, Sutter Health Plus is referred to as “SHP,” “us” or “we” while Members are referred to “you.” The capitalized terms used have specific meanings which are defined in the Definitions chapter.

If you have special health care needs, please pay particular attention to sections of this *EOC* that address those needs. In addition to describing available plan benefits and how to access them, this *EOC* also describes covered health care services, associated costs, any limitations and exclusions, how to file a complaint or grievance, and other important features about your plan.

Please note that this *EOC* constitutes only a summary of the plan. Consult the Group Subscriber Contract to determine the exact terms and conditions of coverage.

To request a copy of the contract between your employer and SHP, commonly referred to as the Group Subscriber Contract, please contact your employer. For questions about this *EOC* or if you need assistance to access or use your benefits, please contact SHP Member Services. You may also find valuable information about your coverage and the SHP Provider Network at sutterhealthplus.org. Please see the Health Plan Benefit and Coverage Matrix for Cost Sharing information.

Confidentiality of Medical Records

SHP is committed to protecting the confidentiality of our Members' records.

A statement describing SHP's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

Language Assistance

Language assistance services, including translations of vital documents and interpreter services, are available for our Members who have limited or no ability to speak English. These language assistance services are available to you at no cost. To get an interpreter or to ask about written information in your language, please contact SHP Member Services at 1-855-315-5800 (TTY 1-855-830-3500).

IMPORTANTE: Los servicios de asistencia en idiomas, incluyendo traducciones de documentos importantes y servicios de interpretación, están disponibles para nuestros miembros con un conocimiento limitado del idioma inglés, o no lo pueden hablar. Estos servicios de asistencia de idiomas están disponibles para usted sin costo alguno. Para obtener un intérprete o para solicitar información por escrito en su idioma, por favor comuníquese con los servicios al miembro de SHP al 1-855-315-5800 (usuarios de TTY deben llamar al 1-855-830-3500).

若會員講英文的能力有限或不講英文，我們可以提供語言協助服務，包括提供重要文件的翻譯和口譯服務。這些語言協助服務是免費向您提供。要獲得口譯服務或詢問以您的語言提供的書面資訊，請聯繫SHP會員服務部，電話號碼是1-855-315-5800 (TTY 1-855-830-3500)

Notice of Language Assistance

IMPORTANT: Can you read this? If not, Sutter Health Plus can have somebody help you read it. You may also be able to get this written in your language. For no-cost help, please call Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500). (English)

IMPORTANTE: ¿Puede leer esto? Si no puede, Sutter Health Plus puede proporcionarle alguien que le ayude a leerlo. También puede obtenerlo por escrito en su idioma. Llame a Sutter Health Plus Member Services al 1-855-315-5800 (TTY 1-855-830-3500), sin costo alguno. (Spanish)

重要提示：您能讀懂這份文件嗎？如果不能，Sutter Health Plus 可以找人幫助您讀它。您還可能得到用您的語言書寫的這份文件。若需要免費幫助，請致電 Sutter Health Plus 會員服務，電話號碼 1-855-315-5800 (TTY 1-855-830-3500)。 (Chinese)

ملحوظة مهمة: هل أنت قادر على قراءة هذا؟ إذا لم تكن قادرًا فاعلم أن صتر هيلث بلاس (Sutter Health Plus) قد يكون لديهم شخصًا يمكنه مساعدتك في قراءة هذا النص. كما يمكنك أيضًا أن تتلقاه مكتوبًا بلغتك. للحصول على مساعدة مجانية، برجاء الاتصال بخدمات أعضاء صتر هيلث بلاس (Sutter Health Plus Member Services) على هاتف 1-855-315-5800 (هاتف النص المرني 1-855-830-3500). (Arabic)

ԿԱՐԵՎՈՐ ՏԵՂԵԿԱՏՎՈՒԹՅՈՒՆ. Կարո՞ղ եք կարդալ սա: Եթե ոչ, Sutter Health Plus-ը կարող է տրամադրել մեկին, ով կօգնի Ձեզ կարդալ այն: Դուք կարող եք նաև ստանալ այն գրված Ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել Sutter Health Plus-ի Անդամների սպասարկման բաժին՝ 1-855-315-5800 (TTY 1-855-830-3500) հեռախոսահամարով: (Armenian)

សារៈសំខាន់៖ តើអ្នកអាចអានសេចក្តីនេះឬទេ? បើសិនមិនអាចទេ Sutter Health Plus អាចមាន នរណាម្នាក់ជួយអានវាជូនអ្នក ។ អ្នកក៏អាចនឹងឲ្យបានសេចក្តីនេះ សរសេរជាភាសារបស់អ្នកដែរ។ សំរាប់ជំនួយដោយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ ផ្នែកសេវាសមាជិក Sutter Health Plus តាមលេខ 1-855-315-5800 (TTY 1-855-830-3500)។ (Cambodian)

نکته مهم: آیا می توانید این مطالب را بخوانید و بفهمید؟ اگر نمی توانید، Sutter Health Plus می تواند از فردی کمک بگیرد تا آنرا برایتان بخواند. همچنین امکان ترجمه این مطالب به زبان فارسی وجود دارد. برای دریافت خدمات و کمک رایگان، لطفاً با دفتر خدمات اعضای Sutter Health Plus با شماره تلفن 1-855-315-5800 (TTY 1-855-830-3500) تماس بگیرید. (Farsi)

महत्वपूर्ण: क्या आप इसे पढ़ सकते/सकती हैं? यदि नहीं, तो सटर हेल्थ प्लस इसे पढ़ने में किसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा में भी लिखवाने में समर्थ हो सकते/सकती हैं। निःशुल्क सहायता के लिए, कृपया 1-855-315-5800 (TTY 1-855-830-3500) पर सटर हेल्थ प्लस मेंबर सर्विसेस को कॉल करें। (Hindi)

LUS TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Yog koj nyeem tsis tau, Sutter Health Plus muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, peb tuaj yeem muab sau ua hom lus koj nyeem tau rau koj tib si. Yog koj xav tau kev pab pub dawb, thov hu rau Sutter Health Plus Lub Chaw Pab Cuam Tswv Cuab ntawm tus xov tooj 1-855-315-5800 (TTY 1-855-830-3500). (Hmong)

重要なお知らせ：これを読むことができます？読めない場合は、Sutter Health Plus が読むのをお手伝いします。あなたの言語で表示できるかもしれません。無料のご相談は、Sutter Health Plus Member Services、電話：1-855-315-5800 (TTY 1-855-830-3500) まで。(Japanese)

중요: 귀하는 이것을 읽으실 수 있습니까? 만약 읽으실 수 없다면, Sutter Health Plus 에서 다른 사람에게 부탁하여 그것을 읽으실 수 있도록 도와드릴 수 있습니다. 또한 이것을 귀하의 사용 언어로 작성해 받으실 수도 있습니다. Sutter Health Plus 회원 서비스(1-855-315-5800 (TTY 1-855-830-3500))에 전화를 하시어 무상으로 도움을 받으십시오. (Korean)

ໝາຍເຫດ: ທ່ານອ່ານໄດ້ຈົດໝາຍສະບັບນີ້ບໍ່? ຖ້າອ່ານບໍ່ໄດ້, ທາງ Sutter Health Plus ມີ ພະນັກງານຊ່ວຍອ່ານໃຫ້ທ່ານ. ນອກຈາກນັ້ນ, ພວກເຮົາຍັງສາມາດຂຽນເປັນພາສາຂອງທ່ານໃຫ້ທ່ານອີກ ດ້ວຍ. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໂດຍບໍ່ເສຍຄ່າບໍລິການ, ກະລຸນາຕິດຕໍ່ ໜ່ວຍບໍລິການ ຂອງ Sutter Health Plus ທີ່ໝາຍເລກໂທລະສັບ 1-855-315-5800 (TTY 1-855-830-3500). (Laotian)

ਅਹਿਮ: ਕੀ ਤੁਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ, Sutter Health Plus (ਸੱਟਰ ਹੈਲਥ ਪਲਸ) ਕਿਸੇ ਤੋਂ ਇਹ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮੱਦਦ ਕਰਵਾ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮੱਦਦ ਲਈ ਕਿਰਪਾ ਕਰ ਕੇ Sutter Health Plus Member Services ਨੂੰ 1-855-315-5800 (TTY 1-855-830-3500) ਉੱਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ВАЖНО: Вы можете это прочитать? Если нет, Sutter Health Plus может предоставить Вам кого-то, кто сможет помочь Вам прочитать это. Вы также можете получить это в письменной форме на своем языке. Для бесплатной помощи позвоните в Службу поддержки членов Sutter Health Plus по телефону 1-855-315-5800 (TTY 1-855-830-3500). (Russian)

MAHALAGA: Nababasa mo ba ito? Kung hindi, maaari kang bigyan ng Sutter Health Plus ng taong babasa para sa iyo. Maaari mo ding hilingin na isulat ito sa iyong wika. Para sa walang-gastos na tulong, mangyaring tumawag sa Sutter Health Plus Member Services sa. 1-855-315-5800 (TTY 1-855-830-3500). (Tagalog)

สำคัญ: คุณอ่านออกหรือไม่ ถ้าอ่านไม่ออก Sutter Health Plus สามารถให้คนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถขอรับเนื้อหานี้เป็นภาษาของคุณได้อีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย กรุณาโทรหา Sutter Health Plus Member Services ที่ 1-855-315-5800 (TTY 1-855-830-3500) (Thai)

QUAN TRỌNG: Qu. vị có thể đọc thông tin này không? Nếu không, Sutter Health Plus có thể yêu cầu ai đó đọc giúp cho qu. vị. Qu. vị cũng có thể nhận được thông tin này dưới dạng văn bản bằng ngôn ngữ của qu. vị. Để được hỗ trợ miễn phí, vui lòng gọi cho ban Dịch Vụ Thành Viên của Sutter Health Plus theo số 1-855-315-5800 (TTY 1-855-830-3500). (Vietnamese)

CONTACT INFORMATION

SHP Contact Information

As a valued health plan Member, we are here for you—whether you are dealing with a health care issue, have questions about your benefits, need a new Primary Care Physician (PCP) or need to replace your membership cards. For important updates and to access our Member portal, please visit sutterhealthplus.org.

SHP Member Services: 1-855-315-5800
(TTY 1-855-830-3500), Monday through Friday,
8 a.m. to 7 p.m.*

Nurse Advice Line (24/7): 1-855-836-3500 (direct), 1-855-315-5800 (through Member Services),
24-hours a day, seven days a week

*Please note all times listed throughout this EOC are Pacific Time.

Mailing address: 2480 Natomas Park Drive, Suite 150 Sacramento, CA 95833

Other SHP Contacts:

- Appeals and Grievances: 1-855-315-5800
- Fraud and Abuse: 1-855-315-5800
- Health and Wellness: 1-855-315-5800
- Language Assistance: 1-855-315-5800
- Member Services: 1-855-315-5800
- Website: sutterhealthplus.org

Contact Information for SHP Health Plan Partners

Mental Health, Behavioral Health and Substance Use Disorder Treatment Benefits (MH/SUD): US Behavioral Health Plan, California (USBHPC)

- USBHPC Member Services: 1-855-202-0984
- Website: liveandworkwell.com

Dental Benefits: Delta Dental, provided through their network DeltaCare® USA

- Delta Dental Member Services: 1-800-422-4234
- Website: deltadentalins.com
- Delta Dental provides dental services for Members whose employer Group has purchased optional dental benefits through DeltaCare USA, Delta Dental's network of dental providers

Pharmacy Benefits: Express Scripts®

- Express Scripts Customer Service: 1-877-787-8661
- Mail Order Pharmacy (Express Scripts PharmacySM): 1-877-787-8661
- Specialty Pharmacy (Accredo®): 1-877-787-8661
- Website: express-scripts.com
- Prior Authorization:
Verbal Requests: 1-800-753-2851
Fax Line: 1-877-251-5896

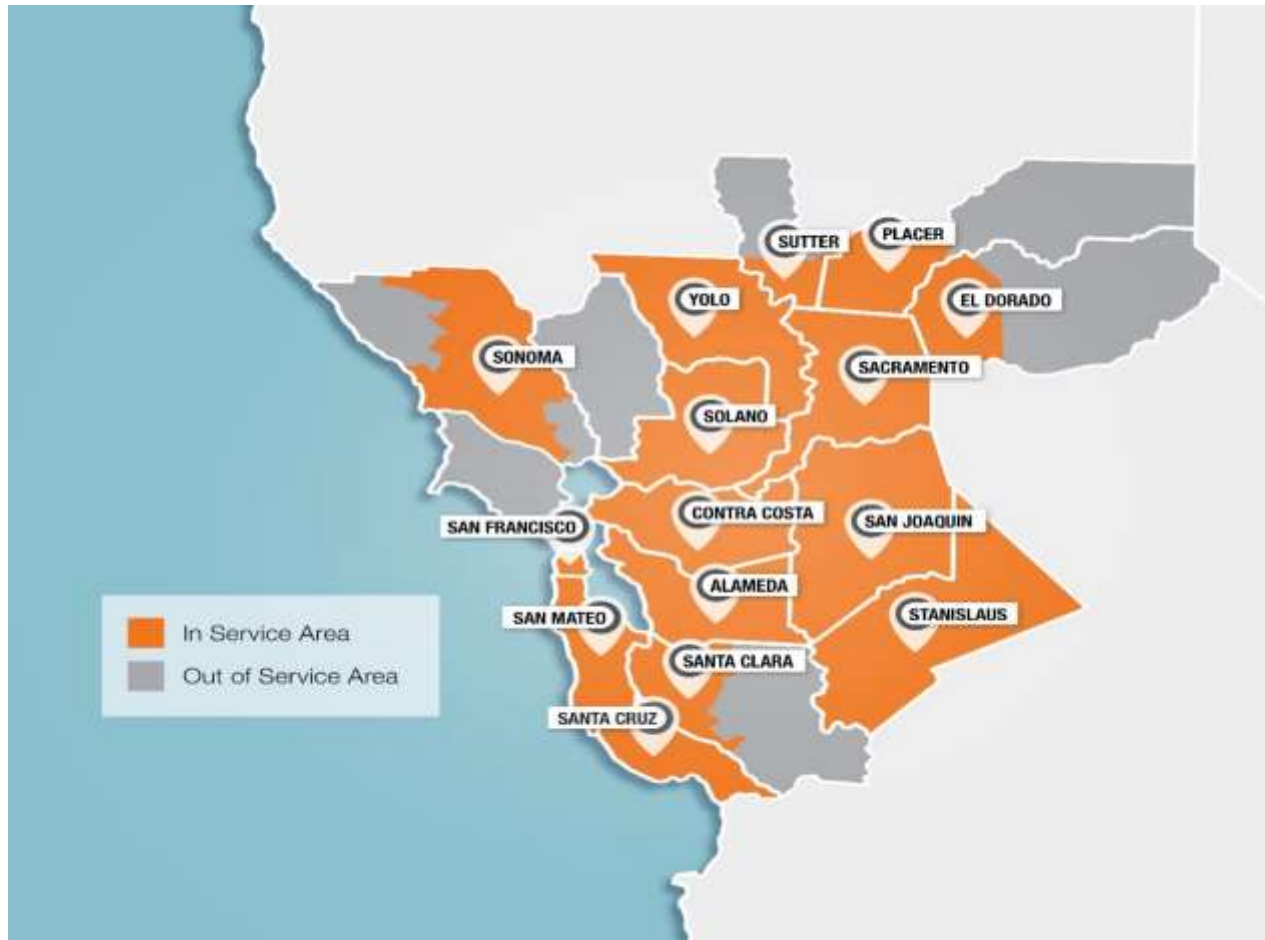
Vision Benefits: Vision Service Plan (VSP)**Vision Care**

- VSP Member Services: 1-800-877-7195
- Website: vsp.com
- VSP provides core refractive eye exams and vision services for Members whose employer Group has purchased optional vision benefits

Contact Information for the California Department of Managed Health Care (DMHC)

- DMHC: 1-888-466-2219
- Website: dmhc.ca.gov

SHP SERVICE AREA



Sutter Health Plus is licensed in the following ZIP codes:

- Alameda County: All ZIP codes
- Contra Costa County: All ZIP codes
- El Dorado County (partial): 95614, 95635, 95651, 95664, 95672, 95682, 95762
- Placer County (partial): 95602, 95603, 95648, 95650, 95658, 95661, 95663, 95677, 95678, 95681, 95703, 95713, 95722, 95746, 95747, 95765
- Sacramento County: All ZIP codes
- San Francisco County: All ZIP codes
- San Joaquin County: All ZIP codes
- San Mateo County: All ZIP codes
- Santa Clara County (partial): 94022, 94024, 94040, 94041, 94043, 94085, 94086, 94087, 94089, 94301, 94303, 94304, 94305, 94306, 95002, 95008, 95014, 95030, 95032, 95033, 95035, 95050, 95051, 95053, 95054, 95070, 95110, 95112, 95113, 95116, 95117, 95118, 95122, 95124, 95125, 95126, 95128, 95129, 95130, 95131, 95133, 95134, 95192
- Santa Cruz County: All ZIP codes
- Stanislaus County: All ZIP codes
- Solano County: All ZIP codes
- Sonoma County (partial): 94926, 94927, 94928, 94931, 94951, 94952, 94953, 94954, 94955, 94972, 94975, 94999, 95401, 95402, 95403, 95404, 95405, 95406, 95407, 95409, 95419, 95421, 95425, 95430, 95436, 95439, 95441, 95442, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471, 95472, 95473, 95486, 95492
- Sutter County (partial): 95645, 95668, 95659
- Yolo County: All ZIP codes

HOW TO USE THE PLAN

This chapter of the *Evidence of Coverage and Disclosure Form (EOC)* describes, in general terms, how to access and use Sutter Health Plus' (SHP's) Covered Services. For information regarding the specific Covered Services provided by the plan as well as a list of exclusions and limitations, please consult those specific chapters in this *EOC*.

Your Membership Card

After enrollment, SHP provides you with a new Member Welcome Book and your membership card, also called a Member identification (ID) card. The card includes important contact information and you should always present it when you seek medical care. If you do not present your ID card each time you receive services, your provider may fail to obtain Prior Authorization when needed and you may be responsible for the resulting costs.

If you need a new Member ID card, you may request a replacement from SHP Member Services or the SHP Member portal at shplus.org/memberportal, or print a temporary membership card from the SHP Member website at sutterhealthplus.org.

The SHP Service Area

SHP provides health care coverage in a specific Service Area as shown on the SHP Service Area Map chapter of this *EOC*. Subscribers must live, work or reside within the SHP Service Area to qualify for coverage. Some ZIP codes span more than one county. In that case, both the ZIP code and the county must be within SHP's licensed Service Area. With the exception of Emergency Services or Urgent Care, all Subscribers and Members must receive all Covered Services in SHP's Service Area. Subscribers must notify SHP if they no longer live, work or reside in our Service Area.

Your Primary Care Physician and Medical Group

When you join SHP, you must choose a Primary Care Physician, or PCP, or SHP will assign one to you. If you want to change your PCP, you may do so at any time through the SHP Member Portal at shplus.org/memberportal or by calling SHP Member Services. When choosing your PCP, you should select one close enough to your home or workplace to allow reasonable access to care.

Your PCP provides most of your health care and coordinates the care you need from other providers. You should receive most of your care from your PCP or other Participating Providers as referred by your PCP. For services that do not require a referral by your PCP, please refer to the Seeing a Doctor or Other Providers chapter.

Your PCP and most of the Specialists you see are usually in the same Medical Group. A Medical Group is a group of doctors and other providers who have a business together. When you choose your PCP, you are also selecting that PCP's Medical Group. In most instances, your PCP will refer you for any specialty care to a Specialist within that Medical Group.

The SHP Network

The SHP network is all the doctors, hospitals, labs and other providers that SHP contracts with to provide Covered Services.

You must receive medical care from your PCP and other providers in your PCP's Medical Group. To find a Participating Provider, please visit sutterhealthplus.org/providersearch. If you see a non-Participating Provider or an SHP Participating Provider that is outside of your PCP's Medical Group, you will be responsible for all costs, unless you received Prior Authorization from your Medical Group or SHP, or you required Emergency Services or Urgent Care. If you are a new Member or your provider's contract ends, in some cases you may continue to see your current health care provider. This process is detailed in the Continuity of Care section.

Understanding SHP's Relationship with Participating Providers

SHP contracts with a comprehensive panel of Participating Providers, such as PCPs, Specialists, hospitals, outpatient centers and other health care service providers. The basic method of provider reimbursement used by SHP is "capitation," a per month payment by SHP to its contracted providers. There are no bonus schedules or financial incentives in place between SHP and its Participating Providers which will restrict or limit the amount of care that is provided under the benefits of the Group Subscriber Contract. If you want to know more about provider compensation issues, you may request additional information from SHP, the provider or the provider's Medical Group or independent practice association.

In addition to SHP's medical network for your core medical benefits, SHP contracts with the following Health Plan Partners as Participating Providers for some specialty care benefits:

- US Behavioral Health Plan, California, or USBHPC, administers and coordinates benefits for mental health, behavioral health and substance use disorder (MH/SUD) treatment services; USBHPC maintains a network of facilities and professional health care service providers contracted to provide you with these services; SHP and USBHPC are committed to

assuring that the services provided by the USBHPC network are properly coordinated with the services provided by the SHP network

- Express Scripts is a pharmacy benefit company that provides you with access to Outpatient Prescription Drug benefits through contracts with pharmacies throughout the United States, including specialty and mail order pharmacy services for your convenience. Members may go to any Participating Pharmacy in the Express Scripts network
- Vision Service Plan, or VSP, provides vision benefits for Members whose employer Group has elected optional vision benefits
- Delta Dental provides dental services for Members whose employer Group has elected optional dental benefits through DeltaCare USA, Delta Dental's network of dental providers

Our contracts with Participating Providers include requirements that providers cannot hold you responsible for any financial obligations between SHP and the Participating Provider. USBHPC, Express Scripts, Delta Dental and VSP contracts with their networks of Participating Providers include similar requirements. However, you may have to pay the full costs related to services you receive from non-Participating Providers without Prior Authorization. Please carefully read the information regarding when and how to obtain prior authorization for Covered Services in the Authorization, Modification and Denial of Health Care Services section in the Seeing a Doctor and Other Providers chapter.

How to Get Health Care When You Need It

Call your PCP for Medical Services or USBHPC provider for mental health or substance use disorder services, unless you have an Emergency Medical Condition.

You need a referral from your PCP or your USBHPC provider and Prior Authorization from your Medical Group, SHP or USBHPC for many Covered Services. See the Authorization, Modification and Denial of Health Care Services section in the Seeing a Doctor and Other Providers chapter.

SHP covers care that is Medically Necessary as outlined in this *EOC*. If you disagree with an SHP or USBHPC decision about whether a service is Medically Necessary, you can request an Independent Medical Review (IMR). Refer to the IMR section in the If You Have a Concern or Dispute with SHP chapter.

SHP covers Emergency Services and Urgent Care provided anywhere in the world. In the case of an Emergency Medical Condition, dial 9-1-1 (when available) or go to the nearest hospital. If you are admitted to a hospital that is not in the SHP network, you must let SHP know within 24 hours, or as soon as you can. You may be transferred to a hospital in the SHP network, if it is safe to do so. SHP will collaborate with the hospitals and doctors handling your care and make appropriate and necessary payment provisions. If you need Urgent Care, please call your PCP, contact the SHP Nurse Advice Line or visit your Medical Group's contracted Urgent Care facility, or if you are out of area, visit the nearest Urgent Care facility. For more details about these services, including any limitations or exclusions, refer to the Emergency Services and Urgent Care chapter. For information regarding the specific SHP Covered Services provides, refer to the Your Benefits chapter and the Emergency Services and Urgent Care chapter.

Evaluation of New Technologies

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions, or are new applications of existing procedures, drugs or devices.

New technologies are considered investigational or experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered investigational or experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into SHP benefits.

SHP develops specific medical policy and technology assessments for areas of clinical practice that are new or emerging technology, or where there is significant controversy about effectiveness. In preparing medical policies, SHP's chief medical officer and registered nurses use multiple sources, including current medical literature, CMS guidelines, other nationally recognized guidelines and specialty society position papers, community standards of care, views of expert physicians practicing in relevant clinical areas, Hayes New Technology Assessment Guidelines, and Agency of Healthcare Research and Quality (AHRQ). SHP does not delegate technology assessment to its contracted providers.

This section does not apply to clinical trials as described in the Your Benefits chapter.

Timely Access to Care

SHP works with Participating Providers to help you access care. SHP and Participating Providers strive to follow timely access standards for appointments. Participating Providers may also review your medical information and for stable conditions, recommend an alternate visit availability standard for your condition.

Access Type	Standard
Access to non-urgent appointments with a Primary Care Physician (PCP) for regular and routine primary care services	Appointment is offered within 10 business days from time of the request
Access to Urgent Care services with a PCP that do not require prior authorization – includes appointment with a physician, nurse practitioner or physician's assistant in office	Appointment is offered within 48 hours from time of the request
Access to after-hours care with a PCP	Ability for Member to contact an on-call physician after hours; return call within 30 minutes for urgent issues PCP provides appropriate after-hours emergency instructions
Access to non-Urgent Care appointments with a Specialist	Appointment is offered within 15 business days from time of the request
Access to Urgent Care services that require prior authorization with a Specialist or other provider	Appointment is offered within 96 hours from time of the request
Non-urgent appointment with a mental health provider (who is not a physician)	Appointment is offered within 10 business days from time of request
Non-urgent appointments for ancillary services for the diagnosis or treatment of an injury, illness or other health condition	Appointment is offered within 15 business days from time of request

WHAT YOU PAY

This chapter discusses all costs associated with the plan, including Copayments, Coinsurance, Deductibles, Out-of-Pocket Maximums and Premiums. This chapter also discusses what you do if you have to pay for care at the time of service, if you have more than one health plan or if there is any third-party liability.

Your Copayment, Coinsurance, Deductible and Out-of-Pocket Maximum amounts are listed in your *Benefits and Coverage Matrix (BCM)*, which is incorporated by reference into this *Evidence of Coverage and Disclosure Form (EOC)*, and included as a separate attachment.

The term Benefit Year refers to the period of time stated in the Group Subscriber Contract, which might not start on January 1. This period of time describes the accrual period for your Cost Sharing. Calendar year Cost Sharing means that your Cost Sharing resets on January 1st of each year. Plan year accrual means that your Cost Sharing contributions reset at the same time that the Group Subscriber Contract renews.

Knowing whether your plan uses a plan year or calendar year accrual method is important and will help you track Deductibles and your Out-of-Pocket Maximum. Your Benefit Year effective date and plan accrual method are available through your employer Group, on your *Summary of Benefits and Coverage (SBC)* and on request through SHP Member Services.

In some cases, a non-participating provider may provide Covered Services at an SHP network facility where SHP or your PCP's Medical Group has authorized the services. You are not responsible for any amount beyond your Cost Sharing for the prior authorized Covered Services you received at the SHP network facility.

Copayment

A Copayment is the amount that you pay each time you see a Participating Provider or receive certain Covered Services. You will have a Copayment for most Covered Services due at the time of service. Copayments may vary depending on the Covered Service. For example, doctor visits, emergency room visits and hospital stays may have different Copayments.

Coinsurance

Coinsurance is the percentage of the cost of a Covered Service that you must pay.

Special notes regarding Copayments and

Coinsurance: If you receive services from more than one provider in a day, and separate Copayments or Coinsurance apply to the Covered Services of each provider, then you are required to pay all applicable Copayments and Coinsurance, even if the Covered Services are provided in the same location, such as your home or a medical clinic.

Additionally, if your visit is for Preventive Care Services and you also receive non-preventive services during the visit that were not scheduled and are not related to the preventive services, you are responsible for Cost Sharing for the non-preventive services.

Deductible

A Deductible is the annual amount you must pay to providers before SHP pays for any Covered Service. If your plan has a Deductible, each covered Member has an individual Deductible; Subscribers with enrolled Dependents also have a Family Deductible.

In a Family plan:

- An individual Member is responsible for an individual Deductible and individual Out-of-Pocket Maximum amount
- The Family unit is subject to a Family Deductible and Family Out-of-Pocket Maximum

In a Family High Deductible Health Plan (HDHP) linked to a Health Savings Account (HSA), the IRS sets minimum Deductible amounts annually. For 2019, the IRS requires Family Deductibles of at least \$2,700 to qualify as an HSA. So each individual Family Member is responsible for the greater of:

- The individual Deductible amount (indicated on the BCM as "self-only enrollment"); or
- \$2,700

Deductibles and other Cost Sharing payments made by each individual Family Member contribute toward meeting the Family Deductible and Family Out-of-Pocket Maximum.

Once the Family Deductible is satisfied by any combination of individual Member payments, Family Members continue to pay Copayments or Coinsurance until the Family Out-of-Pocket Maximum is reached. At that point, the plan pays all costs for Covered Services for all Family Members.

For example, suppose your benefit plan has a \$2,700 self-only Deductible and a \$4,000 Family

maximum Deductible. When you have paid \$2,700 toward health services for yourself, you have reached your individual maximum Deductible, and are only responsible for paying Copayments and Coinsurance. However, the Family maximum Deductible has not been met. So every other Member in your Family must continue to pay the cost for their health services until all of their expenses equal \$1,300 (the remainder of the \$4,000 Family maximum Deductible).

All amounts paid towards the annual Deductible will also apply to the annual Out-of-Pocket Maximum, as explained in the annual Out-of-Pocket Maximum section.

You should keep all receipts when you pay out-of-pocket Cost Sharing amounts that apply to your annual Deductible. If you believe that you have reached your annual Deductible, please call SHP Member Services. If you reached your Annual Deductible, you are only obligated to pay Copayments for Covered Services for the rest of the year. (The next section explains what to do when you reach your annual Out-of-Pocket Maximum.)

Annual Out-of-Pocket Maximum

The annual Out-of-Pocket Maximum is the total you pay each year for Covered Services. Individuals (self-only enrollment) and individual Family Members are responsible for an annual Out-of-Pocket Maximum. Refer to your *Benefits and Coverage Matrix* to find your individual and Family Out-of-Pocket Maximum limits.

If you are a Member in a Family of two or more Members, you reach the annual Out-of-Pocket Maximum when either:

- You meet your individual Member maximum
- Your Family reaches the Family maximum

For example, suppose your benefit plan has a \$4,000 individual Out-of-Pocket Maximum and an \$8,000 Family maximum. You have paid \$4,000 toward health services for yourself. You have reached your individual Out-of-Pocket Maximum. So you will not pay any more Cost Sharing during the rest of the Benefit Year for your individual Covered Services subject to the Out-of-Pocket Maximum. However, the Family maximum has not been met. So every other Member in your Family must continue to pay Cost Sharing for their health services during the Benefit Year until all of their expenses combined with your expenses equal \$8,000. Then your Family has reached the Family annual Out-of-Pocket Maximum and no individual will pay any more Cost Sharing for the rest of the

Benefit Year for Covered Services subject to the annual Out-of-Pocket Maximum.

For HDHPs linked to HSAs in a Family plan, each Family Member must meet an individual annual Out-of-Pocket Maximum equal to the self-only amount listed in the *Benefits and Coverage Matrix*, until the Family Out-of-Pocket Maximum as a whole is met.

You should keep all receipts when you pay a Cost Sharing amount that applies to your annual Out-of-Pocket Maximum.

For information about Covered Services subject to the annual Out-of-Pocket Maximum, refer to the *Benefits and Coverage Matrix*. When your receipts add up to your annual Out-of-Pocket Maximum, please call SHP Member Services to find out how to submit receipts. Once you submit your receipts, SHP will provide you with a document stating that you have met your annual Out-of-Pocket Maximum for the Benefit Year.

SHP complies with state and federal laws that establish Parity and cost-share coordination requirements for mental health, behavioral health and substance use disorder (MH/SUD) treatment services. ("Cost share coordination" means accounting for the Member's share of cost paid for both MH/SUD and non-MH/SUD health services when calculating amounts paid towards Deductibles and Out-of-Pocket Maximums.) For questions about Copayments, Deductibles or Out-of-Pocket Maximum amounts for MH/SUD treatment services provided to you, please call USBHPC Member Services or SHP Member Services.

Premiums

A Premium is the dollar amount due to SHP each month for health care coverage. In most cases, your employer pays part of the Premium and you pay the rest, usually in the form of payroll deduction. Only Members for whom we have received the appropriate Premium are entitled to coverage under this EOC.

The Premium will usually remain the same throughout the Benefit Year and only change when your employer renews its Group Subscriber Contract. SHP will send your employer written notification of any Premium changes at least 60 days before the change takes effect. Please speak to your employer for questions about your Premium.

Your Premium may vary based on your age, geographic location, and whether you are obtaining coverage for yourself or your Family. Any prior claims by you (or your Dependents) will not affect

your Premium. Your employer will provide you with information on your Premium.

Optional Benefits

Your employer Group may have elected optional benefits as part of your benefit plan. SHP offers optional benefit coverage for comprehensive vision, comprehensive dental, infertility treatment, orthotics and special footwear services. There is no requirement for your employer to elect any optional benefit. Optional benefits do not reduce or replace your covered Essential Health Benefits (EHBs), and exclusions or limitations on your optional benefits do not apply to your covered benefits. The limitations and exclusions on your covered benefits are described in the chapters Your Benefits and Exclusions and Limitations.

Cost Sharing: If your plan includes any optional benefits, be aware that any Cost Sharing you pay for optional benefits does not count towards your Deductible or annual Out-of-Pocket Maximum.

Refer to the Your Benefits chapter in this *EOC* for a description of these benefits. If your employer Group has elected optional benefits, you may request the corresponding benefit document describing the optional benefit and your Cost Share. This may include the separate documents for SHP Optional Vision Benefit rider or the Delta Dental *EOC* for Optional Dental Benefit. If you have questions regarding your optional benefits or related Cost Share amounts, please contact SHP Member Services.

If You Have to Pay for Care at the Time You Receive It (Reimbursement Provisions)

There may be times when you have to pay for your care at the time you receive it. If you are asked to pay out-of-pocket for a Covered Service, such as for seeking care at a non-Participating Provider for Emergency Services or Urgent Care, please ask the provider to bill SHP (or USBHPC, if applicable). If that is not possible and you pay out-of-pocket, you may request reimbursement for the Covered Service. Refer to the Payment and Reimbursement chapter for more information.

If You Have More Than One Health Plan (Coordination of Benefits)

Coordination of benefits (COB) is utilized when a Member is covered by more than one insurer or health care service plan. COB ensures that duplicate payments are not made for the same Covered Services. All insurers and health care service plans must follow state and federal law and regulations

when determining the order of payment of claims while providing that the Member does not receive more than 100% coverage from all insurers combined. All of the benefits provided under this *EOC* are subject to COB, and you are required to cooperate and assist with SHP by informing all of your providers if you or your Dependents have any other coverage. You are also required to give SHP your Social Security number and/or Medicare identification number to facilitate the COB process.

If Someone Else is Responsible (Third-Party Responsibility)

In the event a Member suffers injury, illness or death due to the act or omission of a third party (including but not limited to vehicle accidents, slip and falls, dog bites, work injuries, surrogate pregnancies, etc.) and complications incident thereto, and SHP pays for the Covered Services, the Member must agree to the provisions below. In the event any Recovery is obtained by the Member or his or her Representative due to such injury, illness or death, the Member and his or her Representative must reimburse SHP for the value of Covered Services as set forth below. By executing an enrollment application or otherwise enrolling in SHP, each Member grants SHP, the Medical Group or its independent practice association, as appropriate, a lien on any such Recovery and agrees to protect the interests of SHP when there is any possibility that a Recovery may be received. If SHP pays for the Covered Services, the Member also specifically agrees as follows:

- Promptly following the initiation of any injury, illness or death claim, the Member or his or her Representative shall provide the following information to SHP's Recovery Agent in writing: the name and address of the third party; the name of any involved attorneys; a description of any potentially applicable insurance policies; the name and telephone number of any adjusters; the circumstances which caused the injury, illness or death; and copies of any pertinent reports or related documents
- Each Member or Representative shall execute and deliver to SHP or its Recovery Agent any and all lien authorizations, assignments, releases or other documents requested which may be needed to fully and completely protect the legal rights of SHP
- Immediately upon receiving any Recovery, the Member or Representative shall notify SHP's Recovery Agent and shall reimburse SHP for the value of the Covered Services and benefits provided, as set forth below. Any such Recovery

by or on behalf of the Member and/or Representative will be held in trust for the benefit of SHP and will not be used or disbursed for any other purpose without SHP's express prior written consent. If the Member and/or Representative receives any Recovery which does not specifically include an award for medical costs, SHP will nevertheless have a lien against such Recovery; and

- Any Recovery received by the Member or Representative shall first be applied to reimburse SHP for Covered Services provided and/or paid, regardless of whether the total amount of Recovery is less than the actual losses and damages incurred by the Member and/or Representative

Where used within this provision, SHP means the health plan, Participating Hospitals or Participating Physicians providing Covered Services and/or their designees.

Recovery means any compensation received from a judgment, decision, award, insurance payment or settlement in connection with a civil, criminal or administrative claim, complaint, lawsuit, arbitration, mediation, grievance or proceeding which arises from the act or omission of a third party, including uninsured and underinsured motorist claims.

Recovery Agent:
Sutter Health Plus Recovery Agent
P.O. Box 160285
Sacramento, CA 95816

SHP reserves the right to change the Recovery Agent upon written notification to employer Groups, Subscribers or Members via a Plan newsletter, direct letter, e-mail or any other written notification.

Representative means any person pursuing a Recovery due to the injury, illness or death of a Member, including but not limited to the Member's estate, representative, Family Member, appointee, heir or legal guardian.

The following section is not applicable to workers' compensation liens, may not apply to certain Employee Retirement Income Security Act (ERISA) plans, hospital liens, and Medicare plans and certain other plans, and may be modified by written agreement.*

The amount SHP is entitled to recover for capitated and/or non-capitated Covered Services pursuant to its reimbursement rights described in this EOC is determined in accordance with California Civil Code Section 3040. Normally, this amount will not exceed one-third of the Recovery if the Member or Representative engages and pays an attorney or

one-half of the Recovery if no attorney is engaged and paid. SHP's lien is subject to reduction if any final judgment includes a special finding by a judge, jury or arbitrator that the Member was partially at fault for the incident. In that case, the lien will be reduced commensurate with the Member's percentage of fault as determined by the final judgment. This reduction will be calculated using the total value of the lien, and prior to any other reductions.

** Reimbursement related to worker's compensation benefits, ERISA plans, hospital liens, Medicare and other programs not covered by Civil Code Section 3040 will be determined in accordance with the provisions of this EOC and applicable law.*

SEEING A DOCTOR AND OTHER PROVIDERS

SHP's network includes Medical Groups that have many doctors and other health care providers. Your Primary Care Physician (PCP) will partner with you on your health care and coordinate most of your care; this includes any necessary referrals to Specialists or other providers. This chapter will tell you about your choice of a PCP and other providers, as well as the process for referrals, Prior Authorization (or pre-approvals), second opinions and continuity of care.

Your Choice of Doctors and Providers—Your SHP Provider Directory

Please read the following information so you will know from what type of providers you must get your health care.

The SHP website and Provider Directory lists all physicians, hospitals, clinics, Skilled Nursing Facilities, and other facilities in the SHP network. You must receive all of your care from the providers in your PCP's Medical Group, which is a subset of the SHP network, unless you need Emergency Services or Urgent Care or you receive Prior Authorization from your Medical Group or SHP to visit an out-of-network provider or a SHP provider that is outside of your PCP's Medical Group. You can request a current copy of the Provider Directory by contacting Member Services at 1-855-315-5800 (TTY users call 1-855-850-3500), or you may view SHP's online Provider Directory at sutterhealthplus.org.

If SHP fails to pay a Participating Provider for Covered Services, you will not be liable for sums owed by SHP. However, if you use a non-Participating Provider or a SHP provider that is outside of your PCP's Medical Group to get services that are not prior authorized or for urgent or emergency care, the non-Participating Provider can bill you directly for the cost of the services provided and you are responsible for the full cost of the services you receive.

SHP has quality standards for assuring timely access to appointments as required by state law so you can get the care you need. For additional information regarding SHP's standards for appointment waiting times, contact SHP Member Services.

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, or clinic, or call Sutter Health Plus (SHP) Member Services at 1-855-315-5800 (TTY 1-855-830-3500) to ensure that you can obtain the health care services that you need.

Choosing a Primary Care Physician

When you join SHP, you need to choose a Primary Care Physician, or PCP. Your PCP provides your basic care and coordinates the care you need from other providers. A PCP can be:

- A **doctor of internal medicine**
- A **family practice doctor**
- A **general practitioner**
- A **pediatrician**
- An **obstetrician/gynecologist**, or **OB/GYN** – If the OB/GYN has elected to serve as a PCP

When you need care, call your PCP first—unless it is an emergency. When you need to see a Specialist or get tests, your PCP gives you a referral if required. Think of your doctor as your partner in your health care. When choosing a PCP, look for someone with whom you feel comfortable. You should select a PCP reasonably close to your home or place of work so you can access care quickly. You may also want to select one that speaks your language. Each Family Member may choose a different PCP. To request to change your PCP call SHP Member Services or visit shplus.org/memberportal.

Please refer to the How To Use The Plan chapter for more information on your choice of doctors and providers and choosing a Primary Care Physician.

Keeping Your Doctor, Hospital or Other Provider (Continuity of Care)

If you are new to SHP or if your provider's contract with SHP ends, you may have to find a new provider within SHP's network. However, in some cases, you may keep your current provider to complete a course of treatment or a previously scheduled procedure to ensure continuity of care. For example, you may be able to stay with your current provider for the following conditions / duration:

- Acute Condition (such as a broken bone): As long as the Acute Condition lasts
- Serious chronic condition (such as severe diabetes or heart disease): We may cover Services for serious chronic conditions until the earlier of:
 - 12 months from your effective date of coverage if you are a new Member
 - 12 months from the termination date of the terminated provider
 - The first day after a course of treatment is complete when it would be safe to transfer your care to a Participating Provider, as determined by SHP after consultation with the Member and Non-Participating Provider and consistent with good professional practice
- Pregnancy: During pregnancy and immediately after delivery (postpartum period)
- Terminal illness: for the duration of the terminal illness (which may exceed 12 months)
- Care of a Child under three years: Up to 12 months
- A previously scheduled surgery or other procedure (such as colonoscopy): 180 days

An Acute Condition is 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 has a limited duration. A serious chronic condition is an illness or other medical condition that is serious, if one of the following is true about the condition:

- It persists without full cure
- It worsens over an extended period of time
- It requires ongoing treatment to maintain remission or prevent deterioration

If you want to request continuity of care, your request must be submitted to SHP up to 30 days before or 60 days after your effective date of SHP coverage or within 60 days of the end of your provider's contract. You can call SHP Member Services to make the request, or use the Continuity of Care Request Form available on the Member portal at shplus.org/memberportal. Your provider must agree to keep you as a patient and agree to SHP's usual payment terms and conditions for Participating Providers. To keep your provider for mental health, behavioral health and substance use disorder (MH/SUD) treatment services, you must call

US Behavioral Health Plan, California (USBHPC) at 1-855-202-0984 to ask for continuity of care.

If you are new to SHP, you are not eligible for continuity of care with your provider if you had the opportunity to enroll in a health plan with an out-of-network option, or you had the option to continue with your previous health plan or provider but you voluntarily elected to change health plans to SHP. Additionally, SHP provides continuity of care for drugs for new members who have an active prescription of a drug that requires Prior Authorization. Refer to the discussion of Prescription Continuity of Care, located in the Outpatient Prescription Drugs, Supplies, Equipment and Supplements section of the Your Benefits chapter.

Referrals to Specialists

To see a Specialist or another provider, you usually need a referral from your PCP and Prior Authorization from either your Medical Group or SHP. If you do not get the required referral and Prior Authorization and you get the service or treatment, you may have to pay all of the cost.

Services That Do Not Require PCP Referral

You can get the following services without a PCP referral or Prior Authorization from SHP or your Medical Group. However, your provider may have to get Prior Authorization for certain additional Covered Services that may be identified during the visit:

- On-call physician services: Your PCP's on-call physician may provide care in place of your PCP
- Urgent Care: An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, you can go to any Urgent Care facility. SHP encourages you to call your PCP, SHP's nurse advice line or SHP's Member Services using the numbers listed on your SHP membership card. Your PCP or SHP can help direct you to the closest in-network Urgent Care facility to meet your needs.
- Emergency Care: If you are in an emergency situation, please call 9-1-1 or go to the nearest hospital emergency room, in or out of network. You must notify your PCP or SHP Member Services the next business day or as soon as possible (see the Definitions chapter for Emergency Care)
- Gynecology services: You may self-refer to a Participating Provider within your PCP's Medical Group to receive routine or annual gynecological services

- Obstetrical services: You may self-refer to a Participating Provider within your PCP's Medical Group to get obstetrical services
- Mental health, behavioral health or substance use disorder treatment services: You may self-refer to a USBHPC provider for office visits for MH/SUD (see the Mental Health, Behavioral Health and Substance Use Disorder Treatment Services section in the Your Benefits chapter)
- Reproductive or sexual health care services for the following:
 - The prevention or treatment of pregnancy, including birth control, emergency contraceptive services, pregnancy tests, prenatal care, abortion, and abortion-related procedures
 - The screening, prevention, testing, diagnosis, and treatment of sexually transmitted infections and sexually transmitted diseases
 - The diagnosis and treatment of sexual assault or rape, including the collection of medical evidence with regard to the alleged rape or sexual assault, or
 - The screening, prevention, testing, diagnosis, and treatment of the human immunodeficiency virus (HIV)
- Allergy testing and treatment
- Clinical trials
- Diagnostic tests (such as MRI, CT, ultrasound or angiography tests)
- Durable medical equipment
- Elective (non-emergency) inpatient admissions
- Family planning, counseling and services
- Home health care
- Home infusion
- Hospice care
- Infertility treatment if elected as an optional benefit by your employer Group
- New medical technology, drugs, treatment, procedures or equipment that is investigational or experimental
- Nutritional counseling
- Outpatient surgeries (does not include most minor office procedures performed by a PCP or Specialist during an office visit)
- Pharmacy drugs, including exemptions requiring approval for coverage
- Physical therapy, occupational therapy, speech therapy, skilled nursing and other outpatient habilitation or rehabilitation services
- Prosthetics and orthotics
- Referrals to a Specialist by another Specialist
- Second opinion consultations for care from a Specialist or other licensed health provider outside the Member's selected Medical Group

Standing Referrals

If you have a certain Life-threatening, degenerative or disabling condition or disease requiring specialized medical care over a prolonged period of time, including HIV/AIDS, your PCP may provide you with a standing referral. A standing referral will allow you to have multiple visits with a Specialist or specialty care center that has demonstrated expertise in treating a medical condition or disease involving a complicated treatment regimen that requires on-going monitoring. Those Specialists designated as having expertise in treating HIV/AIDS are listed as HIV Disease Specialists on SHP's website. Visit sutterhealthplus.org and click on the Find a Provider tab.

Prior Authorization

Your Medical Group may require that you get Prior Authorization from the Medical Group or SHP before many Medical Services are performed. These services include but are not limited to the following:

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

Contact SHP Member Services and/or your PCP for additional information regarding services that require Prior Authorization. Your PCP must contact SHP or your PCP's affiliated Medical Group to request Prior Authorization for a service or supply.

For the following MH/SUD treatment services, the USBHPC provider must get Prior Authorization from USBHPC:

- Elective (non-emergency) inpatient admissions
- Partial hospitalizations
- Behavioral health treatment for Pervasive Development Disorder (PDD) and autism
- Residential treatment services
- Transitional Residential Recovery Services

- Intensive outpatient program treatment
- Outpatient electro-convulsive treatment
- Psychological testing, except as part of Emergency Services

SHP, your Medical Group or USBHPC review Prior Authorization requests to determine Medical Necessity. They deny services that are not Medically Necessary. If you get any of the services on this list without Prior Authorization, you may have to pay all the costs for the services and supplies.

Authorization, Modification and Denial of Health Care Services

When a Member or a Participating Provider requests health care services, SHP, your Medical Group, Express Scripts and USBHPC use established utilization management (UM) criteria to approve, deny, delay or modify authorization of benefits based on Medical Necessity. The criteria used for evaluating requested health care services are based on empirical research and professionally recognized standards of practice, as follows:

- For medical health care services, SHP and its contracted Medical Groups use nationally professionally recognized sources, including MCG and InterQual Evidence-based Clinical Guidelines
- For behavioral health and substance use disorder treatment services, USBHPC uses level of care guidelines derived from generally accepted standards of behavioral health practice. These standards include guidelines and consensus statements produced by professional specialty societies, as well as guidance from governmental sources such as CMS' National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). The level of care guidelines are also derived from input provided by clinical personnel, providers, professional specialty societies, consumers, and regulators
- For outpatient prescription drugs, including exceptions to step therapy requirements, Express Scripts uses multiple, nationally recognized sources, including pharmacy compendia (Micromedix, Lexicomp) and Food and Drug Administration (FDA) recommendations

SHP provides at no cost to Members and Participating Providers, on request, the UM criteria used to deny, delay, or modify requested services in the Member's specific case. SHP also provides

specific UM criteria or guidelines for a particular diagnosis to the public, upon request.

If you would like a copy of SHP's description of the processes utilized for the authorization or denial of health care services, or the criteria or guidelines related to a particular condition, you may contact SHP Member Services. If you would like a copy of USBHPC's description of the processes utilized for the authorization or denial of MH/SUD treatment services, or the criteria or guidelines related to a particular condition, you may contact the USBHPC Member Services Department or visit the USBHPC Website at liveandworkwell.com.

Additional Information Related to Mental Health, Behavioral Health or Substance Use Disorder Treatment Services

If you or your Dependent(s) are receiving mental health or behavioral health services including Severe Mental Illness, Serious Emotional Disturbance of a Child, autism or pervasive developmental disorder (PDD) from a school district or a regional center, USBHPC will coordinate with the school district or regional center to provide case management of your treatment program. Upon USBHPC's request, you or your Dependent(s) may be required to provide a copy of the most recent Individual Education Plan (IEP) that you or your Dependent(s) received from the school district and/or the most recent Individual Program Plan (IPP) or Individual Family Service Plan (IFSP) from the regional center to coordinate these services.

Timeframe for Prior Authorization – Medical and MH/SUD Treatment Services

SHP and USBHPC and their Participating Providers make decisions to deny, delay, or modify requests for authorization of covered health care services, based on Medical Necessity, within the following timeframes as required by California law:

- Standard (non-urgent) requests – Decisions based on Medical Necessity will be made in a timely fashion appropriate for the nature of the Member's condition, not to exceed five business days from receipt of information reasonably necessary to make the decision

Decisions for non-urgent requests for administered drugs provided in an outpatient setting are made within 72 hours

- Urgent requests – If the Member's condition poses an imminent and serious threat to his/her health, including, but not limited to, severe pain, potential loss of life, limb, or other major bodily functions, or lack of timeliness would be detrimental in regaining maximum functions, the

decision will be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after receipt of the information reasonably necessary to make the determination

Decisions for urgent requests for drugs administered in the outpatient setting are made within 24 hours

If the decision cannot be made within these timeframes because (i) SHP or the Medical Group has not received all of the information reasonably necessary and requested, (ii) SHP or the Medical Group requires consultation by an expert reviewer, or (iii) SHP or the Medical Group has asked that an additional examination or test be performed upon the Member, provided the examination or test is reasonable and consistent with good medical practice, then SHP or the Medical Group will notify the Participating Provider and the Member, in writing, that a decision cannot be made within the required timeframe. The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision will be provided following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested, SHP or the Medical Group shall approve or deny the request for authorization within the timeframe specified previously.

SHP, the Medical Group, or USBHPC will notify requesting Participating Providers of decisions to deny or modify Prior Authorization of requested health care services within 24 hours of the decision. Members are notified of decisions, in writing, within two business days. The written decision will include the specific reason(s) for the decision, a description of the criteria and guidelines used, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity, and information about how to file an appeal of the decision with SHP.

If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an urgent request as defined previously, SHP, the Medical Group, or USBHPC will approve, modify or deny the request as soon as possible, taking into account the Member's health condition, and will notify the Member of the decision within 24 hours of the request, provided the Member made the request to SHP, the Medical Group or USBHPC, as applicable, at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request is not an urgent request as defined previously, SHP will treat the request as a

new request for a Covered Service and will follow the timeframe for non-urgent (standard) requests as explained previously. However, if your provider has requested that your care be continued, your care will not be discontinued until your treating provider has been notified of the decision and your provider agrees upon a care plan that is appropriate for your medical needs.

Timeframe for Prior Authorization – Outpatient Prescription Drugs

Express Scripts reaches a decision in response to submitted Prior Authorization requests and notifies the prescribing provider of the decision within 72 hours for all routine prescription authorization requests and within 24 hours for urgent requests. Members are notified within two business days of the decision.

Refer to the Outpatient Prescription Drugs, Supplies, Equipment and Supplements section in the Your Benefits chapter for more information regarding Prior Authorization of Outpatient Prescription Drugs.

Your Financial Responsibility

If Prior Authorization is not received when required, you may be responsible for paying all the Charges. Please direct your questions about Prior Authorization to your PCP.

Requests for Services

Standard Decision

Participating Providers make the decision about which services are right for you. If you have received a written denial of services from your Medical Group or from SHP and you want to request that SHP cover the requested services, you can file a grievance as described in the If You Have a Concern or Dispute with SHP chapter.

If you have not received a written denial of services, you may make a request for services orally or in writing to SHP. You will receive a written decision in a timely manner appropriate for your condition, and not to exceed five business days unless you are notified that additional information is needed. If additional information is needed, you will be notified as soon as possible and you will receive a written decision within five business days of SHP receiving the additional information reasonably necessary for the decision. If your request is denied in whole or in part, the written decision will fully explain why your request was denied and how you can file a grievance.

If you believe SHP should cover a Medically Necessary service that is not a covered benefit under this EOC, you may file a grievance as

described in the If You Have a Concern or Dispute with SHP chapter.

Expedited Decision

You or your physician may make an oral or written request that SHP expedite the decision about your request. SHP or your Medical Group will make a decision in a timely manner appropriate for your condition and not to exceed 72 hours. SHP will inform your provider orally of its decision within 24 hours of making the decision and will notify you in writing within two days if it finds, or your physician states that waiting five days for its standard decision:

- Could seriously jeopardize your life, health or ability to regain maximum function, or
- Would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting

You or your physician must request an expedited decision in one of the following ways and you must specifically state that you want an Expedited decision:

- Call toll-free 1-855-315-5800 (TTY 1-855-830-3500)
- Send your written request to:
Sutter Health Plus
Attn: Utilization Management – Expedited Review
P.O. Box 160305
Sacramento, CA 95816
- Fax your written request to 1-855-759-8752
- Deliver your request in person to SHP at:
2480 Natomas Park Drive, Suite 150
Sacramento, CA 95833

If SHP denies your request for an expedited decision, it will notify you and will respond to your request for coverage as described under Standard Decision. If SHP denies your request for coverage in whole or in part, its written decision will fully explain why it denied your request and how you can file a grievance.

Concurrent Review

If your request is for an extension of a previously authorized course of treatment that is going to expire, and your request is for an Expedited decision (as explained previously), SHP will inform you as soon as possible, taking into account your health condition, and at least within 24 hours of your request. If your request to extend the ongoing care is not a request for an Expedited decision, SHP will

treat your request as a new request for and will follow the timeframe for a Standard decision (as explained previously). However, if your treating provider has requested that your care be continued, your care will not be discontinued until your treating provider has been notified of the decision and your provider agrees upon a care plan that is appropriate for your medical needs.

Getting a Second Opinion for Medical Benefits

You may ask for a second opinion from another doctor about a condition that your doctor diagnoses or about a treatment that your doctor recommends. The following are some reasons you may want to ask for a second opinion:

- You have questions about a surgery or treatment your doctor recommends
- You have questions about a diagnosis for a serious chronic medical condition
- There is disagreement regarding your diagnosis or test results
- Your health is not improving with your current treatment plan
- Your doctor is unable to diagnose your problem

How to request a second opinion for medical benefits:

- Your Medical Group must approve Prior Authorization for a second opinion
- You may ask for a second opinion from another Participating Provider in your doctor's Medical Group. Your Medical Group may refer you to any Specialist in the SHP network outside of the Medical Group

If your request for a second opinion is approved, a qualified medical professional will provide you with a second opinion. This is a physician who is acting within his or her scope of practice and who possesses a clinical background related to the illness or condition associated with the request for a second medical opinion. You may either ask your Participating Provider to help you arrange for a second medical opinion, or you can make an appointment with another Participating Provider. If either SHP or the Medical Group determines that there is not a Participating Provider who is an appropriately qualified medical professional for your condition, the Medical Group or SHP will authorize a referral to a non-Participating Provider for the second opinion. You are responsible for applicable Copayments or Coinsurance for the second opinion.

Getting a Second Opinion for Mental Health, Behavioral Health or Substance Use Disorder Treatment Services

Either you or your USBHPC Participating Provider, may submit a request for a second opinion to USBHPC either in writing or verbally through the USBHPC Customer Service Department. Second opinions will be authorized for situations, including, but not limited to, when:

- You have questions about the reasonableness or necessity of recommended procedures
- You have questions about a diagnosis or plan for care for a condition that threatens loss of life, loss of limb, loss of bodily functions, or substantial impairment, including but not limited to a chronic condition
- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating Provider is unable to diagnose the condition and the Member requests an additional diagnosis
- The treatment plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment
- You attempted to follow the plan of care or consulted with the initial Provider concerning serious concerns about the diagnosis or plan of care

If there is no qualified Participating Provider within the network, then USBHPC will authorize a second opinion by an appropriately qualified behavioral health professional outside the Participating Provider network. In approving a second opinion either inside or outside of the Participating Provider network, USBHPC will take into account the ability of the Member to travel to the Provider.

You will be responsible for paying any Copayment, as set forth in your *Benefits and Coverage Matrix (BCM)*, to the USBHPC Provider who renders the second opinion. If you obtain a second opinion without preauthorization from your Participating Provider or USBHPC, you will be financially responsible for the cost of the opinion.

If you or your Dependent's request for a second opinion is denied, USBHPC will notify you in writing and provide the reason for the denial. You or your

Dependent may appeal the denial by following the procedures outlined in the section *If You Have a Concern or Dispute With SHP*.

To receive a copy of the USBHPC Second Opinion policy or to request a second opinion from USBHPC, you may call or write the USBHPC Customer Service Department at:

U.S. Behavioral Health Plan, California
P.O. Box 2839
San Francisco, California 94126
1-800-999-9585

EMERGENCY SERVICES AND URGENT CARE

Emergency Services

If you experience an Emergency Medical Condition, immediately dial 9-1-1 (where available) or go to the nearest hospital. Sutter Health Plus (SHP) does not require Prior Authorization for Emergency Services you receive from Participating Providers or non-Participating Providers anywhere in the world as long as the services would have been covered under the Your Benefits chapter (subject to the Exclusions and Limitations chapter) if you had received them from Participating Providers.

An Emergency Medical Condition is a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence could reasonably be expected to result in any of the following:

- Serious jeopardy to your health
- Serious impairment to your bodily functions
- Serious dysfunction of any bodily organ or part

An Emergency Medical Condition is also "active labor," which means a labor when there is inadequate time for safe transfer to a Participating Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn Child.

A Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the Member as being either of the following:

- An immediate danger to himself or herself or to others
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder

The care and treatment necessary to relieve or eliminate a psychiatric Emergency Medical Condition may include admission or transfer to a psychiatric unit within a hospital or to a psychiatric hospital if, in the opinion of the treating provider, the transfer would not result in a material deterioration of the patient's condition.

If you are admitted to a hospital that is not in the SHP network, please let SHP know within 24 hours, or as soon as reasonably possible. SHP will collaborate with the hospitals and doctors handling your care, make appropriate and necessary payment provisions, and possibly transfer you to a hospital in the SHP network, if it is safe to do so.

Please refer to the Provider Directory for the location of Participating Hospitals that provide Emergency Care.

Post-Stabilization Care After an Emergency

Post-Stabilization Care are the Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that your Emergency Medical Condition is Stabilized. SHP and US Behavioral Health Plan, California (USBHPC) provide coverage for Post-Stabilization Care provided by a Participating Provider or if you obtained authorization for a non-Participating Provider.

Once your Emergency Medical Condition is Stabilized, your treating health care provider may believe that you require additional Medically Necessary services before you can be safely discharged. If the hospital providing your Post-Stabilization Care is not part of SHP's or USBHPC's contracted network, the hospital will contact your assigned Medical Group or SHP or USBHPC, as applicable, to obtain timely authorization for Post-Stabilization services.

Requests for Authorization and Notification of Admission

It is important that you (or someone on your behalf) notifies SHP within 24 hours of receiving the care or as soon as is reasonably possible when you are admitted to non-Participating Hospitals or for Post-Stabilization Care authorization.

To request authorization to receive Post-Stabilization Care from a non-Participating Provider, you must call SHP for Medical Services, or USBHPC for MH/SUD treatment services, before you receive the care if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible).

Call SHP at 1-855-315-5800 (TTY 1-855-830-3500); or USBHPC at 1-855-202-0984, to:

- Request authorization for Post-Stabilization Care before you obtain the care from a non-Plan Provider if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible);
- As stated above, please make sure SHP is notified within 24 hours, or as soon as reasonably possible, if you are admitted to a hospital that is not in the SHP network. SHP will

collaborate with the hospitals and doctors handling your care, make appropriate and necessary payment provisions, and possibly transfer you to a hospital in the SHP network, if it is safe to do so.

Note that these telephone numbers are also on your Member identification (ID) card.

Authorization at Non-participating Facility

After SHP is notified, we will discuss your condition with the non-Participating Provider. If SHP decides that you require Post-Stabilization Care and that this care would be covered if you received it from a Participating Provider, SHP will authorize your care from the non-Participating Provider or arrange to have a Participating Provider (or other designated provider) provide the care. If SHP decides to have a Participating Hospital, Skilled Nursing Facility, or designated non-Participating Provider provide your care, we may authorize special transportation that is medically required to get you to the provider. This may include transportation that is otherwise not covered.

Be sure to ask the non-Participating Provider to tell you what care (including any transportation) SHP has authorized because we will not cover unauthorized Post-Stabilization Care or related transportation provided by non-Participating Providers.

Refusal of Transfer

If it is determined that you may be safely transferred to an SHP or USBHPC contracted hospital, and you refuse to consent to the transfer, the hospital providing your Post-Stabilization Care must provide you with written notice that you are financially responsible for all costs for Post-Stabilization Care. Also, if the hospital providing your Post-Stabilization Care is unable to determine your name and the contact information for SHP or USBHPC, as applicable, in order to request Prior Authorization for services once you are stable, the hospital providing you with Post-Stabilization Care may bill you for such services.

Follow Up Care After an Emergency

The Emergency Room should provide you with written instructions for follow up care when you leave the hospital. For most follow-up care after an emergency, you should go to your PCP. Coverage for the following Covered Services is described in other sections of this *Evidence of Coverage and Disclosure Form (EOC)*:

- Follow-up care and other Covered Services that are not Emergency Services or Post-

Stabilization Care described in this Emergency Services and Urgent Care chapter (refer to the Your Benefits chapter for coverage, subject to the Exclusions and Limitations chapter)

- Out-of-Area Urgent Care (refer to the Out-of-Area Urgent Care topic under the Urgent Care section in this chapter)

If you feel that you were improperly billed for services that you received from a non-Participating Provider, contact SHP at 1-855-315-5800, or contact USBHPC at 1-855-202-0984 for MH/SUD treatment services.

Urgent Care

Inside the Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call your PCP, SHP's nurse advice line or SHP Member Services using the numbers listed on your SHP membership card. Your PCP or SHP can help direct you to the closest in-network Urgent Care facility to meet your needs. Urgent Care is not intended to replace care coordinated by your PCP.

Out-of-Area Urgent Care

If you are temporarily outside of our Service Area and have an Urgent Care need due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), SHP covers Medically Necessary services to prevent serious deterioration of your (or your unborn Child's) health if they could not be delayed until you returned to SHP's Service Area.

You do not need Prior Authorization for Out-of-Area Urgent Care. SHP covers Out-of-Area Urgent Care you receive from non-Participating Providers as long as the services would have been covered under the Your Benefits chapter (subject to the Exclusions and Limitations chapter) if you had received them from Participating Providers.

Coverage for the following Covered Services is described in other sections of this *EOC*:

- Follow-up care and other Covered Services that are not Urgent Care or Out-of-Area Urgent Care described in this Urgent Care section – refer to the Your Benefits chapter for coverage, subject to the Exclusions and Limitations chapter

YOUR BENEFITS

Sutter Health Plus (SHP) covers services described in this chapter, subject to the terms and conditions described in this *EOC*.

Preventive Care Services

SHP covers a variety of Preventive Care Services that are subject to all coverage requirements described in other parts of this chapter and all provisions in the Exclusions and Limitations and the What You Pay chapters.

SHP covers Preventive Care Services required by the Patient Protection and Affordability Care Act (PPACA) in accordance with the following:

- Services that have a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF). Refer to the USPSTF website at uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations
- Immunizations for routine use in children, adolescents and adults as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Refer to the CDC website at cdc.gov/vaccines/schedules/index.html
- Preventive care and screenings provided for in the guidelines supported by the Health Resources Services Administration (www.hrsa.gov/womensguidelines)

The following are examples of Preventive Care Services that are currently included in SHP's Preventive Care Services list. **There is no Cost Sharing for Preventive Care Services.**

- Screening services, such as:
 - Obesity screening and counseling for adults and children age six and older
 - Alcohol and substance use disorder screenings
 - Depression screening for adults and adolescents ages 12 to 18
 - Annual preventive refractive eye exam
- Family planning counseling, methods and consultations, including:
 - Tubal ligation
 - Patient education and counseling
 - Follow up services related to covered drugs, devices, products and procedures including,

but not limited to, management of side effects, counseling for continued adherence and device insertion and removal

- All Food and Drug Administration (FDA)-approved contraceptive drugs, devices, and other products, including over-the-counter (OTC) as prescribed by a Participating Provider, with the following considerations:
 - Where the FDA has approved more than one Therapeutically Equivalent of a contraceptive drug, device, or product, SHP covers at least one version of each contraceptive drug, device or product with no Cost-Share to the Member. Member Cost Sharing applies for contraceptive drugs, devices or products offered on the formulary at Tiers 2, 3 and 4
 - If a covered Therapeutic Equivalent of a drug, device or product is not available or is considered medically inadvisable by your Participating Provider, SHP will cover the prescribed drug, device or product at no Cost-Share when prior authorized
 - SHP will cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives that are dispensed at one time for a Member by a provider, pharmacist or location licensed or authorized dispense drugs or supplies
- Smoking cessation interventions, including drugs and counseling
- Health education counseling and programs
- Medical exams, procedures and screenings, including:
 - Blood pressure screening in adults
 - Colorectal cancer screening
 - Well-child preventive care exams, including developmental screenings to diagnose and assess potential developmental delays
 - Comprehensive preventive medicine visits and counseling, including well-woman exams
 - Routine preventive retinal photography screenings
 - Hearing exams and screenings

- Preventive counseling, such as sexually transmitted disease (STD) prevention counseling
- Tuberculosis tests
- Maternity and newborn care, including but not limited to:
 - Scheduled prenatal care exams and first postpartum follow-up consultation and exam
 - Alpha-fetoprotein testing
 - Breast feeding supplies, support and counseling
 - Anemia screening
 - Prenatal diagnosis of genetic disorders of the fetus, including tests for specific genetic disorders for which genetic counseling is available
 - Gestational diabetes screening
 - Rh incompatibility screening
- Routine preventive imaging and laboratory services, including:
 - Abdominal aortic aneurysm screening
 - Bone density scans
 - Screening mammograms for women age 40 and older
 - Cervical cancer screenings
 - Cholesterol tests (lipid panel and profile) for adults at certain ages or at higher risk
 - Diabetes screening (fasting blood glucose tests) for adults in accordance with USPSTF guidelines
 - Fecal occult blood tests
 - HIV tests
 - Prostate-specific antigen tests
 - Certain STD tests
- Acupuncture services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain)
- Administered drugs, if administration or observation by a medical professional is required and they are administered to you in a Participating Provider's office, outpatient facility or during home visits
- Allergy testing and injections (including allergy serum)
- Blood, blood products and their administration
- Male sterilization procedures
- Outpatient procedures (other than surgery) if a licensed staff member monitors your vital signs as you regain sensation and/or awareness after receiving drugs to reduce sensation or to minimize discomfort
- Outpatient surgery if it is provided in an outpatient setting, an ambulatory surgery center or in a hospital operating room or a physician's office as long as a licensed staff member monitors your vital signs as you regain sensation and/or awareness after receiving drugs to reduce sensation or to minimize discomfort
- Physical, occupational, and speech therapy, including services provided in an organized, multidisciplinary habilitation or rehabilitation program
- Preventive Care Services (refer to the Preventive Care Services section)
- Primary and specialty care consultations, exams, and treatment (specific Covered Services are described in more detail below) Some types of outpatient consultations, exams, education, therapy, and treatment may be available as group appointments, for example, group visits for the ongoing management of certain chronic health conditions such as diabetes, high blood pressure, or coronary artery disease, chronic obstructive pulmonary disease (COPD), and group therapy sessions for the treatment or management of mental health, behavioral health or substance use disorders

Preventive Care Exclusions and Limitations

Family planning counseling and services do not include termination of pregnancy or male sterilization procedures, which are covered under the Outpatient Care section. Termination of pregnancy or male sterilization procedures may also occur in other settings. Applicable Cost Sharing will apply to the setting where the Member receives the Covered Services.

Outpatient Care

SHP covers the following Medically Necessary outpatient care:

SHP also covers termination of pregnancy.

Refer to the *Benefits and Coverage Matrix* for information regarding Copayments, Coinsurance, or Deductibles that may apply to these Covered Services.

Other types of outpatient care are discussed elsewhere in this chapter including:

- Bariatric surgery
- Dental and orthodontic services
- Dialysis care
- Durable medical equipment for home use
- Health education
- Hearing services
- Home health care
- Hospice care
- Mental health, behavioral health and substance use disorder treatment services
- Ostomy and urological supplies
- Outpatient imaging, laboratory and special procedures
- Outpatient prescription drugs, supplies, equipment and supplements
- Prosthetic and orthotic devices
- Reconstructive surgery
- Services associated with clinical trials

Acupuncture Services

As described in the Outpatient Care section in this chapter, SHP provides limited coverage of acupuncture services as an Essential Health Benefit (EHB). These services are typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain when Medically Necessary upon referral by an SHP Participating Provider and prior authorized by the Medical Group.

Administered Drugs

SHP covers administered drugs under your medical benefit when a medical professional must administer the drug, or observe the administration. These drugs are administered in a Participating Provider's office, outpatient facility or during home visits.

Administered drugs include:

- Total parenteral nutrition (TPN) (nutrition delivered through the vein)
- Injected or intravenous antibiotic therapy
- Injected or intravenous chemotherapy
- Injected or intravenous pain medication

- Intravenous hydration (substances given through the vein to maintain the patient's fluid and electrolyte balance, or to provide access to the vein)
- Radioactive materials used for therapeutic purposes

SHP covers the prescribed drug as well as professional services to order, prepare, compound, dispense, deliver, administer, or monitor covered drugs or other covered substances used in infusion therapy.

Allergy Testing, Evaluation and Management

SHP covers allergy testing, evaluation and management when provided by the Member's PCP or when provided by a participating Specialist within the SHP network upon referral by the Members' PCP. Allergy testing and treatment also require Prior Authorization by the PCP's Medical Group.

Cost Sharing for allergy injections and serum is included in the Cost Sharing for the office visit with the PCP or Specialist. Please refer to the BCM for Cost Sharing details.

Ambulance Services

Emergency

SHP covers the services of a licensed ambulance anywhere in the world without Prior Authorization (including transportation through the 9-1-1 emergency response system where available) in the following situations:

- There was a medical emergency and the Member required ambulance services
- The Member reasonably believed that the medical condition was an Emergency Medical Condition and reasonably believed that the condition required ambulance transport services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance services that are not ordered by a Participating Provider, you may pay the provider and file a claim for reimbursement unless the provider agrees to bill SHP. Refer to the Payment and Reimbursement chapter for information on how to file a claim for reimbursement.

Nonemergency

SHP covers non-emergency ambulance and psychiatric transport van services within the SHP Service Area if a Participating Provider determines that your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from Covered Services. These services must be arranged by the provider or facility and Prior Authorized.

Ambulance Services Exclusion

SHP does not cover transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van), even if it is your only way to travel to a Participating Provider.

Hospital Inpatient Care

SHP covers hospital care, also referred to as inpatient care. You must use a hospital in the SHP network, unless you have an Emergency Medical Condition or your doctor receives Prior Authorization from SHP or your Medical Group for an out-of-network hospital. The services must be Medically Necessary and generally provided in an acute care general hospital setting. Refer to the *Benefits and Coverage Matrix* for information regarding Copayments, Coinsurance or Deductible amounts that may apply to these Covered Services.

The following Hospital Inpatient Care services are provided:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Participating Providers, including consultation and treatment by Specialists
- Anesthesia
- Drugs dispensed in the hospital
- Radioactive materials used for diagnostic or therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory and special procedures (including MRI, CT, and PET scans)
- Blood, blood products, and their administration

- Obstetrical care and delivery (including cesarean section)
- Physical, occupational and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services, case management and discharge planning

Other types of inpatient care are discussed elsewhere in this chapter including:

- Bariatric surgery
- Dental and orthodontic services
- Dialysis care
- Hospice care
- MH/SUD treatment services
- Prosthetic and orthotic devices
- Reconstructive surgery
- Services associated with clinical trials
- Skilled nursing facility care
- Transplant services

Hospital Inpatient Care Limitations

- SHP only covers services rendered at freestanding birthing centers (not considered part of an SHP network hospital) that are within the SHP network when authorized by the PCP's Medical Group
- SHP only covers services rendered by midwives when the provider is within the SHP network and is supervised by a Participating SHP Physician

Bariatric Surgery

SHP covers hospital inpatient care related to bariatric surgical procedures (including room/board, imaging, laboratory, special procedures and services of Participating Providers) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You received a referral from your PCP to a surgeon who specializes in bariatric surgery; and
- Your bariatric surgeon and your Medical Group determined that bariatric surgery is Medically Necessary for your condition

Your bariatric benefit will include all preoperative education and evaluation programs your bariatric surgeon determines are Medically Necessary for you to complete prior to the bariatric procedure. For example, your treating bariatric surgeon or PCP may determine that you should complete a preoperative education and clinical evaluation program that is four months in duration, during the period of time immediately prior to surgery, depending on your specific clinical needs, and designed to set the stage for postoperative care, safety and efficacy. If your bariatric surgeon determines it is Medically Necessary or otherwise clinically appropriate for your condition, you may be required to adhere to a medically-supervised diet before surgery. There may be pre-operative weight loss requirements if your bariatric surgeon, PCP or anesthesiologist believes that weight loss is necessary for your health and safety to reduce your risks during surgery. Your bariatric surgeon may decide to not require you to complete particular pre-operative education or evaluation requirements if you have met comparable bariatric surgery preparation requirements within a clinically appropriate timeframe. Your bariatric surgeon may delay surgery if medical or behavioral issues are identified that need attention before surgery. Examples of issues that may delay the procedure include major depression requiring treatment, and coronary artery disease.

For Covered Services related to the bariatric surgical procedures that you receive, you will pay the Cost Sharing you would pay for the applicable category of Covered Services. For example, see Hospital Inpatient Care in your *Benefits and Coverage Matrix* for the Cost Sharing that applies for hospital inpatient care.

If you live 50 miles or more from the facility to which you are referred for a covered bariatric surgery, SHP will reimburse you for certain travel and lodging expenses if you receive prior written authorization from the Medical Group and send us adequate documentation including receipts. SHP will not, however, reimburse you for any travel or lodging expenses if you were offered a referral to a facility that is less than 50 miles from your home. SHP will reimburse authorized and documented travel and lodging expenses as follows:

- Transportation for you to and from the facility up to \$130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit)
- Transportation for one companion to and from the facility up to \$130 per round trip for a maximum of two trips (the surgery and one follow-up visit)

- One hotel room, double-occupancy, for you and one companion not to exceed \$100 per day for the pre-surgical visit and the follow-up visit, up to two days per trip
- Hotel accommodations for one companion not to exceed \$100 per day while you are a hospital inpatient during and immediately following your surgery, up to four days

To submit a request for reimbursement of travel expenses, refer to the Payment and Reimbursement chapter.

Bariatric Surgery Exclusion

Specific liquid dietary products that may be recommended or required by your surgeon or weight management provider are not a Covered Service provided by SHP.

Chiropractic Services

SHP does not cover chiropractic services.

Dental and Orthodontic Services

SHP provides the following limited coverage for dental and orthodontic services. The limited Covered Services provided by SHP are:

- For preparation of your jaw for radiation therapy of cancer in your head or neck, SHP covers dental evaluation, X-rays, fluoride treatment and extractions necessary, when provided by a Participating Provider or if the Medical Group authorizes a referral to a dentist (as described in the Referrals to Specialists and the Prior Authorization sections in the Seeing A Doctor and Other Providers chapter)
- General anesthesia for dental procedures at a Participating Provider and the services associated with the anesthesia if all of the following are true:
 - The Member is under age seven or developmentally disabled, or the Member's health is compromised
 - The Member's clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
 - The dental procedure would not ordinarily require general anesthesia
- Covered Services for cleft palate including dental extractions, dental procedures necessary to prepare the mouth for an extraction and orthodontic services, if they meet all of the following requirements:

- The services are an integral part of a reconstructive surgery for cleft palate that SHP covers under Reconstructive Surgery in this Your Benefits chapter
- A Participating Provider provides the services or the Medical Group or SHP authorizes a referral to a Non-Participating Provider who is a dentist or orthodontist
- Custom made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders) are covered if they are Medically Necessary and prior authorized
- Emergency Services to Stabilize an acute injury to sound natural teeth, jawbone and surrounding structures after an injury. Dental services beyond Emergency Services to Stabilize an acute injury are not covered

For Covered Services related to dental and orthodontic services that you receive, you will pay the Cost Sharing you would pay for the applicable category of Covered Services. For example, see Hospital Inpatient Care in your *Benefits and Coverage Matrix*, for the Cost Sharing that applies for hospital care.

Your employer Group may have elected an additional optional benefit for comprehensive dental services, provided through Delta Dental. If elected, the dental benefit is described in the Delta Dental EOC available on request from Delta Dental

The following Covered Services are described under these sections in this Your Benefits chapter:

- Outpatient imaging, laboratory, and special procedures (refer to the Outpatient Imaging, Laboratory, and Therapeutic Procedures section)
- Outpatient administered drugs (refer to the Outpatient Care section), except that SHP covers outpatient administered drugs under general anesthesia in this Dental and Orthodontic Services section
- Outpatient prescription drugs (refer to the Outpatient Prescription Drugs, Supplies, Equipment and Supplements section)

Dental and Orthodontic Services Exclusions

SHP does not cover any other services related to the dental procedure, such as the dentist's services. For a list of excluded services, please see the Exclusions and Limitations chapter in this EOC.

Dialysis Care

SHP covers acute and chronic dialysis services if all of the following requirements are met:

- The services are provided inside the Medical Group's network and the SHP Service Area
- The care is Medically Necessary and authorized by your Medical Group

After you receive appropriate training at a dialysis facility SHP designates, SHP also covers equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside the SHP Service Area when clinically appropriate as determined by the treating provider. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. Your Medical Group decides whether to rent or purchase the equipment and supplies, and selects the vendor.

SHP covers the following Covered Services related to dialysis:

- Inpatient dialysis care
- One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, exam, or treatment
- Hemodialysis treatment by a Participating Provider
- Home peritoneal or hemodialysis under the oversight of a Participating Provider
- Hemodialysis on an emergency basis out of area until such time as you are Clinically Stable for transfer into network
- All other outpatient consultations, examinations and treatment

The following Covered Services are described under these sections in this chapter:

- Durable medical equipment for home use (refer to the Durable Medical Equipment for Home Use section)
- Outpatient laboratory (refer to the Outpatient Imaging, Laboratory, and Therapeutic Procedures section)
- Outpatient prescription drugs (refer to the Outpatient Prescription Drugs, Supplies, Equipment and Supplements section)
- Outpatient administered drugs (refer to the Outpatient Care section)

Dialysis Care Exclusions

SHP does not cover:

- Comfort, convenience or luxury equipment, supplies and features; or non-medical items, such as generators or accessories to make home dialysis equipment portable for travel
- Routine (non-emergency) dialysis when provided during travel outside of the SHP Service Area

Durable Medical Equipment for Home Use

SHP covers the durable medical equipment (DME) specified in this Durable Medical Equipment for Home Use section for use in your home (or another location used as your home) when Medically Necessary and authorized by your PCP's Medical Group. DME for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered DME is provided, including repair or replacement of covered equipment, unless due to loss or misuse. SHP or your Medical Group decides whether to rent or purchase the equipment and selects the vendor. The covered DME includes, but is not limited to the following:

- Infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other drugs)
- Standard curved handle or quad cane and replacement supplies
- Standard or forearm crutches and replacement supplies
- Dry pressure pad for a mattress
- Nebulizers, inhaler spacers and related supplies
- Peak flow meters
- IV pole
- Tracheostomy tube and supplies
- Enteral pump and supplies
- Bone stimulator
- Cervical traction (over door)
- Phototherapy blankets for treatment of jaundice in newborns
- Electronic breast pumps (no charge to Member)
For manual breast pumps, see DME Limitations and Exclusions below and the Outpatient

Prescription Drugs, Supplies, Equipment and Supplements section

- Wheelchairs

DME Limitations and Exclusions

SHP does not cover manual breast pumps through its DME benefit. Manual breast pumps are covered through the pharmacy benefit at no charge. Please refer to the Outpatient Prescription Drugs, Supplies, Equipment and Supplements section.

SHP does not cover most DME for home use outside the SHP Service Area. However, if you live outside the SHP Service Area, SHP will cover DME (subject to the Cost Sharing and all other coverage requirements that apply to DME for home use inside the SHP Service Area) when prior authorized and Medically Necessary for your condition. The following Covered Services are described under these sections in this Your Benefits chapter:

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to the Dialysis Care section)
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to the Outpatient Prescription Medications, Supplies and Supplements section)
- DME related to the terminal illness for Members who are receiving covered hospice care (refer to the Hospice Care section)

SHP does not cover comfort, convenience, or luxury equipment or features.

Health Education

SHP covers a variety of health education counseling, programs, and materials that your personal Participating Provider provides during a visit covered under another part of this Your Benefits chapter. SHP also covers a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes, hypertension, heart failure and asthma).

You pay the following for these Covered Services:

- Covered health education programs, which may include programs provided online and counseling over the phone: no charge
- Individual counseling during an office visit related to smoking cessation: no charge

- Other covered individual counseling when the office visit is solely for health education: no charge
- Health education provided during an outpatient consultation or evaluation covered in another part of this Your Benefits chapter: no additional Cost Share beyond the Cost Share required in that other part of this Your Benefits chapter
- Covered health education materials: no charge

Health Education Limitations and Exclusions

SHP does not cover exercise programs or gym memberships. Your provider may also offer health and wellness programs, including fitness classes and weight management programs (such as Weight Watchers®, Jenny Craig®, or Nutrisystems®). These programs and related materials are not covered by SHP and you may be required to pay a fee to your provider or directly to the program.

Hearing Services

SHP covers the following:

- Routine hearing screenings that are Preventive Care Services
- Hearing exams to determine the need for hearing correction

The following Covered Services are described under these headings in this Your Benefits chapter:

- Covered Services related to the ear or hearing other than those described in this section, such as the Outpatient Care and Outpatient Prescription Drugs, Supplies, Equipment and Supplements sections
- Cochlear implants and osseointegrated hearing devices (refer to Prosthetic and Orthotic Devices section)

Hearing Services Exclusions

SHP does not cover hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid.

Home Health Care

Home health care services are Covered Services provided in your home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. SHP covers home health care if all of the following are true:

- You are substantially confined to your home (or a friend's or relative's home)
- Your condition requires the services of a nurse, physical therapist, occupational therapist, or

speech therapist or Behavioral Health services as described in the Mental Health, Behavioral Health and Substance Use Disorder Treatment Services section

- A Participating Provider determines that it is feasible to maintain effective supervision and control of your care in your home and that the services can be safely and effectively provided in your home
- The Covered Services are provided inside the SHP Service Area or at the Subscriber's residence address if outside the SHP Service Area

SHP covers only part-time or intermittent home health care, as follows:

- Up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health aide
- Up to three visits per day (counting all home health visits)
- Up to 100 visits per Benefit Year (counting all home health visits)

Note: If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than two hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four hours counts as a separate visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as two visits. Also, each person providing Covered Services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two hours it counts as two visits.

The following Covered Services are described under these sections in this chapter:

- Dialysis Care
- Durable Medical Equipment for Home Use
- Ostomy and Urological Supplies
- Outpatient Prescription Drugs, Supplies, Equipment and Supplements
- Prosthetic and Orthotic Devices

Home Health Care Limitations and Exclusions

SHP does not cover:

- Care that an unlicensed Family Member or other layperson could provide safely and effectively in

the home setting after receiving appropriate training (this exclusion does not apply to the provision of Behavioral Health and Substance Use Disorder Treatment services that state or federal law permits unlicensed persons to provide)

- Care in the home if the home is not a safe and effective treatment setting
- Home health aide services, unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide, or Behavioral Health home health treatment services that state or federal law permits unlicensed persons to provide
- Shift nursing or private duty nursing
- Home health outside the SHP Service Area or at a residence outside the Service Area that is not the Subscriber's residence address

Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the Member's Family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

SHP covers the hospice services listed below if all of the following requirements are met:

- A Participating Provider has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- A Participating Provider has referred you to hospice care, and both your Medical Group and hospice agency have approved hospice care
- The services are provided inside the SHP Service Area or at the Subscriber's address
- The services are provided by a licensed hospice agency that is a Participating Provider
- The services are necessary for the palliation and management of your terminal illness and related conditions

If all of the previous requirements are met, SHP covers the following hospice Covered Services,

which are available on a 24-hour basis if necessary for your hospice care:

- Participating Provider services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your Family, and instruction to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness as prescribed by the attending physician to comply with the overall plan of care developed by the hospice interdisciplinary team and as specified under the written plan of care developed by the attending physician and surgeon
- DME
- Incontinence supplies, including disposable incontinence underpads and adult incontinence garments
- Respite care when necessary to relieve your caregivers (Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time)
- Counseling and bereavement services
- Dietary counseling
- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms:
 - Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
 - Short-term inpatient care required at a level that cannot be provided at home

Infertility Treatment

SHP does not cover infertility treatment services unless your employer Group has elected an additional optional benefit for infertility treatment services.

If elected, please refer to the Infertility Services Benefit Rider, available by request to SHP Member Services.

Mental Health, Behavioral Health and Substance Use Disorder Treatment Services

SHP contracts with US Behavioral Health Plan, California (USBHPC) to administer mental health, behavioral health and substance use disorder treatment (MH/SUD) services defined in this section as Covered Services. If you need MH/SUD treatment services, or have questions about these benefits, call USBHPC's Member Services at 1-855-202-0984, visit USBHPC's website at liveandworkwell.com, or contact SHP Member Services.

MH/SUD services are those services provided or arranged by USBHPC for the Medically Necessary treatment of:

- Mental Disorders, including but not limited to treatment for the severe mental illness of an adult or Child and/or the serious emotional disturbance of a Child
- Alcohol and drug problems, also known as chemical dependency, substance use disorder or substance abuse

A Mental Disorder is a mental health condition identified as a "mental disorder" as identified in the *Diagnostic and Statistical Manual of Mental Disorders (DSM), Fourth Edition, Text Revision*.

All mental health conditions identified as a Mental Disorder in the *DSM* are covered under your Group Subscriber Contract. SHP does not cover services for conditions that the *DSM* identifies as something other than a Mental Disorder. For example, the *DSM* identifies relational problems as something other than a Mental Disorder so SHP does not cover services (such as couples counseling or Family counseling) for relational problems. You should carefully read the benefits and exclusions described below so you will understand your coverage.

A Mental Disorder includes, but is not limited to, the following conditions:

- Severe Mental Illness of a person of any age, such as schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders as identified in the most recent edition of the DSM, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa or bulimia nervosa
- A Serious Emotional Disturbance of a Child means a Child under age 18 who has one or more "mental disorders" as identified in the most recent edition of the DSM, other than a primary

substance use disorder or developmental disorder that results in behavior inappropriate to the Child's age according to expected developmental norms, if the Child also meets at least one of the following three criteria:

- As a result of the Mental Disorder: (1) 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 (2) either (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 without treatment
- The Child displays psychotic features or risk of suicide or violence due to a Mental Disorder
- The Child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

Mental Health and Behavioral Health Care Services for the Diagnosis and Treatment of Mental Disorders

- Mental/Behavioral Health Inpatient
 - Inpatient Mental/Behavioral Health services: inclusive of inpatient psychiatric hospitalization and services rendered by physicians and other professional providers who are licensed or certified health care professionals acting within the scope of their license or certification or otherwise authorized by California law, provided at a Hospital, an Inpatient Treatment Center, or Residential Treatment Center, are covered when Medically Necessary, pre-authorized by USBHPC, and provided at a Participating Facility, and will include, but are not limited to, intensive psychiatric treatment programs, short-term treatment in a crisis residential program, psychiatric observation for an acute psychiatric crisis. Also includes the provision of Behavioral Health Treatment for PDD and autism on an inpatient basis when Medically Necessary
 - Inpatient Prescription Drugs: Inpatient prescription drugs are covered only when prescribed by a USBHPC Participating Practitioner for treatment of a Mental Disorder while the Member is confined to a hospital or inpatient treatment center

Note: Coverage for prescription drugs that are needed for treatment of a Mental Disorder while an inpatient in a Residential Treatment Center or Day Treatment Center is provided through the Outpatient Prescription Drug benefit, and will be covered when prescribed by a Participating Practitioner for treatment of a Mental Disorder

- Mental/Behavioral Health Outpatient

- Mental Health Outpatient, Office Visits – Medically Necessary outpatient individual and group Mental Health evaluation services provided by a Participating Practitioner including, but not limited to, initial consultation, individual or group follow up visits and other office visits
- Mental Health Outpatient, Other Items and Services – Outpatient monitoring of drug therapy. Also includes, when Medically Necessary and preauthorized by USBHPC:
 - Psychological testing when necessary to evaluate a mental disorder
 - Short-term hospital-based intensive outpatient care (Partial Hospitalization);
 - Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program (Intensive Outpatient Program Treatment); and
 - Outpatient Electro-Convulsive Treatment

(Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.)

- Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) or Autism – When preauthorized by USBHPC, SHP covers 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 a Covered Person with PDD or autism, and that meet the criteria required by California law, (and which include Medically Necessary Behavioral Health Treatment provided under a treatment plan prescribed by a physician, surgeon or Qualified Autism Service Provider and administered by one of the following:
 - a Qualified Autism Service Provider

- a Qualified Autism Service Professional supervised by the Qualified Autism Service Provider

- a Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional

- Behavioral Health Treatment for PDD or autism must have a treatment plan that has measurable goals over a specific timeline that is developed and approved by the Participating Qualified Autism Service Provider for the specific Member being treated and is discontinued when the treatment goals and objectives are achieved or no longer appropriate. The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to USBHPC upon request.
- Outpatient Prescription Drugs – Outpatient prescription drugs are covered only when prescribed by a Participating Practitioner for treatment of a Mental Disorder
- Injectable Psychotropic Drugs – Injectable psychotropic drugs are covered if prescribed by a USBHPC Participating Practitioner for treatment of a Mental Disorder
- Psychological Testing – Medically Necessary psychological testing is covered when preauthorized by USBHPC and provided by a Participating Practitioner who has the appropriate training and experience to administer such tests

- Intensive Psychiatric Treatment Programs include but are not limited to:

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in a licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for Stabilization of an acute psychiatric crisis
- Psychiatric observation for an acute psychiatric crisis

Substance Use Disorder (SUD) Treatment Services

- SUD Inpatient
 - Inpatient Hospital/Facilities Services—Medically Necessary Substance Use Disorder Services, including Medical Detoxification, and inpatient prescription drugs when pre-authorized by USBHPC and are provided by a Participating Practitioner inclusive of physicians and other professional providers who are licensed or certified health care professionals acting within the scope of their license or certification, or otherwise authorized by California law, while the Member is confined in a Participating Inpatient Treatment Center or Participating Residential Treatment Center
 - Residential Treatment Centers – Medically Necessary Substance Use Disorder Services provided by a Participating Practitioner, provided to a Member during a confinement at a Residential Treatment Center are covered, if provided or prescribed by a Participating Practitioner and preauthorized by USBHPC. Medically Necessary prescription drugs prescribed to Members receiving treatment in a Residential Treatment Center have access to their drugs through the Outpatient Prescription Drug benefit, subject to Copays, Deductibles, limitations and exclusions
 - Transitional Residential Recovery Services - Medically Necessary Substance Use Disorder services provided to a Member during confinement at a Participating Residential Treatment Center, if provided or prescribed by a Participating Practitioner and preauthorized by USBHPC
- SUD Outpatient
 - SUD Outpatient, Office Visits - Medically Necessary Outpatient individual and group Substance Use Disorder evaluation and treatment services provided by a Participating Practitioner in an office setting, including but not limited to initial consultation, individual or group follow up visits, individual and group substance use disorder counseling, and medical treatment for withdrawal symptoms
 - Outpatient Treatments for Substance Use Disorder Services – Medically Necessary Substance Use Disorder Services when pre-authorized by USBHPC and provided at a

participating outpatient treatment center, by physicians and other professional providers who are licensed health care professionals acting within the scope of their license or otherwise authorized by California law, including but not limited to day treatment programs and intensive outpatient treatment programs.

- Outpatient Physician Care – Medically Necessary Substance Use Disorder Services provided by a Participating Practitioner and pre-authorized by USBHPC when required, e.g. Intensive Outpatient Program Treatment. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center
- Outpatient Prescription Drugs - Except for inpatient drugs, which are provided as part of a hospital admission, Medically Necessary prescription drug coverage is provided through the Outpatient Prescription Drug benefit

Exclusions from Mental Health, Behavioral Health and Substance Use Disorder Treatment Services:

- Any Inpatient confinement, treatment, service or supply not authorized by USBHPC (except in the event of an Emergency or Out of Area Urgent Care) and any Outpatient treatment, service or supply for Intensive Outpatient Program Treatment, Outpatient Electro-Convulsive Treatment and Psychological Testing, not authorized by USBHPC (except in the event of an Emergency or Out of Area Urgent Care)
- Speech therapy, physical therapy and occupational therapy services provided for Developmental Delays or Learning Disabilities are not covered. Developmental Delay is a delayed attainment of age appropriate milestones in the areas of speech-language, motor, cognitive, and/or social development. A learning disability is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age. This exclusion does not apply to Medically Necessary speech therapy, physical therapy and occupational therapy services when provided under, and authorized by, the Member's medical benefit plan in connection with Behavioral Health Treatment for individuals with PDD or autism
- Services, supplies and treatments that are not Medically Necessary

- Any services provided by non-licensed providers other than services provided to those diagnosed with PDD or autism that may be provided by a Qualified Autism Service Provider, Qualified Autism Service Professional or Qualified Autism Service Paraprofessional as defined in the Definitions chapter of this *EOC*
 - Pastoral or spiritual counseling
 - Dance, poetry, music or art therapy services except as part of a Behavioral Health Treatment Program
 - School counseling and support services, household management training, peer support services, tutor and mentor services, independent living services, supported work environments, job training and placement services, therapeutic foster care, Emergency aid to household items and expenses, and services to improve economic stability
 - Community Care Facilities that provide 24-hour non-medical residential care
 - Weight control programs and treatment for addictions to tobacco, nicotine or food. This exclusion does not apply to SHP coverage for these services as described under the following sections in this Your Benefits chapter: Bariatric Surgery section (Medically Necessary bariatric procedures for weight loss are covered); Health Education section (tobacco use counseling and intervention are covered); and Outpatient Prescription Drugs, Supplies, Equipment and Supplements section (Medically Necessary tobacco cessation prescription drugs are covered)
 - Counseling for adoption, custody, Family planning or pregnancy in the absence of a *DSM-IV-TR* or *DSM-V* diagnosis. This exclusion does not apply to SHP coverage for Family planning, prenatal and pregnancy care as described in the Preventive Care Services section and Outpatient Services section
 - Sexual therapy programs, including therapy for sexual addiction, the use of sexual surrogates, and sexual treatment for sexual offenders/perpetrators of sexual violence. This exclusion does not apply to Medically Necessary treatment for Gender Identity Disorder or other Covered Mental disorders
 - Personal or comfort items, and non-Medically Necessary private room and/or private duty nursing during inpatient hospitalization are not covered
 - With the exception of injectable psychotropic drugs as set forth previously, all nonprescription and prescription drugs, which are prescribed during the course of outpatient treatment, covered through SHP's pharmacy benefit, not through the MH/SUD benefit. Outpatient prescription drugs for Mental Health, Behavioral Health and Substance Use Disorder treatment services are covered as described in the Outpatient Prescription Drugs, Supplies, Equipment and Supplements section in this Your Benefits chapter. (Non-prescription and prescription drugs prescribed by a USBHPC Participating Practitioner while the Member is confined at an Inpatient Treatment Center and non-prescription and prescription drugs prescribed during the course of inpatient Emergency treatment whether provided by a Participating or non-Participating Practitioner, are covered under the inpatient benefit)
 - Neurological services and tests, including, but not limited to, EEGs, PET scans, MRI's, skull x-rays and lumbar punctures. This exclusion does not apply to SHP coverage for these services as described under the Outpatient Services section
 - Evaluation for professional training, employment investigations, fitness for duty evaluations, or career counseling
 - Educational services for Developmental Delays and Learning Disabilities – Educational services for Developmental Delays and Learning Disabilities are not health care services and are not covered. Educational skills for educational advancement to help students achieve passing marks and advance from grade to grade. The Plan does not cover tutoring, special education/instruction required to assist a Child to make academic progress: academic coaching, teaching Members how to read, educational testing or academic education during residential treatment. Teaching academic knowledge or skills for the purpose of increasing your current levels of knowledge or learning ability to levels that would be expected from a person of your age are not covered
- USBHPC refers to American Academy of Pediatrics *Policy Statement - Learning Disabilities, Dyslexia and Vision: A Subject Review* for a description of educational services. For example, USBHPC does not cover:
- Items and services to increase academic knowledge or skills
 - Special education (teaching to meet the educational needs of a person with mental

retardation, Learning Disability, or Developmental delay. (A Learning Disability is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age. A Developmental Delay is a delayed attainment of age-appropriate milestones in the areas of speech-language, motor, cognitive, and social development.) This exclusion does not apply to Covered Services when they are authorized, part of a Medically Necessary treatment plan, provided by or rendered under the direct supervision of a licensed or certified health care professional, and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law

- Teaching and support services to increase academic performance
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, or swimming, or teaching you how to play. Play therapy services are covered only when they are authorized, part of a Medically Necessary treatment plan, require the direct supervision of a licensed physical therapist or a Qualified Autism Service Provider, and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law. This exclusion does not apply or exclude Medically Necessary behavior health therapy services for treatment of PDD or autism
- Treatment of problems that are not Mental Disorders are not covered, except for diagnostic evaluation

The following Covered Services are described under these sections in this Your Benefits chapter:

- Outpatient self-administered drugs (refer to the Outpatient Prescription Drugs, Supplies, Equipment and Supplements section)
- Outpatient laboratory (refer to Outpatient Imaging, Laboratory, and Therapeutic Procedures section)

The scope of treatment services for mental health conditions that SHP covers varies depending on whether the condition is defined as a severe mental

illness (SMI), a serious emotional disturbance (SED) of a Child, or another type of mental or substance use disorder that is not an SMI or SED.

Notwithstanding many exclusions or limitations described in this EOC, all treatment services for an SMI or SED mental health condition will be covered when Medically Necessary.

Ostomy and Urological Supplies

SHP covers ostomy and urological supplies in the SHP Service Area when Medically Necessary. SHP or your Medical Group selects the vendor, and coverage is limited to the standard supply that adequately meets your medical needs, which may include:

- Ostomy supplies: Adhesives (liquid, brush, tube, disc or pad); adhesive remover; ostomy belt; hernia belts; catheter; skin wash/cleaner; bedside drainage bag and bottle; urinary leg bags; gauze pads; irrigation faceplate; irrigation sleeve; irrigation bag; irrigation cone/catheter; lubricant; urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; gloves; stoma caps; colostomy plug; ostomy inserts; urinary, drainable ostomy pouches; barriers; pouch closures; ostomy rings; ostomy face plates; skin barrier; skin sealant; and waterproof and non-waterproof tape
- Urological supplies: Adhesive catheter skin attachment; catheter insertion trays with and without catheter and bag; male and female external collecting devices; male external catheter with integral collection chamber; irrigation tubing sets; indwelling catheters; Foley catheters; intermittent catheters; cleaners; skin sealants; bedside and leg drainage bags; bedside bag drainage bottle; catheter leg straps and anchoring devices; irrigation tray; irrigation syringes; bulbs and pistons; lubricating gel; sterile individual packets; tubing and connectors; catheter clamp or plug; penile clamp; urethral clamp or compression device; waterproof and non-waterproof tape; and catheter anchoring device

Ostomy and Urological Supplies Exclusion

SHP does not cover comfort, convenience, or luxury equipment or features.

Outpatient Imaging, Laboratory and Therapeutic Procedures

SHP covers the following services when ordered by a Participating Provider and covered for preventive care or diagnostic or therapeutic purposes when Medically Necessary. For information on the Cost Sharing associated with outpatient imaging,

laboratory and therapeutic procedures, refer to the *Benefits and Coverage Matrix*.

- Electrocardiograms
- Therapeutic or diagnostic injections
- Therapeutic or diagnostic radiation services
 - Preventive mammograms
 - Preventive aortic aneurysm screenings
 - Bone density CT scans
 - Bone density DEXA scans
 - All other CT scans, and all MRIs and PET scans
 - All other imaging services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds
 - Nuclear medicine, diagnostic or screening tests
- Laboratory tests
 - Laboratory tests to monitor the effectiveness of dialysis
 - Fecal occult blood tests
 - Routine laboratory tests and screenings that are Preventive Care Services, such as preventive cervical cancer screenings, prostate specific antigen tests, cholesterol tests (lipid panel and profile), diabetes screening (fasting blood glucose tests), certain STD tests, and HIV tests
 - All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available) when:
 - Determined to be Medically Necessary
 - Test is not experimental/investigational
 - Results are used to modify treatment for the Member
- Therapeutic procedures
 - Radiation therapy
 - Ultraviolet light treatments

Outpatient Prescription Drugs, Supplies, Equipment and Supplements

SHP covers outpatient drugs, supplies, equipment and supplements specified in this Outpatient Prescription Drugs, Supplies, Equipment and Supplements section when prescribed as follows and obtained at a Participating Pharmacy, including its mail order service:

- Items prescribed by Participating Providers in accord with SHP's drug formulary guidelines (see the upcoming explanation under SHP Formulary), including Medically Necessary drugs that require a trial and failure of preferred drugs and drugs prescribed by a Participating Provider for "off-label" use (see explanation below under Prior Authorization Process for Prescription Drugs section)
- Items prescribed by the following non-Participating Providers:
 - Dentists if the drug is for medical treatment of a covered dental service
 - Non-Participating Providers if the Medical Group or SHP authorizes a written referral to the Non-Participating Provider and the drug, supply or supplement is Medically Necessary as part of that referral
 - Non-Participating Providers if the prescription was obtained as part of covered Emergency Services, authorized Post-Stabilization Care, or Out-of-Area Urgent Care described in the Emergency Services and Urgent Care chapter (If you must fill the prescription at a non-Participating Pharmacy because a Participating Pharmacy is not available, you may have to pay the costs and ask SHP to reimburse you as described in the section entitled If You Have to Pay for Care at the Time You Receive It, in the What You Pay chapter)
- Diabetes blood testing equipment, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Certain vaccinations (for more information on immunization for children, please refer to the Preventive Care Drugs and Supplies section and for information on travel vaccines, please refer to the Pharmacy Principal Exclusions and Limitations section)
- Prenatal vitamins for pregnant Members
- Oral and injectable medications for the treatment of infertility if elected as an optional benefit by your employer Group

The following Covered Services are not covered as Outpatient Prescription Drug benefits, but are covered as described under these sections in this chapter:

- Insulin pumps and their supplies (refer to the Durable Medical Equipment for Home Use section)

- DME used to administer drugs (refer to the Durable Medical Equipment for Home Use section)
- Outpatient drugs administered by a health care professional (refer to the Outpatient Care section)
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to the Hospital Inpatient Care and the Skilled Nursing Facility Care sections)

How to Obtain Covered Items

You must obtain covered outpatient prescription drugs, supplies, equipment and supplements at a Participating Pharmacy or through Express Scripts mail-order or Specialty Pharmacy service unless the item is obtained as part of the Covered Services described in the Emergency Services and Urgent Care chapter.

To find Participating Pharmacies in your area, you can:

- Visit the SHP Member portal at sutterhealthplus.org and click on the Pharmacy tab
- Go to the Express Scripts website at express-scripts.com and use the pharmacy locator tool, *Find a Pharmacy*
- Call Express Scripts Member Services at 1-877-787-8661

For information on the Cost Sharing associated with outpatient prescription drugs, supplies, equipment and supplements, refer to the *Benefits and Coverage Matrix*.

You may receive prescriptions six days early for every 30 day supply of a drug. If you attempt to receive a prescription drug sooner than allowed, it will not be covered by SHP.

Certain Intravenous Drugs, Supplies, Equipment and Supplements

SHP covers certain intravenous drugs, fluids, additives and nutrients that require specific types of parenteral-infusion and the supplies and equipment required for their administration. In most cases, these are provided by a physician in an office, outpatient or inpatient treatment setting and covered under the medical benefit; however, in some cases, an IV drug may be provided through the pharmacy benefit. **Note:** Self-injectable drugs, such as insulin, are not covered under this paragraph. Refer to the Outpatient Prescription Drugs, Supplies, Equipment and Supplements section.

Preventive Care Drugs and Supplies

SHP covers the following drugs and supplies under the outpatient pharmacy benefit, at zero Cost Share, when prescribed by a Participating Provider:

- Aspirin for Members of a certain age or with certain conditions
- Bowel preparation drugs for colonoscopy screening for Members of a certain age
- Breast cancer drugs raloxifene or tamoxifen for Members of a certain age and at increased risk for the first occurrence of breast cancer, after risk assessment and counseling
- Certain immunizations for routine use in children, adolescents and adults as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Refer to the CDC website at cdc.gov/vaccines/schedules/index.html
- FDA-approved contraceptive drugs and devices as described in the Preventive Care Services section of this chapter
- Folic acid for women considering pregnancy or who are pregnant
- Smoking cessation products, both prescription and OTC agents
- Selective statin therapy for certain ages and disease risk factors
- Iron supplementation for infants
- Manual breast pumps for postpartum lactation support
- Vitamins in conjunction with fluoride for children

The above list of Preventive Care Drugs and Supplies may change, but SHP's Preventive Care coverage will always adhere to preventive care recommendations from the US Preventive Services Task Force (USPSTF).

Member Cost Sharing applies for preventive drugs offered on the formulary at Tiers 2, 3 and 4 when a generic equivalent is available on the formulary at Tier 1. However, your Provider can submit a Prior Authorization request for drugs on Tiers 2, 3 and 4, and for non-formulary drugs for medical appropriateness when a generic or Tier 1 drug is not advisable. On approval, these drugs are provided at no cost share.

Diabetes Urine Testing Supplies and Insulin-Administration Devices

SHP covers ketone test strips for diabetes urine testing and the following insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear).

Specialty Prescription Drugs

Specialty Drugs are usually injectable, infused, oral or inhaled and require close supervision and therapy monitoring. Refer to Specialty Drugs in Definitions chapter. The SHP Specialty Pharmacy Program focuses on patient safety, with requirements designed to assure that you know how to take these drugs correctly, that you receive safe, effective Specialty Drugs, and timely and convenient access to the Specialty Drugs you need. Call Accredo (Express Scripts Specialty Pharmacy) at 1-877-787-8661 or visit their website at express-scripts.com. (**Note:** Specialty Drugs, regardless of tier, are not available through the mail order program at reduced mail order Cost Share discussed later in this section.)

About the SHP formulary

SHP uses a drug formulary to assure that Members have access to Medically Necessary and clinically appropriate prescription drugs. The formulary identifies the drugs available for certain conditions and organizes them into cost levels, also known as tiers.

To receive a copy of the SHP Formulary, call SHP Member Services or go online to the SHP website at www.sutterhealthplus.org. The complete formulary is also available at the Express Scripts website.

SHP uses a Four-Tier formulary:

- Tier 1 – Most Generic Drugs and low-cost preferred brand name drugs are covered at the lowest tier Cost Share level
- Tier 2 – Preferred brand name drugs, non-preferred Generic Drugs and drugs recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost are covered at the second lowest tier Cost Share level
- Tier 3 - Non-preferred brand name drugs or drugs that are recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost are covered at the third tier Cost Share level. These generally have a preferred and often less costly therapeutic alternative at a lower tier
- Tier 4 – Drugs that are biologics and drugs that the FDA or drug manufacturer requires to be distributed through a Specialty Pharmacy; drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars net of rebates for a one-month supply are covered at the 4th tier Cost Share level

Note: Specialty Drugs are not exclusive to Tier 4 and may be on Tiers 1, 2 or 3. All Specialty Drugs have the same fill requirements regardless of which tier they are on. Specialty Drugs are only available for a 30-day supply. There are situations when standard tier Cost Sharing does not apply; for example:

- Member Cost Sharing for oral anti-cancer drugs will not exceed \$200 per prescription per 30-day supply. (If your benefit plan is an HDHP HSA-compatible plan, this will not apply until after the deductible is met)
- Sexual dysfunction and hypoactive sexual disorder drugs – refer to the Pharmacy Principal Exclusions and Limitations discussion later in this section
- Brand drugs dispensed at the prescriber's or Member's request when a U.S. Food and Drug Administration (FDA)-approved generic equivalent is available and dispensing of the brand drug is not Medically Necessary. In these instances, Members are required to pay the difference between the Participating Pharmacy's contracted rate for the brand drug and the Allowed Prescription Drug Amount, plus the generic Copayment
- For brand name drugs that have an FDA-approved generic equivalent available, the Allowed Prescription Drug Amount is the Participating Pharmacy's contracted rate for the Generic Drug. For drugs that do not have an FDA-approved generic equivalent available, the Allowed Prescription Drug Amount is the Participating Pharmacy's contracted rate for the brand drug. The difference in cost for obtaining a brand over generic is not a covered expense, and does not accrue towards the Member's Deductible or Out-of-Pocket Maximum
- A brand drug, with an FDA-approved generic equivalent, may be deemed Medically Necessary and obtained at the default brand Member cost share, through an "exception" process. This process includes prescriber submission of a Prior Authorization form along with a completed FDA MedWatch Form, indicating trial and failure of the available

generic due to adverse event(s) or contraindication

- Upon request from a Member or prescriber, a pharmacist may, but is not required to, dispense a partial fill of a prescription for an oral, solid dosage form of a Schedule II controlled substance in accordance with Section 4052.10 of the California Business and Professions Code. The Cost Sharing for a partial fill of a prescription will be prorated

Tier Changes and Impact on Member Cost Share

Drugs on one tier may be moved to another tier. If you are taking a drug that is moved to a higher tier, you will receive a notice of tier change from Express Scripts.

Note, however, that when a generic version of a brand name drug becomes available, the generic is at a lower tier. If you choose to continue taking the brand name product instead of the generic, you are responsible for the increased cost share. This is equal to the cost difference between the brand name and Generic Drug, as well as the Generic Drug Copayment.

Generics: A generic is an FDA-approved drug that has met the rigorous standards established by the FDA with respect to identity, strength, quality, purity, and potency as the brand product. If you or your prescriber requests that the brand drug be dispensed, when an FDA-approved generic equivalent is available, you will be responsible to pay the generic Copayment plus the cost difference between the Participating Pharmacy's contracted rate for the brand drug and the Allowed Prescription Drug Amount. In this instance, the Allowed Prescription Drug Amount is the Participating Pharmacy's contracted rate for the Generic Drug.

Prior Authorization Process for Outpatient Prescription Drugs

A number of drugs on the SHP formulary require Prior Authorization. If your Provider prescribes a drug that requires Prior Authorization, he or she should proactively initiate the Prior Authorization request. However, if your pharmacy has not filled your prescription because it has not received Prior Authorization, then:

- You may ask the retail pharmacist to contact your prescribing Provider to submit the Prior Authorization request; or

- You may contact your prescribing Provider to request that he or she submit a Prior Authorization request; or
- You may call SHP or Express Scripts Member Services for assistance

Express Scripts, on behalf of SHP, will evaluate whether the requested drug is Medically Necessary for your condition.

If a drug prescribed for a current Member is moved to a higher tier during the contract year or made subject to Prior Authorization for Medical Necessity, it will continue to be covered for the Member at the current Copayment amount and without Prior Authorization for the remainder of the contract year. Prior Authorization and a higher Copayment may be required the following year.

Note: A drug's listing on the SHP formulary does not guarantee that your physician will prescribe the drug. There are a number of drugs that may require Prior Authorization to ensure appropriate use based on criteria set by the SHP Pharmacy and Therapeutics Committee. Examples include:

- **Off-Label Use:** Prior Authorization is required for a non-FDA-approved indication (off label use) of a drug listed on the SHP Formulary. "Off label" use means that a drug has been approved by the FDA but is being prescribed for a use that is different than the indication for which the FDA has approved the drug and a Participating Provider has prescribed the drug for a life threatening condition or a chronic and seriously debilitating condition. To receive Prior Authorization for off-label use, the drug must be FDA-approved for some indication and recognized by the American Hospital Formulary Service Drug Information or one of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology, the National Comprehensive Cancer Network Drug and Biologics Compendium or The Thomson Micromedex DrugDex, or at least two articles from major peer-reviewed medical journals that present data supporting the proposed use as safe and effective, unless there is clear and convincing contradictory evidence in a similar journal
- **Step Therapy:** When a medical condition can be treated with a variety of drugs, SHP may use "step therapy" instead of requiring a Prior Authorization process. Step therapy is when a drug of equal effectiveness and quality or considered safer must be tried and have failed

before another drug is approved. The drugs work in the same way, but in some cases there is a very large difference in cost among the drugs. SHP's Step Therapy Program is reviewed periodically to assure it reflects pharmaceutical improvements and updates. Participating Providers and Members are required to try the more safe and/or cost-effective drugs before receiving coverage for (or "stepping up to") the less safe or more expensive drugs

SHP has a Prior Authorization process for approving exceptions to step therapy requirements when such exceptions are Medically Necessary and/or clinically appropriate. The SHP prescription drug formulary shows which drugs require step therapy, and the formulary is available online at [express-scripts.com](https://www.express-scripts.com) or you may request a copy by contacting SHP or Express Scripts Member Services. Requests for exceptions to the step therapy process are handled by SHP and Express Scripts in the same manner and timeframe as requests for Prior Authorization. Please refer to the following section regarding Prior Authorization Timelines for Prescription Drugs

- **Opiate Quantity Thresholds:** Certain classes, categories, doses or combinations of opiate drugs may require Prior Authorization when the quantity for the last 90 days is above a threshold considered unsafe in the professional clinical judgment of your pharmacist. If your pharmacy provider deems that an opiate quantity above the threshold is Medically Necessary for you, your provider may need to submit a Prior Authorization request to support the medical necessity for coverage

Prior Authorization Timelines

Drug Prior Authorization requests are processed and a decision is reached within a timeframe appropriate for the Member's condition, not to exceed 72 hours. An incomplete request may delay the authorization process or result in a decision of denial, if the provider is not available to supply the necessary clinical information. Express Scripts will notify you and your prescribing Provider of the determination within two business days of a decision.

For a Prior Authorization request after business hours, or on weekends and holidays in an urgent or emergency situation, the Participating Pharmacy may dispense an emergency short supply of the drug to patients requiring such drug until their provider can submit a Prior Authorization request.

- A Member can request up to a five-day emergency supply by calling Express Scripts Customer Service. If the emergency supply is authorized and determined to be Medically Necessary, the Member will be able to obtain the five-day supply at the applicable cost share
- Participating Providers, on behalf of Members, may also request emergency authorization by contacting SHP Member Services or, if after hours and weekend/holidays, by calling Express Scripts Customer Service
- For exigent circumstances, a physician may request an expedited review from Express Scripts for a drug Prior Authorization. Express Scripts makes the determination and notifies the prescribing physician of the decision no later than 24 hours after SHP or Express Scripts receives the request. For a non-formulary drug, if SHP or Express Scripts grants an exception based on exigent circumstances, the exception is for the duration of the exigency
 - Exigent circumstance are when one of the following are true:
 - A Member is suffering from a health condition that may seriously jeopardize his or her life, health, or ability to regain maximum function
 - A Member is undergoing a current course of treatment using a non-formulary drug

If Express Scripts denies a prior authorization request for an outpatient drug as not being on the Sutter Health Plus formulary (non-formulary), including a step therapy exception request relating to a non-formulary drug, and you disagree with Express Scripts' decision, you have the right to request an external exception review with SHP. SHP will submit your exception request to an independent medical organization for review. You, your provider, or someone you designate as your authorized representative may submit your external exception review request verbally or in writing. Please call SHP Member Services to learn how to name your authorized representative or to request a non-formulary external exception review.

If SHP or Express Scripts do not respond to a routine prior authorization request (or exception request to step therapy) within the required 72 hours or to an urgent request based on exigent circumstances within 24 hours, the request is deemed approved.

Prescription Continuity of Care

SHP provides continuity of care of drugs for new members who have an active prescription of a drug that requires prior authorization. The Member's Participating Physician must submit a drug prior authorization request that specifies "continuity of care". For a Member who has previous 30 day use of a drug, documented by the Provider or Pharmacy SHP covers up to a 90-day supply of the drug. **(Note:** quantity limits and other exclusions and limitations apply as described in the Pharmacy Principal Exclusions and Limitations discussion in this section.)

Additional refills or requests for supplies of the drug require additional review for medical necessity. The physician must submit a prior authorization request with relevant clinical information.

SHP Formulary Updates

The SHP Pharmacy and Therapeutics Committee evaluates drugs at least four times per year, to determine if any appropriate changes should be made to the SHP Formulary, to ensure rational and cost-effective use of pharmaceutical agents. Physicians may request that the Committee consider modifications to a guideline or other limitations or restrictions to any drug. The Committee reviews all drugs for the efficacy, quality, safety, similar alternatives, and cost of the drug in determining the placement in the tier, limitations and prior authorization review.

Mail Order and Retail Options for Maintenance Drugs

Covered prescription drugs that are to be taken beyond 60 days are considered Maintenance Drugs. Maintenance Drugs are used in the treatment of chronic conditions like arthritis, high blood pressure, heart conditions and diabetes. While not required, Members may obtain Maintenance Drugs by mail order through Express Scripts Pharmacy mail order/home delivery service. Getting your Maintenance Drugs through mail order may lower your overall Cost Share. Oral contraceptives and preventive care drugs are also available through the Express Scripts Pharmacy mail order service. (As stated earlier in this section, Specialty Drugs, regardless of tier, are not available through the mail order program at reduced mail order Cost Share.) Your Participating Physician can submit a prescription electronically to Express Scripts Pharmacy mail service pharmacy.

To set up mail order delivery, contact Express Scripts Pharmacy

Online: [express-scripts.com](https://www.express-scripts.com)

By phone: 1-877-787-8661

24 hours a day, 7 days a week, 365 days a year

By mail: Mail Pharmacy Service

P.O. BOX 66567

ST. LOUIS, MO 63166-6567

You can get an order form for the mail service delivery from Express Scripts or on the Sutter Health Plus website at sutterhealthplus.org.

When you order drugs by mail order, Express Scripts Pharmacy will tell you when your drugs will arrive, and what to do in the rare situation they do not arrive by the expected delivery date.

If you experience any delays in obtaining mail order drugs, please contact Express Scripts Customer Service at 1-877-787-8661 to arrange for expedited delivery through an alternative method.

In addition to the mail order option, Members may obtain up to a 90-day supply at network retail pharmacies that also participate in the Smart90 program offered through Express Scripts. Members obtaining a 90-day supply through this program will pay the equivalent Cost Sharing of three 30-day supplies provided through retail.

Vacation Overrides

Members are eligible for one vacation override per prescription within any twelve-month period. A vacation override allows the Member to pick up the prescribed drug early for up to a 90-day supply.

Pharmacy Principal Exclusions and Limitations

The covered outpatient prescription drugs previously described are subject to the exclusions and limitations described in this section:

1. Covered prescription drugs are limited to up to a 30-day supply from a retail Participating Pharmacy and for maintenance drugs up to a 90-day supply from a retail Participating Pharmacy that participates in the Express Scripts Smart90 program. Up to a 90-day supply is available through SHP's mail order program. Specialty Drugs are only available for up to a 30-day supply. SHP will cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives that are dispensed at one time for a Member by a provider, pharmacist or location licensed or authorized to dispense drugs or supplies
2. Effective January 1, 2020, prescription drugs that have an available over the counter (OTC)

equivalent formulation are excluded from coverage

3. Treatment of impotence and/or sexual dysfunction and/or hypoactive sexual desire disorder must be Medically Necessary and documentation of a confirmed diagnosis must be submitted to Express Scripts for review. Prescription drugs may be subject to quantity limitations. Please refer to the SHP Formulary
4. Drugs that are experimental or investigational are excluded, except for Life-threatening or seriously debilitating conditions and clinical trials as described in the Independent Medical Review Process/ Investigational and Experimental Treatment Denials section in the If You Have a Concern or Dispute with SHP chapter. (Investigational drugs may be covered if Medically Necessary and an application for approval is under review by the FDA. Medically Necessary drugs provided in an emergency in another country where the drug is allowed will be covered)
5. Immunizations required for foreign travel or occupational purposes are excluded, unless otherwise described in the Preventive Services subsection in the Your Benefits section
6. Prescription products and drugs prescribed solely for cosmetic purposes, including agents for wrinkles or hair growth and over-the-counter health/beauty aids are excluded
7. Drugs prescribed solely for weight loss, and/or dietary/nutritional aids that require a prescription are excluded, unless they are prior authorized for Medical Necessity to treat morbid obesity. SHP may require a Member prescribed such drugs to be enrolled in a comprehensive weight loss program, if covered by SHP, for a reasonable period of time prior to or concurrent with receiving the prescription drugs. This limitation does not apply to drugs or dietary/nutritional supplements prescribed for phenylketonuria (PKU), which are covered under the medical benefit in the Prosthetics and Orthotics section
8. Vitamins and mineral supplements, except those as noted in the previous Preventive Care Drugs and Supplies section
9. Replacement drugs for drugs that are lost or stolen are not covered
10. Repackaged drugs (such as those with unit dose packaging). Drug packaging other than the dispensing pharmacy's standard is excluded
11. Compounded products are excluded if there is a medically appropriate SHP formulary alternative or the compounded drug does not contain at least one prescription drug. Bulk chemicals not approved by the FDA used in compounded products are not covered. SHP shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with the manufacturing, compounding, dispensing or use of any covered prescription drug. Non FDA-approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered if compounded with an FDA-approved drug
12. Drugs prescribed to shorten the duration of the common cold, such as vitamin C, zinc or OTC cough and cold preparations, are excluded
13. Enhancement drugs prescribed solely for the treatment of hair loss, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance (this exclusion shall not apply to drugs for mental performance when used to treat diagnosed mental illness, or medical conditions affecting memory, including, but not limited to treatment of the conditions or symptoms of dementia or Alzheimer's disease)
14. Over-the-counter (OTC) drugs or those that do not require a prescription are excluded. (SHP will not, however, exclude an entire class of drugs when one drug within the class becomes available over the counter.) This exclusion does not apply to insulin and insulin syringes with needles for diabetics, pediatric asthma supplies, aspirin for Members of certain ages or conditions, or OTC drugs which are covered at no Member Cost Share under preventive care recommendations from the US Preventive Services Task Force (USPSTF), when accompanied by a written prescription
15. Drugs prescribed by non-Participating Providers when prescribed for non-covered procedures and not authorized by SHP or the Medical Group are excluded, except for Emergency Services
16. Medical food/nutritional and/or dietary supplements are excluded, except as provided elsewhere in this Your Benefits chapter, or as required by California law. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that may be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist. This exclusion does not apply to formulas, medical food or dietary

supplements prescribed for PKU, which are covered under the medical benefit in the Prosthetics and Orthotics section

17. Manual breast pumps dispensed through a Participating Pharmacy are covered under the prescription drug benefit. Electric breast pumps prescribed by a physician are provided under the DME benefit and must be prior authorized by your Medical Group and obtained as indicated by your Medical Group
18. Non FDA-approved drugs or products unless listed as a preventive drug or product

Note: Pharmacies that dispense covered outpatient prescription drugs to Members pursuant to an agreement with SHP or Express Scripts and this pharmacy benefit, do so as independent contractors. SHP shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by Members as a result of the acts or omissions of the pharmacy benefit manager or a Participating Pharmacy.

Outpatient Rehabilitation and Habilitation Services

SHP covers Medically Necessary rehabilitation and habilitation services upon prior authorization from your Medical Group.

Rehabilitation services are intended to help an individual recover from an illness or injury, or to restore previous functioning. These services include, but are not limited to:

- Physical therapy
- Occupational therapy
- Speech therapy
- Pulmonary rehabilitation
- Cardiac rehabilitation

Habilitation services are appropriate for individuals with many types of developmental, cognitive conditions that, without such services, would prevent them from acquiring certain skills and functions over the course of their lives, particularly in childhood.

Habilitation services are defined as health care services and devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for an individual to function and interact with his or her environment. This may include health care services that help a person to keep, learn, or improve skills and functioning for daily living.

SHP does not apply service limits for rehabilitation and habilitation services.

Exclusions from Rehabilitation and Habilitation Services

SHP does not cover nor consider certain services to be habilitative or rehabilitative, including but not limited to:

- Respite care
- Day care
- Recreational care
- Residential treatment
- Social services
- Custodial care
- Education services of any kind, including, but not limited to, vocational training

Prosthetic and Orthotic Devices

SHP covers the following devices if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from a Participating Provider or vendor
- Your Medical Group prior authorizes the device

Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and services to determine whether you need a prosthetic or orthotic device. If SHP covers a replacement device, then you pay the Cost Sharing that you would pay for obtaining that device.

Internally Implanted Devices

SHP covers prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and replacement joints, if they are implanted during a covered surgery.

External Devices

SHP covers the following external prosthetic and orthotic devices and related supplies when Medically Necessary and authorized by your PCP's Medical Group:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage

does not include electronic voice-producing machines, which are not prosthetic devices)

- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres required to hold a prosthesis every 12 months
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider
- Compression burn garments and lymphedema wraps and garments
- Enteral and parenteral nutrition: enteral formula and additives for adult and pediatric Members who require tube feeding (including for inherited diseases of metabolism) and formulas and special food products that are Medically Necessary for the treatment of phenylketonuria (PKU); related supplies are covered under Durable Medical Equipment described earlier in this chapter
- Prostheses to replace all or part of an external body part that has been removed or impaired as a result of disease, injury or congenital defect

Prosthetic and Orthotic Devices Limitations

SHP covers special contact lenses to treat aniridia (missing iris) or aphakia (absence of the crystalline lens of the eye) when Medically Necessary, subject to the following limitations:

- Aniridia: Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period, whether provided by the plan during the current or a previous 12-month contract period
- Aphakia: Up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per Benefit Year

Prosthetic and Orthotic Devices Exclusions

SHP does not cover:

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described previously in this Prosthetic and Orthotic Devices section
- Comfort, convenience or luxury equipment or features
- Shoes or arch supports, even if custom-made, except footwear described previously in this

Prosthetic and Orthotic Devices section for diabetes-related complications

Enhanced Special Footwear and Orthotic Coverage

SHP covers special footwear and orthotics as described in the SHP Special Footwear and Orthotics Benefit Rider if your employer Group has elected the enhanced special footwear and orthotic coverage. If elected, please refer to the Special Footwear and Orthotics Benefit Rider, available by request to SHP Member Services.

Reconstructive Surgery

SHP covers the following reconstructive surgery services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease, if a Participating Provider determines that it is necessary to improve function or to the extent possible, create a normal appearance
- Following Medically Necessary removal of all or part of a breast, reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

Reconstructive surgery services also include the following Covered Services as Medically Necessary and appropriate:

- Outpatient consultations, exams and treatment
- Outpatient surgery if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- Hospital inpatient care

The following Covered Services are described under these sections in this Your Benefits chapter:

- Dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate (refer to the Dental and Orthodontic Services section)
- Outpatient imaging and laboratory (refer to the Outpatient Imaging, Laboratory, and Therapeutic Procedures section)

- Outpatient prescription drugs (refer to the Outpatient Prescription Drugs, Supplies, Equipment and Supplements section)
- Outpatient administered drugs (refer to the Outpatient Care section)
- Prosthetics and orthotics (refer to the Prosthetic and Orthotic Devices section)

Reconstructive Surgery Exclusions

SHP does not cover surgery that, in the judgment of a Participating Provider specializing in reconstructive surgery, offers only a minimal improvement in appearance; or surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

Services Associated With Clinical Trials

SHP covers services associated with approved clinical trials if all of the following requirements are met:

- You are diagnosed with cancer or another Life-threatening disease or condition
- You are accepted into a phase I, II, III or IV clinical trial for cancer or another Life-threatening disease or condition
- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - The National Institutes of Health (NIH)
 - The U.S. Food and Drug Administration (FDA)
 - The Centers for Disease Control and Prevention
 - The Agency for Health Care Research and Quality
 - The Centers for Medicare & Medicaid Services
 - A cooperative group or center of any of the previously identified entities listed above or the Department of Defense or the Department of Veterans Affairs
 - A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants
 - The Department of Veteran Affairs, The Department of Defense or The Department of Energy, if the study or investigation has been reviewed or approved through a system of peer review that the U.S. Secretary of Health and Human Services

determines meets all of the following requirements: (1) it is comparable to the National Institute of Health system of peer review of studies and investigations and (2) it assured unbiased review of the highest scientific standard by qualified people who have no interest in the outcome

- The services would be covered under this EOC if they were not provided in connection with a clinical trial
- The clinical trial has a therapeutic intent and its end points are not defined exclusively to test toxicity
- The referring Participating Provider or a non-Participating Provider has received prior authorization from SHP or your Medical Group and has concluded that your participation in such trial would be appropriate based upon your meeting the conditions described previously
- You provide medical and scientific information establishing that your participation in such trial would be appropriate based upon your meeting the conditions described previously and it is authorized by SHP or your Medical Group

For Covered Services related to clinical trials, you will pay the Cost Sharing you would pay for the applicable category of Covered Services. For example, see Hospital Inpatient Care in the *Benefits and Coverage Matrix*, for the Cost Sharing that applies for hospital inpatient care.

Services Associated with Clinical Trials Exclusions

SHP does not cover:

- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- Travel, hospital and meals associated with participation in a clinical trial

SHP Nurse Advice Line and USBHPC Intake Line

SHP's Nurse Advice Line offers all Members round-the-clock access to registered nurses who help answer questions about medical problems, including caring for minor injuries and illnesses at home, seeking the most appropriate help based on the medical concern, identifying and addressing

emergency medical concerns and finding the appropriate access to care or SHP Participating Providers. You can access the Nurse Advice Line 24 hours a day, seven days a week by calling 1-855-836-3500 or SHP Member Services.

USBHPC maintains a toll-free Intake Services Line available 24 hours a day, seven days a week. You may call USBHPC's toll-free telephone line to speak with a behavioral health care professional to obtain a referral for MH/SUD treatment services; crisis intervention; and answers questions about your coverage.

Skilled Nursing Facility Care

SHP covers up to 100 days per benefit period of skilled inpatient services in a Skilled Nursing Facility (SNF). The skilled inpatient services must be customarily provided by a SNF, and above the level of custodial or intermediate care.

A benefit period begins on the date you are admitted to a hospital or SNF at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or SNF, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

SHP covers the following services:

- Physician and nursing services
- Room and board
- Drugs prescribed by a Participating Provider as part of your plan of care in the SNF in accord with SHP's drug formulary guidelines if they are administered to you in the SNF by a medical professional
- DME in accordance with SHP's DME policy
- Imaging and laboratory services that SNFs ordinarily provide
- Medical social services
- Blood, blood products and their administration
- Medical supplies
- Physical, occupational and speech therapy
- Behavioral health treatment for pervasive development disorder or autism
- Respiratory therapy

Transplant Services

SHP covers transplants of organs, tissue or bone marrow if the Medical Group provides a written

referral for care to a transplant facility as described under the Referrals to Specialists and the Prior Authorization sections in the Seeing a Doctor and Other Providers chapter. After the referral to a transplant facility, the following applies:

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, SHP will only cover services you receive before that determination is made
- SHP, Participating Hospitals, the Medical Group and Participating Providers are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue or bone marrow donor
- SHP provides certain donation-related services for a living donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These services must be directly related to a covered transplant for you, which shall include services for harvesting the organ, tissue, bone marrow or stem cell and for treatment of complications in accordance with the following guidelines:
 - The services are directly related to a covered transplant service for you or are required to evaluate a potential donor, harvest the organ, bone marrow or stem cells or treat complications
 - SHP provides or pays for donation-related services for actual or potential donors (whether or not they are Members)
 - Donor receives Covered Services no later than 90 days following the harvest or evaluation service
 - Donor receives services inside the United States, with the exception that geographic limitations do not apply to treatment of stem cell harvesting
 - Donor receives written authorization for evaluation and harvesting services
 - For services to treat complications, the donor either receives non-Emergency Services after written authorization, or receives Emergency Services SHP would have covered if the enrollee had received them
- In the event the enrollee's plan membership terminates after the donation or harvest, but before the expiration of the 90 day time limit for services to treat complications, the plan shall continue to pay for Medically Necessary

services for donor for 90 days following the harvest or evaluation service

For Covered Services related to transplant services, you will pay the Cost Sharing you would pay for the applicable category of Covered Services. For example, see Hospital Inpatient Care in the *Benefits and Coverage Matrix*, for the Cost Sharing that applies for hospital inpatient care.

Transplant Services Exclusions

SHP does not cover:

- Treatment of donor complications related to a stem cell registry donation
- HLA blood screening for stem cell donations, for anyone other than the enrollee's siblings, parents, or children
- Services related to post-harvest monitoring for the sole purpose of research or data collection
- Services to treat complications caused by the donor failing to come to a scheduled appointment or leaving a hospital before being discharged by the treating physician

Vision Services

Special Note: This section describes only your covered vision benefit provided through VSP. Coverage for medical and surgical treatment of the eyes is described elsewhere in "Your Benefits" including the sections on "Hospital Services" and "Outpatient Services."

SHP has contracted with Vision Services Plan (VSP) to provide the following:

- Annual preventive refractive eye exam and dilation; complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated; routine preventive annual refractive exams thereafter
- Limited discounts on non-covered services and materials when purchased from VSP Member Doctors.
 - Twenty percent (20%) off purchase of complete pair of glasses
 - Fifteen percent (15%) off of contact lens examination services (does not include contact lenses)
 - Discounts are applied to the VSP Member Doctor's usual and customary fees for such services and are unlimited for 12 months on or following the date of the patient's last eye exam

Preventive Vision Services Limitations and Exclusions

- When routine vision screenings are received from a non VSP provider, VSP will reimburse you up to a maximum of \$45. You will need to first pay the provider and then submit a request for reimbursement from VSP
- Materials Discounts
 - Discounts do not apply to non-VSP Providers
 - Discounts do not apply if prohibited by the manufacturer
 - Discounts do not apply to sundry items: e.g., contact lens solutions, cases, cleaning products or repairs of spectacle lenses or frames
- Contact lenses are excluded
- Eye exams for the purpose of obtaining or maintaining contact lenses are not covered benefits, and are available only as discounted non-covered services as described above
- Orthoptics or vision training and any associated supplemental testing are excluded
- Medical or surgical treatment of the eyes is not covered under this Preventive Vision Exam benefit provided through VSP. Medically Necessary medical or surgical treatment of the eyes may be Covered Services when provided to treat a Medical Emergency Condition, or by your PCP, or upon prior authorization and referral to an SHP network specialist physician). Please refer to "Emergency Care," "Outpatient Care" and "Inpatient Hospital Care" in the Your Benefits section
- Any vision care service other than the refractive exam is excluded. A separate charge will apply if you obtain an additional vision service (other than the covered refractive exam) during an appointment for the covered refractive exam. This exclusion does not apply to coverage for Medically Necessary care or treatment for a medical condition involving the eye. There will be no additional charge for an additional exam if requested by the VSP Member Doctor and approved by SHP

Please refer to the Prosthetics and Orthotics section of this EOC for a description of coverage for aniridia and aphakia.

How to Access Your Vision Benefit

To obtain your vision benefit, you must first call a vision services provider and schedule an appointment. Be sure to tell the provider you have VSP coverage under Sutter Health Plus. If you schedule an appointment with a VSP Member Doctor, that provider will confirm your eligibility and obtain any prior authorization necessary for services.

A directory of VSP Member Doctors is available at the VSP web site at www.VSP.com or by calling VSP Member Services at 1-800-877-7195.

If you have a problem with VSP or any VSP Member Doctor, please contact VSP Member Services at 1-800-877-7195 or on line at VSP.com to request assistance or to submit a complaint or grievance.

Your employer Group may have elected an additional optional benefit for comprehensive vision services, provided through VSP. If elected, the comprehensive vision benefit is described in the SHP Vision Benefit Rider available on request from SHP Member Services.

EXCLUSIONS AND LIMITATIONS

Exclusions and limitations are services and expenses that Sutter Health Plus (SHP) does NOT cover. The exclusions and limitations for each kind of benefit are also listed under the benefit in the Your Benefits chapter. See Outpatient Prescription Drugs, Supplies, Equipment and Supplements section in the Your Benefits chapter for exclusions and limitations regarding prescription drugs.

General Exclusions

The services listed below are excluded from coverage. These exclusions apply to all services that would otherwise be covered under this *Evidence of Coverage and Disclosure Form (EOC)*. Additional exclusions that apply only to a particular service are listed in its description in the Your Benefits chapter. When a service is excluded, all related services are also excluded, even if they would otherwise be covered under this EOC. The exception is for Medically Necessary treatment of complications resulting from non-Covered Services that exceed routine care provided for such non-Covered Services.

SHP does not cover (excludes) the following:

- 1) Any services or supplies obtained before the Member's effective date of coverage or after the Member's coverage has ended
- 2) Services, supplies and treatments which are not Medically Necessary
- 3) Non-emergent services and supplies rendered by non-Participating Providers unless prior authorized by the PCP's Medical Group or SHP
- 4) Any services or supplies provided by a person who lives in the Member's home, or by an immediate relative of the Member
- 5) Personal comfort or convenience items (e.g., television, radio), home or automobile modifications or improvements (e.g., chair lifts, purifiers)
- 6) Penile prostheses, unless prescribed by a Participating Physician or mental health provider and determined to be Medically Necessary treatment for a medical condition or mental health disorder (e.g., secondary to penile trauma, tumor, physical disease to the circulatory system or nerve supply or transgender migration)
- 7) Vitamins and mineral supplements, except those noted in the Preventive Care Drugs and Supplies subsection of the Outpatient Prescription Drugs, Supplies, Equipment and Supplements section in the Your Benefits chapter
- 8) Over-the-counter (OTC) drugs, supplies or equipment that may be obtained without a prescription, except for aspirin for Members of certain ages or conditions, and diabetes and pediatric asthma supplies as described in the Your Benefits chapter. This exclusion does not apply to Food and Drug Administration (FDA)-approved OTC contraceptive drugs and devices or OTC drug covered under preventive care recommendations from the US Preventive Services Task Force (USPSTF), when accompanied by a written prescription
- 9) Services related to the treatment of infertility, including all services related to artificial insemination and conception by artificial means, such as: Ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF) and zygote intrafallopian transfer (ZIFT). This exclusion does not apply if your employer Group elected optional infertility treatment services benefits
- 10) Home birth delivery
- 11) SHP does not cover routine physical exams when the purpose of the exam is to satisfy requirements for obtaining or maintaining insurance, licensing or employment, or for entering school, camp or athletic programs. A routine physical exam is:
 - Obtained for the purposes of checking a Member's general health in the absence of symptoms
 - Obtained at the Member's request (not requested by a Participating Provider)
 - Not Medically Necessary, and
 - Not part of a periodic preventive wellness exam or other preventive purpose
- 12) Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy services does not apply to therapy services that are part of a physical therapy treatment plan and covered under Hospital Inpatient Care, Outpatient Care, Home Health Care, Hospice Services, or Skilled Nursing Facility Care in this EOC. This exclusion or limitation does not apply to Medically Necessary services to treat severe mental illnesses or serious emotional disturbances of a child

- 13) Chiropractic services and the services of a chiropractor
- 14) Cosmetic services intended primarily to alter or reshape normal structures of the body in order to improve your appearance
- 15) Custodial care such as assistance with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medicine
- 16) Dental care, including:
 - a) Items or services in connection with the care, treatment, filling, removal, replacement, or artificial restoration of the teeth or structures directly supporting the teeth;
 - b) Treatment of dental abscesses;
 - c) Orthodontia (dental services to correct irregularities or malocclusion of the teeth), for any reason other than reconstructive treatment of cleft palate, including treatment to alleviate temporomandibular joint disease (TMJ);
 - d) Any procedure intended to prepare the mouth for dentures or for the more comfortable use of dentures;
 - e) Bridges, dental plates, dental prostheses and dental orthoses, including anesthetic agents or drugs used for the purpose of dental care

Note: if Subscriber Group has elected to purchase an optional, comprehensive dental benefit provided by Delta Dental, please see the Delta Dental EOC for additional information on dental benefits

- 17) Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies. This exclusion does not apply to disposable supplies covered under the sections entitled Durable Medical Equipment for Home Use, Home Health Care, Hospice Care, Ostomy and Urological Supplies, and Outpatient Prescription Drugs, Supplies, Equipment and Supplements in the Your Benefits chapter
- 18) Experimental and investigational services. A service is experimental or investigational if SHP, in consultation with the Medical Group, determines that one of the following is true:
 - a) Generally accepted medical standards do not recognize it as safe and effective for

treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)

- b) It requires government approval that has not been obtained when the service is to be provided
- c) This exclusion does not apply to any of the following:
 - i. Experimental or investigational services when an investigational application has been filed with the federal FDA and the manufacturer or other source makes the services available to you or SHP through an FDA-authorized procedure, except that SHP does not cover services that are customarily provided by research sponsors at no cost to enrollees in a clinical trial or other investigational treatment protocol
 - ii. Covered Services under the Services Associated with Clinical Trials section in the Your Benefits chapter

Refer to the If You Have a Concern or Dispute with SHP chapter for information about Independent Medical Review related to denied requests for experimental or investigational services.

- 19) Items and services for the promotion, prevention, or other treatment of hair loss or hair growth
- 20) Care in a licensed intermediate care facility. This exclusion does not apply to Covered Services covered under the Durable Medical Equipment for Home Use, Home Health Care, and Hospice Care sections in the Your Benefits chapter. This exclusion or limitation does not apply to Medically Necessary services to treat severe mental illnesses or serious emotional disturbances of a child
- 21) Items and services that are not health care items and services. For example, SHP does not cover:
 - a) Teaching and support services to develop planning skills, such as daily activity planning and project or task planning
 - b) Items and services that increase academic knowledge or skills
 - c) Teaching you how to read, (whether or not you or a Dependent has dyslexia)
 - d) Educational testing
 - e) Teaching skills for employment or vocational purposes

- f) The following are also excluded unless the services are authorized as part of a Medically Necessary treatment plan and provided by persons acting within the scope of their licensure or as authorized by California law, or provided as part of Medically Necessary services to treat severe mental illnesses or serious emotional disturbances of a child including Behavioral Health Treatment:
 - i. Teaching and support services to increase intelligence
 - ii. Teaching art, dance, horse riding, music or swimming
 - iii. Aquatic therapy and other water therapy
 - iv. Play therapy
- 22) Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia or astigmatism. This exclusion does not apply to covered services described under the section entitled Vision Services in the Your Benefits chapter or in the SHP Vision Benefit Rider if your employer Group has elected to purchase optional vision benefits
- 23) Massage therapy, except that this exclusion does not apply to massage therapy services that are part of an authorized physical therapy treatment plan and covered under the Hospital Inpatient Care, Outpatient Care, Home Health Care, Hospice Services, or Skilled Nursing Facility Care sections under the Your Benefits chapter. This exclusion or limitation does not apply to Medically Necessary services to treat severe mental illnesses or serious emotional disturbances of a child
- 24) Food supplements or infant formulas, except when Medically Necessary and covered in the Your Benefits chapter
- 25) Residential and long-term care in a facility where you stay overnight. This exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility (SNF), inpatient respite care covered in the Hospice Care section, a licensed facility providing crisis residential services covered under inpatient psychiatric hospitalization and intensive psychiatric treatment programs in the Mental Health, Behavioral Health and Substance Use Disorder Treatment Services sections, or a licensed facility providing Transitional Residential Recovery Services covered under

the Substance Use Disorder Treatment Services discussion in the Mental Health, Behavioral Health and Substance Use Disorder Treatment Services section in the Your Benefits chapter. This exclusion or limitation does not apply to Medically Necessary services to treat severe mental illnesses or serious emotional disturbances of a child

- 26) Routine foot care items and services that are not Medically Necessary
- 27) Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require FDA approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside the U.S. This exclusion does not apply to any of the following:
 - a) Services covered under the Emergency Services and Urgent Care chapter that you receive outside the United States
 - b) Experimental or investigational services when an investigational application has been filed with the FDA and the manufacturer or other source makes the services available to you or SHP through an FDA-authorized procedure, except that SHP does cover not services that are customarily provided by research sponsors at no cost to enrollees in a clinical trial or other investigational treatment protocol
 - c) Services covered under the Services Associated with Clinical Trials section in the Your Benefits chapter

Refer to the If You Have a Concern or Dispute with SHP chapter for information about Independent Medical Review related to denied requests for experimental or investigational services.

- 28) Services performed by people who are not licensed or certified by the state to provide health care services. This exclusion does not apply to Medically Necessary services to treat severe mental illnesses or serious emotional disturbances of a child, including Behavioral Health Treatment
- 29) When a service is not covered, all services related to the non-Covered Service are excluded, except for services SHP would otherwise cover to treat complications of the non-Covered Service. For example, if you have a non-covered cosmetic surgery, SHP will not cover services you receive in preparation for the surgery or for follow-up care. If you later suffer a

Life-threatening complication such as a serious infection, this exclusion would not apply and SHP would cover any services that we would otherwise cover to treat that complication

- 30) All services involved in Surrogacy, including but not limited to embryo transfers, services and supplies related to donor sperm or sperm preservation for artificial insemination. Surrogacy is pregnancy under a Surrogate arrangement. A Surrogate Pregnancy is one in which a woman (the surrogate) has agreed to become pregnant with the intention of surrendering custody of the child to another person. If the Surrogate is a Member, she is entitled to maternity services, but in the event pregnancy services are rendered to a woman in a Surrogate arrangement, the Plan or its Medical Group has the right to impose a lien against any amount received by the Surrogate/Member for reasonable costs incurred by SHP or its contracted Medical Groups
- 31) Travel and lodging expenses. This exclusion does not apply to reimbursement for travel and lodging expenses provided under the Bariatric Surgery section in the Your Benefits chapter
- 32) Exercise equipment, gym memberships, fitness trainers, and fitness classes
- 33) Dietary supplements or replacement foods used to promote weight loss, such as all liquid diets, purified foods, protein shake diets, vitamin and mineral supplements
- 34) Commercially available weight loss programs that offer group support or specific meals, such as Weight Watchers®, Jenny Craig®, or Nutrisystems®
- 35) Complementary, alternative and integrative medicine:
- “Complementary” generally refers to use of a non-mainstream approach together with conventional medicine. This includes non-physician practitioners who prescribe “natural products” and “mind and body practices” which are not considered health plan benefits
 - “Alternative” refers to use of a non-mainstream approach in place of conventional medicine
 - “Integrative” refers to healing-oriented medicine that takes account of the whole person, including all aspects of lifestyle

Note: this exclusion does not apply to acupuncture benefits included in your benefit plan as an Essential Health Benefit (EHB)

- 36) Immunizations required for foreign travel or occupational purposes, unless otherwise described in the Preventive Services subsection in the Your Benefits chapter
- 37) Private duty nursing or shift care
- 38) Services and supplies associated with the donation of organs when the recipient is not a Member of SHP
- 39) Services and supplies in connection with the reversal of voluntary sterilization
- 40) Circumcisions performed more than 30 days after the birth of the newborn are not covered unless Medically Necessary and Prior Authorized by the PCP's Medical Group

Pre-existing Conditions and Health Assessments

SHP will not limit or exclude coverage for you (or your Dependents) based on a pre-existing condition whether or not any medical advice, diagnosis, care or treatment was recommended or received before your effective date of coverage.

You (and any Dependents) will not be required to fill out a health assessment or medical questionnaire prior to enrollment and SHP will not acquire or request information that relates to your (or your Dependent's) health status-related factors from you, your Dependents nor any other source prior to enrollment.

Limitations

In the event of a major disaster, epidemic, war, riot, civil insurrection, complete or partial destruction of facilities, and labor dispute, SHP will make a good faith effort to provide or arrange for Covered Services. If you have an Emergency Medical Condition, call 9-1-1 or go to the nearest hospital as described under Emergency Services and Urgent Care chapter and SHP will provide coverage and reimbursement as described.

Specific limitations that apply only to a particular benefit are listed in the description of that benefit in the Your Benefits chapter.

ENROLLING IN SHP AND ADDING NEW DEPENDENTS

To be eligible to enroll in Sutter Health Plus (SHP), all Subscribers must live, work or reside within SHP's Service Area which is comprised of specific ZIP codes in Northern California. For additional information about SHP's Service Area, refer to the Definitions chapter. For additional information about coverage, please refer to the SHP Service Area section in the How To Use The Plan chapter.

Non-Discrimination

Sutter Health Plus does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Differences in premiums, pricing and/or other charges may be applied as permitted by law and when based on objective, valid, and up-to-date statistical and actuarial data.

Who Is Eligible

In addition to living or working in SHP's Service Area, to enroll and continue enrollment, you must meet your Group's eligibility requirements. Your Group will inform you, as an SHP Subscriber, of its eligibility requirements, such as the minimum number of hours that employees must work.

If your Group permits enrollment of Dependent(s), they may be eligible to enroll under this *Evidence of Coverage and Disclosure Form (EOC)*.

A Dependent may be:

- Your Spouse
- Child of a Subscriber or Spouse

A Dependent Child is eligible at least up to age 26, whether married or unmarried and whether a student or not a student. In addition, a Dependent may be entitled to an extension of the limiting age.

- **Note** – a newborn Child that is a Dependent of a qualified Dependent Family Member is not eligible for coverage under this plan

Any Dependents who qualify as Eligible Dependents, except for the age limit, which cannot be less than age 26, are eligible as disabled Dependents if they meet all of the following requirements:

- Your Group permits enrollment of Dependent children
- They are your or your Spouse's children or stepchildren, you or your Spouse's adopted children, children placed with you or your

Spouse for adoption, or children for whom you or your Spouse has assumed a parent-Child relationship (refer to the definition of a Child)

- They are incapable of self-support because of a physically- or mentally-disabling injury, illness or condition which existed prior to age 26
- They receive 50 percent or more of their support and maintenance from you or your Spouse and you provide SHP with proof of their incapacity and dependency within 60 days after it is requested (see the following Disabled Dependent Certification section)

Disabled Dependent Certification: One of the requirements for a Dependent to be eligible for membership as a disabled Dependent is that the Subscriber must provide SHP with documentation of the Dependent's incapacity and dependency as follows:

- If the Dependent is a Member, SHP will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in SHP's notice unless the Subscriber provides SHP with documentation of the Dependent's incapacity and dependency within 60 days of receipt of notice and it is determined that the Dependent is eligible as a disabled Dependent. If the Subscriber provides SHP with this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until a determination is made. If SHP determines that the Dependent does not meet the eligibility requirements as a disabled Dependent, SHP will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If SHP determines that the Dependent is eligible as a disabled Dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit of 26, the Subscriber must provide SHP with documentation of the Dependent's incapacity and dependency annually within 60 days after SHP requests the documentation so SHP may determine if the Dependent continues to be eligible as a disabled Dependent
- If the Dependent is not a Member and the Subscriber is requesting enrollment of the Dependent, the Subscriber must provide SHP

with documentation of the Dependent's incapacity and dependency within 60 days after SHP requests the documentation so that SHP may determine if the Dependent is eligible to enroll as a disabled Dependent. If SHP determines that the Dependent is eligible as a disabled Dependent, the Subscriber must provide SHP with documentation of the Dependent's incapacity and dependency annually within 60 days after requested so that SHP can determine if the Dependent continues to be eligible as a disabled Dependent

When You Can Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and your coverage effective date. If you are eligible to enroll as described under the Who Is Eligible section in this chapter, enrollment is permitted as described in this section and membership begins at the beginning (12 a.m.) of the effective date of coverage, except that your Group may have additional requirements approved by SHP which allow enrollment in other situations.

New Employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a SHP enrollment application to your Group within 31 days.

Effective Date of Coverage

Your coverage effective date is based on the date your Premium is submitted. If your Premium is delivered to SHP or postmarked, whichever is earlier, within the first 15 days of a month, your coverage under the plan Group Subscriber Contract shall become effective no later than the first day of the following month. If your Premium is neither delivered nor postmarked until after the 15th day of a month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the Premium. Your effective date of coverage is contingent upon your eligibility and shall not begin prior to the expiration of the waiting period or affiliation period imposed by your Group.

Waiting and Affiliation Periods

Your Group may require some period of time to pass, known as waiting or affiliation periods, before your coverage becomes effective. Waiting or affiliation periods may be no longer than 90 days and, if combined, any waiting and affiliation period must run concurrently. You will not have to pay for Premiums until any waiting or affiliation periods have expired and your coverage has commenced

Adding New Dependents to an Existing Account

To enroll a Dependent who first becomes eligible to enroll after you became a Subscriber (such as a new Spouse, a newborn Child, or a newly adopted Child), you must submit an SHP change of enrollment form to your Group within 31 days after the Dependent first becomes eligible.

Effective Date of Coverage for New Dependents

The effective date of coverage for newly acquired Dependents is as follows:

- For a newborn Child, coverage is effective from the moment of birth, however, if you do not enroll the newborn Child within 60 days, the newborn is covered for only 30 days (including the date of birth)
Note – a newborn Child that is a Dependent of a qualified Dependent Family Member is not eligible for coverage under this plan
- For a newly adopted Child or Child placed with you or your Spouse for adoption, coverage is effective on the date of adoption or the date when you or your Spouse have newly assumed a legal right to control the Child's health care in anticipation of adoption.
 - For purposes of this requirement, "legal right to control health care" means you have a signed written document, such as a health facility minor release report, a medical authorization form, or a relinquishment form, or other evidence that shows you or your Spouse have the legal right to control the Child's health care
- For all other newly acquired Dependents, the effective date of coverage is the first of the month following the date SHP receives the request for enrollment

Open Enrollment

You may enroll as a Subscriber (along with any Dependents), and existing Subscribers may add Dependents, by submitting an SHP enrollment application to your Group during your Group's open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage.

Late Enrollee

If you declined to enroll in SHP during your Group's initial enrollment period, you (along with any Dependents) may later enroll in SHP as a late enrollee during the next open enrollment period. You will not have to pay for Premiums until your coverage has commenced.

Special Enrollment

If you do not enroll when you are first eligible and later want to enroll, you may enroll only during open enrollment in most cases. However, in some cases, you may qualify to enroll in a Special Enrollment period. The following sections describe when you may be eligible for Special Enrollment.

You may also be eligible if all of the following are true:

- You did not enroll in any coverage offered by your Group when you were first eligible
- Your Group does not give us a written statement verifying you signed a document that either:
 - Explained restrictions about enrolling in the future
 - You declined coverage

The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives an SHP enrollment or change of enrollment application from the Subscriber.

Special Enrollment Due to Loss of Other Coverage

You may enroll as a Subscriber (along with any Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

- The Subscriber or at least one of the Dependents had other coverage when he or she previously declined all coverage through your Group
- The loss of the other coverage is due to one of the following:
 - Exhaustion of COBRA coverage
 - Termination of employer contributions for non-COBRA coverage
 - Loss of eligibility for non-COBRA coverage (for example, this loss of eligibility may be due to legal separation or divorce, moving out of previous carrier's service area, reaching the age limit for Dependent children, or the Subscriber's death, termination of employment, reduction in hours of employment)
 - Loss of eligibility for Medicaid coverage (known as Medi-Cal in California)
 - Loss of coverage because an individual no longer resides, lives or works in the previous carrier's service area (whether or not within the choice of the individual), and

no other benefit package is available to the individual

Note: If you are enrolling yourself as a Subscriber along with at least one Dependent, only one of you must meet the requirements stated previously.

To request enrollment, the Subscriber must submit an SHP enrollment or change of enrollment form to your Group within 60 days after loss of other coverage or cessation of employer contribution requirements.

Special Enrollment Due to New Dependents

You may enroll as a Subscriber (along with Dependents), and existing Subscribers may add Dependents, within 60 days after marriage, establishment of domestic partnership, birth, adoption or placement in anticipation of adoption by submitting to your Group an SHP enrollment form.

The effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments due to birth, adoption or placement in anticipation of adoption are effective on the date of birth, or the date you or your Spouse have newly assumed a legal right to control health care in anticipation of adoption.

Special Enrollment Due to Court or Administrative Order

Within 60 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or Child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or Child as a Dependent by submitting to your Group an SHP enrollment or change of enrollment form.

The effective date of coverage resulting from a court or administrative order is the first of the month following the date SHP receives the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special Enrollment Due to Release From Incarceration

You will be eligible for a 30-day special enrollment period following a release from incarceration.

Special Enrollment Due to Health Coverage Issuer Substantially Violating a Material Provision of the Health Coverage Contract

If you (or a Dependent) received coverage from an issuer who has substantially violated a material

provision of a health coverage contract, you will be eligible for a 60-day special enrollment period following such violation.

Special Enrollment Due to Gaining Access to New Health Care Benefit Plans as a Result of a Permanent Move

If you (or a Dependent) have gained access to new health care benefit plans as a result of a permanent move, you will be eligible for a 60-day special enrollment period following such permanent move.

Special Enrollment Due to Completion of Covered Services

If you (or a Dependent) were receiving care from a provider for an Acute Condition, a serious chronic condition, a pregnancy, a terminal illness, care of a newborn Child or have yet to receive a scheduled surgery from a provider and that provider is no longer participating in you or your Dependent's health benefit plan, you will be eligible for a 60-day special enrollment period following such termination of participation.

Special Enrollment Due to Eligibility or Premium Assistance

You may enroll as a Subscriber (along with Dependents), and existing Subscribers may add Dependents, if you or a Dependent become eligible for Premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of Premiums for employer Group coverage for a Medi-Cal beneficiary. To request enrollment in your Group's health care coverage, the Subscriber must submit an SHP enrollment or change form to your Group within 60 days after you or a Dependent become eligible for Premium assistance. Please contact the California Department of Health Care Services to find out if Premium assistance is available and the eligibility requirements.

Special Enrollment Due to Misinformation Regarding Coverage

If you are able to demonstrate to the Department of Managed Health Care (DMHC) that you did not enroll yourself or your Dependent(s) in a health benefit plan during the immediately preceding enrollment period available to you because you were misinformed that you were covered under minimum essential coverage, you will be eligible for a 60 day special enrollment period.

Special Enrollment Due to Reemployment After Military Service

If you terminated your health care coverage because you were called to active duty in the military service,

you may be able to reenroll in your Group's health plan if required by state or federal law. Please ask your Group for more information.

Renewal Provisions

Your SHP coverage is subject to all the terms agreed to by your Group and SHP as set forth in the Group Subscriber Contract. The Group Subscriber Contract is renewed annually and SHP reserves the right to change the terms and conditions as permitted by law, including the Premium, when your Group renews its contract with SHP. If this happens, you will receive notice through your Group at least 60 days before the change takes effect.

WHEN YOUR SHP HEALTH COVERAGE ENDS (TERMINATION OF BENEFITS)

Your membership with Sutter Health Plus (SHP) may end for several reasons. If your membership is terminated, you may be able to continue your health care coverage. Please see the next chapter entitled Individual Continuation of Health Coverage (COBRA and Cal-COBRA).

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (e.g., If your termination date is January 1, 2019, your last minute of coverage was on December 31, 2018 at 11:59 p.m.). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Covered Services you receive after your membership terminates, **even if you are hospitalized or undergoing treatment for an ongoing condition.** SHP and Participating Providers have no further liability or responsibility under this *Evidence of Coverage and Disclosure Form (EOC)* after your membership terminates, except as provided under the Payments after Termination section of this chapter.

Termination Due to Loss of Eligibility

If at any time you lose eligibility, your membership will end at 11:59 p.m. on the last day of that month. SHP terminates your coverage effective the first day of the following month.

Termination of Group Subscriber Contract

If your Group's Subscriber Contract with us terminates for any reason, including for loss of the Group's eligibility or non-payment of Premium, your membership ends on the same date as the effective date of the Group contract termination. Your Group is required to notify Subscribers in writing if the Group Subscriber Contract with us terminates. SHP also sends a Notice of Termination to the Subscriber once SHP terminates your membership.

Termination for Cause

If you commit fraud or an intentional misrepresentation of material fact in connection with your membership, SHP or a Participating Provider, SHP may terminate your membership by sending written notice to the Subscriber. Termination is effective on the date specified in the SHP termination notice.

SHP may report criminal fraud and other illegal acts to the authorities for prosecution.

Termination of a Product or all Products

SHP may terminate a particular product or all products offered in a small or large Group market as permitted or required by law. If SHP discontinues offering a particular product in a market, SHP will terminate the particular product by sending you written notice at least 90 days before the product terminates. If SHP discontinues offering all products to Groups in a small or large Group market, as applicable, SHP may terminate your Group Subscriber Contract by sending you written notice at least 180 days before the Group Subscriber Contract terminates.

Payments After Termination

If SHP terminates your membership for cause or for nonpayment, SHP will:

- Refund any amounts SHP owes your Group for Premiums paid after the termination date
- Pay you any amounts SHP determines is owed you for claims during your membership in accord with the chapters entitled Emergency Services and Urgent Care and If You Have A Concern or Dispute with SHP; SHP will deduct any amounts you owe SHP or Participating Providers from any payment due to you
- You will not be responsible for any amounts SHP or any of its plan partners owes to a provider for services rendered before the effective termination date
- You will be responsible for any applicable Copayments or Deductibles for services rendered by a provider before the effective termination date

State Review of Membership Termination

If you believe SHP has (or will) improperly cancelled, rescinded or not renewed your plan coverage, you have the right to file a Request for Review.

You have the options of going to SHP and/or the Department of Managed Health Care (DMHC) if you do not agree with the decision to cancel, rescind or not renew your plan coverage.

SHP makes the Request for Review forms available on its website at sutterhealthplus.org, in the Forms section.

Option 1 – Submit a Request for Review to SHP

TDD: 1-877-688-9891

You may submit a Request for Review to SHP using one of the following methods:

- By writing:
Sutter Health Plus
Attn: Appeals and Grievances Department
P.O. Box 160305
Sacramento, CA 95816
 - By calling:
SHP Member Services
1-855-315-5800
TTY 1-855-830-3500
 - By faxing:
1-855-759-8755
1-916-736-5422
 - Online:
sutterhealthplus.org
- By faxing:
1-916-255-5241
 - Online:
www.HealthHelp.ca.gov

You may want to submit your Request for Review to SHP first if you believe your cancellation, rescission or nonrenewal is the result of a mistake. You should submit a Request for Review as soon as possible after you receive the Notice of Cancellation, Rescission or Nonrenewal.

SHP will resolve your Request for Review or provide a pending status within three days. If SHP upholds your cancellation, rescission or nonrenewal, SHP will immediately transmit your Request for Review to DMHC. SHP will also notify you of SHP's decision and your right to also seek a further review of the decision by DMHC as detailed under Option 2, below.

Option 2 – Submit a Request for Review to DMHC

You may submit a Request for Review directly to DMHC without first submitting it to SHP, or after you have received the health plan's decision on your Request for Review.

You may submit Requests for Review to the DMHC using one of the following methods:

- By writing:
Help Center
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
- By calling:
1-888-466-2219

INDIVIDUAL CONTINUATION OF HEALTH CARE COVERAGE (COBRA AND CAL-COBRA)

Federal and California laws protect the rights of you and your Dependents to continue your health coverage under certain circumstances or qualifying events. This is called “continuation of health coverage” or “continuation of benefits.”

Continuation of Group Coverage

If at any time you become entitled to continuation of Group coverage such as Cal-COBRA, please examine your coverage options carefully before declining this coverage.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires continuation coverage to be offered to covered employees, their spouses, their former spouses and their Dependent children (referred to as “qualified beneficiaries”) when Group health plan coverage would otherwise be lost due to certain specific events (known as “qualifying events”). Group health plans maintained by employers with at least 20 employees are generally subject to COBRA. Under COBRA, a Member or a Dependent may elect to keep SHP coverage for up to 18 or 36 months, depending on the type of qualifying event and other circumstances. If you are no longer eligible for benefits under COBRA, you may be able to keep your benefits through Cal-COBRA. With COBRA, you have the same benefits as current Members of SHP. To maintain COBRA coverage, you must pay the full cost of the monthly Premium, which may include administrative costs. Each qualified beneficiary may independently elect COBRA coverage although a parent or legal guardian may elect COBRA for a minor Child.

Important Deadlines for Electing/Enrolling in COBRA with Sutter Health Plus (SHP)

Notification of qualifying event:

- Employers must notify SHP within 30 days after the following qualifying events:
 - The employee’s job ends
 - The employee’s hours of employment are reduced
 - The employee becomes eligible to receive Medicare benefits
 - The employee dies

- You or your Dependent must notify SHP in writing within 60 days after any of the following qualifying events:
 - You become divorced or legally separated
 - A child or other Dependent no longer qualifies as a Dependent under plan rules

Election notice:

- Generally, you must be sent an election notice not later than 14 days after SHP receives notice that a qualifying event has occurred

Election period:

- You have 60 days to notify SHP in writing that you want to elect/enroll in Cal-COBRA continuation coverage. The 60 days starts on the later of the following two dates:
 - The date you receive the election notice
 - The date your coverage ended

If you do not meet the following deadline you will lose your right to COBRA coverage.

Premium payment:

- You must pay the Premiums for your COBRA coverage within 45 days from the date you provided written notice of your election to continue coverage through COBRA, in accordance with your employer Group’s COBRA administration policies. Contact your employer Group COBRA administrator for questions

If your COBRA is ending, you may be able to elect/enroll in Cal-COBRA:

- When your 18 months of COBRA ends, you may be able to keep SHP coverage for up to 18 more months under Cal-COBRA, for a maximum of 36 months. If you were on COBRA for 36 months, you cannot get Cal-COBRA for any additional period of time. If you are interested in enrolling in Cal-COBRA, contact SHP Member Services to request enrollment information.

You will lose COBRA if:

- You move outside the SHP Service Area
- Your former employer no longer offers any health plan
- You become eligible for Medicare
- You sign up for another health plan

- You commit fraud or intentional misrepresentation of material fact

Consult your employer Group COBRA administration policies for other possible requirements.

Cal-COBRA

Cal-COBRA is a California law that applies to employers that have between two and 19 employees in their Group health plan. Cal-COBRA may allow you, your Dependents and former Dependents to keep SHP coverage for up to 36 months. With Cal-COBRA, you have the same benefits as current Members of SHP. To maintain Cal-COBRA coverage, you must pay the full cost of the monthly Premium to SHP, which may include administrative costs.

Important Definitions for Cal-COBRA:

- **Continuation coverage** means extended coverage under the Group benefit plan in which an Eligible Employee or eligible Dependent is currently enrolled, or, in the case of a termination of the Group benefit plan or an employer open enrollment period, extended coverage under the Group benefit plan currently offered by the employer
- **Core Coverage** means coverage of basic health care services, as defined in subdivision (b) of Section 1345, and other hospital, medical, or surgical benefits provided by the group benefit plan that a qualified beneficiary was receiving immediately prior to the qualifying event, other than noncore coverage
- **Employer** for the purposes of Cal-COBRA means a Small Employer that:
 - Employed two to 19 Eligible Employees on at least 50 percent of its working days during the preceding calendar year, or, if the employer was not in business during any part of the preceding calendar year, employed two to 19 Eligible Employees on at least 50 percent of its working days during the preceding calendar quarter
 - Has contracted for health care coverage through a Group benefit plan offered by a health care service plan
 - Is not subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.
- **Group health plan** means any health care service plan contract provided pursuant to Article 3.1 of the Knox-Keene Act to an employer with two to 19 Eligible Employees
- **Noncore Coverage** means coverage for vision and dental care (pediatric vision and pediatric dental are considered part of Core coverage)
- **Qualified beneficiary** means any individual who, on the day before the qualifying event, is an enrollee in a Group benefit plan offered by a health care service plan pursuant to Article 3.1 of the Knox-Keene Act and has a qualifying event
- **Qualifying event** means any of the following events that, but for the election of continuation coverage, would result in a loss of coverage under the Group benefit plan to a qualified beneficiary:
 - The death of the covered employee
 - The termination of employment or reduction in hours of the covered employee's employment, except that termination for gross misconduct does not constitute a qualifying event
 - The divorce or legal separation of the covered employee from the covered employee's spouse
 - The loss of Dependent status by a Dependent enrolled in the Group benefit plan
 - With respect to a covered Dependent only, the covered employee's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare)

Important Deadlines for Electing/Enrolling in Cal-COBRA with SHP

If you do not meet the following deadlines you will lose your right to Cal-COBRA coverage.

- **Notification of qualifying event:**
 - Employers must notify SHP within 30 days after the following qualifying events:
 - The employee's job ends
 - The employee's hours of employment are reduced
 - You or your Dependent must notify SHP in writing within 60 days after any of the following qualifying events:
 - The employee dies
 - The employee divorces or legally separates

- A Child or other Dependent no longer qualifies as a Dependent under plan rules
- The employee becomes eligible to receive Medicare benefits
- **Election notice:**
 - Generally, you must be sent an election notice not later than 14 days after SHP receives notice that a qualifying event has occurred
- **Election period:**
 - You have 60 days to notify SHP in writing that you want to elect/enroll in Cal-COBRA continuation coverage. The 60 days starts on the later of the following two dates:
 - The date you receive the election notice
 - The date your coverage ended
- **Premium payment:**
 - You must pay the Premiums for your Cal-COBRA coverage to SHP
 - SHP must receive your first Premium within 45 days after you enroll in Cal-COBRA. Your first payment must cover at least all monthly Premiums from the date your coverage ended (due to a qualifying event) up to the last day of the month in which you make your first payment
 - Following your enrollment in Cal-COBRA and payment of the first Premium, you must then pay all subsequent monthly Premiums on the due date or within the grace period of at least 30 days, for as long as you are eligible to stay on Cal-COBRA

If your former employer stops offering SHP when you are on Cal-COBRA:

- You are no longer eligible for coverage with SHP. You may be able to elect/enroll in Cal-COBRA with the new health plan offered by your employer

You will lose Cal-COBRA if:

- You do not pay your Premiums on the due date or within the grace period of at least 30 days
- You move outside the SHP Service Area
- Your former employer no longer offers any health plan
- You sign up for or become eligible for Medicare

- You sign up for another health plan
- You commit fraud or intentional misrepresentation of material fact
- You sign up for or become eligible for federal COBRA
- You do not submit your election notice
- You qualify for another federal program such as the Federal Employees Health Benefits Program

Cal-COBRA Termination and Premature Termination of Continuation Coverage

SHP sends a notice of termination to subscribers that lose Cal-COBRA coverage. The notice specifies the reason for termination and the effective date of the termination.

If SHP is cancelling your coverage due to non-payment of Premium, SHP sends a notice of cancellation prior to the termination. The notice provides information on the grace period. The grace period allows you time to remit past-due Premium payment(s) without losing your health care coverage. A grace period is a period of at least 30 days beginning no sooner than the first day after the last day of paid coverage.

All notices of cancellation and termination provide information on your right to file a Request for Review. If you believe SHP has (or will) improperly cancelled, rescinded or not renewed your plan coverage, you have the right to file a Request for Review. You have the options of going to SHP, the Department of Managed Health Care (DMHC) or both if you do not agree with the decision to cancel, rescind or not renew your plan coverage. For specific instructions on submitting a Request for Review, refer to the State Review of Membership Termination section in the previous chapter When Your SHP Health Coverage Ends (Termination of Benefits).

Uniformed Covered Services Employment and Reemployment Rights Act (USERRA)

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this *Evidence of Coverage and Disclosure Form (EOC)* for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group to find out how to elect USERRA coverage and how much you must pay your Group.

Coverage for a Disabling Condition

If you became totally disabled while you were a Member under your Group's Subscriber Contract with us and while the Subscriber was employed by your Group, and your Group's Subscriber Contract with us terminates and is not renewed, SHP will cover services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's Subscriber Contract with us terminated
- You are no longer totally disabled
- Your Group's Subscriber Contract with us is replaced by another Group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this EOC, including Cost Sharing, but SHP will not cover services for any condition other than your totally disabling condition.

To request continuation of coverage for your disabling condition, you must call SHP Member Services within 30 days after your Group's Subscriber Contract with us terminates.

Important Definitions for Disabling Condition

- **Totally disabled for Subscribers and adult Dependents** means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in the activities of day to day living such as gainful employment or independent living that a person of the same age and gender without a similar disabling condition can perform
- **Totally disabled for Dependent children** means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the Child unable to substantially engage in any of the normal activities of children in good health of like age

PAYMENT AND REIMBURSEMENT

If you receive Emergency Services, Post-Stabilization Care or Out-of-Area Urgent Care from a non-Participating Provider as described in the Emergency Services and Urgent Care chapter, or emergency ambulance services described under the Ambulance Services section in the Your Benefits chapter, you must pay the provider and file a claim for reimbursement with Sutter Health Plus (SHP), unless the provider agrees to bill SHP. Also, you may be required to pay and file a claim for any Covered Services prescribed by a non-Participating Provider as part of covered Emergency Services, Post-Stabilization Care and Out-of-Area Urgent Care even if you receive the Covered Services from a Participating Provider.

SHP will reduce any payment made to you or the non-Participating Provider by your applicable Cost Sharing.

How to File a Claim

To file a claim for payment or reimbursement for a service you paid for, you must:

- Send us a completed claim form for reimbursement and attach itemized bills from the non-Participating Provider, including receipts
- Complete and return any information requested by SHP to process your claim, such as claim forms, consents for the release of medical records, assignments and claims for any other benefits to which you may be entitled
- Mail the completed request and information, as well as any additional information requested by SHP as soon as possible after receiving the care. Send to Sutter Health Plus, Attn: Claims Department, at the P.O. Box listed on the back of your Member ID card

SHP will respond to your claim as follows:

- If coverage under this Evidence of Coverage is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), we will send our written decision within 30 calendar days after we receive the claim unless we request additional information from you or the Non-Participating Provider. If we request additional information, we will send our written decision no later than 15 calendar days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in the letter, we will make our decision based on the information we have. If coverage under this EOC is not subject to the

ERISA claims procedure regulation, SHP will send its written decision within 45 business days after SHP receives the claim unless we request additional information from you or the non-Participating Provider. If SHP requests additional information, we will send our written decision no later than 45 business days after the date SHP receives the additional information. If SHP does not receive the necessary information within the timeframe specified in the letter, we will make our decision based on the information we have available

- If SHP's decision is not fully in your favor, it will tell you the reasons and how to file a grievance as described under Grievances section in the If You Have a Concern or Dispute with SHP chapter

Pharmacy Payment and Reimbursement

If you have a situation in which you paid the full price for a prescription at a Participating Pharmacy, you may submit a Direct Member Reimbursement (DMR) request to Express Scripts. To complete this process, you must:

- Complete and submit a DMR Form with your receipt, which can be found under Help Desk on the Express Scripts website, by following the instructions listed on the form within 90 days

All requests must be for covered outpatient drugs, supplies, equipment and supplements as specified in the Outpatient Prescription Drug section. If a Drug requires Prior Authorization or step therapy, it may not be reimbursed.

If your DMR request is approved, you will be reimbursed at the SHP contracted rate, minus your Copayment or Coinsurance. If you have a Deductible, and you have not yet met your Deductible, the contracted rate will be applied to your Deductible. SHP recommends you first check to see if the pharmacy can submit a claim on your behalf and reimburse you.

SHP does not reimburse claims to your previous insurance that have been processed in error.

IF YOU HAVE A CONCERN OR DISPUTE WITH SHP

Sutter Health Plus (SHP) is committed to providing you with access to high-quality care and with a timely response to your concerns. If you have encountered any difficulties or have had any concerns with SHP or a Participating Provider, please give us a chance to help. You may discuss your concerns with SHP Member Services by calling toll-free at 1-855-315-5800 (TTY 1-855-830-3500) 8 a.m. to 7 p.m., Monday through Friday. You may submit a formal complaint or grievance at any time.

Please read all of the important information in this chapter about the processes available to help you resolve concerns and complaints. Call SHP Member Services if you have any questions about these processes, which include grievances, including expedited grievances; complaints to the Department of Managed Health Care (DMHC); independent medical review, and voluntary mediation.

Grievances

You may file a grievance for issues such as the following:

- You are not satisfied with the quality of care you received
- You received a written denial of Covered Services that require prior authorization from either the Medical Group or SHP or a Notice of Non-Coverage and you want SHP to cover the services
- A Participating Provider determines that Covered Services are not Medically Necessary and you want SHP to cover the services
- You were told that services are not covered and you believe that the services are Covered Services
- You received care from a non-Participating Provider without Prior Authorization (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care or emergency Ambulance Services) and you want SHP to pay for the care
- SHP did not decide fully in your favor on a claim for Covered Services described in the Emergency Services and Urgent Care chapter and you want to appeal the decision
- You are dissatisfied with how long it took to receive Covered Services, including scheduling an appointment and time in the waiting or exam rooms

- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- SHP terminated your coverage and you believe it terminated your coverage improperly; you can file a grievance for cancellation of coverage or for non-renewal of coverage

Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about Covered Services you received. **You may submit grievances online, in writing or by telephone.** You must submit your grievance within 180 days of the date of the incident that caused your dissatisfaction as follows:

- By writing:
Sutter Health Plus
Attn: Member Appeals and Grievances
P.O. Box 160305
Sacramento, CA 95816
- By calling: SHP Member Services at 1-855-315-5800 (TTY 1-855-830-3500)
- By faxing: 1-855-759-8755
- Online: sutterhealthplus.org

SHP sends you a confirmation letter within five calendar days after we receive your grievance. SHP sends you its written decision within 30 calendar days after we receive your grievance. If SHP does not approve your request, we tell you the reasons and about additional dispute resolution options.

You may submit grievances to USBHPC for Mental Health and Substance Use Disorder Treatment Services provided through SHP's contract with USBHPC as follows:

- By writing:
U.S. Behavioral Health Plan, California dba Optum Behavioral Solutions of California
Attn: Appeals Department
P.O. Box 30512
Salt Lake City, UT 84130-0512
- By calling: USBHPC Member Services at 1-855-202-0984
- By faxing: 1-855-312-1470
- Online: liveandworkwell.com

You may submit grievances to VSP for optional vision benefits only if elected as an optional benefit

by your employer Group as part of your benefit plan, provided through SHP's contract with VSP.

- By writing:
Vision Service Plan of California
Attn: Appeals Department
P.O. Box 2350
Rancho Cordova, CA 95741
- By calling: VSP Customer Service at 1-800-877-7195
- Online: vsp.com

You may also submit grievances to Delta Dental for optional dental benefits if elected as an optional benefit by your employer Group as part of your benefit plan, provided through SHP's contract with Delta Dental.

- By writing:
Delta Dental
Attn: Quality Management Department
P.O. Box 6050
Artesia, CA 90702
- By calling: Delta Dental Member Services at 1-800-422-4234
- Online: deltadentalins.com

Grievance Handled by Phone Within One Business Day

If you submit your grievance by telephone and SHP resolves your issue to your satisfaction by the end of the next business day, and SHP Member Services notifies you by telephone about the decision, SHP will not send you a confirmation letter or a written decision unless your grievance involves a coverage dispute, a dispute about whether a Covered Service is Medically Necessary or an experimental or investigational treatment.

Expedited Grievance

You or your authorized representative may make an oral or written request that SHP expedite its decision about your grievance if it involves an imminent and serious threat to your health, such as severe pain or potential loss of life, limb or major bodily function. SHP will inform you of its decision within three calendar days (orally and in writing).

If the request is for a continuation of an expiring course of treatment and you make the request at least 24 hours before the treatment expires, SHP will inform you of its decision within 24 hours.

You or your authorized representative must request an expedited decision in one of the following ways

and you must specifically state that you want an expedited decision:

- By calling: SHP's Member Services at 1-855-315-5800 (TTY 1-855-830-3500) available Monday through Friday from 8 a.m. to 7 p.m. (If you call after hours, please leave a message and a representative will return your call the next business day)
- By writing:
Sutter Health Plus
Attn: Member Appeals and Grievances
P.O. Box 160305
Sacramento, CA 95816
- By faxing: 1-855-759-8755
- Online: sutterhealthplus.org

SHP sends you written notification within three calendar days of receiving your request for expedited grievance, in which you are advised whether your request for expedited handling is approved and, if so, our decision on the grievance. If SHP does not approve your request for an expedited decision, SHP notifies you and provides the decision on your grievance within 30 calendar days. If SHP does not approve your grievance, it sends you a written decision that tells you the reasons and about additional dispute resolution options.

You may also submit expedited grievances to USBHPC in a similar manner. Expedited grievances submitted to USBHPC are for mental health services provided through SHP's contract with USBHPC:

- By writing:
U.S. Behavioral Health Plan, California dba
Optum Behavioral Solutions of California
Attn: Appeals Department
P.O. Box 30512
Salt Lake City, UT 84130-0512
- By calling: USBHPC Member Services at 1-855-202-0984
- By faxing: 1-855-312-1470
- Online: liveandworkwell.com

You may also submit expedited grievances to VSP in a similar manner. Expedited grievances submitted to VSP are for optional vision benefits only if elected as an optional benefit by your employer Group as part of your benefit plan provided through SHP's contract with VSP:

- By writing:

Vision Service Plan of California
Attn: Appeals Department
P.O. Box 2350
Rancho Cordova, CA 95741

- By calling: VSP Customer Service at 1-800-877-7195
- Online: vsp.com

You may also submit expedited grievances to Delta Dental in a similar manner. Expedited Grievances submitted to Delta Dental are for optional dental benefits if elected by your employer) provided through SHP's contract with Delta Dental:

- By writing:
Delta Dental
Quality Management Department
P.O. Box 6050
Artesia, CA 90702
- By calling: Delta Dental Member Services at 1-800-422-4234
- Online: deltadentalins.com

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb or major bodily function), you may contact the DMHC directly prior to filing a grievance with SHP at any time by calling 1-888-HMO-2219 (TDD 1-877-688-9891).

Supporting Documents

It is helpful for you to include any information that clarifies or supports your position. You may want to include supporting information with your grievance, such as medical records or physician opinions. When appropriate, SHP will request medical records from Participating Providers on your behalf. If you have consulted with a non-Participating Provider and are unable to provide copies of relevant medical records, SHP will contact the provider to request a copy of your medical records. SHP will ask you to send or fax a written authorization so that it may request your records. If SHP does not receive the information requested in a timely fashion, SHP will make a decision based on the information it has.

Who May File

The following persons may file a grievance:

- You may file for yourself
- You may appoint someone as your authorized representative, including your physician, by completing SHP's authorization form, which is available by calling SHP Member Services (your

completed authorization form must accompany the grievance)

- You may file for your Dependent under age 18, except that he or she must appoint you as his or her authorized representative if he or she has the legal right to control release of information that is relevant to the grievance
- You may file for your ward if you are a court-appointed guardian, except that he or she must appoint you as his or her authorized representative if he or she has the legal right to control release of information that is relevant to the grievance
- You may file for your conservatee if you are a court-appointed conservator
- You may file for your principal if you are an agent under a currently effective health care proxy, to the extent provided under state law

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against SHP, you should first telephone SHP toll free at

1-855-315-5800 (TTY 1-855-830-3500) and use SHP's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by SHP, 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 instructions online.

You may request that SHP participate in voluntary mediation before you submit a grievance to the DMHC. The use of mediation services shall not prevent you from submitting a grievance to the

DMHC after mediation. Refer to the upcoming section on Voluntary Mediation.

Independent Medical Review (IMR) Process

The DMHC determines which cases qualify for IMR. If your case qualifies, you or your authorized representative may have your issue reviewed through the IMR process managed by the DMHC at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against SHP.

You may qualify for IMR if all of the following are true:

- One of these situations applies to you:
 - You have a recommendation from a provider requesting Medically Necessary Covered Services
 - You have received Emergency Services, emergency Ambulance Services or Urgent Care from a provider who determined the Covered Services to be Medically Necessary
 - You have been seen by a Participating Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Covered Services has been denied, modified, or delayed based in whole or in part on a decision that the Covered Services are not Medically Necessary
- You have filed a grievance and SHP has denied it or we haven't made a decision about your grievance within 30 calendar days (or three calendar days for expedited grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function

You may also qualify for IMR if the service you requested has been denied on the basis that it is experimental or investigational as described under the following Experimental or Investigational Denials section.

If the DMHC determines that your case is eligible for IMR, it will ask us to send your case to the DMHC's Independent Medical Review organization. The DMHC will promptly notify you of its decision after it receives the IMR organization's determination. If the decision is in your favor, SHP will contact you to arrange for the Service or payment.

Experimental or Investigational Denials

If SHP denies a Covered Service because it is experimental or investigational, SHP will send you its written explanation within five days of making a decision. In the denial letter, SHP will explain why the service is denied and provide additional dispute resolution options, including an explanation of your right to request an IMR of the decision through the DMHC. Your IMR application will need to include the following information:

- A written statement from your treating physician that you have a Life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy SHP covers than the therapy being requested. ("Life-threatening" means diseases or conditions 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. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity)
- If your treating physician is a Participating Provider, that he or she recommended a treatment, drug, device, procedure or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Participating Provider in certifying his or her recommendation
- That you (or your non-Participating Provider who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy; the physician's certification included a statement of the evidence relied upon by the physician in certifying his or her recommendation; SHP does not cover the services of the non-Participating Provider

SHP's denial letter will include more detailed information about the IMR process; an IMR application and envelope addressed to the Department; the physician certification form; and the Department's toll-free information number.

Note: You can request IMR for experimental or investigational denials at any time without first filing a grievance with us.

Voluntary Mediation

You may request that SHP participate in voluntary mediation before you submit a grievance to the DMHC. The use of mediation services shall not prevent you from submitting a grievance to the DMHC after mediation. Mediation is strictly voluntary and SHP is not required to agree to mediation, but if a Member and SHP mutually agree to mediation, the mediation will be administered by JAMS in accordance with JAMS Mediation Rules and Procedures, unless otherwise agreed to by the parties. Expenses for mediation shall be borne equally by the parties. The DMHC shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.

To request voluntary mediation, please send your written request to SHP at the following address:

Sutter Health Plus
Member Services – Voluntary Mediation
2480 Natomas Park Drive, Suite 150
Sacramento, CA 95833

Binding Arbitration

Disputes between you and SHP are typically handled and resolved through SHP's Grievance, Appeal and Independent Medical Review processes described previously. However, in the event that a dispute is not resolved in those processes, SHP uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership, you agree that any and all disputes between yourself (including any heirs or assigns) and SHP, including claims of medical malpractice (that is as to whether any Medical Services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for Small Claims Court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and SHP, including any heirs or assigns to this agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter. SHP's binding arbitration process

is conducted by mutually acceptable arbitrator(s) selected by the parties.

If the parties fail to reach an agreement on arbitrator(s) within 30 days of the filing of the arbitration with the American Arbitration Association, then either party may apply to a court of competent jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

A Member must initiate arbitration within one year of completing the SHP grievance process, which includes IMR if the Member elects to use IMR. The one-year time frame for initiating arbitration will begin on the day after the date of the final grievance disposition letter or the final IMR disposition letter sent to the Member, whichever is later.

A Member may initiate arbitration by submitting a demand for arbitration to SHP at the address that follows. The demand must have a clear statement of the facts, the relief sought and a dollar amount and be sent to:

Sutter Health
Office of the General Counsel
2200 River Plaza Dr.
Sacramento, CA 95833

The arbitration procedure is governed by the American Arbitration Association commercial rules. Copies of these rules and other forms and information about arbitration are available through the American Arbitration Association at adr.org or 1-800-778-7879.

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this *Evidence of Coverage and Disclosure Form (EOC)* but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award, setting forth findings of fact and conclusions of law. The award will be final and binding on all parties except to the extent that state or federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Member, SHP may assume all or a portion of the Member's share of the fees and expenses associated with the arbitration. Upon written notice by the Member requesting a hardship application, SHP will forward the request to an independent, professional dispute resolution organization for a determination. Such a request for

hardship should be submitted to the address provided previously. Effective July 1, 2002, Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. §1001 et seq., a federal law regulating benefit plans, are not required to submit to mandatory binding arbitration any disputes about certain "adverse benefit determinations" made by SHP. Under ERISA, an "adverse benefit determination" means a decision by SHP to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and SHP may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

MEMBER RIGHTS AND RESPONSIBILITIES

Sutter Health Plus' (SHP's) Member Rights and Responsibilities outline the Member's rights as well as the Member's responsibilities. You may request a separate copy of this Member Rights and Responsibilities by contacting SHP Member Services, or you may download a copy at sutterhealthplus.org.

What Are My Rights?

Member rights may be exercised without regard to age, sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status or the source of payment or utilization of services. SHP's Member rights include but are not limited to the following:

- To be provided information about the SHP organization and its services, providers and practitioners, managed care requirements, processes used to measure quality and improve Member satisfaction, and your rights and responsibilities as a Member
- To be treated with respect and recognition of your dignity and right to privacy
- To actively participate with providers in making decisions about your health care, to the extent permitted by law, including the right to refuse treatment or leave a hospital setting against the advice of the attending Physician
- To expect candid discussion of appropriate, or Medically Necessary, treatment options regardless of cost or benefit coverage
- To voice a complaint or to appeal a decision to SHP about the organization or the care it provides, and to expect that a process is in place to assure timely resolution of the issue
- To make recommendations regarding SHP's Member Rights and Responsibilities policies
- To know the name of the provider who has primary responsibility for coordinating your care and the names and professional relationships of others who may provide services, including the practitioner's education, certification or accreditation, licensure status, number of years in practice and experience performing certain procedures
- To receive information about your illness, the course of treatment and prospects for recovery in terms that can be easily understood
- To receive information about proposed treatments or procedures to the extent necessary for you to make an informed consent to either receive or refuse a course of treatment or procedure. Except in emergencies, this information shall include: a description of the procedure or treatment, medically significant risks associated with it, alternate courses of treatment or non-treatment including the risks involved with each and the name of the person who will carry out a planned procedure
- To confidential treatment and privacy of all communications and records pertaining to care you received in any health care setting. Written permission will be obtained before medical records are made available to persons not directly concerned with your care, except as permitted by law or as necessary in the administration of SHP. SHP's policies related to privacy and confidentiality are available to you upon request
- To full consideration of privacy and confidentiality around your plan for medical care, case discussion, consultation, examination and treatment, including the right to be advised of the reason an individual is present while care is being delivered
- To reasonable continuity of care along with advance knowledge of the time and location of an appointment, as well as the name of the provider scheduled to provide your care
- To be advised if the provider proposes to engage in or perform human experimentation within the course of care or treatment and to refuse to participate in such research projects if desired
- To be informed of continuing health care requirements following discharge from a hospital or provider office
- To examine and receive an explanation of bills for services regardless of the source of payment
- To have these Member rights apply to a person with legal responsibility for making medical care decisions on your behalf. This person may be your Provider
- To have access to your personal medical records
- To formulate advance directives for health care

SHP Public Policy Participation Subcommittee

SHP has a Public Policy Participation subcommittee to the health plan's Board of Directors. The subcommittee includes providers, members, and employer clients who advise on ways to improve member and employer client experience. This may include reviewing materials and programs and providing candid feedback and suggestions for improvement. If you would like to be considered for this committee, please write to SHP at:

Sutter Health Plus
Attn: Administration
P.O. Box 160307
Sacramento, CA 95833

What Are My Responsibilities?

It is the expectation of SHP and its providers that enrollees adhere to the following Member responsibilities to facilitate the provision of high-level quality of care and service to Members.

Your Member responsibilities include but are not limited to the following:

- To know, understand and abide by the terms, conditions, and provisions set forth by SHP as your health plan. (The *Evidence of Coverage and Disclosure Form (EOC)* contains this information)
- To supply SHP and its providers and practitioners (to the extent possible) the information they need to provide care and service to you. This includes informing SHP's Member Services when a change in residence occurs or other circumstances arise that may affect entitlement to coverage or eligibility
- To select a PCP who will have primary responsibility for coordination of your care and to establish a relationship with that PCP
- To learn about your medical condition and health problems and to participate in developing mutually agreed upon treatment goals with your practitioner, to the degree possible
- To follow preventive health guidelines, prescribed treatment plans and guidelines/instructions that you have agreed to with your health care professionals and to provide to those professionals information relevant to your care
- To schedule appointments as needed or indicated, to notify the Participating Provider when it is necessary to cancel an appointment

and to reschedule cancelled appointments if indicated

- To show consideration and respect to the providers and their staff and to other patients
- To express Grievances regarding SHP, or the care or service received through one of SHP's providers, to SHP Member Services for investigation through SHP's Grievance process
- To ensure SHP is notified within 24 hours of receiving the care or as soon as is reasonably possible when you are admitted to non-Participating Hospitals or for Post-Stabilization Care authorization.

To facilitate greater communication between patients and providers, SHP will:

- Upon the request of a Member, disclose to consumers factors, such as methods of compensation, ownership of or interest in health care facilities, that can influence advice or treatment decisions
- Ensure that provider contracts do not contain any so-called "gag clauses" or other contractual mechanisms that restrict the health care provider's ability to communicate with or advise patients about Medically Necessary treatment options

Reporting Suspected Fraud and Abuse

SHP's compliance program integrates ethical, legal and regulatory guidance to foster an environment in which Members are empowered and encouraged to ask questions and report concerns.

The SHP anti-fraud program serves to prevent, detect and correct instances of fraud, thereby reducing costs to Members and others caused by fraudulent activities. The anti-fraud program also serves to protect consumers in the delivery of health care services through the timely detection, investigation, and prosecution of suspected fraud in accordance with Section 1348 of the Knox-Keene Act, and applicable federal and state regulations.

There are many examples of fraud and abuse which include:

- Billing for services or items that were not provided
- Billing for services or equipment that are more expensive than what was supplied
- Members allowing someone else to use their SHP ID card

- A provider paying a Member to obtain care or services
- Identity theft
- Falsifying medical records

SHP Members should report any suspected fraud and abuse to SHP via one of the following methods:

- By calling: SHP Member Services at 1-855-315-5800 (TTY 1-855-830-3500)
- By email: shpcompliance@sutterhealth.org

If sending an email please include the following information:

- Date suspected fraud occurred
- Date suspected fraud was discovered
- Where suspected fraud occurred
- A description of the incident or suspected fraud
- A list of all persons engaged in this suspected fraud
- Description of how you became aware of the suspected fraud
- A list of any individuals who have attempted to conceal the issue, and the steps they took to conceal it

DEFINITIONS

Some terms have special meaning in this *Evidence of Coverage and Disclosure Form (EOC)*. When Sutter Health Plus (SHP) uses a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this Definitions section have special meaning when capitalized and used in any section of this *EOC*.

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.

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.

Benefit Year: This is the 12-month period during which the Member's or employer Group's plan of coverage is effective, which may be either a calendar year (start date of January 1) or a plan year (start date varies based on employer Group's contract).

Charges: Means the Participating Provider's contracted rates or the actual Charges payable for Covered Services, whichever is less. Actual Charges payable to non-Participating Providers shall not exceed usual, customary and reasonable Charges as determined by SHP.

Child: A Child means an adopted, step, or recognized natural child or any child for whom the employee has assumed a parent-child relationship, as indicated by intentional assumption of parental status, or assumption of parental duties by the employee, as certified by the employee at the time of enrollment of the child, and annually thereafter up to the age of 26 unless the child is disabled. A disabled child is one who at the time of attaining age 26, is incapable of self-support because of a physical or mental disability which existed continuously from a date prior to attainment of age 26 until termination of such incapacity.

Clinically Stable: You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Coinsurance: A percentage of Charges that you must pay when you receive a Covered Service as described in the What You Pay chapter and in the *Benefits and Coverage Matrix*.

Copayment(s): A specific dollar amount that you must pay when you receive a Covered Service as described in the What You Pay chapter and in the *Benefits and Coverage Matrix*.

Cost Sharing: The amount you are required to pay for a Covered Service (i.e., Deductibles, Copayments or Coinsurance). Refer to the *Benefits and Coverage Matrix* for Cost Sharing information.

Covered Services: Means those Medically Necessary health care services and supplies which a Member is entitled to receive, described in the Emergency Services and Urgent Care and Your Benefits chapters subject to the Exclusions and Limitations chapter of this *EOC*.

Deductible: The amount you must pay in a Benefit Year for certain Covered Services before SHP will cover those Covered Services at the applicable Copayments or Coinsurance in that Benefit Year. Refer to the *Benefits and Coverage Matrix*, for more information about the Covered Services that are subject to Deductibles.

Dependent: Means the Spouse, or Child of an SHP Subscriber, who works or resides within the Service Area and who is eligible for enrollment as a dependent in SHP and includes the Spouse or Child, of guaranteed association members if the association elects to include dependents under its health coverage at the same time it determines its membership composition.

Eligible Employee: Means an individual who lives or works in SHP's Service Area and who meets the Group's eligibility requirements.

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

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

An Emergency Medical Condition is also "active labor," which means a labor when there is inadequate time for safe transfer to a Participating Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn Child.

A psychiatric Emergency Medical Condition is a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the Member as being one either of the following:

- An immediate danger to himself or herself or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

Emergency Services: All of the following with respect to an Emergency Medical Condition:

- A medical screening exam that is within the capability of the emergency department of a hospital, including services such as imaging and laboratory, routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, services you receive are Post-Stabilization Care and not Emergency Services)
- 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

Essential Health Benefits (EHBs): A set of health care service categories identified by the Patient Protection and Affordable Care Act that must be covered by certain health plans as of 2014.

Evidence of Coverage and Disclosure Form (EOC): This EOC document, which describes the health care coverage under SHP's Group Subscriber Contract with your Group.

Exchange: The California Health Benefit Exchange created by Section 100500 of the Government Code.

Family: A Subscriber and all of his or her Dependents.

Generic Drug/Drugs: As defined by the US Food and Drug Administration (FDA), a Generic Drug is identical – or bioequivalent - to a brand name drug in dosage, safety, strength, how it is taken, quality, performance, and intended use. Before approving a Generic Drug product, FDA requires many rigorous

tests and procedures to assure that the Generic Drug can be substituted for the brand name drug. The FDA bases evaluations of substitutability, or "therapeutic equivalence," of Generic Drugs on scientific evaluations. By law, a Generic Drug product must contain the identical amounts of the same active ingredient(s) as the brand name product. Drug products evaluated as "therapeutically equivalent" can be expected to have equal effect and no difference when substituted for the brand name product. A Generic Drug typically costs less than the brand name drug.

Group: The entity, usually an employer, with which SHP has entered into the Group Subscriber Contract that includes this EOC.

Group Subscriber Contract: Means the contract between your Group and SHP that establishes the Covered Services Members are entitled under this EOC.

Life-threatening: means either or both of the following:

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

Maintenance Drugs: Maintenance Drugs are drugs that do not require frequent dosage adjustments, which are usually prescribed for long-term use, such as birth control, or for a chronic condition, like diabetes or high blood pressure. These drugs are usually taken longer than 60 days.

Medical Group: Means a group of Physicians and other providers who do business together who have entered into a written agreement with SHP to provide or arrange for the provision of Covered Services and to whom a Member is assigned for purposes of primary medical management.

Medical Services: Means those professional services of Physicians and other health care professionals, including medical, surgical, diagnostic, therapeutic and Preventive Care Services, which are included in Your Benefits chapter and which are performed, prescribed or directed by a Participating Physician or health care professional otherwise authorized under California law to practice his or her profession in the State of California.

Medically Necessary: Means that which SHP determines:

- Is appropriate and necessary for the diagnosis or treatment of the Member's medical condition, in accordance with professionally recognized standards of care
- Is not mainly for the convenience of the Member or the Member's Physician or other provider, and
- Is the most appropriate supply or level of service for the injury or illness

For hospital admissions, this means that acute care as an inpatient is necessary due to the kind of services the Member is receiving, and that safe and adequate care cannot be received as an outpatient or in a less intensive medical setting.

Medicare: The federal health insurance program for people aged 65 or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Member: Means a Subscriber or qualified Dependent Family Member who is entitled to receive Covered Services under this EOC and for whom we have received applicable Premium.

Other Health Professional: Means non-Specialist practitioners such as dentists, nurses, podiatrists, optometrists, physician's assistants, clinical psychologists, social workers, pharmacists, nutritionists, occupational therapists, physical therapists and other Professionals engaged in the delivery of health services who are licensed to practice, are certified, or practice under authority authorized by applicable California law.

Out-of-Area Urgent Care: Medically Necessary services to prevent serious deterioration of your (or your unborn Child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside SHP's Service Area; and
- You reasonably believed that your (or your unborn Child's) health would seriously deteriorate if you delayed treatment until you returned to SHP's Service Area

Out-of-Pocket Maximum: The annual Out-of-Pocket Maximum is the total amount a Member is liable to pay each year for most Covered Services. When the Member reaches the applicable Out-of-Pocket Maximum the Member is not required to pay any additional Cost Sharing fees, such as Copayments, Coinsurance or Deductibles, for the

remainder of the Benefit Year. SHP accounts for both mental health and non-mental health services when calculating amounts paid towards Deductibles and Out-of-Pocket Maximums.

Outpatient Prescription Drugs: Self-administered drugs approved by the Federal Food and Drug Administration for sale to the public through retail or mail-order pharmacies that require prescriptions and are not provided for use on an inpatient basis. "Self-administered" means those drugs that need not be administered in a clinical setting or by a licensed health care provider.

Parity: Parity refers to federal requirements that annual lifetime or dollar limits on mental health benefits be no lower than any such dollar limits for medical benefits offered by a Group health plan.

Participating Hospital: Means a duly licensed hospital which, at the time care is provided to a Member, has a contract in effect with SHP or a Contracted Medical Group to provide hospital services to Members. The Covered Services which some Participating Hospitals may provide to Members are limited by SHP's utilization review and quality assurance policies or by SHP's contract with the hospital.

Participating Pharmacy: Means a pharmacy under contract with SHP through Express Scripts, authorized to dispense covered Prescription Drugs to Members. To find a Participating Pharmacy, contact Express Scripts Customer Service or register on the Express Scripts website at [express-scripts.com](https://www.express-scripts.com) and use the Locate a Pharmacy service.

Participating Physician: Means a Physician who, at the time care is provided to a Member, has a contract in effect with SHP or an SHP-contracted plan partner, Medical Group or independent practice association (IPA) to provide Covered Services to Members.

Participating Practitioner: A psychiatrist, psychologist or other allied behavioral health care professional who is qualified and duly licensed, certified or otherwise authorized under California law to practice his or her profession under the laws of the State of California and who has entered into a written agreement with USBHPC to provide Mental Health, Behavioral Health or Substance Use Disorder Treatment Services to Member.

Participating Provider: Means a Contracted Medical Group, Participating Physician, Participating Hospital or other licensed health professional or licensed health facility or Other Health Professional otherwise authorized under California law to practice his or her profession in the State of California who or which, at the time care is provided to a Member, has

a contract in effect with SHP to provide Covered Services to Members.

Participating Qualified Autism Service Provider:

Means either of the following:

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

Participating Qualified Autism Service

Professional is an individual who meets all of the following criteria:

- Provides Behavioral Health Treatment, which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider
- Is supervised by a Participating Qualified Autism Service Provider
- Provides treatment pursuant to a treatment plan developed and approved by the Participating Qualified Autism Service Provider
- Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program
- Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code

- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan

Participating Qualified Autism Service

Paraprofessional: An unlicensed and uncertified individual who meets all of the following criteria:

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

Post-Stabilization Care: Medically Necessary services related to your Emergency Medical Condition that you receive after your treating physician determines that this condition is Stabilized.

PPACA: Means the Patient Protection and Affordable Care Act and any rules, regulations, or guidance issued thereunder.

Premiums: Means the payment fee to be paid by or on behalf of Members in order to be entitled to receive the Covered Services provided for in this EOC.

Preventive Care Services: Services that do one or more of the following:

- Protect against disease, such as in the use of immunizations
- Promote health, such as counseling on tobacco use
- Detect disease in its earliest stages before noticeable symptoms develop, such as screening for breast cancer

Primary Care Physician or PCP: Means a Participating Physician who:

- Practices in the area of family practice, internal medicine, pediatrics, general practice or obstetrics/gynecology
- Acts as the coordinator of care, including such responsibilities as supervising continuity of care, record keeping and initiating referrals to Specialist physicians for Members who select such a Primary Care Physician
- Is designated as a Primary Care Physician by the Medical Group

Prior Authorization: The process used by Sutter Health Plus/Medical Groups to review a request for specified health care services/products, resulting in a decision (based on applicable medical standards/criteria, regulatory requirements, plan benefits, etc.) to either approve, modify or deny the requested service or item

Professional: Means a Primary Care Physician (PCP), Specialist or Other Health Professional.

Residential Treatment Center: A residential facility that provides services in connection with the diagnosis and treatment of behavioral health conditions including, but not limited to substance use disorders and which is licensed, certified, or approved as such by the appropriate state agency

Service Area: The geographic area in which Sutter Health Plus is licensed to provide services.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. A Skilled Nursing Facility (SNF) may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Specialist: Includes physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology and other designated as appropriate.

Specialty Drugs: Drugs that are often high cost, have the potential for significant waste and have one or more of the following characteristics:

- Therapy of chronic or complex disease
- Specialized patient training and provider coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy

- Unique patient compliance and safety monitoring requirements
- Unique requirements for handling, shipping and storage
- Have restricted distribution by the U.S. Food and Drug Administration

Specialty Pharmacy: A licensed facility for the purpose of dispensing Specialty Drugs.

Spouse: The Subscriber's legal husband or wife, "Spouse" includes the Subscriber's registered domestic partner who meets all of the requirements of Sections 297 or 299.2 of the California Family Code. If your Group allows enrollment of domestic partners who do not meet all of the requirements of Sections 297 or 299.2 of the California Family Code, the term "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners.

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn Child), Stabilize means to deliver (including the placenta).

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see Who Is Eligible section in the Enrolling in SHP and Adding New Dependents chapter).

Surrogate Pregnancy: A pregnancy in which a woman (the surrogate) has agreed to become pregnant with the intention of surrendering custody of the child to another person.

Transitional Residential Recovery Services: Substance use disorder treatment in a nonmedical transitional residential recovery setting. This setting provides counseling and support services in a structured environment.

Urgent Care: Medically Necessary services for a condition that requires prompt medical attention but is not an Emergency Medical Condition. Urgent Care services are Medically Necessary to prevent serious deterioration of a Member's health resulting from unforeseen illness, injury or complications of an existing medical condition