Sutter Health Plus
We Plus You

Sutter Health Plus Large Group Disclosure Form and Evidence of Coverage

Plan Name: Sutter Health Plus HMO HDHP

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.

Effective January 1, 2014

Sutter Health Plus
2880 Gateway Oaks Drive, Suite 150
Sacramento, CA 95833

Member Services
8:00 AM – 7:00 PM
Monday - Friday
1(855) 315-5800
Hearing and speech impaired
TTY line 1(855)830-3500
www.sutterhealthplus.org

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INTRODUCTION

Welcome to Sutter Health Plus! We are committed to arranging the highest quality of care for you in order to meet your health care needs. This combined Evidence of Coverage and Disclosure Form (EOC) is the roadmap that describes how, when and where you access covered health care services. Every applicant has a right to view the EOC prior to enrollment. Please it read carefully and completely to make sure you understand how the plan works.

If you have special healthcare needs please pay particular attention to sections of this EOC that address such needs. In addition to describing the benefits available under the plan and how to access them, this EOC also describes the costs associated with receiving covered health care services, the limitations and exclusions provided for under the plan, how you can file a grievance or expedited grievance with the plan as well as other important features about the plan.

A special note about US Behavioral Health Plan, California ("USBHPC"). SHP has contracted with USBHPC to provide you with Behavioral Health Care Services, including Mental Health and Substance Use Disorder Treatment Services. This EOC explains how to access Behavioral Health Care services provided by USBHPC. SHP and USBHPC have processes for the coordination of your care when you need care from providers in both SHP and USBHPC provider networks, but it is also very important that you read and understand the information provided in this EOC, and especially the processes that apply and the contact information to use when you need assistance. Please see, in particular, the sections entitled "Choosing a Provider," "Referrals to Specialists," Prior Authorization," and "Mental Health, Behavioral Health and Substance Use Disorder Services.":

In some places, this EOC refers to SHP and USBHPC individually as "Health Plan" and collectively as "Health Plans.

SHP Member Services: 1-855-315-5800 (TTY users call 1-855-320-5200)

USBHPC Member Services: 855-202-0984

Please note this Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health plan. The Group Subscriber Contract must be consulted to determine the exact terms and conditions of coverage.

To request a copy of the contract between your employer and Sutter Health Plus, commonly referred to as the Group Subscriber Contract, please contact your employer. If you have questions about the information provided in this EOC or need assistance to access or use your benefits, you can contact Sutter Health Plus' Member Services at 1-855-315-5800 (TTY users call 1-855-320-5200). Sutter Health Plus also has a website, www.sutterhealthplus.org where you can find valuable information about your coverage and the Sutter Health Plus provider network.

Language Assistance

Language assistance services, including translations of vital documents and interpreter services, are available for our members who have a limited or no ability to speak English. These language assistance services are available to you at no cost. If you need language assistance services, please contact Member Services at 1-855-315-5800 (TTY users call 1-855-320-5200).

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

HEALTH PLAN BENEFITS AND COVERAGE MATRIX

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

BENEFIT PLAN NAME: Sutter Health Plus HMO HDHP

HEALTH SAVINGS ACCOUNT (HSA)-COMPATIBLE PLAN

Plan Year Deductible (Combined Medical and Pharmacy)	
For self-only enrollment (a Family of one Member).....	$1,500
For an entire Family of two or more Members[1].....	$3,000
Maximum Benefits	Unlimited
Plan Year Out-of-Pocket Maximum (Combined Medical and Pharmacy)[2]	
For self-only enrollment (a Family of one Member).....	$1,500
For an entire Family of two or more Members[1].....	$3,000
Professional Services (Plan Provider office visits)	**You Pay**
Primary care consultations, exams, and treatment, except as listed below[3].....	$0 per visit after deductible
Specialty care consultations, exams, and treatment, except as listed below[3].....	$0 per visit after deductible
Other practitioner office visit[3, 4].....	$0 per visit after deductible
Preventive and routine physical maintenance exams (including routine screening tests).....	No Charge
Well-child preventive care exams (through age 23 months).....	No Charge
Family planning counseling and services[5].....	No Charge
Eye exams for refraction.....	No Charge
Hearing exams.....	No Charge

Urgent care consultations, exams, and treatment…….	$0 per visit after deductible
Physical, occupational, and speech therapy (including rehabilitation and habilitation)……...	$0 per visit after deductible
Acupuncture (PCP referral required)[6]……..	$0 per visit after deductible

Outpatient Services	**You Pay**
Outpatient surgery (facility fee)……...	$0 per visit after deductible
Outpatient surgery (physician/surgeon fees)……	$0 per visit after deductible
Immunizations (including vaccines)…….	No Charge
Laboratory Tests (non-preventive)……..	$0 per visit after deductible
Preventive X-rays, screenings, and laboratory tests as described in the "Your Benefits" section	No Charge
Imaging (MRI, CT, and PET scans)…….	$0 per visit after deductible
Diagnostic and therapeutic X-rays and imaging……...	$0 per visit after deductible

Hospitalization Services	**You Pay**
Facility Fee (e.g. hospital room)……..	$0 per day after deductible
Physician/Surgeon Fee……	$0 per day after deductible

Emergency Health Services	**You Pay**
Emergency Room visits……	$0 per visit after deductible

This cost sharing does not apply if admitted directly to the hospital as an inpatient for covered services. If admitted directly to the hospital as an inpatient stay, the Cost Sharing for "Hospitalization Services" will apply.

Ambulance Services	**You Pay**
Ambulance Services…….	$0 per trip after deductible

Prescription Drug	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines at network retail pharmacies or through mail-order service:	
For Drugs Filled at Outpatient Retail Pharmacies	
Generic Drugs……..	$0 after deductible for up to a 30-day supply
Preferred brand drugs……	$0 after deductible for up to a 30-day supply
Non-preferred brand drugs……	$0 after deductible for up to a 30-day supply
Specialty Drugs…….	$0 after deductible for up to a 30-day supply
For Drugs Filled Through Mail-Order Service (90-day supply)	
Generic Drugs……..	$0 after deductible for up to a 90-day supply
Preferred brand drugs……	$0 after deductible for up to a 90-day supply
Non-preferred brand drugs……	$0 after deductible for up to a 90-day supply
Specialty Drugs…….	$0 after deductible for up to a 90-day supply
Deductible for Generic Drug…….	$0
Deductible for Brand-Name Drugs……	$0

Durable Medical Equipment	**You Pay**
The durable medical equipment for home use listed in the "Your Benefits" section in accord with our durable medical equipment formulary guidelines (limited to $2,500 benefit maximum per Plan Year)…….	$0 after deductible

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization……..	$0 per day after deductible
Day treatment, partial hospitalization and residential treatment center……..	$0 per day after deductible
Individual Outpatient mental health services evaluation and treatment…….	$0 per visit after deductible

Chemical Dependency Services	You Pay
Inpatient chemical dependency hospitalization, including detoxification……..	$0 per day after deductible
Day treatment, intensive outpatient program and residential treatment center……...	$0 per day after deductible
Individual outpatient chemical dependency evaluation and treatment……...	$0 per visit after deductible

Pregnancy Services	You Pay
Prenatal care and preconception visits……	No Charge
Delivery and all inpatient services (Hospital)…….	$0 per day after deductible
Delivery and all inpatient services (Professional)……..	$0 per day after deductible

Home Health Services	You Pay
Home health care (up to 100 visits per Plan Year)…….	$0 per visit after deductible

Other	You Pay
Skilled nursing care (up to 100 visits per Plan Year)…….	$0 per day after deductible
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the "Your Benefits" section…….	No Charge
Hospice Care……..	No Charge

Footnotes:

1. Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out-of-pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out-of-pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out-of-pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
2. Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
3. Member cost-sharing will be charged separately from a preventive service provided during an office visit.

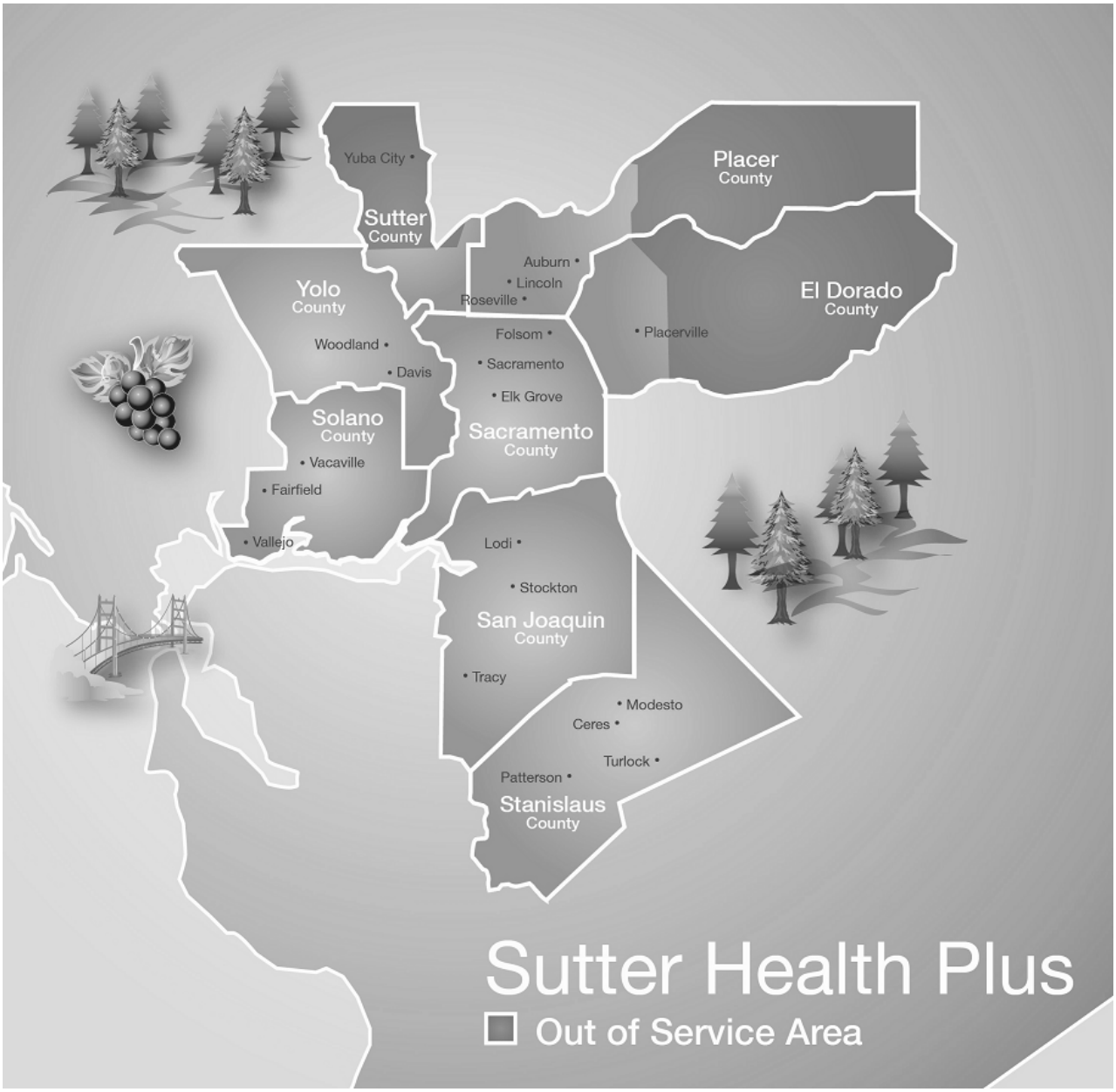
4. "Other practitioner Office Visits" include Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

5. This category of services include all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include termination of pregnancy or male sterilization procedures, which are covered under "outpatient surgeries and certain other outpatient procedures."

6. Typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.

7. Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.

SHP SERVICE AREA MAP



HOW TO USE THE PLAN

This section of the EOC provides you with important plan contact information and describes, in general terms, how to access and use 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 Evidence of Coverage.

How to Contact SHP

We are here to help you. Call us if:

- You have a question or a problem.
- You need a new Primary Care Physician.
- You need to replace your membership card.

SHP Member Services can be reached by calling toll free 1-855-315-5800 (TTY users call 1-855-320-5200) between the hours of 8:00AM and 7:00PM Pacific Time Monday through Friday. The SHP website also provides valuable information at www.sutterhealthplus.org. You can write to SHP at 2880 Gateway Oaks Drive, Suite 150, Sacramento, CA 95833.

Your SHP Membership Card

Your membership card will be provided to you after enrollment. It lists important phone numbers and you should show it whenever you get health care services.

The SHP Service Area

SHP has a service area in which it provides health care coverage. You must live or work in one of the zip codes in the service area in order to become a member of SHP. You must receive all Covered Services within the SHP service area, unless you need Emergency Services or Urgent Care. If you move out of the service area or no longer work within its boundaries, you must notify SHP.

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 get your health care from your Primary Care Physician and other providers who are in the network. Request a SHP Provider Directory by calling 1-855-315-5800 (TTY users call 1-855-320-5200).
- If you go to providers outside the network, you will have to pay all of the cost, unless you received prior authorization (pre-approval) from either your Medical Group or SHP or you needed Emergency Services or you needed Urgent Care away from home.
- If you are new to SHP or SHP ends your provider's contract, you can continue to see your current doctor or other health care provider in some cases. This is called "continuity of care".

Understanding SHP's Relationship with Participating providers

SHP contracts with Participating Providers to provide health care services to SHP Members. The basic method of provider reimbursement used by SHP is "capitation": a per member per month payment by SHP to its contracted providers. Because SHP is a California nonprofit health plan, owned and directed by Sutter Health, a local nonprofit healthcare system, there are no bonus schedules or financial incentives in place between SHP and its contracted 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 additional information regarding provider compensation issues, you may request additional information from SHP, the provider or the provider's medical group or IPA (Independent Practice Association)

SHP also contracts with US Behavioral Health Plan, California (USBHPC) to administer and coordinate the Mental Health, Behavioral Health and Substance Use Disorder Treatment Services covered under the Group Subscriber Contract. USBHPC maintains a network of facilities and professional health care services providers who are contracted to provide these services to you. SHP and USBHPC are committed to assuring that the services provided by USBHPC network are properly coordinated with the services provided by the SHP contracted network.

SHP provides for your Outpatient Prescription Drug benefit, including mail order prescriptions, through a contract with OptumRx, a pharmacy benefit company that contracts with many pharmacies in the SHP service area, to enable you to obtain your prescription drugs from pharmacies located near you.

SHP has contracted with VSP to provide vision benefits. Please refer to the section under "Vision Services" for a complete description of the vision benefits.

SHP's contracts with Participating Providers include requirements that you are not financially responsible for any amounts that SHP owes to a Participating Provider. USBHPC, OptumRx, Delta Dental and VSP contracts with their Participating Providers include similar requirements. However, you may be liable for the cost of non-Covered Services or Covered Services you obtain from non–Participating Providers. Please carefully read the information regarding when and how

to obtain prior authorization for Covered Services in chapter "Authorization, Modification and Denial of Health Care Services".

Your Primary Care Physician and Medical Group

When you join SHP, you need to choose a Primary Care Physician (also called a PCP). This doctor provides your basic care and coordinates the care you need from other providers.

Your Primary Care Physician 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 must also select that PCP's Medical Group. In the event your chosen PCP is in more than one medical group, choose the medical group that has the participating specialists you will want to see when your PCP refers you for specialty care.

Language and Communication Assistance

Good communication with SHP and with your providers is important. If English is not your first language, SHP provides interpretation services and translation of certain written materials.

- To ask for language assistance services call SHP at 1-855-315-5800 (TTY users call 1-855-320-5200).
- If you are deaf, hard of hearing or have speech impairment, you may also receive language assistance services by calling SHP via TTY at 1-855-320-5200.
- If you have a preferred language, please notify us of your personal language needs by calling 1-855-315-5800 (TTY users call 1-855-320-5200).
- You need a referral from your Primary Care Physician and prior authorization (pre-approval) from either your Medical Group or SHP for many Covered Services

How to Get Health Care When You Need It

Call your Primary Care Physician or, for mental health or chemical dependency services, call your USBHPC provider, unless it is an emergency.

- You need a referral from your Primary Care Physician or your USBHPC provider and prior authorization (pre-approval) from your Medical Group, SHP or USBHPC for many Covered Services. See chapter "Authorization, Modification and Denial of Health Care Services".
- The care must be Medically Necessary for your health. Your health care providers, SHP and USBHPC follow guidelines and policies to decide if the care is Medically Necessary. If you disagree with SHP or USBHPC about whether a service you want is Medically

Necessary, you can request an Independent Medical Review. See chapter "Independent Medical Review (IMR)".

- The care must be a service that SHP covers. (Covered Services are also called "benefits.)
- For information regarding the specific Covered Services SHP provides, please see the "Emergency Services and Urgent Care" and "Your Benefits" chapters.

Emergency Care (see chapter EMERGENCY SERVICES AND URGENT CARE)

Emergency care is covered anywhere in the world.

- If it is an emergency, call 9-1-1 or go to the nearest hospital.
- If you can, go to a hospital in the SHP network. If you are admitted to a hospital that is not in the 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 hospital and doctors handling your care, make appropriate and necessary payment provisions.
- It is an emergency if you reasonably believe that not getting immediate care could be dangerous to your life or to a part of your body. Emergency care may include care for a bad injury, severe pain, a sudden serious illness, active labor, or an emergency psychiatric condition.
- Go to your Primary Care Physician for follow-up care after you leave the hospital. Do not go back to the emergency room for follow-up care.

Urgent Care (see chapter EMERGENCY SERVICES AND URGENT CARE)

Urgent care is care that you need soon to prevent a serious health problem or serious deterioration in your health due to unforeseen illness or injury. Urgent care is covered anywhere in the world. If you think you need Urgent Care, please call your Primary Care Physician or the SHP Nurse Advice Line at 1-855-836-3500.

Care When You Are Away from Home

- Only Emergency Services and Urgent Care are covered.
- If you are admitted into a hospital because of an Emergency Medical Condition, you must let SHP know within 24 hours, or as soon as you can.

Costs *(*see the "Health Plan Benefits and Coverage Matrix")

- The "Premium" is what you and/or your employer pays each month to SHP to keep coverage.
- A "Copayment" is the amount that you must pay each time you see a doctor or get other Covered Services.
- "Coinsurance" is the percentage of a health plan's cost that you must pay each time you see a doctor or get other Covered Services.
- The yearly Deductible is the amount you pay directly to providers for certain Covered Services, before SHP starts to pay.
- The yearly (annual) out-of-pocket maximum is the most money you have to pay for most of your health care in SHP in a year. Some Covered Services, such as prescription drugs, may not be included in this maximum.
- After you pay your Copayments or Coinsurance and you have met your yearly Deductible if you have one, SHP pays the rest of the cost of the service, as long as it is a Covered Service.

If You Have a Concern or Dispute with SHP *(see chapter IF YOU HAVE A CONCERN OR DISPUTE WITH SHP)*

- If you have a concern or dispute with SHP, you can file a grievance with SHP.
- If you disagree with SHP's decision about your grievance, you can get help from the State of California's Health Plan Help Center. The Health Plan Help Center can help you apply for an Independent Medical Review (IMR) or file a grievance. IMR is a review of your case by doctors who are not part of your health plan.

WHAT YOU PAY

This chapter tells you about your costs in SHP. The costs you pay may include:

- Premiums
- Copayments
- Coinsurance
- Yearly deductible
- Yearly out-of-pocket maximum

This chapter also tells you what you need to do if:

- You have to pay for care at the time you get it.
- You have more than one health plan (Coordination of Benefits).
- If there is third party liability

Premiums

A Premium is the amount that SHP charges each month for health care. Usually your employer pays part of the Premium and you pay the rest. The amount you pay is usually taken out of your paycheck each month. If you have questions about your Premium, please ask your employer. If the Premium changes, SHP will let your employer know in writing at least 30 days before the change takes effect. The Premium usually changes only when your employer renews its Group Subscriber Contract with SHP.

Premium Rates; Variables

The amount of your premium will vary according to 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 premiums. Your employer will provide you with detailed information on your premium.

Copayments

A Copayment is the amount that you pay each time you see a doctor in the SHP network or get Covered Services. You have to pay a Copayment for most Covered Services you get and you must pay the Copayment at the time you get the service. Different kinds of Covered Services may have different Copayment amounts. For example, doctor visits, emergency room visits, and hospital stays have different Copayments. The Copayments are listed in the "Health Plan Benefits and Coverage Matrix".

Coinsurance

Co-insurance is the percent of the cost of a service that you must pay. Co-insurance amounts are listed in the "Health Plan Benefits and Coverage Matrix".

SPECIAL NOTES REGARDING COPAYMENTS AND COINSURANCE

- References to "Annual" or "Yearly" mean the twelve (12) month period of your plan contract, which might not start on January 1st of each year. Knowing when your plan contract starts and renews is very important when keeping track of your deductibles and out of pocket maximum cost share as described below.
- If you receive services from more than one provider in a day, and separate copayments or coinsurance apply to the services of each provider, then you will be required to pay all applicable copayments/coinsurance, even if the services are provided in the same location, such as your home or a medical clinic. For example, if you have outpatient appointments in the same day for physical therapy and speech therapy after an injury, you will pay the applicable copayment at each office visit with each provider.

Deductible

A Deductible is the amount you must pay each year to providers before SHP starts to pay part of the costs. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out-of-pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out-of-pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out-of-pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.For information about the Covered Services subject to the Deductible, please see the "Health Plan Benefits and Coverage Matrix". All amounts paid towards the annual Deductible will also apply to the annual out-of-pocket maximum, which is explained in the next section "Annual Out of Pocket Maximum."

When you pay any cost share amounts that apply to your annual Deductible, you should ask for and keep the receipt. If you believe that you have reached your annual Deductible, please call Member Services for directions on how to submit copies of your receipts and receive a statement that you reached your Annual Deductible and 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.)

This is an "umbrella" deductible, which means that for members with family coverage, an individual member of the family unit will not reach the deductible until the total paid by all members of the family unit reaches the stated deductible for the entire family.

Annual Out-of-Pocket Maximum

The "annual (yearly) out-of-pocket maximum" is the total you have to pay each year for most of your Covered Services. Each family member has an annual out-of-pocket maximum. If you are a Member in a Family of two or more Members, you reach the annual out-of-pocket maximum either when you meet the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the **$1,500** maximum. For Covered Services subject to the maximum, you will not pay any more Cost Sharing during the rest of the calendar year for Covered Services subject to the out-of-pocket maximum, but every other Member in your Family must continue to pay Cost Sharing during the calendar year until your Family reaches the **$3,000** maximum.

This is an "umbrella" out-of-pocket maximum, which means that for members with family coverage, an individual member of the family unit will not reach the out-of-pocket maximum until the total Cost Sharing, including the deductible, paid by all members of the family unit reaches the stated out-of-pocket maximum for the entire family.

When you pay a Cost Sharing amount that applies toward the annual out-of-pocket maximum, ask for and keep the receipt. For information about the Covered Services subject to the annual out-of-pocket maximum, please see the "Health Plan Benefits and Coverage Matrix". When the receipts add up to the annual out-of-pocket maximum, please call our Member Services to find out where to turn in your receipts. When you turn them in, we will give you a document stating that you don't have to pay any more Cost Sharing for Covered Services subject to the annual out-of-pocket maximum through the end of the calendar year.

SHP complies with state and federal laws that establish "parity" and cost-share coordination requirements for mental health care and chemical dependency treatment services. ("Cost share coordination" means accounting for the Member's share of cost paid for both mental health and non-mental health services when calculating amounts paid towards deductibles and out of pocket maximums.) If you have any concerns regarding co-payments, deductibles or out of pocket maximum amounts in connection with Mental Health, Behavioral Health or Substance Use Disorder Treatment Services provided to you, please call USBHPC's Member Services at 855-202-0984 or SHP Member Services at 1-855-315-5800 (TTY users call 1-855-320-5200).

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, and then request reimbursement from SHP (or USBHPC if applicable). For example, if you get Emergency Services or Urgent Care from a provider who is not in the SHP or USBHPC network, you may have to pay for the service at the time you get care. Ask the provider to bill SHP directly (or USBHPC, if applicable). If that is not possible, you will have to pay and then ask the Health Plan to reimburse you (pay you back). The Health Plans will reimburse you as long as the care you get is a Covered Service. Please see the "Payments and Reimbursements" chapter for additional information.

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

Coordination of benefits ("COB") is a process used by SHP and other health plans, employer benefit plans, union welfare plans, HMOs, insurance companies, government programs and other types of payors ("Insurers") to make sure that duplicate payments are not made for the same claims when more than one Insurer covers a Member. SHP and other insurers 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 one hundred percent (100%) coverage from all insurers combined. Please contact SHP Member Services for information regarding the coordination of your benefits, or if you would like a copy of SHP's COB policy. All of the benefits provided under this EOC are subject to COB. You are required to cooperate and assist with SHP's coordination of benefits by telling all of your health care 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 coordination of benefits.

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, etc.) and complications incident thereto, SHP will furnish Covered Services. 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 this Health Plan, each Member grants SHP or its Medical Group/IPA, 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. Each Member also specifically agrees as follows:

1) 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;
2) 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;
3) 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

4) 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" means:

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 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 (1/3) of the Recovery if the Member or Representative engages and pays an attorney or one half (1/2) 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 has a network that includes many doctors and other health care providers. Your Primary Care Physician coordinates most of your care. Your Primary Care Physician will refer you to specialists and other providers.

This chapter tells you about:

- Your choice of doctors and providers
- Choosing a Primary Care Physician
- Referrals and pre-approval (prior authorization)
- Getting a second opinion
- Keeping a doctor, hospital, or other provider you go to now (continuity of care)

Your Choice of Doctors and Providers –Your SHP Provider Directory

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

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 SHP Member Services at 1-855-315-5800 (TTY users call 1-855-320-5200)to ensure that you can obtain the health care services that you need.

The SHP Provider Directory lists all the doctors and other providers in the SHP network. It also lists hospitals, clinics, skilled nursing facilities, and other facilities and pharmacies in the network. You must get all of your care from the providers in the SHP network, unless you get Emergency Services or Urgent Care or either your Medical Group or SHP prior authorizes a visit to a provider who is not in our network. To get the latest SHP Provider Directory, call Member Services at 1-855-315-5800 (TTY users call 1-855-320-5200) or go to www.sutterhealthplus.org.

All of SHP's contracts with its Participating Providers state that, if SHP fails to pay a Participating Provider for Covered Services, you, as the Member, will not be liable for sums owed by SHP. However, if you seek Covered Services from a non-Participating Provider that are not Emergency Services or Urgent Care services and you do not have a prior authorization from either the Medical Group or SHP, you will be responsible for the full cost of the services you receive from the non-

Participating Provider. This means the non-Participating Provider can bill you directly for the cost of the services provided and you will be responsible for paying those costs.

SHP makes sure that there are always enough providers in the network, so you can get the care you need, and has quality standards for assuring timely access to appointments as required by state law.

If you would like additional information regarding SHP's standards for appointment waiting times, Please contact SHP Member Services at 1-855-315-5800 (TTY users call 1-855-320-5200).

Choosing a Primary Care Physician

Your Primary Care Physician gives you your basic care and coordinates the care you need from other providers. When you join SHP, you need to choose a Primary Care Physician (also called a PCP). Look for a Primary Care Physician you feel comfortable with and can talk to about all of your health concerns and think of your doctor as your partner in your health care. Each new Member should select a PCP close enough to his or her home or place of work, to allow reasonable access to care. You may also want to consider selecting a doctor who speaks your language. Please be sure to call the office to make sure the doctor you want is taking new patients. When you need to see a specialist or get tests, your Primary Care Physician gives you a referral. When you need care, call your Primary Care Physician first—unless it is an emergency. Most doctors belong to Medical Groups. If your Primary Care Physician cannot see you, someone else in your doctor's Medical Group will see you. Each family member must have a Primary Care Physician. Each family member can choose a different doctor. If you do not choose a Primary Care Physician, SHP will choose one for you. You can change your doctor if you want. To change your doctor, call SHP at 1-855-315-5800 (TTY users call 1-855-320-5200).

When you choose your PCP, you must also select that PCP's Medical Group. In the event your chosen PCP is in more than one Medical Group, choose the Medical Group that has the participating specialists you will want to see when your PCP refers you for specialty care.

Your Primary Care Physician can be:

- A **doctor of internal medicine** (for adults 18 years and older)
- A **family practice doctor** (for adults and children of all ages)
- A **pediatrician** (for children up to age 18)
- An **OB-GYN** (for women) who meets the plan's eligibility criteria for all specialists seeking to be a primary care provider and who has elected to serve as a PCP

Referrals to Specialists

- To see a specialist or another provider, you usually need a referral from your Primary Care Physician 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 will have to pay all of the cost.

The following services do not require a referral from your Primary Care Physician:

Although a referral or prior authorization is not required to receive care from the Participating Providers listed below, the Participating Provider may have to get prior authorization for certain Covered Services. For example, certain labs tests, hospital admissions or transplants may require prior authorization from either SHP or the Medical Group. See the section below on Prior Authorization for the process and timeframes for obtaining prior authorization for referrals to specialists and other services.

- On-call Physician Services: The on-call physician for your Primary Care Physician can provide care in place of your physician.
- Urgent Care: When an Urgent Care situation arises while you are in SHP's Service Area call your Primary Care Physician, any time of the day, including evenings and weekends. Your doctor or the Physician on-call will direct your care. (See Definitions for Urgent Care.)
- Emergency Care: If you are in an emergency situation, please call "911" or go to the nearest hospital emergency room. Notify your Primary Care Physician the next business day or as soon as possible. (See Definitions for Emergency Care.)
- Gynecology Examination: A referral is not needed for gynecological services from a Participating Provider within your PCP's Medical Group.
- Obstetrical Services: A referral is not needed for obstetrical care from a Participating Provider within your PCP's Medical Group.
- Vision: An annual refractive eye exam arranged through VSP does not require a PCP referral. To locate a VSP provider, please visit their website at www.vsp.com or please contact VSP member services at 800-877-7195 for assistance with finding a provider or scheduling your covered services from a VSP Member Doctor.
- Mental Health Behavioral Health and Substance Use Disorder Treatment Services: Mental Health Behavioral Health and Substance Use Disorder Treatment Services are coordinated and administered by US Behavioral Health Plan of California (USBHPC).
    - You do not need a referral from your PCP or from USBHPC to see a USBHPC Participating Provider for office visits for mental health care, behavioral health care, medication management or substance use disorder treatment
    - You may find a USBHPC Participating Provider on line at www.liveandworkwell.com. To access the full website, you must register after you click on www.liveandworkwell.com or call SHP Member Services to obtain the access code. You may also access the link through the SHP web page. and you may call USBHPC at 855-202-0984 for assistance in selecting a USBHPC Participating Provider and making an appointment for Mental Health, Behavioral Health or Substance Use Disorder Treatment Services
    - Certain Mental Health, Behavioral Health and Substance Use Disorder services require prior authorization from USBHPC. Please see the section on Prior Authorization, below.

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 or AIDS, you may be provided with a standing referral. A standing referral is a referral for more than one visit, to 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 or AIDS are designated in our Provider Directory under their licensed specialty with an asterisk.

Prior Authorization

The following health care services require Prior Authorization by your Medical Group or SHP in order to be covered:

- Elective (non-emergency) inpatient admissions
- Outpatient surgeries (does not include minor office procedures performed by a PCP or specialist during an office visit)
- Second opinion consultations for care from a specialist or other licensed health provider outside the member's selected medical group
- Major diagnostic tests (such as MRI, CT Scan, Angiography,)
- Home health care/home infusion
- Hospice care
- Durable medical equipment (DME)
- Prosthetics and orthotics
- New medical technology, drugs, treatment, procedures or equipment that is Investigational or Experimental
- Clinical trials
- Pharmacy drug formulary exceptions, including exceptions to step therapy

Please contact SHP Member Services for additional information regarding services that require prior authorization.

Your Primary Care Physician must contact SHP or in some cases, the participating Medical Group with which your Primary Care Physician is affiliated to request the service or supply be approved for coverage before it is rendered.

The following Mental Health, Behavioral Health or Substance Use Disorder Treatment Services require Prior Authorization by US Behavioral Health Plan of California (USBHPC) in order to be covered:

- Elective (non-emergency) inpatient admissions
- Residential Treatment Services
- Intensive Outpatient Program Treatment
- Outpatient Electro-Convulsive Treatment
- Outpatient Treatment extending beyond 45 minutes
- Psychological Testing – except in the event of an Emergency

For Mental Health, Behavioral Health or Substance Use Disorder Treatment Services, the USBHPC Participating Provider must contact USBHPC for Prior Authorization. If Prior Authorization is not obtained when required, you may be liable for the payment of services or supplies. Requests for Prior Authorization will be denied if the requested services are not Medically Necessary as determined by SHP or the Medical Group or USBHPC, as applicable.

Authorization, Modification and Denial of Health Care Services

When a Member or a Participating Provider on behalf of a Member, requests health care services, SHP 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.

- For Medical Health Care Services SHP and its contracted Medical Groups use multiple nationally professionally recognized sources including Milliman Care Guidelines, InterQual, St. Anthony's Medicare Benefit Guidelines and Hayes New Technology Assessment Guidelines.

- For Mental Health and Behavioral Health Services USBHPC uses MCAP Behavioral Health Criteria.

- For Substance Use Disorder Services, USBHPC uses the American Society of Addiction Medicine Placement Guidelines for Substance Related Disorder - Version II-Revised.

The UM criteria used to deny, delay, or modify requested services in the Member's specific case will be provided free of charge to the Participating Provider and to the Member. The public is also able to receive specific criteria or guidelines, based on a particular diagnosis, upon request.

If you would like a copy of SHP's description of 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 at 1-855-315-5800 (TTY users call 1-855-320-5200) or visit the SHP website at www.sutterhealthplus.org.

If you would like a copy of USBHPC's description of processes utilized for the authorization or denial of Mental Health, Behavioral Health or Substance Use Disorder Treatment Services, or the criteria or guidelines related to a particular condition, you may contact the USBHPC Customer Service Department or visit the USBHPC Website at www.liveandworkwell.com.

Additional Information Related to Mental Health and Behavioral Health 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) 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

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 state law:

- 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 (5) business days from receipt of information reasonably necessary to make the decision.
- 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 would be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed seventy-two (72) hours after receipt of the information reasonably necessary to make the determination.

If the decision cannot be made within these timeframes because (i) the Health Plan has not received all of the information reasonably necessary and requested, or (ii) the Health Plan requires consultation by an expert reviewer, or (iii) the Health Plan 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 the Health Plan 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 by Plan then the Health Plan shall approve or deny the request for authorization within the timeframe specified above as applicable.

The Health Plan will notify requesting Participating Providers of decisions to deny or modify request for authorization of requested health care services within twenty-four (24) hours of the decision. Members are notified of decisions, in writing, within two (2) business days of the decision. 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 the Health Plan. 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 above, the Health Plan 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 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 above, the Health Plan, will treat the request as a new request for a Covered Service and will follow the timeframe for non-Urgent requests as explained above. 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. <u>Present Your SHP ID card for Accurate Prior Authorizations.</u>

Your SHP ID card lets your provider know that you are a SHP member and that certain services will require Prior Authorization. If you do not present your ID card each time you receive

services, he/she may fail to obtain Prior Authorization when needed, and you could be responsible for the resulting charges. Your physician will receive written notice of authorized or denied services and you will be notified of any denials.

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 Primary Care Physician.

Getting a Second Opinion

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. Below 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:

- You must have pre-approval from your Medical Group to get a second opinion.
- You can ask for a second opinion from another Participating Physician in your doctor's Medical Group or from any specialist in the SHP network.
- You may also request a second opinion from USBHPC regarding your Mental Health, Behavioral Health and Substance Use Disorder Treatment Services

If you request a second opinion, it will be provided to you by an appropriately qualified medical professional. 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 can 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 isn't 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 will be responsible for the Copayments or Coinsurance applicable to the Service you receive for the second opinion. For example, if you see a specialist for a second opinion, you will pay the co-pay or coinsurance applicable to a specialist office visit.

Keeping a Doctor, Hospital, or Other Provider You Go to Now (Continuity of Care)

You may have to find a new provider when you join SHP if the provider you have now is not in the SHP or USBHPC network. Or, you may have to find a new provider if you are already a member of SHP and your provider's contract with SHP or USBHPC ends.

However, in some cases, you may be able to keep going to the same provider to complete a treatment or to have treatment that was already scheduled. This is called "Continuity of Care."

- You can keep your provider **only** if you have certain health problems or conditions.
- To keep a Mental Health or Chemical Dependency Treatment services provider, you must call USBHPC at 855-202-0984 to ask for Continuity of Care.
- To keep a non-Mental Health provider, you must call SHP at 1-855-315-5800 (TTY users call 1-855-320-5200) to ask for Continuity of Care. Your provider must agree to keep you as a patient. The provider must also agree to SHP's usual terms and conditions for contracting providers.
- For more information about whether you may request Continuity of Care, or to obtain a copy of the SHP Continuity of Care policy, call SHP at 1-855-315-5800 (TTY users call 1-855-320-5200).

If you are new to SHP, you may not be eligible for Continuity of Care with your provider if:

- You were offered a health plan (such as a PPO) where you can see out-of-network providers, or
- You had the option to continue with your previous health plan or provider and you voluntarily chose to change to SHP.

The following chart explains when you will be able to keep a provider.

Keeping Your Doctor, Hospital, or Other Provider	
Type of problem or condition	**How long you will be able to stay with the provider, starting from the date that:** You join SHP *or* SHP ends its contract with the provider
Acute condition (such as pneumonia)	As long as the condition lasts
Serious chronic condition (such as severe diabetes or heart disease)	Until you complete a course of treatment, or for up to 12 months

Pregnancy	During pregnancy and immediately after delivery (postpartum period)
Terminal illness	As long as the person lives
Care of a child under 3 years	For up to 12 months
Surgery or another procedure (such as colonoscopy) that is already scheduled	180 days

EMERGENCY SERVICES AND URGENT CARE

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital emergency room. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover 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 you could reasonably expect the absence of immediate medical attention 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 the absence of immediate mental health care or behavioral health care services the Member would be 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.

Post-Stabilization And Follow Up Care After an Emergency

Post-Stabilization Care is the Covered Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable. SHP and USBHPC provide coverage for Post-Stabilization Care if a Participating Provider provides it or if you obtain

authorization to receive the care from a non–Participating Provider. To request authorization for Post-Stabilization Care, you must call SHP (or USBHPC for post-stabilization Mental Health, Behavioral Health or Substance Use Disorder Treatment Services) before you receive the care if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible). After we are notified, we will discuss your condition with the non–Participating Provider and decide whether to authorize your care from the non–Participating Provider or arrange to have a Participating Provider (or other designated provider) provide the care. Please ask the non–Participating Provider whether we authorized your Post-Stabilization Care.

Coverage Limitations on Post-Stabilization Care

Call us for admissions to non-Participating Hospitals or Post-Stabilization Care authorization

Once your medical or psychiatric emergency 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 these post-stabilization services. 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 will be financially responsible for 100% of the cost for services provided to you once your emergency condition is stable. Also, if the hospital providing your post-stabilization care is unable to determine your name and 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

Post-Stabilization Care are Covered Services related to your Emergency Medical Condition that you receive after your treating physician determines that this condition is Stabilized. We cover Post-Stabilization Care from a non–Participating Provider, including inpatient care at a non–Participating Hospital, only if we provide prior authorization for the care or if otherwise required by applicable law ("prior authorization" means that we must approve the Covered Services in advance).

To request authorization to receive Post-Stabilization Care from a non– Participating Provider, you must call SHP or, for Mental Health, Behavioral Health or Substance Use Disorder Treatment Services call USBHPC *before* you receive the care if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible).

You must call SHP at 1-855-315-5800 (TTY users call 1-855-320-5200); or USBHPC at 855-202-0984 (These telephone numbers are also on your Member ID card) 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);

- Notify us that you have been admitted to a non-Plan Hospital. You must notify us within 24 hours of any admission or as soon as reasonably possible. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you don't notify us as soon as reasonably possible, we will not cover any services you receive after transfer would have been possible.

After we are notified, we will discuss your condition with the non-Participating Provider. If we decide that you require Post-Stabilization Care and that this care would be covered if you received it from a Participating Provider, we will authorize your care from the non-Participating Provider or arrange to have a Participating Provider (or other designated provider) provide the care. If we decide to have a Participating Hospital, Skilled Nursing Facility, or designated Non-Participating Provider provide your care, we may authorize special transportation Covered Services that are 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) we have authorized because we will not cover unauthorized Post-Stabilization Care or related transportation provided by Non-Participating Providers.

We understand that extraordinary circumstances can delay your ability to call us to request authorization for Post-Stabilization Care from a Non-Participating Provider, for example, if a young child is without a parent or guardian present, or you are unconscious. In these cases, you must call us as soon as reasonably possible. Please keep in mind that anyone can call us for you. We do not cover any care you receive from Non-Participating Providers after your Emergency Medical Condition is Stabilized unless we authorize it, so if you don't call as soon as reasonably possible, you increase the risk that you will have to pay for this care.

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

- 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 "Out-of-Area Urgent" care under "Urgent Care" in this "Emergency Services and Urgent Care" chapter)

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR SERVICES THAT YOU RECEIVED FROM A NON-CONTRACTED PROVIDER, PLEASE CONTACT SHP AT 855-

315-5800 OR, FOR MENTAL HEALTH, BEHAVIORAL HEALTH OR SUBSTANCE USE DISORDER TREATMENT SERVICES, CONTACT USBHPC AT 855-202-0984.

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, please call your PCP or call the appropriate appointment or advice telephone number on your SHP membership card.

Out-of-Area Urgent Care

If you have an Urgent Care need due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), we cover Medically Necessary Covered Services to prevent serious deterioration of your (or your unborn child's) health from a Non-Participating Provider if all of the following are true:

- You receive the Covered Services from Non-Participating Providers while you are temporarily outside our Service Area
- You reasonably believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

You do not need prior authorization for Out-of-Area Urgent Care. We cover 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 "General 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 Evidence of Coverage:

- 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

SHP covers the services described in this "Your Benefits" chapter, subject to the "Exclusions and Limitations" chapter and well as the "Coordination of Benefits" and "Third Party Liability" sections in the "What You Pay" chapter, only if all of the following conditions are satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
    - health care items and services for preventive care
    - health care items and services for diagnosis, assessment, or treatment
    - health education covered under "Health Education" in this "Your Benefits" chapter
    - other health care items and services
- The services are provided, prescribed, authorized, or directed by a Participating Provider except where specifically noted in the sections listed below for the following Covered Services:
    - drugs prescribed by dentists as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Your Benefits" chapter
    - emergency ambulance services as described under "Ambulance Services" in this "Your Benefits" chapter
    - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" chapter
- You receive the Services from Participating Providers inside our Service Area, except where specifically noted to the contrary in the sections listed below for the following Services:
    - authorized referrals as described under "Referrals and Prior Authorization" section in the "Seeing A Doctor And Other Providers " chapter
    - emergency ambulance services as described under "Ambulance Services" in this "Your Benefits" chapter
    - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" chapter
    - hospice care as described under "Hospice Care" in this "Your Benefits" chapter
- The Medical Group or SHP has given prior authorization for the Covered Services, if required.

The only services we cover under this Evidence of Coverage are those that this "Your Benefits" chapter says that we cover, subject to exclusions and limitations described in this "Your Benefits" chapter and to all provisions in the "Exclusions and Limitations" chapter as well the "Coordination of Benefits" and "Third Party Liability" sections in the "What You Pay" chapter.

Preventive Care Services

SHP covers a variety of Preventive Care Services. These Preventive Care Services are subject to all coverage requirements described in other parts of this "Your Benefits" chapter and all provisions in the "Exclusions and Limitations" chapter as well the "Coordination of Benefits" and "Third Party Liability" sections in the "What You Pay" chapter.

SHP covers the Preventive Care Services on the preventive care services list for Members required by PPACA. You may obtain our most current list of covered Preventive Care Services by visiting our website at **www.sutterhealthplus.org** or by calling our Member Services at 1-855-315-5800 (TTY users call 1-855-320-5200).

The following are examples of Preventive Care Services that are currently included in our preventive care services list **(as noted above, subject to change.). There are no copays for Preventive Services**

- Alcohol and substance abuse screenings
- Developmental screenings to diagnose and assess potential developmental delays
- Eye exams for refraction and preventive vision screenings
- Family planning counseling, methods and consultations, including all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity
- Screening flexible sigmoidoscopies and colonoscopies
- Health education counseling and programs
- Hearing exams and screenings
- Immunizations administered by a Participating Provider
- Preventive counseling, such as STD prevention counseling
  - Routine preventive imaging services, such as the following:
  - abdominal aortic aneurysm screening
  - bone density scans
  - mammograms
- Routine physical maintenance exams, including well-woman exams
- Routine preventive retinal photography screenings
- 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
  - Prenatal diagnosis of genetic disorders of the fetus, including tests for specific genetic disorders for which genetic counseling is available
- Tuberculosis tests

- Well-child preventive care exams (0–23 months)

The following routine preventive laboratory tests and screenings:

- cervical cancer screenings
- cholesterol tests (lipid panel and profile)
- diabetes screening (fasting blood glucose tests)
- fecal occult blood tests
- HIV tests
- prostate specific antigen tests
- certain sexually transmitted disease (STD) tests

Outpatient Care

SHP covers the following Medically Necessary Outpatient Services:

- Primary and specialty care consultations, exams, and treatment (specific Covered Services are described in more detail below)
- Preventive Care Services (please see the "Preventive Services" section above):
- Allergy injections (including allergy serum)
- 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.
- 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.
- Voluntary termination of pregnancy.
- Physical, occupational, and speech therapy, including services provided in an organized, multidisciplinary rehabilitation day-treatment program.
- House calls by a Participating Provider (or a Participating Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Participating Provider.
- 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).
- Blood, blood products, and their administration.
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in a Participating Provider's Office or during home visits.
- Some types of outpatient consultations, exams, and treatment may be available as group appointments, for example, group consultations for the ongoing management of certain chronic health conditions such as diabetes, high blood pressure, or coronary artery disease,

and COPD, and group therapy sessions for the treatment or management of mental health, behavioral health or substance use disorders.

Please see the "Health Plan Benefits and Coverage Matrix" for information regarding Copayments, Coinsurance, or Deductible amounts that may apply to these Covered Services

Other types of Outpatient Care are discussed elsewhere in this chapter "Your Benefits" 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 Services
- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures
- Outpatient Prescription Drugs, Supplies, and Supplements
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials

Ambulance Services

Emergency

We cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- A reasonable person would have believed that the medical condition was an Emergency Medical Condition that required ambulance 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 must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. Please refer to "Payment and Reimbursement" in the "Emergency Services and Urgent Care" chapter for how to file a claim for reimbursement.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance and psychiatric transport van services 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.

Ambulance Services exclusion

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 the only way to travel to a Participating Provider

Hospital Inpatient Care

SHP covers care in the hospital also referred to as "inpatient care."

- You must use a hospital in the SHP network, unless you have an emergency or your doctor gets pre-approval from SHP for you to go to another hospital.
- The services must be Medically Necessary and generally provided in an acute care general hospital setting.
- Please see the "Health Plan Benefits and Coverage Matrix" for information regarding co-pays, co-insurance, or deductible amounts that may apply to these Covered Services.

The following Hospital Inpatient Care services are provided subject to the conditions listed above:

- 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 prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, please refer to the "Outpatient Prescription Drugs, Supplies and Supplements" section)
- Radioactive materials used for 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). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Participating Provider may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, please refer to the "Preventive Care" section)

- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services and discharge planning

Other types of Inpatient Care are discussed elsewhere in this chapter "Your Benefits" including:

- Bariatric Surgery
- Dental and Orthodontic Services
- Dialysis Care
- Hospice Care
- Mental Health, Behavioral Health and Substance Use Disorder Treatment Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Skilled Nursing Facility Care
- Transplant Services

Bariatric Surgery

SHP covers hospital inpatient care related to bariatric surgical procedures (including room and 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 have received a referral from your PCP to a bariatric surgeon; and

- Your bariatric surgeon has evaluated you and 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 before performing the bariatric procedure. For example, your treating bariatric surgeon may determine that you should complete a preoperative education and clinical evaluation program that could range from 1 week to 12 weeks, 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 are no specific pre-operative weight loss requirements, unless your bariatric surgeon or anesthesiologist believes that weight loss is necessary for your health and safety. Your bariatric surgeon may decide to not require you to complete particular pre-operative education or evaluation requirements if you have comparable bariatric surgery preparation requirements within a clinically appropriate timeframe. Your bariatric surgeon may delay surgery if issues are identified that need attention before surgery. Examples of

issues that may delay the procedure include major depression requiring treatment, and active 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 Health Plan 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, we 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. We 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. We 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.

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

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care ")

Dental and Orthodontic Services

SHP provides limited coverage for Dental and Orthodontic services. The limited Covered Services are:

- Dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a Participating Provider provides the services or if the Medical Group authorizes a referral to a dentist (as described under "Referral and Prior Authorization" section 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:
  - You are under age 7, or you are developmentally disabled, or your health is compromised
  - Your 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 we are covering 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.

- Emergency medical services to stabilize an acute injury to sound natural teeth, jawbone and surrounding structures after an injury. Dental services beyond emergency medical treatment 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 Health Plan Benefits and Coverage Matrix for the Cost Sharing that applies for hospital inpatient care.

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

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

Dental and Orthodontic Services exclusions:

SHP does not cover any other services related to the dental procedure, such as the dentist's services.

Dialysis Care

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

- The services are provided inside our Service Area
- You satisfy all medical criteria developed by the Medical Group or SHP and by the facility providing the dialysis
- A Participating Provider provides a written referral for care at the facility

After you receive appropriate training at a dialysis facility we designate, SHP also covers equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside our Service Area. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. SHP decides whether to rent or purchase the equipment and supplies, and selects the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

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 at a Plan Facility
- All other outpatient consultations, exams, and treatment

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

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

Dialysis Care exclusions:

- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Durable Medical Equipment for Home Use

Inside our Service Area, we cover the durable medical equipment specified in this "Durable Medical Equipment for Home Use" section for use in your home (or another location used as your home) based upon medical necessity. Durable medical equipment 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 durable medical equipment (including repair or replacement of covered equipment, unless due to loss or misuse) is provided. SHP or your Medical Group decides whether to rent or purchase the equipment, and selects the vendor. SHP covers durable medical equipment for use in your home (or another location used as your home) inside our Service Area. The covered durable medical equipment includes, but is not limited to the following:

- For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices), please refer to the section on Outpatient Prescription Drugs, Supplies and Supplements
- 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
- Wheelchairs

Outside the Service Area

SHP does not cover most durable medical equipment for home use outside our Service Area. However, if you live outside our Service Area, we cover the following durable medical equipment (subject to the Cost Sharing and all other coverage requirements that apply to durable medical equipment for home use inside our Service Area) when the item is prior authorized and dispensed by a Participating Provider:

- Standard curved handle cane
- Standard crutches
- Insulin pumps and supplies to operate the pump (but not including insulin or any other drugs), after completion of training and education on the use of the pump
- Nebulizers, inhaler spacers and related supplies for the treatment of pediatric asthma
- Peak flow meters from a Participating Pharmacy

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

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

Durable medical equipment for home use exclusion

- Comfort, convenience, or luxury equipment or features

Health Education

SHP provides 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 and asthma). For more information about our health education counseling, programs, and materials, please contact our Member Services, ask your PCP, or go to our website at www.sutterhealthplus.org. Some of these services may involve a fee, however, tobacco cessation counseling does not require a fee. Also, if they are provided a part of another Covered Service under another part of this "Your Benefits" chapter, you may be responsible for the cost sharing associated with that covered service.

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 outpatient care to treat an ear infection and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Your Benefits" chapter)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusions

- Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid

Home Health Care

"Home health care" means Covered Services provided in the 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 provided by persons permitted by state or federal law to provide such services. (home health aide services are not covered 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)
- 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 our Service Area

We cover 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 calendar 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, that counts as two visits.

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

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

Home health care exclusions

- Care of a type 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 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

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
- The services are provided inside our Service Area or inside California but within 15 miles or 30 minutes from our Service Area (including a friend's or relative's home even if you live there temporarily)
- 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 above 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 at least a 30-day supply or 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. If not provided through the Hospice provider, you must obtain these drugs from Plan Pharmacies. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Services for the current list of these drugs).
- Durable medical equipment
- 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

Mental Health, Behavioral Health and Substance Use Disorder Treatment Services

SHP covers the Mental Health, Behavioral Health and Substance Use Disorder Treatment Services described in this section. SHP has contracted with US Behavioral Health Plan California (USBHPC) to administer these Covered Services. If you need mental health care, behavioral health care or substance use disorder treatment services, or have questions about these t benefits, please visit www.liveandworkwell.com or call USBHPC's Member Services at 855-202-0984 or SHP Member Services at 1-855-315-5800 (TTY users call 1-855-320-5200).

Mental Health, Behavioral Health and Substance Use Disorder 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, and/or
- 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" in the *Diagnostic and Statistical Manual of Mental* Disorders, *Fourth Edition, Text Revision (DSM)* that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

All mental health conditions identified as a "mental disorder" in the DSM IV-TR 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 we do not cover services (such as couples counseling or family counseling) for relational problems. You should carefully read the exclusions described below so you will understand your coverage.

"Mental Disorders" include, but are not limited to, the following conditions:

- Severe Mental Illness of a person of any age. "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa

- A Serious Emotional Disturbance of a child under age 18. A "Serious Emotional Disturbance" of a child under age 18 means a condition identified as a "mental disorder" in 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

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

A. Inpatient

1. **Inpatient Mental Health Services** inclusive of services rendered by physicians and other professional providers who are licensed or certified health care professionals acting

within the scope of the their license or certification, provided at an Inpatient Treatment Center, Residential Treatment Center, or Day Treatment Center are covered when Medically Necessary, pre-authorized by USBHPC, and provided at a Participating Facility, and will include the provision of Behavioral Health Treatment for PDD and Autism on an inpatient basis when Medically Necessary (see B.2,below).

2. **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.

B. Outpatient

1. **Outpatient Professional Care** – Medically Necessary Mental Health Services provided by a Participating Practitioner including initial consultation, individual or group follow up visits and other office visits that do not exceed 45 minutes and services for the purpose of medication management. Also includes, when Medically Necessary and preauthorized by USBHPC, Intensive Outpatient Program Treatment, Outpatient Electro-Convulsive Treatment, Outpatient Treatment extending beyond 45 minutes per session and Psychological Testing. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center. Intensive psychiatric treatment programs may include partial hospitalization as intensive outpatient care.

2. **Behavioral Health Treatment for Pervasive Developmental Disorder ("PDD") or Autism** – When preauthorized by USBHPC 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 pervasive developmental disorder or autism, and that meet the criteria required by California law, (and which include Medically Necessary Behavioral Health Treatment administered by qualified autism service providers who are either

licensed providers under the Business and Professions Code or other health professionals as authorized under California law or persons, entities or groups certified by a national entity, qualified autism professionals and paraprofessionals that are employed and supervised by a qualified autism service provider who may provide Behavioral Health Treatment for PDD or autism)..

3. **Outpatient Prescription Drugs** – Outpatient prescription drugs are covered only when prescribed by a Participating Practitioner for treatment of a Mental Disorder.

4. **Injectable Psychotropic Medications** – Injectable psychotropic medications are covered if prescribed by a USBHPC Participating Practitioner for treatment of a Mental Disorder

5. **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.

C. Intensive Psychiatric Treatment Programs include but are not limited to:

1. Short-term hospital-based intensive outpatient care (partial hospitalization);
2. Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program;
3. 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; and
4. Psychiatric observation for an acute psychiatric crisis.

II. Substance Use Disorder Treatment Services

A. Inpatient

1. **Inpatient Hospital/Facilities Services**– Medically Necessary Substance Use Disorder Services, including Medical Detoxification, and inpatient prescription drugs, which have been 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 while the Member is confined in a Participating Inpatient Treatment Center or Participating Residential Treatment Center.

2. **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 medications through the Outpatient Prescription Drug Benefit, subject to co-pays, deductibles, limitations and exclusions.

3. **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.

B. Outpatient

1. **Outpatient Treatments for Substance Use Disorder Services** – Medically Necessary Substance Use Disorder Services when pre-authorized by USBHPC inclusive of physicians and other professional providers who are licensed health care professionals acting within the scope of their license:

    a. Day-treatment programs
    b. Intensive outpatient programs
    c. Individual and group chemical dependency counseling
    d. Medical treatment for withdrawal symptoms

2. **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 and Outpatient Treatment extending beyond 45 minutes per session. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.

3. **Outpatient Prescription Drugs** - Except for inpatient medications, 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

1. 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, Outpatient Treatment extending beyond 45 minutes per

session and Psychological Testing, not authorized by USBHPC (except in the event of an Emergency or Out of Area Urgent Care).

2. Behavioral Health Treatment for Pervasive Developmental Disorder (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.

3. 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 Pervasive Developmental Disorders or Autism.

4. Services, supplies and treatments that are not Medically Necessary or any of the following:
   - not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
   - not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
   - not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome

5. Any services provided by non-licensed providers other than services provided to those diagnosed with PDD or autism that may be provided by a QAS provider, QAS professional or QAS paraprofessional as defined in the definitions section of this Evidence of Coverage.

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6. Pastoral or spiritual counseling

7. Dance, poetry, music or art therapy services except as part of a Behavioral Health Treatment Program

8. 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.

9. Community Care Facilities that provide 24-hour non-medical residential care.

10. 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 sections titled "Bariatric Surgery" (medically necessary bariatric procedures for weight loss are covered), "Health Education" (tobacco use counseling and intervention are covered" and "Outpatient Prescription Drugs, Supplies, and Supplements" (medically necessary tobacco cessation prescription drugs are covered).

11. Counseling for adoption, custody, family planning or pregnancy in the absence of a DSM-IV-TR diagnosis. This exclusion does not apply to SHP coverage for family planning, prenatal and pregnancy care as described under the sections titled "Preventive Services" and "Outpatient Services."

12. 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.

13. Personal or comfort items, and non-Medically Necessary private room and/or private duty nursing during inpatient hospitalization are not covered.

14. With the exception of injectable psychotropic medication as set forth above, all nonprescription and prescription drugs, which are prescribed during the course of outpatient treatment, are not covered. Outpatient prescription drugs for Mental Health, Behavioral Health and Substance Use Disorder treatment services are covered as described in the preceding section titled "Outpatient Prescription Drugs" in the "Your Benefits" section. (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.)

15. Neurological services and tests, including, but not limited to, EEGs, Pet scans, beam scans, MRI's, skull x-rays and lumbar punctures. This exclusion does not apply to SHP coverage for these services as described under the sections titled "Outpatient Services."

16. Treatment sessions by telephone or computer Internet services (instant messaging, chat rooms, etc.). Exception**:** Telehealth technology may be utilized in rural geographic areas where other appropriate treatment settings for PDD and/or autism are not available and/or for supervision of treatment sessions for PDD and/or autism.

17. Evaluation for professional training, employment investigations, fitness for duty evaluations, or career counseling.

18. **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;
- Speech training that is intended to address speech impediments, such as lisping and stuttering, that are not caused by an illness or injury. This exclusion does not apply

to speech therapy for pervasive developmental disorders, autism or other medical conditions when part of a Medically Necessary treatment plan, provided by or rendered under the direct supervision of a licensed or certified therapist or as authorized under California law, and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law;

- 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 pervasive developmental disorders (PDD) or Autism.

19. Treatment of problems that are not Mental Disorders are not covered, except for diagnostic evaluation.

20. Substance Use Disorder services in a specialized facility for alcoholism, drug abuse, or drug addiction are not covered except as otherwise specified in the "**Substance Use Disorder Treatment Services"** section above.

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

- Outpatient self-administered drugs (refer to " Prescription Drugs ")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Ostomy and Urological Supplies

SHP covers ostomy and urological supplies in our Service area when Medically Necessary. SHP 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.
- Incontinence supplies for hospice patients: disposable incontinence underpads; adult incontinence garments.

Ostomy and urological supplies exclusion

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

SHP covers the following services only when prescribed as part of care covered under other headings in this "Your Benefits" chapter:

Imaging Services that are preventive care 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

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 sexually transmitted disease (STD) tests, and HIV tests

- All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)

Special Procedures

- Routine preventive retinal photography screenings
- All other diagnostic procedures provided by Participating Providers who are not physicians (such as EKGs and EEGs)
- 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, and Supplements" section when prescribed as follows and obtained at a Plan Pharmacy or through our mail-order service:

- Items prescribed by Participating Providers in accord with our drug formulary guidelines see explanation below, under "SHP Formulary"), including medically necessary drugs that are not in the formulary, and drugs prescribed by a Participating Provider for "off label" use (see explanation below under "Prior Authorization for Formulary and Non-Formulary Drugs").
- Items prescribed by the following Non-Participating Providers unless a Participating Provider determines that the item is not Medically Necessary or the drug is for a sexual dysfunction disorder:
  - Dentists if the drug is for dental care
  - 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 covered as part of that referral
  - Non–Participating Providers if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" chapter (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described under "If You Have to Pay for Care at the Time You Get 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)

The following Covered Services are not covered as Outpatient Prescription Drug benefits, but are covered as described under these headings in this "Your Benefits" section:

- Insulin pumps and their supplies (refer to "Durable Medical Equipment for Home Use")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment for Home Use")
- Outpatient drugs administered by a health care professional (refer to "Outpatient Care")

- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care")

How To Obtain Covered Items

You must obtain covered outpatient prescription drugs, supplies, and supplements at a Plan Pharmacy or through our mail-order service unless the item is obtained as part of the covered services described in the section on “Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care” in "Your Benefits" chapter.

Please go to OptumRx’s website at www.optumrx.com for the locations of Plan Pharmacies in your area or you can call OptumRx Member Services at 888-574-7417.

For information on the Cost Sharing associated with Outpatient Prescription Drugs, Supplies and Supplements please see the “Health Plan Benefits and Coverage Matrix”.

Certain intravenous drugs, supplies, and supplements

We cover certain self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an intravenous or intraspinal-infusion) up to a 30-day supply and the supplies and equipment required for their administration. Note: Injectable drugs and insulin are not covered under this paragraph (instead, refer to the "Outpatient drugs, supplies, and supplements" section).

Diabetes urine-testing supplies and insulin-administration devices

We cover ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing up to a 100-day supply. We cover the following insulin-administration devices for up to a 100-day supply: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear).

Specialty Prescription Medications

Specialty medications are usually injectable, infused, oral or inhaled, and require close supervision and monitoring. The SHP Specialty Pharmacy Program focuses on patient safety, with requirements designed to assure that you know how to take these medications correctly, that you receive safe, effective specialty medications, and that you have timely and convenient access to the specialty medications you need. Specialty medications require special shipping and handling and may not be routinely stocked by all Plan Pharmacies, in which case the Plan Pharmacy may have a special order process. Specialty Prescription Medications that cannot be stocked or special ordered by a Plan Pharmacy, are always conveniently available by mail order directly to your home, your work or to a nearby Plan Pharmacy. For more information regarding mail order, please see below.

About the SHP Formulary

SHP uses a Drug formulary to assure that Members have access to Medically Necessary and clinically appropriate prescription drugs. The SHP Formulary includes the list of drugs that have been approved by SHP. To receive a copy of the formulary, call Member Services at 1-855-315-5800.

SHP uses a Three-Tier formulary. The three tiers are: Tier 1 – Generic Drugs, Tier 2 – Preferred Brand Name Drugs, Tier 3 – Non-Preferred Brand Name Drugs. Preferred Brand Name Drugs, Non-Preferred Brand Name Drugs, Specialty Drugs, and drugs not listed on the SHP Formulary (Non-Formulary drugs) are covered only when determined to be medically necessary through the prior authorization process as described below.

Prior Authorization for Formulary and Non-Formulary Drugs

Preferred Brand Name Drugs, Non-Preferred Brand Name Drugs, Specialty Drugs, and Non-formulary drugs require prior authorization. If a prescription drug you need is a Preferred Brand Name Drug, Non-Preferred Brand Name Drug, Specialty Drug, is not on the SHP Formulary, or was previously on the SHP Formulary and later removed, you and your physician may request prior authorization for coverage of the drug. SHP will evaluate whether the requested non-formulary drug:

- Is Medically Necessary for your condition; or
- Was prescribed by your physician before the drug was removed from the formulary; or
- Is prescribed by your physician for an "off label use" (see "Special Note" below)

If a Non-Formulary drug is prior authorized, your Cost-Share will be the same as it would be for Tier 2- Preferred Brand Name Drugs. If a drug prescribed for a current Member is removed from the Formulary during the contract year and 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 may be required the following year.

Special Note: A drug's listing on the SHP Formulary does not guarantee that your physician will prescribe the drug. There are a number of Tier 2- Preferred Brand Name 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 be required for a non-FDA-approved indication (off label use) of a drug listed on the Formulary. "Off-label" use means that a drug has been approved by the FDA but is being prescribed for a use that is different that the use for which the FDA has approved the drug and a Participating Provider has prescribed the drug for (1) a life threatening condition or (2) a chronic and seriously debilitating condition. To receive Prior Authorization for "off label use," the medication 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 requires "step therapy" in addition to Medical Necessity as part of Prior Authorization. In some cases, there is a very large difference in cost among the medications, but a very small difference in the way the medications work. SHP's Step Therapy Program is approved by the Pharmacy and Theraputics (P&T) Committee and requires a Member to try the more cost-effective medications before receiving coverage for (or "stepping up to") the more expensive medications. Many members find the first medication very effective and never need to step up. Prior Authorization requests for step therapy medications are reviewed on a case-by-case basis, and include criteria for exceptions to step-therapy requirements when clinically appropriate. In addition, SHP will not require step therapy for a new Member when the Member is already being treated for a medical condition by a prescription drug if the drug is appropriately prescribed and is considered safe and effective for the Member's condition. Each medication has specific criteria for approval, which are established by the P&T Committee. Formulary or non-formulary drugs may be included in a step therapy program. To see which medications have step therapy requirements, refer to your SHP Prescription Drug Formulary. Drugs denoted with "ST" require step therapy.

Prior Authorization Timelines for Prescription Drugs

Routine/non-urgent requests for Prior Authorization are processed within three business days if all applicable information is included with the request. Requests that are indicated as urgent will be reviewed within one business day. An incomplete request may delay the authorization process if the provider is not available to supply the necessary clinical information. For a Prior Authorization request after business hours, or on weekends and holidays in an urgent or emergency situation, the Pharmacy is authorized to dispense an emergency short supply of the medication.

SHP Formulary Updates

The SHP Pharmacy and Therapeutics Committee evaluates drugs regularly, to determine if any should be added to or deleted from the SHP Formulary, and to ensure rational and cost-effective use of pharmaceutical agents. The SHP Pharmacy and Therapeutics Committee meets every other month. Physicians may request that the Committee consider adding specific prescription medications to the SHP Formulary. The Committee reviews all medications for the efficacy, quality, safety, similar alternatives, and cost of the drug in determining the inclusion in the SHP Formulary.

Mail Order for Specialty and Maintenance Medications

Covered Prescription Medications that are to be taken beyond sixty (60) days are considered Maintenance Medications. Maintenance Medications are used in the treatment of chronic conditions like arthritis, high blood pressure, heart conditions and diabetes. Maintenance Medications may be, but are not required to be, obtained by mail order through OptumRx, SHP's prescription benefit manager. Oral contraceptives are also available through the mail order program.

As described above, Specialty Prescription Medications are also conveniently available by mail order.

You can request the order form and brochure for Mail Order of Maintenance and Specialty medications by contacting OptumRx Customer Service at 888-574-7417.

When you order drugs by mail order, Optum Rx will tell you when your medications 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 medications, please contact OptumRx Member Services at 888-574-7417 **to arrange for expedited delivery through an alternative method at no additional cost to you.** For example, if your medication is normally $20 for a 30 day supply from your Plan Pharmacy and $30 for a 90 day supply by mail order, and you need to get a 30 day supply at a Plan Pharmacy because your mail order did not arrive on time, your copayment for the 30 day supply will be adjusted so you only pay $10**.**

Pharmacy Principal Exclusions and Limitations

The covered Outpatient Prescription Drugs described above are subject to the exclusions and limitations described in this section:

1) Generic Drugs are required unless there is not a Generic equivalent medication available. If a Generic equivalent drug is available, the pharmacist will automatically substitute an equivalent Generic Drug for the prescribed Preferred or Non-Preferred Brand Name Drug unless: (1) your physician writes, "do not substitute" or "prescribe as written"; or (2) the drug is included in the list of Narrow Therapeutic Index (NTI) drugs that currently have potential equivalency issues. In these two circumstances, the Member will be provided the Preferred or Non-Preferred Brand Name Drug as written by the Member's Physician, even if a Generic equivalent drug is available. The Member will pay the Preferred or Non-Preferred Brand Name Drug Copayment. A Member may request a list of applicable NTI drugs by calling SHP Member Services at 1-855-315-5800 (TTY users call 1-855-320-5200)

2) Covered Prescription Drugs are limited to a 30-day supply at a Participating Pharmacy. A 90-day supply of oral Maintenance Medications is available through SHP's Mail Order program (see Limitation No. 3, below).

3) Optional Mail Order for Maintenance Medications. Covered Prescription Medications that are to be taken beyond sixty (60) days are considered Maintenance. The initial Prescription for Maintenance Medications may be dispensed through a Participating Pharmacy (limited to a 30-day supply). Subsequent refills for a 90-day supply may be, but are not required to be, obtained through the Mail Order Program.

4) Medications that are not Medically Necessary are excluded (not covered).

5) Treatment of impotence and/or sexual dysfunction must be Medically Necessary and documentation of a confirmed diagnosis of erectile dysfunction must be submitted to SHP for review. Drugs and medications are limited to eight (8) pills per 30-day period, and are subject to a 50% Copayment.

6) Medications that are experimental or investigational are excluded, except for Life-Threatening or Seriously Debilitating conditions and clinical trials as described in the section "Independent Medical Review of Investigational/Experimental Treatment". 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.

7) Drugs required for foreign travel are excluded, unless they are prior authorized for Medical Necessity.

8) Cosmetic purposes. Prescription products for cosmetic indications, including agents for wrinkles or hair growth, over-the-counter dietary/nutritional aids and health/beauty aids.

9) Weight loss. 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 is 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.

10) Vitamins (except prenatal prescription vitamins or vitamins in conjunction with fluoride) are excluded.

11) Replacement of lost or stolen drugs. Replacement medications for drugs that are lost or stolen are not covered.

12) Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging

13) Compounded products unless the drug is listed on our drug formulary or one of the ingredients requires a prescription by law. 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 Medication.

14) Drugs prescribed to shorten the duration of the common cold

15) Enhancement Drugs. 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

16) Over the Counter (OTC) drugs. However, SHP will not exclude an entire class of drugs when one drug within the class becomes available over the counter. Over-the-counter medications or medications that do not require a Prescription are excluded. This exclusion does not apply to insulin and insulin syringes with needles for diabetics, or OTC FDA approved contraceptive drugs or devices.

17) Drugs prescribed by Non-Contracted Providers. When prescribed for non-covered procedures and not authorized by a plan or plan provider except for emergency services

Special Note: Pharmacies that dispense covered Outpatient Prescription Drugs to Members pursuant to an agreement with SHP or its pharmacy benefit manager 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 contracted pharmacies.

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 the provider or vendor that we select
- 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 hip joints, if they are implanted during a surgery that we are covering under another section of this "Your Benefits" chapter.

External devices

SHP covers the following external prosthetic and orthotic devices and related supplies:

- 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 or by a Participating Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral and Parenteral Nutrition: enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding supply kits; enteral nutrition infusion pump; enteral tubing; gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump, parenteral nutrition solutions; stomach tube; and supplies for self-administered injections
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

Prosthetic and orthotic devices limitations:

- Special contact lenses to treat aniridia (missing iris) or aphakia,(absence of the crystalline lens of the eye) are covered 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 calendar year for members through age 9.

Prosthetic and orthotic devices exclusions

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described above 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 above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications

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 create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, we cover 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 headings in this "Your Benefits" chapter

- Dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate (refer to "Dental and Orthodontic Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")

Reconstructive surgery exclusions

- Surgery that, in the judgment of a Participating Provider specializing in reconstructive surgery, offers only a minimal improvement in appearance
- 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
- Your treating Participating Provider, or your treating Non–Participating Provider if the Medical Group or SHP authorizes a written referral to the Non–Participating Provider for treatment of cancer or another life-threatening disease or condition (in accord with the "Referrals and Prior Authorization" section in the "Seeing a Doctor and Other Providers" chapter), recommends participation in the clinical trial after determining that it has a meaningful potential to benefit you
- The services would be covered under this Evidence of Coverage 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 clinical trial involves a drug that is exempt under federal regulations from a new drug application, or the clinical trial is approved by: one of the National Institutes of Health, the federal Food and Drug Administration (in the form of an investigational new drug application), the U.S. Department of Defense, or the U.S. Department of Veterans Affairs

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 Health Plan Benefits and Coverage Matrix for the Cost Sharing that applies for hospital inpatient care.

Services associated with clinical trials exclusions

- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management
- Services that are customarily provided by the research sponsors free of charge to members in the clinical trial

SHP Nurse Advice Line and USBHPC Intake Line

SHP offers all Members around-the-clock access to registered nurses who help answer questions about a medical problem they may have, 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.

They can also help you get the appropriate care you need with the right SHP health care providers. Nurse Advice Line services are available 24 hours a day, seven days a week by calling 855-836-3500.

USBHPC maintains a 24/7 toll free "Intake Services Line." You may call USBHPC's twenty-four (24)-hour, toll-free telephone line to speak with a behavioral health care professional to obtain the following services:

- Referral for Mental Health, Behavioral Health and Substance Use Disorder Services,
- Crisis intervention, and
- Answers to your questions about your covered Mental Health, Behavioral health and Substance Use Disorder Services.

Skilled Nursing Facility Care

SHP covers 100 visits per plan year of skilled inpatient services in a Skilled Nursing Facility. The skilled inpatient services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 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 Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Blood, blood products, and their administration
- Medical supplies
- Physical, occupational, and speech therapy
- Behavioral health treatment for pervasive developmental disorder or autism
- Respiratory therapy

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

- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

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 "Referrals and Prior Authorization" 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, we 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
- In accord with our guidelines for services for living transplant donors, we provide certain donation-related services for a 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 may include certain services for harvesting the organ, tissue, bone marrow or stem cell and for treatment of complications. Our guidelines for donor services are available by calling SHP Member Services.
- We provide or pay for donation-related services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor services.
- 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 member had received them; and
- In the event the member'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 Health Plan Benefits and Coverage Matrix for the Cost Sharing that applies for hospital inpatient care.

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

- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Transplant Services exclusions

- Blood transfusions or blood products required for treating complications resulting from the evaluation or donation of organs, tissue, bone marrow or stem cells;
- Treatment of donor complications related to a stem cell registry donation;
- HLA blood screening for stem cell donations, for anyone other than the member's siblings, parents, or children;
- Services related to post-harvest monitoring for the sole purpose of research or data collection; or
- 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: Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated (eyeglasses prescription only). 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.

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 800-877-7195.

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

EXCLUSIONS AND LIMITATIONS

Exclusions and limitations are services and expenses that SHP does NOT cover. The exclusions and limitations for each kind of benefit are also listed under the benefit in the chapter "Your Benefits".

See chapter "Outpatient Prescription Drugs, Supplies, Equipment and Supplements" 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 EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Your Benefits" section. When a Service is excluded, all Services related to the excluded Service are also excluded, even if they would otherwise be covered under this *Agreement*. 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 will not cover (excludes) the following:

1) Any services or supplies obtained before the Member's effective date of coverage.
2) Services,supplies and treatments which are not Medically Necessary, or are any of the following:

    - not consistent with the symptoms and signs of diagnosis and treatment of the behavioral disorder, psychological injury or substance abuse;
    - not consistent with prevailing national standards of clinical practice for the treatment of such conditions;
    - not consistent with prevailing professional research demonstrating that the service or supplies will have a measurable and beneficial health outcome

If a service is denied or is not covered based on Medical Necessity, a Member may appeal the decision through the Independent Medical Review (IMR) process found in the "If You Have A Problem with SHP" chapter.

3) Non-emergent services and supplies rendered by non-Participating Providers without written referral by the Member's PCP, and any service for which a PCP referral or Prior Authorization is required as described in this Evidence of Coverage. Prior Authorization and care by non-Participating Providers will only be provided as a Covered Service if the care is determined to be Medically Necessary and not available through Participating Providers.
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 except prenatal prescription vitamins or vitamins in conjunction with fluoride.
8) Over-the-counter medications, supplies or equipment that may be obtained without a Prescription, except for diabetes and pediatric asthma supplies as described in the "Your Benefits" chapter. This exclusion will not be applied to FDA approved over-the-counter contraceptive drugs required by the Affordable Care Act and HSRA guidelines.
9) Services related to the diagnosis and 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).
10) Physical exams and other services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation. This exclusion does not apply if a Participating Physician determines that the services are Medically Necessary.
11) 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.
12) Chiropractic Services and the services of a chiropractor.
13) Cosmetic services that are intended primarily to change or maintain your appearance. This exclusion does not apply to any of the following:
    a) Covered Services covered under "Reconstructive Surgery" in the "Your Benefits" chapter
    b) The following devices covered under "Prosthetic and Orthotic Devices" in the "Your Benefits" chapter: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a mastectomy, and prostheses to replace all or part of an external facial body part
14) Custodial care such as assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).
    a) This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, Skilled Nursing Facility, or inpatient hospital care.
15) Dental care, except for (1) non-dental surgical and hospitalization procedures incidental to facial fractures, tumors or congenital defects, such as cleft lip or cleft palate, (2) when integral to reconstructive surgery for cleft palate or (3) surgery on the maxilla or mandible that is Medically Necessary to correct temporomandibular joint disease (TMJ) or other medical conditions, when Medically Necessary and prior authorized. Other dental services excluded include:

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, braces, bridges, dental plates, dental prostheses and dental orthoses, including anesthetic agents or drugs used for the purpose of dental care.

16) Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies.
a) This exclusion does not apply to disposable supplies covered under "Durable Medical Equipment for Home Use," "Home Health Care," "Hospice Care," "Ostomy and Urological Supplies," and "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Your Benefits" chapter.

17) 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. 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 Food and Drug Administration (FDA) and the manufacturer or other source makes the services available to you or SHP through an FDA-authorized procedure, except that we do not cover services that are customarily provided by research sponsors free of charge to members in a clinical trial or other investigational treatment protocol
ii. Covered Services under "Services Associated with Clinical Trials" in the “Your Benefits” chapter

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

18) Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.
19) Care in a licensed intermediate care facility. This exclusion does not apply to Covered Services covered under "Durable Medical Equipment," "Home Health Care," and "Hospice Care" in the "Your Benefits" chapter. This exclusion shall also not apply to the provision of mandated mental health services required by state and federal law.
20) 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 and support services to increase intelligence except when authorized as part of a medically necessary treatment plan

d) Teaching you how to read, whether or not you have dyslexia
e) Educational testing
f) Teaching art, dance, horse riding, music, or swimming
g) Teaching skills for employment or vocational purposes
h) Aquatic therapy and other water therapy except when authorized as part of a medically necessary treatment plan
i) Play therapy

Exclusions 20(c), (f), (h) and (i) above shall not apply if 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, and shall not be applied to exclude medically necessary behavioral health treatment services for pervasive developmental disorders or autism.

21) 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 chapter "Vision Services".
22) 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 "Hospital Inpatient Care," "Outpatient Care," "Home Health Care, "Hospice Services," or "Skilled Nursing Facility Care" in this EOC.
23) Food supplements or infant formulas, except when medically necessary and covered in the "Prosthetics and Orthotic Devices" section in this EOC.
24) Residential and Long Term care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, 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 and Behavioral Health Care Substance Abuse Services" section, or a licensed facility providing transitional residential recovery services covered under the Substance Use Disorder Treatment Services section.
25) Routine foot care items and services that are not Medically Necessary.
26) Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration (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 U.S.
    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 we do not services that are customarily provided by research sponsors free of charge to members in a clinical trial or other investigational treatment protocol
    c) Services covered under "Services Associated with Clinical Trials" in the "Your Benefits" chapter

Please refer to the "If You Have A Concern or Dispute With SHP" section for information about Independent Medical Review related to denied requests for experimental or investigational services.

27) Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider except that this exclusion shall not be applied to exclude medically necessary behavioral health treatment services for pervasive developmental disorders or autism provided by unlicensed persons as permitted by California law.
28) When a service is not covered, all services related to the non-covered service are excluded, except for services we would otherwise cover to treat complications of the non-covered Service. For example, if you have a non-covered cosmetic surgery, we would 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 we would cover any services that we would otherwise cover to treat that complication.
29) Services for anyone in connection with a surrogacy arrangement, except for otherwise-Covered Services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.
30) Travel and lodging expenses, except that in some situations if the Medical Group refers you to a Non-Participating Provider as described in the "Referral and Prior Authorization" of the section "Seeing A Doctor And Other Providers" chapter, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. Our travel and lodging guidelines are available from our Member Services. This exclusion does not apply to reimbursement for travel and lodging expenses provided under "Bariatric Surgery" in the "Your Benefits" section.

Preexisting Conditions and Health Assessments

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

You (along with any Dependents) will not be required to fill out a health assessment or medical questionnaire prior to enrollment in SHP 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 911 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 SHP, all subscribers and dependents must live or work within SHP's Service Area which is comprised of specific zip codes in Northern California. For additional information about SHP's Service Area, please see the "Definitions" chapter.

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 a Subscriber, of its eligibility requirements, such as the minimum number of hour that employees must work. In addition, if your Group permits enrollment of Dependent(s), they may be eligible to enroll as your Dependent(s) under this Evidence of Coverage.

Termination for Loss of Eligibility

If you lose your eligibility for coverage, your health care coverage will terminate at 11:59 pm on the last day of the month in which you lost your eligibility. Please see the section entitled "Termination" below for more information regarding the bases for termination of coverage.

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 as described below.

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 (please refer to the definition of "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 you give us proof of their incapacity and dependency within 60 days after we request it (see "Disabled dependent certification" below.

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 us documentation of the Dependent's incapacity and dependency as follows:

If the Dependent is a Member, we 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 our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as a disabled Dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as a disabled Dependent, we will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine 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, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can 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, the Subscriber must provide us documentation of the Dependent's incapacity and dependency within 60 days after we request it so that we can determine if the Dependent is eligible to enroll as a disabled Dependent. If we determine that the Dependent is eligible as a disabled Dependent, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as a disabled Dependent.

Persons barred from enrolling

You cannot enroll if you have had your entitlement to receive Covered Services through Health Plan terminated for cause or if you don’t meet the eligibility requirements described in above.

When You Can Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described under "Who Is Eligible" in this chapter, enrollment is permitted as described below and membership begins at the beginning (12:00 a.m.) of the effective date of coverage indicated below, except that your Group may have additional requirements that we have approved, 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 Health Plan–approved enrollment application to your Group within 31 days.

Effective date of coverage.

The date your coverage is effective is based on the date your premium is submitted. If your premium is delivered to us or postmarked, whichever is earlier, within the first 15 days of a month, your coverage under the plan 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 and affiliation period.

Waiting and affiliation periods

Your group may require some period of time to pass before your coverage becomes effective; such periods are known as "waiting periods" or "affiliation periods." Waiting or affiliation periods may be no longer than 60 days and, if combined, any waiting and affiliation period must run concurrently. You will not be charged 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 a Health Plan–approved 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)
- For a newly adopted child or child placed with you or your Spouse for adoption, coverage is effective on the date when you or your Spouse gain the legal right to control the child's health care. 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 of acquisition

Open enrollment

You may enroll as a Subscriber (along with any Dependents), and existing Subscribers may add Dependents, by submitting a Health Plan–approved 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 be charged premiums until your coverage has commenced.

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

You become eligible as described in this "Special enrollment" section.

You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future, or that you signed a document verifying that 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 a Health Plan–approved 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 the plan'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), Children's Health Insurance Program coverage (known as the Healthy Families Program in California), or Access for Infants and Mothers Program coverage
- Reaching a lifetime maximum on all benefits
- Loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
- A situation in which a plan no longer offers any benefits to the class of similarly situated individuals (as described in § 54.9802-1(d)) that includes 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 above.

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 60 days after loss of other coverage or cessation of employer contributions 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 for adoption by submitting to your Group a Health Plan–approved enrollment application.

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 for adoption are effective on the date of birth, adoption, or placement for 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 a Health Plan–approved enrollment or change of enrollment application.

The effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive 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 60 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 for 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 a Health Plan–approved enrollment or change of enrollment application 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 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 in SHP can end for several reasons. If your membership is terminated, you may be able to continue your health care coverage. Please see the next chapter, "Individual Continuation of Health Coverage (COBRA, Cal-COBRA, Conversion Coverage, and HIPAA)".

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 (for example, if your termination date is January 1, 2013, your last minute of coverage was at 11:59 p.m. on December 31, 2012). 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.** Health Plan and Participating Providers have no further liability or responsibility under this Evidence of Coverage after your membership terminates, except as provided under "Payments after Termination" section of this "When Your SHP Health Coverage Ends" chapter.

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who Is Eligible" in the "Enrolling in SHP and Adding New Dependents" chapter on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month (except that we will notify you of the date that your membership ends if you become ineligible for a reason described in the "Who Is Eligible" section). For example, if you become ineligible on December 5, 2012 (except if you become ineligible for a reason described in the "Who Is Eligible" section), your termination date is January 1, 2013, and your last minute of coverage is at 11:59 p.m. on December 31, 2012.

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, 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.

Termination for Cause

If you commit an intentional misrepresentation of material fact (fraud) in connection with membership, Health Plan, or a Participating Provider, we may terminate your membership immediately by sending written notice to the Subscriber; termination will be effective on the date we send the notice. Some examples of fraud include:

- Intentionally misrepresenting a material fact regarding eligibility information about you or a Dependent
- Knowingly presenting an invalid prescription or physician order
- Knowingly misusing a SHP ID card (or letting someone else use it)
- Intentionally failing to notify us of changes in family status, such as divorce, or disabled dependent child over age 26 no longer disabled or dependent on Subscriber for support, or intentionally failing to notify SHP that a Member has signed up for Medicare coverage.

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution.

Termination for Nonpayment of Premiums

If we do not receive the full Premiums required for your Family by the due date, we may terminate the memberships of everyone in your Family. Termination will be effective at 12:01 a.m. on the 31st day after we issue thirty (30) days notice of termination, whichever is later. We will send written notice of the termination to the Subscriber at least 30 days before the termination date. Also, if we terminate your membership, we will reinstate your membership without a lapse in coverage if we receive full payment from your Group on or before your Group's next scheduled payment due date.

Your Group is responsible for paying Premiums, except that Members who have Cal-COBRA coverage under this Evidence of Coverage are responsible for paying Premiums for Cal-COBRA coverage (for information about termination for nonpayment of Cal-COBRA Premiums, please refer to "Termination for nonpayment of Cal-COBRA Premiums" in the "Individual Continuation of Health Care Coverage" chapter).

Your Group will be billed monthly for premiums. The premium bill will be issued on the 15th of each month, and the premium payment will be due two weeks later, on the first (1st) of the month for which coverage will be provided. If payment is not received from Your Group by the 10th day following the due date, a 30 Day Notice of Termination will be issued to Your Group. The Notice of Termination will be effective 30 days after the date of the notice, unless full payment is received from Your Group within the 30 days' notice period. If full payment is not received within the 30 days' notice period, coverage will terminate at 12:01 a.m. on the 31st day after the date Notice of Termination was mailed to Your Group.

Termination of a Product or all Products

We may terminate a particular product or all products offered in a small or large group market as permitted or required by law. If we discontinue offering a particular product in a market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products to groups in a small or large group

market, as applicable, we may terminate your Group's Subscriber Contract by sending you written notice at least 180 days before the Group Subscriber Contract terminates.

HIPAA Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act (HIPAA) requires employers or health plans to issue a "Certificate of Creditable Coverage" to Members whose coverage terminates. The certificate documents health care coverage and you can use it to prove prior creditable health care coverage if you seek new coverage after your membership terminates. When your membership terminates, or at any time upon request, we will mail the certificate to the Subscriber.

Payments after Termination

If we terminate your membership for cause or for nonpayment, we will:

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Emergency Services and Urgent Care" and "If You Have A Problem With SHP" chapters. We will deduct any amounts you owe Health Plan or Participating Providers from any payment we make to you
- You will not be responsible for any amounts SHP or USBHPC 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 that we terminated your membership because of your ill health or your need for care, you may request a review of the termination by the California Department of Managed Health Care (please see "Department of Managed Health Care Complaints" in the "If You Have a Problem with SHP" chapter. You can request State review for a cancellation of coverage or for non-renewal of coverage.

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

Federal and California state laws protect your right and your Dependents' right to continue your health coverage under certain circumstances or qualifying events. This is called "continuation 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. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in higher premiums or you could be denied coverage entirely. Note: Medical history does not impact premiums or eligibility for our Individual Conversion Plan and HIPAA Individual Plan described under "Conversion from Group Membership to an Individual Plan" section. However, the individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

COBRA

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 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 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. (See the Cal-COBRA section below for more information.) 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. 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 SHP:

It is important to meet the following deadlines. If you do not, you lose your right to COBRA coverage.

1. **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:
  - The employee divorces or legally separates
  - A Child or other Dependent no longer qualifies as a Dependent under plan rules

2. **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.

3. **Election period:** You have 60 days to notify SHP in writing that you want to elect/enroll in COBRA 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.

4. **Premium payment:** You must pay the premiums for your COBRA coverage. SHP must receive your first premium within 45 days from the date you provided written notice of your election to continue coverage through COBRA. This first premium must be sufficient to pay for coverage from the date your coverage ended because of the qualifying event up to the day you enroll in COBRA. Failure to submit the correct premium within the 45 days period will disqualify you from continuing coverage. Following your enrollment in COBRA and payment of the first premium, you must pay a monthly premium as long as you stay on COBRA.

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. If you were on COBRA for 36 months, you cannot get Cal-COBRA for any additional period of time.

- SHP should send you an enrollment form. Or you can call SHP to add phone number and ask for information.
- You must fill out the enrollment form, send it to SHP, and pay your premium no more than 30 days after you receive the enrollment form.

You will lose COBRA if:

- You do not pay your premiums on time.
- 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, which means that you intentionally deceive SHP or you misrepresent yourself or allow someone else to do so in order to get health care services.

Cal-COBRA

Cal-COBRA is a California law that applies to employers who have between 2 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.

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.

"**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 2 to 19 eligible employees.

"**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:
(1) The death of the covered employee.
(2) 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.
(3) The divorce or legal separation of the covered employee from the covered employee's spouse.
(4) The loss of Dependent status by a Dependent enrolled in the group benefit plan.
(5) 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).

"**Employer**" for the purposes of Cal-COBRA, the term "employer" means, a Small Employer (as defined in the "Definitions" section of this EOC, that employed 2 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 2 to 19 eligible employees on at least 50 percent of its working days during the preceding calendar quarter, (2) has contracted for health care coverage through a group benefit plan offered by a health care service plan, and (3) 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.

"Small employer" means any of the following:

(A) For plan years commencing on or after January 1, 2014, and on or before December 31, 2015, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 50, eligible employees, the majority of whom were employed within this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists. For plan years commencing on or after January 1, 2016, any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or service, that, on at least 50 percent of its working days during the preceding calendar quarter or preceding calendar year, employed at least one, but no more than 100, eligible employees, the majority of whom were employed within

this state, that was not formed primarily for purposes of buying health care service plan contracts, and in which a bona fide employer-employee relationship exists.

"**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.

Important deadlines for electing/enrolling in Cal-COBRA with SHP:

It is important to meet the following deadlines. If you do not, you lose your right to Cal-COBRA coverage.

1. 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

2. **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.

3. **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.

4. Premium payment: You must pay the premiums for your Cal-COBRA coverage. SHP must receive your first premium within 45 days after you enroll in Cal-COBRA. This first premium covers the time from the date your coverage ended because of the qualifying event up to the day you signed up for Cal-COBRA. You must then pay a monthly premium as long as you stay on Cal-COBRA.

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

- You can elect/enroll in Cal-COBRA with the new health plan offered by your employer.
- You must enroll and pay your first premium with the new health plan no more than 30 days after you receive notice that SHP plan is no longer being offered. If you do not meet this deadline, your Cal-COBRA benefits end.

You will lose Cal-COBRA if:

- You do not pay your premiums on time.

- 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, which means that you intentionally deceive SHP or you misrepresent yourself or allow someone else to do so in order to get health care services.

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 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, we 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 Evidence of Coverage, including Cost Sharing, but we will not cover services for any condition other than your totally disabling condition.

For Subscribers and adult Dependents, "Totally Disabled" 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.

For Dependent children, "Totally Disabled" 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.

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

Conversion from Group Membership to an Individual Plan

After your Group notifies us to terminate your membership, we will send a termination letter to the Subscriber's address of record. The letter will include information about options that may be available to you to remain a Health Plan member.

SHP Conversion Plan

If you want to remain a Health Plan member, one option that may be available is an individual plan called "SHP Individual Conversion Plan." You may be eligible to enroll in our Individual Conversion Plan if you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Enrolling in SHP and Adding New Dependents" chapter. Also, if you enroll in Group continuation coverage through COBRA, Cal-COBRA, or USERRA, you may be eligible to enroll in our Individual Conversion Plan when your Group continuation coverage ends. The premiums and coverage under our Individual Conversion Plan are different from those under your Group Subscriber Contract. The Group is solely responsible for notifying a Member of the availability, terms and conditions of the conversion coverage within 15 days of the termination of the Member's group coverage. A Member can always request a conversion application by calling our Member Services.

To be eligible for our Individual Conversion Plan, there must be no lapse in your coverage and we must receive your enrollment application and your first premium payment within 63 days of the date of our termination letter or of your membership termination date (whichever date is later) unless this requirement is waived by the SHP in writing. If your enrollment application and initial premium payment are received within 63 days of our termination letter or your membership termination date, coverage will be effective on the day following termination of your group coverage.

You may not convert to our Individual Conversion Plan if any of the following is true:

- You continue to be eligible for coverage through your Group (but not counting COBRA, Cal-COBRA, or USERRA coverage)
- Your membership ends because your Group's Subscriber Contract with us terminates and it is replaced by another plan within 15 days of the termination date
- We terminated your membership under "Termination for Cause" in the "When Your SHP Health Coverage Ends" chapter.
- You knowingly furnished incorrect information or otherwise improperly obtained the benefits of SHP.
- The Member is covered by or eligible for benefits under Title XVIII of the United States Social Security Act.
- The Member is covered by or eligible for any group contract.
- The Member is covered for similar benefits by an individual policy or contract.

- The Member has not been continuously covered during the three-month period immediately preceding that person's termination of coverage.

HIPAA and Other Individual Plans

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health care coverage for workers and their families when they change or lose their jobs. If you lose group health care coverage and meet certain criteria, you are entitled to purchase individual (non-group) health care coverage from any health plan that sells individual health care coverage.

Every health plan that sells individual health care coverage must offer individual coverage to an eligible person under HIPAA. The health plan cannot reject your application if you are an eligible person under HIPAA, you agree to pay the required premiums, and you live or work inside the plan's service area. To be considered an eligible person under HIPAA, you must meet the following requirements:

- You have 18 or more months of Creditable Coverage without a break of 63 days or more between any of the periods of Creditable Coverage or since the most recent coverage was terminated
- Your most recent Creditable Coverage was under a group, government, or church plan (COBRA and Cal-COBRA are considered group coverage)
- You were not terminated from your most recent Creditable Coverage due to nonpayment of premiums or fraud
- You are not eligible for coverage under a group health plan, Medicare, or Medicaid (Medi-Cal)
- You have no other health care coverage
- You have elected and exhausted any continuation coverage you were offered under COBRA or Cal-COBRA

For more information (including premiums and complete eligibility requirements), please refer to the SHP HIPAA Individual Plan evidence of coverage. To request a copy of the HIPAA Individual Plan evidence of coverage or for information about other individual plans, please call our Member Services.

REQUESTS FOR PAYMENT OR SERVICES

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 "Ambulance Services" in the "Your Benefits" chapter, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. 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, such as a Participating Pharmacy.

We will reduce any payment we make to you or the Non-Participating Provider by applicable Cost Sharing.

How to file a claim

To file a claim for payment or reimbursement, this is what you need to do:

- If you have paid for the Services, you must send us a completed claim form for reimbursement. Please attach any bills from the non–Participating Provider and receipts;
- You must complete and return to us any information that we request 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;
- The completed request and information must be mailed to the following address as soon as possible after receiving the care. Any additional information we request should also be mailed to this address:

Sutter Health Plus
Attn: Claims Department
PO Box 254708
Sacramento, CA 95865

We 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 Evidence of Coverage is not subject to the ERISA claims procedure regulation, we will send our written decision within 45 business 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 45 business 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 our decision is not fully in your favor, we will tell you the reasons and how to file a grievance as described under "Grievances" in the "If You Have A Concern or Dispute With SHP" chapter.

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 Medical Group or from SHP and you want to request that we cover the requested services, you can file a grievance as described in the "If You Have A Problem" section.

If you have not received a written denial of services, you may make a request for services orally or in writing to the SHP Member Services Department. You will receive a written decision in a timely manner appropriate for your condition, and not to exceed five (5) 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 (5) 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 we should cover a Medically Necessary Service that is not a covered benefit under this *Agreement*, you may file a grievance as described in the "If You Have A problem" section.

Expedited Decision

You or your physician may make an oral or written request that we expedite our decision about your request. We will make a decision in a timely manner appropriate for your condition and not to exceed 72 hours. We will inform your provider orally of our decision within 24 hours of making the decision and will notify you in writing within 2 days if we find, or your physician states, that waiting 15 days for our "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.

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 an "Urgent Request" as defined above, we 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 an Urgent Request as described above under Expedited Decisions, we will treat your request as a new request for and will follow the timeframe for non-Urgent requests as explained above. 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.

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 users call 1-855-320-5200).
- Send your written request to Sutter Health Plus, P.O. Box 160305, Sacramento, CA 95816, Attn: Grievance & Appeals-Expedited Review.
- Fax your written request to (855) 759-8755.
- Deliver your request in person to our Member Services Department at the address above.

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

IF YOU HAVE A CONCERN OR DISPUTE WITH SHP

We are committed to providing you with quality care and with a timely response to your concerns.If you have encountered any difficulties or have had any concerns with Sutter Health Plus or a Sutter Health Plus Participating Provider, please give us a chance to help. Our Member Service representatives are available to discuss your concerns toll free at 1-855-315-5800 (TTY users call 1-855-320-5200) 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 below about the processes available to help you resolve concerns and complaints. Please 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
- Independent Medical Review
- Voluntary Mediation

Grievances

You can file a grievance for any issue. Here are some examples of reasons you might file a grievance:

- 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 us to cover the services
- A Participating Provider has said that Covered services are not Medically Necessary and you want us 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 that we did not authorize (other than Emergency, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency Ambulance Services) and you want us to pay for the care
- We 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 our decision
- You are dissatisfied with how long it took to get Covered Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility

- Health Plan has terminated your coverage and you believe your coverage has been terminated 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. **Grievances may be submitted on line, 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:

You can submit your grievance in one of the following ways:

- Please submit written grievances to SHP at the following address:

  Attn: Grievance & Appeals
  Sutter Health Plus
  P.O. Box 160305
  Sacramento, CA 95816

- You may also submit written grievances by facsimile to the following number (855) 759-8755
- You may submit a grievance to SHP by telephone by calling our Member Services at 1-855-315-5800 (TTY users call 1-855-320-5200)
- You may also submit a grievance on line within SHP's secure member portal at www.sutterhealthplus.org.

You may also submit grievances to USBHPC in a similar manner. Grievances submitted to USBHPC are for mental health services provided through our contract with USBHPC.

- In writing to:
  U.S. Behavioral Health Plan, California
  P.O. Box 2839
  San Francisco, CA 94126
  Attn: Appeals Department

- Or on line at the USBHPC website: www.liveandworkwell.com
- Or by phone to USBHPC at: 1-855-202-0984.

You may also submit grievances to VSP in a similar manner. Grievances submitted to VSP are for vision services provided through our contract with VSP.

- In writing to:

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

- Or on line at the VSP website: www.vsp.com
- Or by phone to VSP at: 800-877-7195.

You may also submit grievances to Delta Dental in a similar manner. Grievances submitted to Delta Dental are for dental services provided through our contract with Delta Dental.

- By phone to Delta Dental at: 800-422-4234
- Or on line at the Delta Dental website: www.deltadental.com
- Or in writing to:

  Quality Management Department
  P.O. Box 6050
  Artesia, CA 90702

We will send you a confirmation letter within five days after we receive your grievance. We will send you our written decision within 30 days after we receive your grievance. If we do not approve your request, we will tell you the reasons and about additional dispute resolution options.

Grievance handled by phone within one business day: If you submit your grievance by telephone and we resolve your issue to your satisfaction by the end of the next business day, and a Member Services representative notifies you by telephone about our decision, we 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 physician may make an oral or written request that we expedite our 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. We will inform you of our decision within 72 hours (orally or 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, we will inform you of our decision within 24 hours.

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 our Expedited Review Unit toll free at 1-855-315-5800 (TTY users call 1-855-320-5200), which is available Monday through Saturday from 8:30 a.m. to 7 p.m. After hours, you may leave a message and a representative will return your call the next business day

- Send your written grievance including your request for expedited handling to:

  Attn: Grievance & Appeals-Expedited Review

Sutter Health Plus

P.O. Box 160305

Sacramento, CA 95816

- You may fax your written grievance including request for expedited handling toll free at (855) 759-8755.
- You may submit your expedited grievance by telephone by calling Member Services at 1-855-315-5800 (TTY users call 1-855-320-5200). You may also submit your expedited grievance on line within SHP's secure member portal at www.sutterhealthplus.org.

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

- In writing, including your request for expedited handling to:

  U.S. Behavioral Health Plan, California.
  P.O. Box 2839
  San Francisco, CA 94126
  Attn: Appeals Department

- Or on line at the USBHPC website: www.liveandworkwell.com
- Or by phone to USBHPC at: 855-202-0984.

You may also submit expedited grievances to VSP in a similar manner. Expedited grievances submitted to VSP are for vision services provided through our contract with VSP.

- In writing to:

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

- Or on line at the VSP website: www.vsp.com
- Or by phone to VSP at: 800-877-7195.

You may also submit expedited grievances to Delta Dental in a similar manner. Expedited grievances submitted to Delta Dental are for dental services provided through our contract with Delta Dental.

- In writing to:

  Quality Management Department
  P.O. Box 6050
  Artesia, CA 90702

- Or on line at the Delta Dental website: www.deltadental.com

  Or by phone to Delta Dental at: 800-422-4234.

We will send you written notification within three days of receiving your request for expedited grievance, in which we will advise you whether we have approved your request for expedited handling and, if so, our decision on the grievance. If we do not approve your request for an expedited decision, we will notify you and we will provide the decision on your grievance within 30 days. If we do not approve your grievance, we will send you a written decision that tells you the reasons and about additional dispute resolution options.

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 can contact the California Department of Managed Health Care directly at any time at 1-888-HMO-2219 (TDD 1-877-688-9891) without first filing a grievance with us.

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, we 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, we will contact the provider to request a copy of your medical records. We will ask you to send or fax us a written authorization so that we can request your records. If we do not receive the information we request in a timely fashion, we will make a decision based on the information we have.

Who may file

The following persons may file a grievance:

- You may file for yourself
- You may appoint someone as your authorized representative by completing our authorization form. Authorization forms are available by calling our 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

- Your physician may request an expedited grievance as described under this "Expedited grievance" section

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 your health plan, you should first telephone your health plan toll free at **1-855-315-5800 (TTY users call 1-855-320-5200)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website **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. Please see below section on Voluntary Mediation.

Independent Medical Review (IMR)

If you qualify, you or your authorized representative may have your issue reviewed through the Independent Medical Review (IMR) process managed by the California Department of Managed Health Care. The Department of Managed Health Care determines which cases qualify for IMR. This review is 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 us.

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 we have denied it or we haven't made a decision about your grievance within 30 days (or three days for expedited grievances). The Department of Managed Health Care 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 "Experimental or investigational denials."

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

Experimental or investigational denials

If we deny a covered service because it is experimental or investigational, we will send you our written explanation within five days of making our decision. In the denial letter we will explain why we denied the service and provide additional dispute resolution options, including an explanation of your right to request Independent Medical Review (IMR) of the decision through the Department of Managed Health Care. 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 we cover 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. We do not cover the services of the Non-Participating Provider.

The denial letter we send you 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 Department of Managed Health Care 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:

Member Services- Voluntary Mediation
Sutter Health Plus
2880 Gateway Oaks 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 above. 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 in SHP, you agree that any and all disputes between yourself (including any heirs or assigns) and the Health Plan, 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 thirty (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 Drive
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 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 above. 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

SHP's Member Rights and Responsibilities outline not only the Member's rights but also the Member's responsibilities as a Member of SHP. You may request a separate copy of this Member Rights and Responsibilities by contacting Member Services at 1-855-315-5800 (TTY users call 1-855-320-5200). It is also available on our website at www.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. SHPS's Member rights include but are not limited to the following:

- To be provided information about 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 practitioners 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 the Health Plan. 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 practitioner scheduled to provide your care.
- To be advised if the Physician 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 practitioner's 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 has a public policy committee. This committee includes providers, members, and a member of the Board of Directors. If you would like to be considered for this committee, please write to SHP at:

  Sutter Health Plus
  2880 Gateway Oaks Drive, Suite 150
  Sacramento, CA 95833

  This committee advises the Board of Directors about how to assure the comfort, convenience, and dignity of our members. The committee may also review SHP's financial information and information about the complaints we receive.

What Are My Responsibilities?

- It is the expectation of SHP and its providers that members 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 you received at the time of enrollment and/or that is available on SHP's website at www.sutterhealthplus.org 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 effect 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 Physician 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 Member Services for investigation through SHP's Grievance process.

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.

DEFINITIONS

Some terms have special meaning in this Evidence of Coverage. When we use a term with special meaning in only one section of this Evidence of Coverage, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this Evidence of Coverage.

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.

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 Health Plan Benefits and Coverage Matrix.

Copayment: 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 Health Plan Benefits and Coverage Matrix.

Cost Sharing: The amount you are required to pay for a Covered Service, for example: the Deductible, Copayment, or Coinsurance. Please see the Health Plan 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 Evidence of Coverage.

Creditable Coverage: Means the Member had coverage under any one or combination of the following as defined by federal law and applicable regulations:

- Health insurance coverage through a group medical plan or individual health policy;
- Medicare;
- Medicaid;
- Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care.
- A medical care program of the Uniformed Services;
- A medical care program of the Indian Health Services or of a tribal organization;

- A State health benefits risk pool;
- A State Children's Health Insurance Program;
- A health plan offered under the Federal Employee Health Benefits Program;
- A public health plan, including any plan established or maintained by a State, the US Government, a foreign country or any political subdivision of the same; or
- A health benefit plan under section 5(e) of the Peace Corps Act.
- Any other Creditable Coverage as defined by subsection (c) of Section 2704 of Title XXVII of the Federal Public Health Service Act

Deductible: The amount you must pay in a calendar year for certain Covered Services before we will cover those Covered Services at the applicable Copayment or Coinsurance in that calendar year. Please see the Health Plan Benefits and Coverage Matrix for more information about the Covered Services that are subject to a Deductible.

Dependent: Means the spouse, registered domestic partner, or child of an eligible employee, who works or resides within the service area and who is eligible for enrollment as a Dependent in the Health Plan and includes the spouse or registered domestic partner, 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: "Eligible employee" means either of the following:

(1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of an average of 30 hours per week over the course of a month, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer's business and included as employees under a health care service plan contract of a small employer, but does not include employees who work on a part-time, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be eligible employees if all four of the following apply:

   A. They otherwise meet the definition of an eligible employee except for the number of hours worked.

   B. The employer offers the employees health coverage under a health benefit plan.

   C. All similarly situated individuals are offered coverage under the health benefit plan.

   D. The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The health care service plan may

request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

E. Any member of a guaranteed association as defined in subdivision (m).

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) 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 mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to himself or herself or to others
- The person is immediately unable to provide for, or use, 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 ancillary services (such as imaging and laboratory services) 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)

Emergency services and care also means 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.

Evidence of Coverage: This Evidence of Coverage document, which describes the health care coverage under Health Plan'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.

Group: The entity, usually an employer, with which Health Plan has entered into the Group Subscriber Contract that includes this Evidence of Coverage.

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

Health Plan: Sutter Health Plus Inc., a California not-for-profit corporation. This Evidence of Coverage sometimes refers to Health Plan as "we" or "us."

Large Employer: An employer other than a Small Employer.

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 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 65 years of age 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

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 our Service Area
- You reasonably believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

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, authorized to dispense covered Prescription Medications to Members who are entitled under this Supplement to receive them. A list of all SHP Participating Pharmacies is contained in the SHP Provider Directory.

Participating Physician: Means a Physician who, at the time care is provided to a Member, has a contract in effect with SHP or a Contracted Medical Group 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 Covered Persons.

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: Either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, 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, entity, or group that 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.
- Is employed and 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 approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in Section 54342 of Title 17 of the California Code of Regulations.
- 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.

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

- Is employed and supervised by a Qualified Autism Service Provider.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Participating Qualified Autism Service Provider.
- Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the California Welfare and Institutions Code.
- Has adequate education, training, and experience, as certified by a Participating Qualified Autism Service Provider.

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 Evidence of Coverage.

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 Physicians or PCP: Means a Participating Physician who:

1) Practices in the area of family practice, internal medicine, pediatrics, general practice or obstetrics/gynecology;
2) 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; and
3) Is designated as a Primary Care Physician by the Medical Group.

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 abuse disorders and which is licensed, certified, or approved as such by the appropriate state agency.

Service Area: The ZIP codes below for each county are in our Service Area:
Solano County: All ZIP Codes
Yolo County: All ZIP Codes
Sacramento County: All ZIP Codes
San Joaquin County: All Zip Codes
Stanislaus County: All Zip Codes

Placer County (partial): 95602, 95603, 95648, 95650, 95658, 95661, 95663, 95677, 95678, 95681, 95703, 95713, 95722, 95746, 95747, 95765
Western El Dorado County (partial): 95614, 95635, 95651, 95664, 95672, 95682, 95762
Sutter County (partial): 95645, 95668, 95659

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" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

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" in the "Premiums, Eligibility, and Enrollment" section).

Transitional residential recovery services: Chemical dependency 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.