



2023

Sutter Health Plus

Small Group Evidence of Coverage and Disclosure Form

Plan Name: Gold CC83 HMO
(Gold HMO B)

Effective January 1, 2023

Sutter Health Plus
2700 Gateway Oaks, Suite 1200
Sacramento, CA 95833

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

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SUTTER HEALTH PLUS NONDISCRIMINATION POLICY

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

Sutter Health Plus:

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

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

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

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

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

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

If you need help with a grievance involving an emergency, a grievance not satisfactorily resolved by Sutter Health Plus, or a grievance unresolved for more than 30 days, call the department for assistance. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website www.dmhc.ca.gov has complaint forms online.

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

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

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

Throughout this *EOC*, Sutter Health Plus is referred to as “SHP,” “us,” “we” or “your health plan” while Members are referred to as “you.” The capitalized terms used have specific meanings which are defined in the Definitions chapter. Also, please note that all times listed throughout this *EOC* are Pacific Time.

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

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

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

Confidentiality of Medical Records

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

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

Confidential Communication of Medical Information

Members 12 years and older may request that SHP send confidential communications to an alternative mailing address, telephone number or email address. To make this request, please download the Request for Confidential Communication form at sutterhealthplus.org and follow the instructions or you can call SHP Member Services. Sutter Health Plus will accommodate requests for confidential communications in the form and format requested by Members if it is readily producible in that form and format, or at alternative locations.

Requests will be processed within 7 days if submitted electronically or by phone, or 14 days if submitted by first-class mail. SHP will acknowledge receipt of the request, but you may also contact SHP for the status. The confidential communications request will apply to all communications that disclose medical information or provider name or address related to the receipt of medical services by the Member requesting the confidential communication and will be valid until the Member either revokes the request or submits a new request.

Privacy Practices

Sutter Health Plus will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. PHI means individually identifiable health information. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI for treatment, payment, and health care operations purposes, including health research and measuring the quality of care and Services. We are sometimes required by law to give PHI to government agencies or in judicial actions. In addition, we will not use or disclose your PHI for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices*. Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* describing our policies and procedures for preserving the confidentiality of medical records and other PHI is available and will be furnished to you upon request. To request a copy, please call our Member Services Department toll free at 1-855-315-5800 or TTY users call 1-855-830-3500, 8 a.m. to 7 p.m., Monday through Friday, or you may access our website at sutterhealthplus.org.

Language Assistance

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

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

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

ERISA Notices

This "ERISA Notices" section applies only if your Group's health benefit plan is subject to the Employee Retirement Income Security Act (ERISA). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *Evidence of Coverage and Disclosure Form (EOC)*.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Sharing applicable to other medical and surgical benefits provided, as determined by your plan design.

Governing Law

Except as preempted by federal law, this *Evidence of Coverage and Disclosure Form (EOC)* will be governed in accord with California law and any provision that is required to be in this *EOC* by state or federal law shall bind Members and Health Plan whether or not set forth in this *EOC*.

Notice of Language Assistance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CONTACT INFORMATION

SHP Contact Information

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

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

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

Mailing Address: 2700 Gateway Oaks, Suite 1200 Sacramento, CA 95833

Other SHP Contacts:

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

Contact Information for SHP Health Plan Partners

Mental Health and Substance Use Disorder (MH/SUD) Benefits: U.S. Behavioral Health Plan, California (USBHPC) dba OptumHealth Behavioral Solutions of California

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

Browse as a guest with company access code: “Sutter”

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

- Delta Dental Member Services: 1-800-422-4234
- Website: deltadentalins.com
- Delta Dental provides Pediatric Dental Services for pediatric Members and, when an employer Group has purchased optional adult dental benefits, Delta Dental also provides comprehensive dental services for adult Members

Pharmacy Benefits: CVS Caremark®

- CVS Caremark Customer Care: 1-844-740-0635
- Mail Order Pharmacy (CVS Caremark® Mail Service Pharmacy): 1-844-740-0635
- Specialty Pharmacy (CVS Specialty®): 1-800-237-2767
- Website: caremark.com
- Prior Authorization for non-Specialty Drugs:
Verbal Requests: 1-800-294-5979
Fax Line: 1-888-836-0730
- Prior Authorization for Specialty Drugs:
Verbal Requests: 1-866-814-5506
Fax Line: 1-866-249-6155

Vision Benefits: Vision Service Plan (VSP)

- VSP Member Services: 1-800-877-7195
- Website: vsp.com
- VSP provides Pediatric Vision Services for pediatric Members and, when an employer Group has purchased optional adult vision benefits, VSP also provides comprehensive vision services for adult Members

Acupuncture-Chiropractic Benefits: ACN Group of California, Inc. dba OptumHealth Physical Health (ACN)

- Member Services: 1-800-428-6337
- Website: myoptumhealthphysicalhealthofca.com
- ACN provides optional acupuncture and/or chiropractic benefits if purchased by your employer Group

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

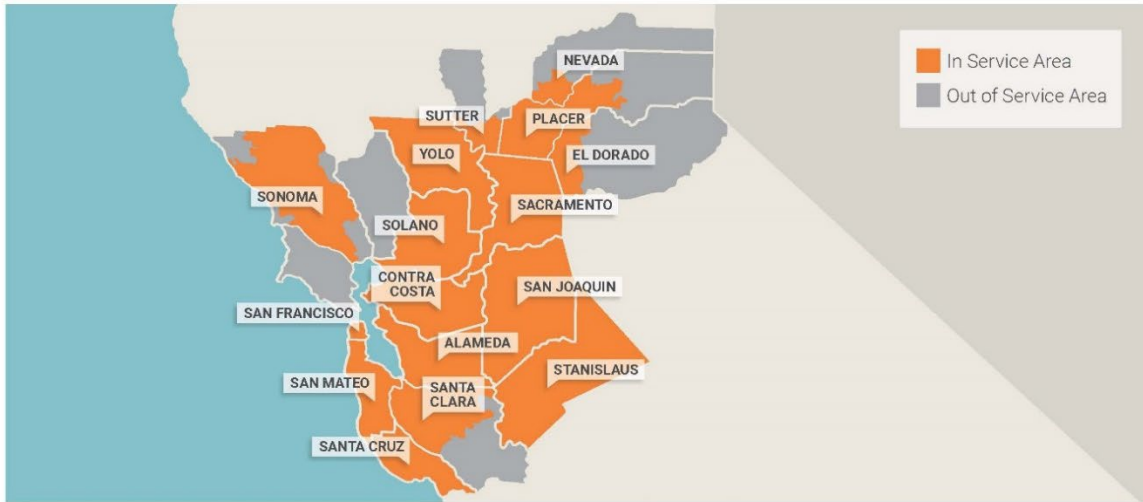
- DMHC: **1-888-466-2219 (TDD 1-877-688-9891)**
- Website: www.dmhc.ca.gov

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

SHP SERVICE AREA MAP

Licensed Service Area Map

Sutter Health Plus



Alameda County	All ZIP codes
Contra Costa County	All ZIP codes
El Dorado County (partial)	95614 95635 95651 95664 95672 95682 95762
Nevada County (partial)	95602 95949
Placer County (partial)	95602 95603 95604 95626 95631 95648 95650 95658 95661 95663 95668 95677 95678 95681 95703 95713 95722 95736 95746 95747 95765
Sacramento County	All ZIP codes
San Francisco County	All ZIP codes
San Joaquin County	All ZIP codes
San Mateo County	All ZIP codes
Santa Clara County (partial)	94022 94024 94040 94041 94043 94085 94086 94087 94089 94301 94303 94304 94305 94306 95002 95008 95013 95014 95030 95032 95033 95035 95050 95051 95053 95054 95070 95076 95110 95111 95112 95113 95116 95117 95118 95119 95120 95121 95122 95123 95124 95125 95126 95127 95128 95129 95130 95131 95132 95133 95134 95135 95136 95138 95139 95140 95148 95192
Santa Cruz County	All ZIP codes
Stanislaus County	All ZIP codes
Solano County	All ZIP codes
Sonoma County (partial)	94926 94927 94928 94931 94951 94952 94953 94954 94955 94972 94975 94999 95401 95402 95403 95404 95405 95406 95407 95409 95419 95421 95425 95430 95436 95439 95441 95442 95444 95446 95448 95450 95452 95462 95465 95471 95472 95473 95486 95492
Sutter County (partial)	95645 95668 95659
Yolo County	All ZIP codes

Some ZIP codes span more than one county. In that case, both the ZIP code and the county must be within the licensed service area for a member to enroll.

Member Services 1-855-315-5800 | sutterhealthplus.org

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HOW TO USE THE PLAN

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

Your Membership Card

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

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

The SHP Service Area

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

Your Primary Care Physician and Medical Group

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

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

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

The SHP Network

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

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

Understanding SHP's Relationship with Plan Partners

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

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

- U.S. Behavioral Health Plan, California, or USBHPC, administers and coordinates benefits for mental health disorder services, including Behavioral Health Treatment for autism spectrum disorder, and substance use disorder services. USBHPC maintains a network of Participating Practitioners, which includes facilities and behavioral health professionals, to provide you with these services. SHP and

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

- CVS Caremark, part of the CVS Health family, provides pharmacy benefit management (PBM) services for Outpatient Prescription Drug benefits. CVS Caremark maintains one of the largest networks of Participating Pharmacies with retail, mail order delivery and Specialty Drug distribution channels
- Vision Service Plan, or VSP, provides Pediatric Vision Services and vision services for adult Members whose employer Group has elected optional adult vision benefits
- Delta Dental provides Pediatric Dental Services and dental services for adult Members whose employer Group has elected optional adult dental benefits through DeltaCare USA, Delta Dental's network of dental providers

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

How to Get Health Care When You Need It

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

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

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

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

For specific information regarding the Covered Services that SHP provides, refer to the Your Benefits chapter and the Emergency Services And Urgent Care chapter.

Evaluation of New Technologies

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

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

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

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

Timely Access to Care

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

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

WHAT YOU PAY

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

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

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

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

In some cases, a non-Participating Provider may provide Covered Services at an SHP network facility where SHP or your PCP's Medical Group has authorized the services. You are not responsible for any amount beyond your Cost Sharing for the prior authorized Covered Services you received at the SHP network facility. Additionally, you are not responsible for any amounts beyond your Cost Sharing for any Covered Services rendered by a SHP Participating Provider or for Covered Services by a non-Participating Provider when prior authorized or provided for Emergency Services or Urgent Care.

Copayment

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

Coinsurance

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

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

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

Deductible

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

In a Family plan:

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

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

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

For example, suppose your benefit plan has a \$3,000 self-only Deductible and a \$4,000 Family maximum Deductible. When you have paid \$3,000 toward Covered Services for yourself, you have reached your individual maximum Deductible, and are only responsible for paying Copayments and Coinsurance. However, the Family maximum Deductible has not been met. So every other Member in your Family must continue to pay the cost for their health services until all of their

expenses equal \$1,000 (the remainder of the \$4,000 Family maximum Deductible).

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

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

Annual Out-of-Pocket Maximum

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

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

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

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

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

For information about Covered Services subject to the annual Out-of-Pocket Maximum, refer to the *Benefits and Coverage Matrix*. When your receipts add up to your annual Out-of-Pocket Maximum, please call SHP Member Services to find out how to submit receipts. Once you submit your receipts, SHP

will provide you with a document stating that you have met your annual Out-of-Pocket Maximum for the Benefit Year.

SHP complies with state and federal laws that establish parity and Cost Share coordination requirements for mental health and substance use disorder (MH/SUD) services. "Cost Share coordination" means accounting for the Member's share of cost paid for both MH/SUD services and Medical Services when calculating amounts paid towards Deductibles and Out-of-Pocket Maximums. "Parity" refers to state and federal requirements that MH/SUD services may not be subject to less favorable benefit limitations, such as Cost Sharing or treatment limitations, than those applied to Medical Services. For questions about Copayment, Coinsurance, Deductible or Out-of-Pocket Maximum amounts for MH/SUD services provided to you, please call USBHPC Member Services or SHP Member Services.

Timing of Accruals to the Annual Deductible and Out-of-Pocket Maximum:

SHP applies Cost Sharing amounts that accrue to the Deductible and Annual Out-of-Pocket Maximum based upon the date the information or claim is processed in our system. As a result, the accruals may not be applied in the same date order in which the services were received. You may access up-to-date balances at any time through the SHP Member portal or by calling Member Services. You will also receive a statement in the mail for the months your Deductible and Out-of-Pocket Maximum balances are updated. You can change your delivery preferences for these statements on the Member portal or by calling Member Services.

Premiums

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

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

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

Optional Benefits

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

Additional note applicable to optional acupuncture benefits:

Any limitations or exclusions that apply to the optional acupuncture benefits, such as the maximum number of self-referred office visits, will not apply to the mandated Essential Health Benefit of acupuncture described under the section "Outpatient Care" in the Your Benefits chapter. The Essential Health Benefit of acupuncture is typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain, and will be provided when Medically Necessary upon referral by your SHP PCP and prior authorized by your PCP's Medical Group.

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

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

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

There may be times when you have to pay for your care at the time you receive it. If you are asked to pay out-of-pocket for a Covered Service, such as for seeking care at a non-Participating Provider for Emergency Services or Urgent Care, please ask the provider to bill SHP (or USBHPC or CVS Caremark,

if applicable). If that is not possible and you pay out-of-pocket, you may request reimbursement for the Covered Service. Refer to the Payment And Reimbursement chapter for more information.

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

Coordination of benefits (COB) is utilized when a Member is covered by more than one insurer or health care service plan. COB ensures that duplicate payments are not made for the same Covered Services. All insurers and health care service plans must follow state and federal law and regulations when determining the order of payment of claims while providing that the Member does not receive more than 100% coverage from all insurers combined. All of the benefits provided under this *EOC* are subject to COB, and you are required to cooperate and assist with SHP by informing all of your providers if you or your Dependents have any other coverage. You are also required to give SHP your Social Security number and/or Medicare identification number to facilitate the COB process.

If Someone Else is Responsible (Third-Party Responsibility)

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

- Promptly following the initiation of any injury, illness or death claim, the Member or their Representative shall provide the following information to SHP's Recovery Agent in writing: the name and address of the third party; the name of any involved attorneys; a description of any potentially applicable insurance policies; the name and telephone number of any adjusters; the circumstances which caused the injury, illness or death; and copies of any pertinent reports or related documents
- Each Member or Representative shall execute and deliver to SHP or its Recovery Agent any

and all lien authorizations, assignments, releases or other documents requested which may be needed to fully and completely protect the legal rights of SHP

- Immediately upon receiving any recovery, the Member or Representative shall notify SHP's Recovery Agent and shall reimburse SHP for the value of the Covered Services and benefits provided, as set forth below. Any such recovery by or on behalf of the Member and/or Representative will be held in trust for the benefit of SHP and will not be used or disbursed for any other purpose without SHP's express prior written consent. If the Member and/or Representative receives any recovery which does not specifically include an award for medical costs, SHP will nevertheless have a lien against such recovery; and
- Any recovery received by the Member or Representative shall first be applied to reimburse SHP for Covered Services provided and/or paid, regardless of whether the total amount of recovery is less than the actual losses and damages incurred by the Member and/or Representative

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

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

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

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

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

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

The amount SHP is entitled to recover for capitated and/or non-capitated Covered Services pursuant to its reimbursement rights described in this EOC is determined in accordance with California Civil Code Section 3040. Normally, this amount will not exceed one-third of the recovery if the Member or Representative engages and pays an attorney or one-half of the recovery if no attorney is engaged and paid. SHP's lien is subject to reduction if any final judgment includes a special finding by a judge, jury or arbitrator that the Member was partially at fault for the incident. In that case, the lien will be reduced commensurate with the Member's percentage of fault as determined by the final judgment. This reduction will be calculated using the total value of the lien, and prior to any other reductions.

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

SEEING A DOCTOR AND OTHER PROVIDERS

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

Your Choice of Doctors and Providers—Your SHP Provider Directory

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

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

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

SHP has quality standards for assuring timely access to appointments as required by state law so you can get the care you need. For additional information regarding SHP's standards for appointment waiting times, refer to the Timely Access to Care section of the How To Use The Plan chapter in this *EOC* or contact SHP Member Services.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments or abortion. You

should obtain more information before you enroll. Call your prospective doctor, Medical Group, independent practice association, or clinic, or call Sutter Health Plus (SHP) Member Services at 1-855-315-5800 (TTY 1-855-830-3500) to ensure that you can obtain the health care services that you need.

Choosing a Primary Care Physician

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

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

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

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

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

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

- Acute Condition (such as a broken bone): As long as the Acute Condition lasts
- Serious chronic condition (such as severe diabetes or heart disease): We may cover Services for serious chronic conditions until the earlier of:

- 12 months from your effective date of coverage if you are a new Member
- 12 months from the termination date of the terminated provider
- The first day after a course of treatment is complete when it would be safe to transfer your care to a Participating Provider, as determined by SHP after consultation with the Member and Non-Participating Provider and consistent with good professional practice
- Pregnancy: During pregnancy and immediately after delivery (postpartum period)
 - For Members with a documented maternal mental health condition diagnosis from their treating provider, completion of covered services for the maternal mental health condition will not exceed 12 months from the diagnosis or from the end of the pregnancy, whichever comes later
- Terminal illness: for the duration of the terminal illness (which may exceed 12 months)
- Care of a Child under three years: Up to 12 months
- A previously scheduled surgery or other procedure (such as colonoscopy): When performed within 180 days of the effective date of coverage (for a new Member) or the termination date of the terminated Participating Provider

An Acute Condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and has a limited duration. A serious chronic condition is an illness or other medical condition that is serious, if one of the following is true about the condition:

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

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

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

Referrals to Specialists

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

Services That Do Not Require PCP Referral

A PCP referral or Prior Authorization from SHP or your Medical Group is not required for the following services:

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

Orthodontic Services section in the Your Benefits chapter)

- Pediatric vision: You may contact VSP to arrange for Pediatric Vision Services (see the Vision Services – Pediatric section in the Your Benefits chapter)
- Mental health and substance use disorder (MH/SUD) services: You may self-refer to a USBHPC Participating Practitioner for MH/SUD office visits (see the Mental Health and Substance Use Disorder Services section in the Your Benefits chapter of this *EOC*)
- Reproductive or sexual health care services for the following:
 - The prevention or treatment of pregnancy, including birth control, emergency contraceptive services, pregnancy tests, prenatal care, and outpatient abortion services
 - The screening, prevention, testing, diagnosis, and treatment of sexually transmitted infections and sexually transmitted diseases
 - The diagnosis and treatment of sexual assault or rape, including the collection of medical evidence with regard to the alleged rape or sexual assault, or
 - The screening, prevention, testing, diagnosis, and treatment of the human immunodeficiency virus (HIV)
- Walk-In Care: Sutter Walk-In Care clinics offer same-day visits for everyday illnesses and health needs

Please note that your provider may have to get Prior Authorization for certain additional Covered Services that may be identified during the visit.

Standing Referrals

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

Prior Authorization

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

- Acupuncture services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain)
- Allergy testing and treatment
- Clinical trials
- Diagnostic tests (such as MRI, CT, ultrasound or angiography tests and tests for genetic disorders). Note: Prior Authorization is not required for biomarker testing for an FDA-approved therapy for advanced or metastatic stage 3 or 4 cancer
- Durable medical equipment
- Elective (non-emergency) inpatient admissions
- Family planning, counseling and services
- Home health care
- Home infusion
- Hospice care
- Infertility treatment for Plus Plans
- New medical technology, drugs, treatment, procedures or equipment that is investigational or experimental
- Nutritional counseling
- Outpatient surgeries (does not include most minor office procedures performed by a PCP or Specialist during an office visit)
- Pharmacy drugs, including exemptions requiring approval for coverage
- Physical therapy, occupational therapy, speech therapy, skilled nursing or other outpatient habilitation and rehabilitation services
- Prosthetics and orthotics
- Referrals to a Specialist by another Specialist
- Second opinion consultations for care from a Specialist or other licensed health provider outside the Member's selected Medical Group

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

For the Medically Necessary treatment of mental health and substance use disorders (MH/SUDs),

Prior Authorization is required for all MH/SUD inpatient admissions (except in the case of a Psychiatric Emergency Medical Condition), Post-Stabilization Care and treatment at a Residential Treatment Center. Prior Authorization is also required for MH/SUD non-routine outpatient services, including, but not limited to:

- Behavioral Health Treatment for autism spectrum disorder
- Intensive outpatient program day treatment
- Outpatient electroconvulsive treatment
- Partial hospitalization program day treatment
- Psychological testing, except as part of Emergency Services
- Transcranial magnetic stimulation

For the above Medically Necessary treatment of MH/SUDs, the USBHPC Participating Practitioner must get Prior Authorization from USBHPC.

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

Authorization, Modification and Denial of Health Care Services

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

- For Medical Services, SHP and its contracted Medical Groups use nationally professionally recognized sources, including MCG and InterQual Evidence-based Clinical Guidelines
- For mental health and substance use disorder (MH/SUD) services, USBHPC bases any Medical Necessity and utilization review criteria for the diagnosis, prevention and treatment of MH/SUDs on current generally accepted standards of MH/SUD care.

“Generally accepted standards of MH/SUD care” means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and Behavioral Health Treatment.

Valid, evidence-based sources establishing generally accepted standards of MH/SUD care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the Food and Drug Administration (FDA)

- For Outpatient Prescription Drugs, CVS Caremark uses objective criteria that are based on sound clinical evidence as defined by the accreditation agencies as relevant findings of the latest FDA-approved product labeling, uses listed in authorized compendia (American Hospital Formulary Service Drug Information and Thomson MicroMedex) supported by an adequate level of evidence, nationally accepted practice guidelines, government agencies and published peer-reviewed clinical literature.

CVS Caremark’s criteria is internally reviewed by a CVS health physician, externally reviewed by practicing clinical experts, approved by an independent National Pharmacy and Therapeutics Committee (“P&T Committee”) and structured to meet applicable standards of the National Committee for Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC) and State or Federal agencies. The criteria is updated at least yearly and when drug indication or safety information changes

SHP provides at no cost to Members and Participating Providers, on request, the UM criteria used to deny, delay, or modify requested services in the Member’s specific case. SHP also provides specific UM criteria or guidelines for a particular diagnosis to the public, upon request.

If you would like a copy of SHP’s description of the processes utilized for the authorization or denial of health care services, or the criteria or guidelines related to a particular condition, you may contact SHP Member Services.

SHP utilizes the current version of the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) as the basis for Medical Necessity determinations. To access the WPATH SOC and additional resources about the SOC, please visit the Member Resources section of [SutterHealthPlus.org/Members](https://www.sutterhealthplus.org/Members).

If you would like a copy of USBHPC’s description of the processes utilized for the authorization or denial of MH/SUD services, then you may contact USBHPC Member Services or visit the USBHPC website at [liveandworkwell.com](https://www.liveandworkwell.com). The most recent versions of the clinical treatment criteria for the relevant clinical specialty, and related education

programs or training materials, are developed by nonprofit professional associations and are used for utilization review, in accordance with California law. To access the clinical criteria, please visit providerexpress.com/content/open-provexpr/us/en/clinical-resources/guidelines-policies.html. Upon request, USBHPC will provide paper copies of the clinical criteria and any training materials or resources at no cost.

Additional Information Related to MH/SUD Services

If you or your Dependent(s) are receiving MH/SUD services, including but not limited to Behavioral Health Treatment for autism spectrum 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 Individualized Education Program (IEP) that you or your Dependent(s) received from the school district and/or the most recent Individual Program Plan (IPP) or Individualized Family Service Plan (IFSP) from the regional center to coordinate these services.

Timeframe for Prior Authorization – Medical and MH/SUD Services

SHP, your Medical Group and USBHPC make decisions to approve, deny, delay, or modify requests for authorization of Covered Services, based on Medical Necessity, within the following timeframes as required by California law:

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

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

- Urgent requests – If the Member's condition poses an imminent and serious threat to his/her health, including, but not limited to, severe pain, potential loss of life, limb, or other major bodily functions, or lack of timeliness would be detrimental in regaining maximum functions, the decision will be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after receipt of the information reasonably necessary to make the determination

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

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

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

If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an urgent request as defined previously, SHP, the Medical Group, or USBHPC will approve, modify or deny the request as soon as possible, taking into account the Member's health condition, and will notify the Member of the decision within 24 hours of the request, provided the Member made the request to SHP, the Medical Group or USBHPC, as applicable, at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request is not an urgent request as defined previously, SHP will treat the request as a new request for a Covered Service and will follow the timeframe for non-urgent (standard) requests as explained previously. However, if your provider has requested that your care be continued, your care will not be discontinued until your treating provider has been notified of the decision and your provider agrees upon a care plan that is appropriate for your medical needs.

Timeframe for Prior Authorization – Outpatient Prescription Drugs

Upon receipt of a completed prior authorization or step therapy request, CVS Caremark makes a decision and notifies the prescribing Provider and Member of the decision within 72 hours for non-urgent requests and within 24 hours for exigent circumstances. Refer to the Outpatient Prescription Drugs, Supplies, Equipment and Supplements section of the Your Benefits chapter for complete details.

Your Financial Responsibility

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

Requests for Services

Standard Decision

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

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

If you believe SHP should cover a Medically Necessary service that is not a covered benefit under this EOC, you may file a grievance as described in the If You Have A Concern Or Dispute With SHP chapter.

Expedited Decision

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

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

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

- Call toll-free 1-855-315-5800 (TTY 1-855-830-3500)
- Send your written request to:
Sutter Health Plus
Attn: Utilization Management – Expedited Review
P.O. Box 160305
Sacramento, CA 95816
- Fax your written request to 1-855-759-8752
- Deliver your request in person to SHP at:
2700 Gateway Oaks, Suite 1200
Sacramento, CA 95833

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

Concurrent Review

If your request is for an extension of a previously authorized course of treatment that is going to expire, and your request is for an expedited decision (as explained previously), SHP will inform you as soon as possible, taking into account your health condition, and at least within 24 hours of your request. If your request to extend the ongoing care is not a request for an expedited decision, SHP will treat your request as a new request for and will follow the timeframe for a Standard decision (as explained previously). However, if your treating provider has requested that your care be continued, your care will not be discontinued until your treating provider has been notified of the decision and your provider agrees upon a care plan that is appropriate for your medical needs.

Getting a Second Opinion for Medical Services

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

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

How to request a second opinion for medical benefits:

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

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

Getting a Second Opinion for Mental Health and Substance Use Disorder Services

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

- You have questions about the reasonableness or necessity of recommended procedures
- You have questions about a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily functions, or substantial impairment, including but not limited to a chronic condition

- The clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating provider is unable to diagnose the condition and the Member requests an additional diagnosis
- The treatment plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or continuance of the treatment
- You attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care

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

You will be responsible for paying any Cost Sharing, as set forth in your *Benefits and Coverage Matrix (BCM)*, to the provider who renders the second opinion. If you obtain a second opinion without Prior Authorization from USBHPC, then you will be financially responsible for the cost of the opinion.

If you or your Dependent's request for a second opinion is denied, USBHPC will notify you in writing and provide the reason for the denial. You or your Dependent may appeal the denial by following the procedures outlined in the section *If You Have a Concern or Dispute With SHP*.

To receive a copy of the USBHPC Second Opinion policy or to request a second opinion from USBHPC, you may contact USBHPC Member Services:

- By telephone:
1-800-999-9585
- In writing:
OptumHealth Behavioral Solutions of California
P.O. Box 30512
Salt Lake City, UT 84130-0512

EMERGENCY SERVICES AND URGENT CARE

Emergency Services

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

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

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

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

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

- An immediate danger to themselves 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 an acute psychiatric hospital if, in the opinion of the treating provider, no material deterioration of the Member's condition is likely to result from, or occur during, a transfer.

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

of Participating Hospitals that provide Emergency Services.

Post-Stabilization Care After an Emergency

Post-Stabilization Care are the Medically Necessary services related to your Emergency Medical Condition that you receive in a hospital (including the emergency department) after your treating physician determines that your Emergency Medical Condition is Stabilized. SHP and USBHPC provide coverage for Post-Stabilization Care provided by a Participating Provider/Practitioner or if you obtained Prior Authorization for a non-Participating Provider/Practitioner.

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

If you require continuing or follow up mental health or substance use disorder (MH/SUD) services following Post-Stabilization Care, all out-of-area MH/SUD services must be coordinated and authorized by USBHPC.

Requests for Authorization and Notification of Admission

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

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

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

- Request authorization for Post-Stabilization Care before you obtain the care from a non-Plan Provider if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible);
- As stated above, please make sure SHP is notified within 24 hours, or as soon as

reasonably possible, if you are admitted to a hospital that is not in the SHP network. SHP will collaborate with the hospitals and doctors handling your care, make appropriate and necessary payment provisions, and possibly transfer you to a hospital in the SHP network, if it is safe to do so.

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

Authorization at Non-participating Facility

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

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

Refusal of Transfer

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

Follow Up Care After an Emergency

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

- Follow-up care and other Covered Services that are not Emergency Services or Post-Stabilization Care described in this Emergency

Services And Urgent Care chapter (refer to the Your Benefits chapter in this *EOC* for coverage, subject to the Exclusions And Limitations chapter)

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

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

Urgent Care

Inside the Service Area

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

Out-of-Area Urgent Care for Medical Services

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

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

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

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

Out-of-Area Urgent Care for MH/SUD Services

USBHPC will coordinate urgently needed mental health and substance use disorder (MH/SUD) services if you are temporarily outside the SHP Service Area and you experience a condition that you believe could result in the serious deterioration of your mental health if not treated before your return to the SHP Service Area where you may

access a USBHPC Participating Practitioner. An urgently needed service is one in which immediate care is not needed for Stabilization, but if not addressed in a timely manner could escalate to an emergency situation.

If you believe that you require MH/SUD urgently needed services, you are encouraged to call (or have someone else call on your behalf) your USBHPC Participating Practitioner, if you have one. If you are calling during nonbusiness hours, and your USBHPC Participating Practitioner is not immediately available, or you do not yet have a USBHPC Participating Practitioner, call USBHPC Member Services for assistance in finding a Participating Practitioner near your area. If your USBHPC Participating Practitioner or USBHPC is temporarily unavailable or inaccessible, you should seek urgently needed services from a licensed behavioral health professional wherever you are located.

You do not need Prior Authorization for out-of-area urgently needed MH/SUD services. SHP covers Out-of-Area Urgent Care you receive from non-Participating Practitioners as long as the services would have been covered under the Your Benefits chapter of this *EOC* (subject to the Exclusions And Limitations chapter) if you had received them from Participating Practitioners.

If you require continuing or follow up MH/SUD services following urgently needed services, then all out-of-area MH/SUD services must be coordinated and authorized by USBHPC.

If it does not create an unreasonable risk to your health, USBHPC may require that you transition your care to a USBHPC Participating Practitioner designated by USBHPC for any treatment following the urgently needed services.

Failure to transfer or to obtain approval from USBHPC for continued treatment may result in all further treatment being denied if the services were not Medically Necessary or did not meet the urgently needed services criteria.

YOUR BENEFITS

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

Preventive Care Services

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

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

- Services that have a rating of A or B in the current recommendations of the U.S. Preventive Services Task Force (USPSTF). Refer to the USPSTF website at [uspreventiveservicestaskforce.org/uspstf/](https://www.uspreventiveservicestaskforce.org/uspstf/)
- Immunizations for routine use in children, adolescents and adults as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). (Lab tests to determine the presence of vaccine antibodies (titer tests) are considered diagnostic services, not preventive, and Cost Sharing applies.) Refer to the CDC website at [cdc.gov/vaccines/schedules/index.html](https://www.cdc.gov/vaccines/schedules/index.html)
- Preventive care and screenings provided for in the guidelines supported by the Health Resources Services Administration (HRSA) at [hrsa.gov/womens-guidelines/index.html](https://www.hrsa.gov/womens-guidelines/index.html)

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

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

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

- Contraceptive methods that are Food and Drug Administration (FDA)-approved, -granted, or -cleared, including over-the-counter (OTC) items, as prescribed by a Participating Provider. At least one form of contraception in each of the methods that the FDA has identified in its current Birth Control Guide, with the exception of sterilization surgery for men, are covered with no Cost Sharing. Approved contraceptive methods include, but are not limited to, barrier methods, hormonal methods and implanted devices
- Contraceptive care includes counseling on contraceptive use, initiation of a contraceptive method and follow-up care including management and evaluation of the prescribed contraceptive method as well as changes to and removal or discontinuation of the contraceptive method
- Smoking cessation interventions, including drugs and counseling
- Health education counseling and programs
- Medical exams, procedures and screenings, including:
 - Blood pressure screening in adults
 - Colorectal cancer screening
 - Annual preventive refractive eye exam through the end of the month in which the Member turns age 19
 - Routine preventive retinal photography screenings
 - Hearing exams and screenings
 - Preventive counseling, such as sexually transmitted disease (STD) prevention counseling
 - Tuberculosis tests
- Maternity and newborn care, including but not limited to:
 - The normal series of scheduled prenatal care exams after confirmation of pregnancy and the first postpartum follow-up consultation and exam
 - Alpha-fetoprotein testing
 - Lactation support services including breastfeeding equipment and supplies (e.g.

double electric breast pumps), consultations, counseling, and education

- Anemia screening
- Procedures for the prenatal diagnosis of genetic disorders of the fetus, including tests for specific genetic disorders for which genetic counseling is available
- Gestational diabetes screening
- Rh incompatibility screening
- HIV Preexposure Prophylaxis (PrEP) baseline, follow-up testing and monitoring Medical Services in accordance with USPSTF and CDC guidelines, including:
 - Adherence counseling
 - Creatine testing
 - Hepatitis B testing
 - Hepatitis C testing
 - HIV testing
 - Lipid panel testing
 - Pregnancy testing
 - Sexually transmitted infection (STI) screening and counseling
- Routine preventive imaging and laboratory services, including:
 - Abdominal aortic aneurysm screening
 - Bone density scans
 - Screening mammograms for women age 40 and older
 - Cervical cancer screenings
 - Cholesterol tests (lipid panel and profile) for adults at certain ages or at higher risk
 - Diabetes screening (fasting blood glucose tests) for adults in accordance with USPSTF guidelines
 - Fecal occult blood tests
 - HIV tests
 - Prostate-specific antigen tests
 - Certain STD tests
- Well-child care – A schedule of comprehensive preventive health services provided at well-child visits from infancy through adolescence as recommended by the American Academy of Pediatrics’ (AAP) Bright Futures initiative, supported by HRSA. Care includes screenings, assessments, procedures, immunizations, and physical examinations, including developmental screenings to diagnose and assess potential

developmental delays. Refer to the Periodicity Schedule on the Bright Futures website at:

brightfutures.aap.org

- Well-woman care – A schedule of comprehensive preventive health services provided at well-woman visits starting at adolescence as recommended by The American College of Obstetricians and Gynecologists’ (ACOG) Women’s Preventive Services Initiative (WPSI), supported by HRSA. Care includes screenings, assessments, counseling and procedures including, but not limited to, immunizations. Refer to the Well-Woman Chart on the WPSI website at:
womenspreventivehealth.org

Preventive Care Exclusions and Limitations

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

Covered carrier screening and cell-free DNA testing that provide an estimate of the risk of a fetal abnormality but do not confirm a prenatal diagnosis of genetic disorders of the fetus are not considered preventive and applicable Cost Sharing will apply.

Colonoscopies that do not have a rating of A or B in the current recommendations of the USPSTF guidelines, including diagnostic and surveillance colonoscopies, are not considered Preventive Care Services and Cost Sharing will apply. A colonoscopy required due to a positive colorectal cancer screening test (other than a screening colonoscopy) will be covered with no Cost Sharing.

Acupuncture Services

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

Your employer Group may have elected an additional optional benefit for acupuncture services. This coverage is provided through an arrangement with ACN Group of California, Inc. dba OptumHealth Physical Health (ACN). If elected, the acupuncture benefit is described in the ACN EOC for Optional Acupuncture Benefits, available upon request from ACN.

If your employer Group elected optional acupuncture benefit coverage, any limitations or exclusions that apply to the optional acupuncture benefits, such as the maximum number of self-referred office visits, will not apply to the EHB of acupuncture.

Allergy Testing, Evaluation and Management

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

Cost Sharing for allergy injections and serum when provided as part of an office visit is included in the Cost Sharing for the office visit with a PCP or Specialist. There is no Cost Sharing, after Deductible if applicable, for allergy injections and serum that are provided without an accompanying office visit when a PCP or Specialist is not seen and no other services are received. Please refer to the *BCM* for Cost Sharing details.

Ambulance Services

Emergency

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

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

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

Nonemergency

SHP covers non-emergency ambulance and psychiatric transport van services within the SHP Service Area if a Participating Provider determines that your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of

transportation would endanger your health. These services are covered only when the vehicle transports you to or from Covered Services. These services must be arranged by the provider or facility and Prior Authorized.

Ambulance Services Exclusion

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

Bariatric Surgery

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

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

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

For Covered Services related to the bariatric surgical procedures that you receive, you will pay the Cost Sharing you would pay for the applicable category of

Covered Services. For example, see Hospital Inpatient Care in your *Benefits and Coverage Matrix* for the Cost Sharing that applies for hospital inpatient care.

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

- Transportation for you to and from the facility up to \$130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit)
- Transportation for one companion to and from the facility up to \$130 per round trip for a maximum of two trips (the surgery and one follow-up visit)
- One hotel room, double-occupancy, for you and one companion not to exceed \$100 per day for the pre-surgical visit and the follow-up visit, up to two days per trip
- Hotel accommodations for one companion not to exceed \$100 per day while you are a hospital inpatient during and immediately following your surgery, up to four days

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

Bariatric Surgery Exclusion

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

Chiropractic Services

SHP does not cover chiropractic services unless your employer Group has elected an additional optional benefit for chiropractic services. This optional benefit is provided through an arrangement with ACN Group of California, Inc. dba OptumHealth Physical Health (ACN). If elected, the chiropractic benefit is described in the ACN EOC for Optional Chiropractic Benefits, available on request from ACN.

Dental and Orthodontic Services

SHP provides the following limited medical and surgical coverage for dental and orthodontic services:

- For preparation of your jaw for radiation therapy of cancer in your head or neck, SHP covers dental evaluation, X-rays, fluoride treatment and extractions necessary, when provided by a Participating Provider or if the Medical Group authorizes a referral to a dentist (as described in the Referrals to Specialists and the Prior Authorization sections in the Seeing A Doctor And Other Providers chapter)
- General anesthesia for dental procedures at a Participating Provider and the services associated with the anesthesia if all of the following are true:
 - The Member is under age seven or developmentally disabled, or the Member's health is compromised
 - The Member's clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
 - The dental procedure would not ordinarily require general anesthesia
- Covered Services for cleft palate including dental extractions, dental procedures necessary to prepare the mouth for an extraction and orthodontic services, if they meet all of the following requirements:
 - The services are an integral part of a reconstructive surgery for cleft palate that SHP covers under Reconstructive Surgery in this Your Benefits chapter
 - A Participating Provider provides the services or the Medical Group or SHP authorizes a referral to a Non-Participating Provider who is a dentist or orthodontist
- Custom made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders) are covered if they are Medically Necessary and prior authorized
- Emergency Services to Stabilize an acute injury to sound natural teeth, jawbone and surrounding structures after an injury. Dental services beyond Emergency Services to Stabilize an acute injury are not covered
- Pediatric Dental Services required as an EHB for Members through the end of the month in which the Member turns 19 – SHP contracts with Delta Dental to provide Pediatric Dental Services described in the Pediatric Dental Addendum at the end of this document

For Covered Services related to dental and orthodontic services that you receive, you will pay

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

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

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

Dental and Orthodontic Services Exclusions

SHP does not cover any other services related to a dental procedure, such as the dentist's services, except as described in the pediatric dental benefit or as part of an optional adult dental benefit, if elected by your employer Group. For a list of excluded services, please see the Exclusions And Limitations chapter in this EOC.

How to Access Your Pediatric Dental Benefit

Pediatric Dental Services are administered by Delta Dental. Services are provided through DeltaCare® USA, Delta Dental's network of dental providers. Delta Dental assigns you a dentist upon enrollment. Delta Dental sends you a separate dental ID card that identifies the assigned dentist. Refer to the Pediatric Dental Addendum at the end of this document for information.

For a directory of DeltaCare USA's network of dental providers, or if you have a problem with a dental provider, or if you would like to submit a complaint or grievance, call DeltaCare USA's Member Services at 1-800-422-4234 or visit deltadentalins.com.

Dental Services - Adult

SHP does not cover adult dental services unless your employer Group has elected an additional optional benefit for comprehensive adult dental services. This optional benefit is provided through Delta Dental to Members 19 years of age and older. If elected, the comprehensive adult dental benefit is described in the Delta Dental EOC, a separate document available on request from SHP or Delta Dental.

Dialysis Care

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

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

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

SHP covers the following Covered Services related to dialysis:

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

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

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

Dialysis Care Exclusions

SHP does not cover:

- Comfort, convenience or luxury equipment, supplies and features; or non-medical items,

such as generators or accessories to make home dialysis equipment portable for travel

- Routine (non-emergency) dialysis when provided during travel outside of the SHP Service Area

Durable Medical Equipment for Home Use

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

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

- Infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other drugs)
- Continuous glucose monitors
- 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
- Electric breast pumps are a covered Preventive Care Service with no Cost Sharing when prescribed by a Participating Provider, prior authorized by your Medical Group and obtained as indicated by your Medical Group. For manual breast pumps, please refer to the DME Limitations and Exclusions below

- Wheelchairs

DME Limitations and Exclusions

While the rental or purchase of electric breast pumps is administered through the DME benefit at no charge to the member, SHP does not cover manual breast pumps through its DME benefit. Manual breast pumps are covered through the pharmacy benefit at no charge; please refer to the Outpatient Prescription Drugs, Supplies, Equipment and Supplements section of this Your Benefits chapter for details.

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

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

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

Fertility Preservation Services

SHP covers standard fertility preservation services when a covered treatment may directly or indirectly cause iatrogenic infertility. Iatrogenic infertility means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

SHP covers the following Covered Services related to fertility preservation:

- Consultations, exams and fertility preservation counseling with reproductive specialists
- Cryopreservation lab services for mature oocytes (eggs), embryos and sperm and the services leading up to successful cryopreservation, including but not limited to:
 - Ovarian stimulation or suppression with injectable medically administered drugs
 - egg retrieval services
 - egg fertilization services

- Sperm retrieval services (both in-office and surgical-based procedures, e.g. sperm aspiration or extraction) that result in a fresh sample of sperm for the cryopreservation of sperm
- Fertility-sparing gynecologic surgery, e.g. ovarian transposition, ovarian cystectomy and radical trachelectomy
- Gonadal shielding during radiation therapy
- Storage of cryopreserved mature oocytes (eggs), embryos and sperm

Fertility Preservation Limitations and Exclusions

Voluntary sterilization services, such as tubal ligation and vasectomy, are not considered covered treatments that may cause iatrogenic infertility and are not eligible for fertility preservation services.

Services deemed investigational or experimental may be covered if performed as part of an approved clinical trial. Refer to the Services Associated with Clinical Trials section in this Your Benefits chapter for details on approved clinical trials.

SHP does not cover:

- At-home sperm freezing kits where a fresh sample of sperm is obtained at home and then mailed to a lab before cryopreservation
- Sperm retrieval services for the cryopreservation of embryos. This exclusion does not include services related to the analysis and preparation of sperm once a sample is obtained
- Additional infertility treatments and procedures that aim to achieve pregnancy, including but not limited to:
 - Artificial insemination
 - Services related to the transfer of embryos into a uterus
 - Thawing of any cryopreserved reproductive material

This exclusion does not apply if you have a Plus Plan that includes infertility treatment as an embedded benefit. If you have a Plus Plan, please refer to the attached Infertility Services Benefit Addendum for details on Covered Services.

Health Education

SHP covers a variety of health education counseling, programs, and materials that your personal Participating Provider provides during a visit covered under another part of this Your Benefits chapter. SHP also covers a variety of health education counseling, programs, and materials to help you take an active role in protecting and

improving your health, including programs and/or support for tobacco cessation, stress management, and chronic conditions (such as diabetes and heart failure).

You pay the following for these Covered Services:

- Covered health education programs, which may include programs provided online and counseling over the phone: no charge
- Individual counseling during an office visit related to smoking cessation: no charge
- Other covered individual counseling when the office visit is solely for health education: no charge
- Health education provided during an outpatient consultation or evaluation covered in another part of this Your Benefits chapter: no additional Cost Share beyond the Cost Share required in that other part of this Your Benefits chapter
- Covered health education materials: no charge

Health Education Limitations and Exclusions

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

Hearing Services

SHP covers the following:

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

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

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

Hearing Services Exclusions

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

Home Health Care

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

- You are substantially confined to your home (or a friend's or relative's home)
- Your condition requires the services of a nurse, physical therapist, occupational therapist or speech therapist
- A Participating Provider determines that it is feasible to maintain effective supervision and control of your care in your home and that the services can be safely and effectively provided in your home
- The Covered Services are provided inside the SHP Service Area or at the Subscriber's residence address if outside the SHP Service Area

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

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

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

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

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

Home Health Care Limitations and Exclusions

SHP does not cover:

- Care that an unlicensed Family Member or other layperson could provide safely and effectively in the home setting after receiving appropriate training
- Care in the home if the home is not a safe and effective treatment setting
- Home health aide services, unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist or speech therapist that only a licensed provider can provide
- Home health outside the SHP Service Area or at a residence outside the Service Area that is not the Subscriber's residence address
- Shift nursing or private duty nursing

For home health care for the Medically Necessary treatment of a mental health disorder, including Behavioral Health Treatment for autism spectrum disorder, or a substance use disorder, refer to the Mental Health and Substance Use Disorder Services section of this Your Benefits chapter.

Hospice Care

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

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

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

If all of the previous requirements are met, SHP covers the following hospice Covered Services, which are available on a 24-hour basis if necessary for your hospice care:

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

Hospital Inpatient Care

SHP covers hospital care, also referred to as inpatient care. You must use a hospital in the SHP network, unless you have an Emergency Medical Condition or your doctor receives Prior Authorization from SHP or your Medical Group for an out-of-network hospital. The services must be Medically Necessary and generally provided in an acute care general hospital setting. Refer to the *Benefits and*

Coverage Matrix for information regarding Copayments, Coinsurance or Deductible amounts that may apply to these Covered Services.

The following Hospital Inpatient Care services are provided:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Participating Providers, including consultation and treatment by Specialists
- Anesthesia
- Drugs dispensed in the hospital
- Radioactive materials used for diagnostic or therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory and special procedures (including MRI, CT, and PET scans)
- Blood, blood products, and their administration
- Obstetrical care and delivery (including cesarean section)
- Physical, occupational and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services, case management and discharge planning

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

- Bariatric surgery
- Dental and orthodontic services
- Dialysis care
- Hospice care
- Mental health and substance use disorder services
- Prosthetic and orthotic devices
- Reconstructive surgery
- Services associated with clinical trials
- Skilled nursing facility care
- Transplant services

Hospital Inpatient Care Limitations

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

Medically Administered Drugs

When Medically Necessary, SHP covers medically administered drugs under your medical benefit when a medical Professional must administer the drug, or observe the administration. These drugs may be dispensed separately to a Participating Provider and are typically administered in a Participating Provider's office, outpatient facility or during home visits.

Medically administered drugs include:

- Botulinum toxin therapy/chemodenervation
- Injected or intravenous antibiotic therapy
- Injected or intravenous chemotherapy
- Injected or intravenous pain drugs
- Intravenous hydration (substances given through the vein to maintain the patient's fluid and electrolyte balance, or to provide access to the vein)
- Radioactive materials used for therapeutic purposes
- Total parenteral nutrition (TPN) (nutrition delivered through the vein)

SHP covers the prescribed, medically administered drugs as well as Professional services to order, prepare, compound, dispense, deliver, administer, or monitor covered drugs or other covered substances. If your plan is an HDHP, separate Cost Sharing will apply for the Professional services as well as the drugs dispensed to the Participating Provider.

Mental Health and Substance Use Disorder Services

SHP contracts with U.S. Behavioral Health Plan, California (USBHPC) to administer Medically Necessary treatment of mental health disorders, which includes Behavioral Health Treatment for autism spectrum disorder (ASD), and substance use disorders; these disorders are commonly abbreviated in this EOC as "MH/SUD". If you need MH/SUD services, or have questions about these benefits, call USBHPC's Member Services toll-free number 1-855-202-0984, available 24 hours a day 7

days a week, visit USBHPC's website at liveandworkwell.com or contact SHP Member Services. To request language interpreter services from USBHPC, provided at no cost to Members, call 1-800-999-9585.

A MH/SUD means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorder chapter of the most recent edition of the International Classification of Diseases (ICD) or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

The Medically Necessary treatment of a MH/SUD means a service or product that addresses the specific needs of a Member for the purpose of preventing, diagnosing or treating an illness, injury, condition or its symptoms, including minimizing progression. Medically Necessary treatment of a MH/SUD is provided in a manner that is all of the following:

- In accordance with the generally accepted standards of mental health and substance use disorder care
- Clinically appropriate in terms of type, frequency, extent, site and duration
- Not primarily for the economic benefit of SHP or its Members or for the convenience of the Member, treating physician or other health care provider

Covered Services include inpatient and outpatient benefits that are prior authorized by USBHPC, as needed, are typically rendered by a Participating Practitioner and provide the following Medically Necessary treatment of a MH/SUD:

- Basic health care services as defined in subdivision (b) of Section 1345 of the California Health and Safety Code
- Intermediate services, including the full range of levels of care, including but not limited to residential treatment, partial hospitalization and intensive outpatient treatment
- Prescription drugs

If services for the Medically Necessary treatment of a MH/SUD are not available within USBHPC's network of Participating Practitioners within the geographic and timely access standards set by law or regulation, then USBHPC will arrange coverage to ensure the delivery of Medically Necessary out-of-network services and any medically necessary follow-up services. To arrange coverage includes, but is not limited to, providing services to secure Medically Necessary out-of-network options that are available to the Member within geographic and timely access standards. If USBHPC arranges

coverage for an out-of-network provider, then the Member will pay the same Cost Sharing for covered MH/SUD services as they would pay if the same Covered Services were received from a Participating Practitioner.

Mental Health Disorder Services

Mental health disorder inpatient services are covered as follows:

- Inpatient services are inpatient hospitalization and professional services rendered by a Participating Practitioner and provided at a participating facility, such as a hospital or Residential Treatment Center. These services are covered when Prior Authorized by USBHPC and are inclusive of, but not limited to, the following:
 - Inpatient Behavioral Health Treatment for ASD
 - Inpatient psychiatric hospitalization, including inpatient psychiatric observation for an acute psychiatric crisis
 - Treatment in a crisis residential program
- Inpatient prescription drugs are covered only when prescribed by a USBHPC Participating Practitioner for the Medically Necessary treatment of a mental health disorder while the Member is confined to a hospital or inpatient treatment center.

Please note that prescription drugs prescribed by a Participating Practitioner while the Member is inpatient in a Residential Treatment Center are covered through the Outpatient Prescription Drug benefit and not as part of the hospital inpatient care benefit

Mental health disorder outpatient services are covered as follows:

- Outpatient office visits are individual and group evaluation and treatment services provided by a Participating Practitioner which include, but are not limited to, initial consultation and individual or group follow up visits for office-based services, such as mental health counseling and outpatient monitoring of drug therapy
- Outpatient other items and services require Prior Authorization by USBHPC, can be received in a facility, office, home or other non-institutional setting by a Participating Practitioner and are inclusive of, but not limited to, the following:
 - Electroconvulsive therapy
 - Multidisciplinary intensive psychiatric treatment programs such as:
 - Outpatient psychiatric observation for an acute psychiatric crisis

- Intensive outpatient program day treatment
- Partial hospitalization program day treatment
- Psychological testing provided by a Participating Practitioner who has the appropriate training and experience to administer such tests
- Behavioral Health Treatment for autism spectrum disorder (ASD), including pervasive developmental disorder (PDD), requires Prior Authorization by USBHPC, can be received in a facility, office, home or other non-institutional setting and is inclusive of 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 Member with ASD, and meet all of the following criteria required by California law:
 - Treatment is prescribed by a physician or surgeon or is developed by a psychologist licensed in accordance with California law
 - Treatment is provided under a treatment plan prescribed by a Qualified Autism Service Provider and administered by one of the following:
 - A Qualified Autism Service Provider
 - A Qualified Autism Service Professional supervised by the Qualified Autism Service Provider
 - A Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional
 - The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the specific Member being treated. The treatment plan shall be reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever 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

Behavioral Health Treatment for ASD is covered as part of the “MH/SUD other outpatient services” benefit, refer to the *Benefits and Coverage Matrix* for Cost Sharing.

- Outpatient Prescription Drugs are covered when prescribed by a USBHPC Participating Practitioner or SHP Participating Provider. They are covered as Outpatient Prescription Drugs through SHP's pharmacy benefit, not through USBHPC's MH/SUD benefit, and may require Prior Authorization from CVS Caremark
- Injectable antipsychotic drugs are covered only if prescribed by a USBHPC Participating Practitioner or by a SHP Participating Provider in consultation with a USBHPC Participating Practitioner. They are covered as Outpatient Prescription Drugs through SHP's pharmacy benefit, not through USBHPC's MH/SUD benefit, and require Prior Authorization from CVS Caremark

Substance Use Disorder (SUD) Services

SUD inpatient services are covered as follows:

- Inpatient services are inpatient hospitalization and professional services rendered by a Participating Practitioner and provided at a participating facility, such as a hospital or Residential Treatment Center. These services are covered when Prior Authorized by USBHPC and are inclusive of, but not limited to, the following:
 - Inpatient chemical dependency hospitalization, including medical detoxification and medical treatment for withdrawal symptoms
- Treatment at a Residential Treatment Center
- Inpatient prescription drugs are covered only when prescribed by a USBHPC Participating Practitioner for the Medically Necessary treatment of a SUD while the Member is confined to a hospital or inpatient treatment center.

Please note that prescription drugs prescribed by a Participating Practitioner while the Member is inpatient in a Residential Treatment Center are covered through the Outpatient Prescription Drug benefit and not as part of the hospital inpatient care benefit

SUD outpatient services are covered as follows:

- Outpatient office visits are individual and group evaluation and treatment services provided by a Participating Practitioner which include, but are not limited to, initial consultation and individual or group follow up visits for office-based services, such as SUD counseling and medical treatment for withdrawal symptoms
- Other outpatient items and services require Prior Authorization by USBHPC, can be provided in a treatment facility or other non-institutional setting

by a Participating Practitioner, and are inclusive of, but not limited to, the following:

- Multidisciplinary intensive treatment programs such as:
 - Intensive outpatient program day treatment
 - Partial hospitalization day treatment
- Outpatient Prescription Drugs are covered when prescribed by a USBHPC Participating Practitioner or SHP Participating Provider. They are covered as Outpatient Prescription Drugs through SHP's pharmacy benefit, not through USBHPC's MH/SUD benefit, and may require Prior Authorization from CVS Caremark
- Injectable drugs for SUD treatment are covered only if prescribed by a USBHPC Participating Practitioner or by a SHP Participating Provider in consultation with a USBHPC Participating Practitioner. They are covered as Outpatient Prescription Drugs through SHP's pharmacy benefit, not through USBHPC's MH/SUD benefit, and require Prior Authorization from CVS Caremark

Exclusions from Mental Health and Substance Use Disorder Services:

- Any inpatient admission, treatment or service and other outpatient item or service, such as intensive outpatient program treatment, outpatient electroconvulsive treatment and psychological testing, not Prior Authorized by USBHPC (except in the event of Emergency Services or Urgent Care)
- Medically Necessary speech therapy, physical therapy and occupational therapy services, including those in connection with Behavioral Health Treatment, are covered Medical Services and are not covered MH/SUD services
- Services, supplies and treatments for a MH/SUD that are not Medically Necessary
- Services provided by people who are not licensed or certified by the state to provide behavioral health services, except for those authorized under California law to provide Medically Necessary treatment of a MH/SUD, which includes Behavioral Health Treatment for ASD, including, but not limited to, a Qualified Autism Service Paraprofessional
- Pastoral or spiritual counseling
- Dance, poetry, music or art therapy services except as part of Behavioral Health Treatment
- School counseling and support services, household management training, peer support services, tutor and mentor services, independent living services, supported work environments,

job training and placement services, therapeutic foster care, emergency aid to household items and expenses, and services to improve economic stability

- Community care facilities, as defined under California Health Safety Code 1502(a)(1), that provide 24-hour non-medical residential care of persons in need of personal services, supervision or assistance essential for sustaining the activities of daily living or for the protection of the individual
- Counseling for adoption, custody, family planning or pregnancy that is not part of the Medically Necessary treatment of a MH/SUD. This exclusion does not apply to covered family planning and maternity care benefits described in the Preventive Care Services section in this Your Benefits chapter
- Services provided by a sexual surrogate partner
- Personal or comfort items including, but not limited to, non-Medically Necessary private duty nursing and/or a private room during an inpatient hospitalization
- Neurological services and tests including, but not limited to, EEGs, PET scans, MRI's, skull X-rays and lumbar punctures are covered Medical Services and are not covered MH/SUD services. For coverage information refer to the Outpatient Imaging, Laboratory and Therapeutic Procedures section and the Hospital Inpatient Care section in this Your Benefits chapter
- Evaluation for professional training, employment investigations, fitness for duty evaluations, or career counseling
- Special education for a specific learning disability. Specific learning disability, or learning disorder, means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in the imperfect ability to listen, think, speak, read, write, spell or to do mathematical calculations, including conditions such as dyslexia. Special education, or educational services, means specially designed instruction to meet the unique needs of an individual with a specific learning disability that advances educational, employment or independent living skills. This exclusion does not apply to Covered Services when they are Prior Authorized and part of Medically Necessary treatment of a MH/SUD, including, but not limited to, Behavioral Health Treatment

Ostomy and Urological Supplies

SHP covers ostomy and urological supplies in the SHP Service Area when Medically Necessary. SHP

or your Medical Group selects the vendor, and coverage is limited to the standard supply that adequately meets your medical needs, which may include:

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

Ostomy and Urological Supplies Exclusion

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

Outpatient Care

SHP covers the following Medically Necessary outpatient care:

- 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)
- Medically administered drugs, if administration or observation by a medical professional is required and they are administered to you in a Participating Provider's office, outpatient facility or during home visits
- Allergy testing and injections (including allergy serum)
- Blood, blood products and their administration
- Standard fertility preservation services
- Male sterilization procedures

- Nurse midwife services are covered when medically appropriate and the nurse midwife is a Participating Provider in your PCP's medical group
- Outpatient procedures (other than surgery) if a licensed staff member monitors your vital signs as you regain sensation and/or awareness after receiving drugs to reduce sensation or to minimize discomfort
- Outpatient surgery if it is provided in an outpatient setting, an ambulatory surgery center or in a hospital operating room or a physician's office as long as a licensed staff member monitors your vital signs as you regain sensation and/or awareness after receiving drugs to reduce sensation or to minimize discomfort
- Physical, occupational, and speech therapy, including services provided in an organized, multidisciplinary habilitation or rehabilitation program
- Preventive Care Services (refer to the Preventive Care Services section)
- Primary and specialty care consultations, exams, and treatment (specific Covered Services are described in more detail below). Some types of outpatient consultations, exams, education, therapy, and treatment may be available as group appointments, for example, group visits for the ongoing management of certain chronic health conditions such as diabetes, high blood pressure, or coronary artery disease, chronic obstructive pulmonary disease (COPD), and group therapy sessions for the treatment or management of mental health and substance use disorders

SHP also covers abortion and abortion-related services, including pre-abortion and follow-up services.

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

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

- Bariatric surgery
- Dental and orthodontic services
- Dialysis care
- Durable medical equipment for home use
- Health education
- Hearing services
- Home health care

- Hospice care
- Mental health and substance use disorder services
- Ostomy and urological supplies
- Outpatient imaging, laboratory and special procedures
- Outpatient Prescription Drugs, supplies, equipment and supplements
- Prosthetic and orthotic devices
- Reconstructive surgery
- Services associated with clinical trials

Outpatient Imaging, Laboratory and Therapeutic Procedures

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

- Electrocardiograms
- Therapeutic or diagnostic injections
- Therapeutic or diagnostic radiation services
 - Preventive mammograms
 - Preventive aortic aneurysm screenings
 - Bone density CT scans
 - Bone density DEXA scans
 - All other CT scans, and all MRIs and PET scans
 - All other imaging services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds
 - Nuclear medicine, diagnostic or screening tests
- Laboratory tests
 - Laboratory tests to monitor the effectiveness of dialysis
 - Fecal occult blood tests
 - Laboratory tests to determine the presence of antibodies (titer tests); these are considered diagnostic services, not preventive, and Cost Sharing applies
 - Routine laboratory tests and screenings that are Preventive Care Services, such as preventive cervical cancer screenings, prostate specific antigen tests, cholesterol tests (lipid panel and profile), diabetes

screening (fasting blood glucose tests), certain STD tests, and HIV tests

- All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available) when:
 - o Determined to be Medically Necessary
 - o Test is not experimental/investigational
 - o Results are used to modify treatment for the Member
- Therapeutic procedures
 - Radiation therapy
 - Ultraviolet light treatments

Outpatient Prescription Drugs, Supplies, Equipment and Supplements

SHP contracts with CVS Caremark® to administer the Outpatient Prescription Drug benefit as part of your covered health care services. SHP covers Outpatient Prescription Drugs specified in this section and in accordance with SHP's drug formulary guidelines. You must obtain covered Outpatient Prescription Drugs through a CVS Caremark retail Participating Pharmacy, the CVS Caremark Mail Service Pharmacy or CVS Specialty, unless the item is obtained as part of the Covered Services described in the Emergency Services And Urgent Care chapter.

Outpatient Prescription Drugs must be prescribed as follows:

- Items prescribed by Participating Providers
- Items prescribed by the following non-Participating Providers:
 - Dentists if the drug is for medical treatment of a covered dental service
 - Non-Participating Providers if the Medical Group or SHP authorizes a written referral to the Non-Participating Provider and the item is Medically Necessary as part of that referral
 - Non-Participating Providers if the prescription was obtained as part of covered Emergency Services, authorized Post-Stabilization Care, or Out-of-Area Urgent Care described in the Emergency Services And Urgent Care chapter

Retail Options

Covered Outpatient Prescription Drugs are covered up to a 30-day supply from a CVS Health National Network retail location, also known as a Participating Pharmacy.

To find retail Participating Pharmacies in your area, you can:

Go to the SHP CVS Caremark website at caremark.com/oe/sutterhealthplus, click on Find a Pharmacy and use the Pharmacy Locator tool or call CVS Caremark Customer Care at 1-844-740-0635

If you must fill the prescription at a non-Participating Pharmacy because a Participating Pharmacy is not available, you may have to pay the costs and ask SHP to reimburse you as described in the Pharmacy Payment and Reimbursement section of the Payment And Reimbursement chapter.

Covered prescription drugs that are usually prescribed for long-term use and taken longer than 60 days are considered Maintenance Drugs. While not required, Members may obtain up to a 100-day supply of Maintenance Drugs from SHP's CVS Health Retail-90 Network, which is made up of all retail CVS pharmacy locations. You can receive up to a 100-day supply at one time for two times the 30-day retail Copayment, as determined by your plan design.

Mail Order for Maintenance Drugs

While not required, Members may sign up for the mail order program through the CVS Caremark Mail Service Pharmacy to obtain up to a 100-day supply of Maintenance Drugs that can be delivered to your home, office or other location of choice with free standard shipping. Please note that Specialty Drugs are not eligible for the mail order program.

You can receive up to a 100-day supply at one time for two times the 30-day retail Copayment, as determined by your plan design.

To sign up for the mail order program, you will need to request a new prescription. You can make this request and sign up by doing either of the following:

- Ask your Participating Provider to send a new mail service prescription to the CVS Caremark Mail Service Pharmacy using one of the following methods:
 1. Phone: Your prescribing provider can call in a prescription toll-free at 1-800-378-5697
 2. Fax: Your prescribing provider can fax a prescription using the FastStart® New Prescription Fax Form to 1-800-378-0323
 3. Electronically: Your prescribing provider can submit the FastStart® New Prescription Fax Form using the e-prescribing tool
- Request a new mail service prescription yourself from the CVS Caremark Mail Service Pharmacy using one of the following methods:
 1. Phone: Call CVS Caremark's Customer Care at 1-844-740-0635 and then CVS

Caremark will contact your prescribing provider for a prescription

2. Online: Sign in to Caremark.com and select "Start Rx Delivery by Mail". Use the search feature to find your drug name, select "Price this drug" and then the "Request a New Prescription" button. CVS Caremark will then contact your prescribing provider for a prescription
3. Mail: Complete the CVS Caremark Mail Service Order Form and mail it, along with your new prescription and payment to the address on the form. You can get the order form by contacting CVS Caremark's Customer Care at 1-844-740-0635 or on the Sutter Health Plus website at sutterhealthplus.org/pharmacy

Upon receipt of a new prescription from your Participating Provider, it will take up to 10 business days for the CVS Caremark Mail Service Pharmacy to process and ship your order. You can request expedited shipping of your prescription at additional cost.

If you experience any delays in obtaining your mail order drugs as a result of CVS Caremark, then please contact Customer Care at 1-844-740-0635 to arrange for expedited delivery through an alternative method at no additional cost.

Specialty Prescription Drugs

Specialty Drugs are usually injected or infused, however some are oral or inhaled drugs, and as they are typically used to treat complex or rare chronic conditions, they often require close supervision and therapy monitoring. Specialty Drugs are obtained through CVS Specialty. CVS Specialty focuses on patient safety, with support available 24 hours a day, seven days a week to ensure that you receive safe and effective Specialty Drugs for your condition, that you know how to take these drugs correctly, and that you have timely and convenient access to the Specialty Drugs you need.

Regardless of tier placement, Specialty Drugs have the same fill requirements and are limited to a 30-day supply. Specialty Drugs are not available through the mail order program however you can arrange for the delivery of certain Specialty Drugs to your current location or a nearby retail CVS pharmacy location at no additional cost.

To get more details about Specialty Drugs:

- Visit the CVS Specialty website at cvsspecialty.com
- Call CVS Specialty Customer Care at 1-800-237-2767

About the SHP Formulary

SHP uses a drug formulary to assure that Members have access to Medically Necessary and clinically appropriate prescription drugs. The formulary identifies the drugs available for certain conditions and organizes them into cost levels, also known as tiers. Please note that the presence of a drug on the SHP formulary does not guarantee that you will be prescribed the drug by a Participating Provider for a particular medical condition.

To receive a copy of the SHP formulary, go online to info.caremark.com/oe/sutterhealthplus or the SHP website at sutterhealthplus.org/pharmacy. The formulary is also available upon request by calling SHP Member Services.

SHP uses a four-tier formulary:

- Tier 1 – Most Generic Drugs and low-cost preferred brand name drugs are covered at the lowest tier Cost Share level
- Tier 2 – Preferred brand name drugs, non-preferred Generic Drugs and drugs recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost are covered at the second lowest tier Cost Share level
- Tier 3 – Non-preferred brand name drugs or drugs that are recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost are covered at the third tier Cost Share level. These generally have a preferred and often less costly therapeutic alternative at a lower tier
- Tier 4 – Drugs that are biologics, drugs that the FDA or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply are covered at the 4th tier Cost Share level

For information on the Cost Sharing associated with Outpatient Prescription Drugs, refer to the *Benefits and Coverage Matrix*. The applicable Cost Sharing paid by the enrollee will apply to both the Deductible, if applicable, and the Out-of-Pocket Maximum limit.

There are situations when standard tier Cost Sharing does not apply, for example:

- When a pharmacy's retail price or contracted rate for a prescription drug is less than the applicable Cost Sharing amount for a drug, then the lowest amount will automatically be charged at the point of sale

- By law, Member Cost Sharing for oral anticancer drugs may not exceed \$250 per prescription per 30-day supply. Orally administered anticancer drugs follow applicable tier-based Cost Sharing and Members may have a Cost Sharing maximum equal to or lower than \$250. The applicable maximum is determined by each plan's prescription drug benefits; please refer to your *BCM* for the maximum Cost Sharing for your plan. For plans with a separate annual Deductible for prescription drugs, oral anticancer drugs on any tier are not subject to the prescription drug Deductible.
- **Dispense-as-Written (DAW) Penalty:** If brand drugs are dispensed at the prescriber's or Member's request when a U.S. Food and Drug Administration (FDA)-approved generic equivalent is available, then Members may be required to pay the Generic Drug Cost Share and a penalty, which is the difference between the Participating Pharmacy's contracted rate for the brand drug and the contracted rate for the Generic Drug. The penalty for obtaining a brand over generic is not a covered expense, and does not accrue towards the Member's Deductible, if applicable, or Out-of-Pocket Maximum. The penalty will not apply if a brand drug, with an FDA-approved generic equivalent, is deemed Medically Necessary through an "exception" process; please refer to the Generic Substitution bullet in the Prior Authorization for Outpatient Prescription Drugs section for details
- Upon request from a Member or prescriber, a pharmacist may, but is not required to, dispense a partial fill of a prescription for an oral, solid dosage form of a Schedule II controlled substance in accordance with Section 4052.10 of the California Business and Professions Code. The Cost Sharing for a partial fill of a prescription will be prorated
- Amounts paid to reduce the Cost Sharing for specific Outpatient Prescription Drugs using any form of direct financial support, also known as "coupons" or "copay cards", offered by pharmaceutical drug manufacturers are not counted toward your accruals, including the annual Deductible, if applicable, or Out-of-Pocket Maximum.

When copay cards are used for Specialty Drugs, CVS Caremark automatically adjusts the out-of-pocket costs applied to your accruals. Members may self report when copay cards are used for non-Specialty Drugs to have their accruals adjusted by submitting a Prescription Drug Coupon Adjustment Request form. This form can be found within the Forms and Resources page of SutterHealthPlus.org or within the SHP Member Portal

SHP Formulary Updates

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

If you are actively prescribed a drug that is moved to a higher tier on the SHP formulary, CVS will provide you a notice of tier change with at least a 60-day advance notice of the change. If you are actively prescribed a drug that becomes subject to Prior Authorization, CVS will notify you with at least a 60-day advance notice of the change.

When a generic version of a brand name drug becomes available, the generic may be available at a lower tier. In this case, if you choose to continue taking the brand name drug instead of the lower tiered generic, then you are responsible for the increased cost. Please refer to the DAW Penalty section above for details.

Preventive Care Drugs and Supplies

SHP covers certain Outpatient Prescription Drugs as Preventive Care Services with no Cost Sharing and without Prior Authorization in accordance with the Patient Protection and Affordability Care Act. Please refer to the Preventive Care Services section of the Your Benefits chapter for specific details on Preventive Care Services.

Preventive care Outpatient Prescription Drugs listed in the SHP formulary at Tier 0 have no Cost Sharing. Member Cost Sharing may apply for preventive care Outpatient Prescription Drugs that are listed on other tiers; please refer to the DAW Penalty section above for details.

Outpatient Prescription Drugs that may be covered as Preventive Care Services include, but are not limited to, the following:

- Immunizations/vaccines as recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Refer to the CDC website at cdc.gov/vaccines/schedules/index.html
- Preventive Outpatient Prescription Drugs that have a current rating of "A" or "B" as recommended by the United States Preventive Services Task Force (USPSTF), refer to the USPSTF website at uspreventiveservicestaskforce.org/uspstf/,

and/or as recommended by the HRSA-sponsored Women's Preventive Services Initiative (WPSI), refer to the WPSI website at womenspreventivehealth.org. Some examples include:

- Aspirin for pregnant Members at high risk for preeclampsia
- Bowel preparation drugs needed for a colonoscopy as part of a colorectal cancer screening for Members of a certain age
- Breast cancer risk-reducing drugs, such as raloxifene or tamoxifen, for asymptomatic Members of a certain age who are at increased risk for breast cancer. This does not apply to Members who have a current or previous breast cancer diagnosis
- Breast pump (manual) to support breastfeeding. For electric breast pumps, please refer to the Durable Medical Equipment for Home Use section of this Your Benefits chapter
- Folic acid for Members who are planning or capable of pregnancy, including those who are pregnant
- HIV preexposure prophylaxis (PrEP) and, in accordance with California law, HIV post exposure prophylaxis for the prevention of HIV infection
- Oral fluoride supplementation for children of certain ages whose water supply is deficient in fluoride
- Statin therapy for the primary prevention of cardiovascular disease for Members of certain ages with disease risk factors
- Tobacco smoking cessation products that are FDA-approved, both prescription and over-the-counter (OTC) agents
- Contraceptive drugs and devices that are FDA-approved, -granted, or -cleared, including over-the-counter (OTC) items, as prescribed by a Participating Provider. At least one form of contraception in each of the methods that the FDA has identified in its current Birth Control Guide are covered with no Cost Sharing.

If a particular covered therapeutic equivalent of a drug, device or product is not available or any drug (generic or brand name) is determined to be medically inappropriate by your Participating Provider, then SHP will cover the prescribed drug at no Cost Share when Prior Authorized.

In accordance with California law, SHP will cover up to a 12-month supply of FDA-

approved, self-administered hormonal contraceptives that are dispensed at one time for a Member by a provider, pharmacist or location licensed or authorized dispense drugs or supplies

- SHP covers certain prenatal vitamins for pregnant Members at no Cost Share

SHP does not limit sex-specific recommended preventive Outpatient Prescription Drugs based on a Member's sex assigned at birth, gender identity or recorded gender. When a Participating Provider determines that a Preventive Care Service is medically appropriate for a Member who satisfies the criteria in the relevant recommendation, then SHP will cover the recommended Outpatient Prescription Drug without cost sharing.

Outpatient Prescription Drugs for Diabetes and Pediatric Asthma

SHP covers the following Outpatient Prescription Drugs for the management and treatment of diabetes and pediatric asthma, in accordance with California law, as medically necessary:

- Blood glucose meters and their testing strips
- Certain continuous blood glucose monitors and their supplies
- Certain insulin pumps and their supplies
- Disposable needles and syringes for the administration of insulin
- Inhaler spacers
- Ketone urine testing strips
- Lancets and lancet puncture devices
- Nebulizers, including face masks and tubing
- Pen delivery systems for the administration of insulin
- Prescriptive drugs for the treatment of diabetes including insulin and glucagon
- Visual aids, excluding eyewear, required to assist the visually impaired with proper dosing of insulin

Some of the above Outpatient Prescription Drugs may be available over-the-counter (OTC) and if so, require a valid prescription. See the SHP formulary for details on OTC items.

Please see the SHP formulary for the specific continuous blood glucose monitors, insulin pumps and their supplies that are covered as Outpatient Prescription Drugs. For additional continuous glucose monitors, insulin pumps and their supplies, please refer to the Durable Medical Equipment For Home Use section of this Your Benefits chapter.

Prior Authorization for Outpatient Prescription Drugs

Prior Authorization is used to ensure proper patient selection, dosage, drug administration and duration of selected drugs. Several drugs on the SHP formulary require Prior Authorization to ensure clinically appropriate and safe use based on criteria set by the SHP Pharmacy and Therapeutics Committee.

If your Provider prescribes a drug that requires Prior Authorization, they should submit a Prescription Drug Prior Authorization request to CVS Caremark. CVS Caremark, on behalf of SHP, will evaluate whether the requested drug is Medically Necessary for your condition.

If your pharmacy has not filled your prescription because it has not received Prior Authorization, then you may:

- Ask the pharmacist to contact your prescribing Provider to submit the Prior Authorization request; or
- Contact your prescribing Provider to request that they submit a Prior Authorization request using the contact information listed in the Contact Information for SHP Health Plan Partners section of the Contact Information chapter; or
- Call CVS Caremark Customer Care at 1-844-740-0635 for assistance

Situations when Prior Authorization is required include, but are not limited to, the following:

- **Generic Substitution:** When Prior Authorization is provided for a drug that has a generic equivalent, the authorization applies to the Generic Drug. If a brand drug is deemed Medically Necessary, it may be obtained at the default brand Member Cost Share through an "exception" process. This process may include a prescribing Provider submitting a Prior Authorization form along with a completed FDA MedWatch Form, indicating trial and failure of the available generic due to adverse event(s) or contraindication
- **Off-Label Use:** When an FDA-approved drug is being prescribed for a use that is different than the FDA's approved indication, or labeling, for the drug (i.e. "off-label use"), Prior Authorization is required. To receive Prior Authorization for off-label use, all the following conditions must be met:
 - The drug is approved by the FDA
 - The drug is prescribed by a Participating Provider for the treatment of either a Life-threatening condition or a chronic and seriously debilitating condition

- The drug has been recognized for treatment of the needed condition by any of the following:
 - The American Hospital Formulary Service's Drug Information
 - 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
 - Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use as safe and effective, unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal

- **Step Therapy:** When multiple drugs with equal effectiveness can be used for a particular medical condition, Participating Providers and Members may be required to try the safer and/or more cost-effective drugs before receiving coverage for (or "stepping up to") the less safe or more expensive drugs. The SHP formulary shows which drugs require step therapy and step therapy requirements are reviewed periodically using national treatment guidelines, FDA recommendations and the relative cost of treatment to assure they reflect pharmaceutical improvements and updates.

If you would like to bypass the step therapy guidelines for a drug, then the prescribing Participating Provider or Member can request a step therapy exception using the Prescription Drug Prior Authorization Or Step Therapy Exception Request Form. Prior Authorization is used to approve Medically Necessary exceptions to the step therapy process and are handled in the same manner and timeframe as all Prescription Drug Prior Authorization requests. An exception may be granted taking into consideration the Member's needs and medical circumstances, along with the professional judgment of the prescribing Provider

- **Opioid Quantity Limits:** Prescription opioids can be used to treat moderate to severe pain and are generally safe when taken for a short time and as directed by the prescribing Provider. Since they can be misused and have addiction potential, certain classes, categories, doses or combinations of opioid drugs may require Prior Authorization. Guidelines for prescription opioid quantity limits align with the Centers for Disease

Control and Prevention's Guidelines for Prescribing Opioids for Chronic Pain

- **Non-Formulary Drugs:** When self-administered, FDA-approved drugs are not listed on the SHP formulary (i.e. "non-formulary drugs"), your prescribing Provider may request Prior Authorization for a Medically Necessary non-formulary prescription drug. Please note that if CVS Caremark approves the Prior Authorization request of a non-formulary drug based on exigent circumstances only, the approval may only be for the duration of the exigency.
- **Continuity of Care:** SHP provides continuity of care of drugs both for new Members who have an active prescription from their prior provider and for existing Members who have an active prescription from a now terminated Participating Provider, when the actively prescribed drug requires Prior Authorization. The Member's new Participating Physician must submit a Prior Authorization request that specifies "continuity of care". If the active 30-day prescription is documented by the prior provider or pharmacy, then SHP may cover up to a 90-day supply of the drug. Additional refills or requests for supplies of the drug require additional review for medical necessity and the prescribing Provider must submit a Prior Authorization request

Upon receipt of a completed prior authorization or step therapy request, CVS Caremark makes a decision and notifies the prescribing Provider and Member of the decision within 72 hours for non-urgent requests and 24 hours for exigent circumstances.

An incomplete request may result in a decision of denial if material information necessary to approve the request is missing and not provided upon request. If CVS Caremark does not respond to a Prior Authorization or step therapy exception request within the required timeframe, the request is deemed approved.

Exigent circumstances are when one of the following is true:

- A Member is suffering from a health condition that may seriously jeopardize their life, health, or ability to regain maximum function
- A Member is undergoing a current course of treatment using a non-formulary drug

In an exigent circumstance, if a Prior Authorization request is needed after business hours, or on weekends and holidays, then the Participating Pharmacy may dispense an emergency short supply of the drug to patients requiring such drug until their prescribing Provider can submit a Prior Authorization request during business hours (refer to the

emergency supply information in the Prescription Fill Exceptions section).

If CVS Caremark denies a Prior Authorization request, you have the right to dispute the decision (refer to the If You Have A Concern Or Dispute With SHP chapter in this EOC). You or your prescribing Provider also have the option to request an external exception review within 30 days of the Prior Authorization denial. During an external exception review, SHP will submit the original request for coverage and subsequent denial of that request to be reviewed by an independent review organization. SHP will notify you and your prescribing Provider of the independent review organization's decision within 72 hours, if the original Prior Authorization request was non-urgent, and within 24 hours, if the original Prior Authorization request was for exigent circumstances. If you disagree with the independent review organization's decision, you may file a grievance with SHP or submit a complaint to the California Department of Managed Health Care. For more information about the external exception review process, including information on how to submit a request for an external exception review, contact SHP Member Services.

Prescription Fill Exceptions

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

Members are eligible for one vacation override per prescription within any 180 days (six-month period). A vacation override allows the Member to pick up the prescribed drug early for up to a 90-day supply.

A Member can request up to a five-day emergency supply by calling CVS Caremark Customer Care. If the emergency supply is authorized and determined to be Medically Necessary, the Member will be able to obtain the five-day supply at the applicable cost share. Participating Providers, on behalf of Members, may also request emergency authorization by contacting SHP Member Services or, if after hours and weekend/holidays, by calling CVS Caremark Customer Care.

Pharmacy Principal Exclusions and Limitations

Drugs, supplies and equipment provided in certain care settings are excluded from coverage in this Outpatient Prescription Drugs, Supplies, Equipment and Supplements section and are covered in accordance with the benefits described in the identified sections of this Your Benefits chapter as follows:

- DME used to administer drugs (refer to the Durable Medical Equipment for Home Use section); this does not apply to specific

items listed in the above Outpatient Prescription Drugs for Diabetes and Pediatric Asthma section

- Drugs provided during a covered stay in a Participating Hospital (refer to the Hospital Inpatient Care section)
- Drugs provided during a covered stay in a Skilled Nursing Facility (refer to the Skilled Nursing Facility Care section)
- Outpatient drugs that are not self-administered and administered by a health care Professional (refer to the Medically Administered Drugs section); this does not apply to certain injectable drugs for the Medically Necessary treatment of a mental health or substance use disorder that are prescribed by a USBHPC Participating Practitioner or by a SHP Participating Provider in consultation with a USBHPC Participating Practitioner

The covered Outpatient Prescription Drugs previously described are subject to the following exclusions and limitations:

1. Prescription drugs that have an available over-the-counter (OTC) equivalent formulation are excluded from coverage; this may not apply to specific drugs and items for which OTCs are mentioned in this Outpatient Prescription Drugs, Supplies, Equipment and Supplements section, including, but not limited to, Outpatient Prescription Drugs for diabetes, pediatric asthma and Preventive Care Services
2. Drugs prescribed solely for the treatment of impotence and/or sexual dysfunction and/or hypoactive sexual desire disorder must be Medically Necessary and may be subject to Prior Authorization and quantity limitations; please refer to the SHP formulary for details
3. Drugs that are experimental or investigational are excluded, except for Life-threatening or seriously debilitating conditions and clinical trials as described in the Independent Medical Review Process/ Investigational and Experimental Treatment Denials section in the If You Have A Concern Or Dispute With SHP chapter. Investigational drugs may be covered if Medically Necessary and an application for approval is under review by the FDA. Medically Necessary drugs provided for an Emergency Medical Condition in another country where the drug is allowed will be covered
4. Vaccinations required for foreign travel (travel vaccines) or occupational purposes are excluded, unless otherwise described in the Preventive Care Services section in the Your Benefits chapter

5. Drugs and other items prescribed solely for cosmetic purposes, including agents for anti-aging or hair growth, and over-the-counter health/beauty aids are excluded; this does not apply to the Medically Necessary treatment of a mental health or substance use disorder, such as gender dysphoria
6. Drugs prescribed solely for weight loss that require a prescription are excluded. This does not apply to drugs that are prior authorized for the Medically Necessary treatment of morbid obesity for which SHP may require a Member prescribed such drugs to be enrolled in a comprehensive weight loss program, if covered by SHP, for a reasonable period of time prior to or concurrent with receiving the prescription drugs
7. Vitamins and mineral supplements are excluded from coverage, except for those as mentioned above in the previous Preventive Care Drugs and Supplies section
8. Replacements for drugs that are lost or stolen are not covered
9. Repackaged drugs (such as those with unit dose packaging), other than the dispensing pharmacy's standard, are excluded
10. Compounded products are excluded if there is a medically appropriate SHP formulary alternative or the compounded drug does not contain at least one prescription drug. Bulk chemicals not approved by the FDA used in compounded products are not covered. SHP shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with the manufacturing, compounding, dispensing or use of any covered prescription drug. Non-FDA-approved, non-proprietary, multisource ingredients that are vehicles essential for compound administration may be covered if compounded with an FDA-approved drug
11. Drugs prescribed solely for the purpose of shortening the duration of the common cold, such as vitamin C, zinc or OTC cough and cold preparations, are excluded
12. Enhancement drugs prescribed solely for athletic performance and mental performance are excluded; this does not apply to drugs for the Medically Necessary treatment of a mental health or substance use disorder, such as dementia, or medical conditions that affect memory, including, but not limited to Alzheimer's disease
13. Over-the-counter (OTC) drugs, supplies or equipment and that may be obtained without a prescription are excluded including, but not

limited to, ketone blood testing strips; this may not apply to specific drugs and items for which OTCs are mentioned in this Outpatient Prescription Drugs, Supplies, Equipment and Supplements section when accompanied by a written prescription, including, but not limited to, Outpatient Prescription Drugs for diabetes, pediatric asthma and Preventive Care Services

14. Drugs prescribed by non-Participating Providers when prescribed for non-covered services and which are not authorized by SHP or the Medical Group are excluded; this does not apply to drugs provided as part of care for an Emergency Medical Condition
15. Medical food and dietary/nutritional aids or supplements are excluded. This exclusion includes, but is not limited to, nutritional formulas and dietary supplements that may be purchased OTC, which by law do not require either a written prescription or dispensing by a licensed pharmacist. This exclusion does not apply to enteral and parenteral nutrition products for the medically necessary treatment of PKU, which are covered under the medical benefit in the Prosthetics and Orthotics section of this Your Benefits chapter
16. Non-FDA-approved drugs or products are excluded unless specifically listed in in this Outpatient Prescription Drugs, Supplies, Equipment and Supplements section

Note: Pharmacies that dispense covered Outpatient Prescription Drugs to Members pursuant to an agreement with CVS Caremark do so as independent contractors. SHP shall not be liable for any claim or demand on account of damages arising out of or in any manner connected with any injuries suffered by Members as a result of the acts or omissions of the pharmacy benefit manager or a Participating Pharmacy.

Outpatient Rehabilitation and Habilitation Services

SHP covers Medically Necessary rehabilitation and habilitation services upon Prior Authorization from your Medical Group.

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

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

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

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

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

Exclusions from Rehabilitation and Habilitation Services

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

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

Prosthetic and Orthotic Devices

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

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

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

Internally Implanted Devices

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

External Devices

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

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres required to hold a prosthesis every 12 months
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Participating Provider
- Compression burn garments and lymphedema wraps and garments
- Enteral and parenteral nutrition: enteral formula and additives for adult and pediatric Members who require tube feeding (including for inherited diseases of metabolism) and formulas and special food products that are Medically Necessary for the treatment of phenylketonuria (PKU); related supplies are covered under Durable Medical Equipment described earlier in this chapter
- Prostheses to replace all or part of an external body part that has been removed or impaired as a result of disease, injury or congenital defect

Prosthetic and Orthotic Devices Limitations

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

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

Prosthetic and Orthotic Devices Exclusions

SHP does not cover:

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described previously in this Prosthetic and Orthotic Devices section
- Comfort, convenience or luxury equipment or features
- Orthopedic shoes, arch supports and other supportive devices for the feet, unless:
 - The shoe or device is an integral part of a leg brace and its expense is included in the cost of the brace;
 - They are therapeutic shoes and inserts for the treatment and prevention of diabetes-related complications;
 - They are rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care;
 - You have a Plus Plan and they are included in the Enhanced Special Footwear and Orthotic Coverage section of this Your Benefits chapter

Reconstructive Surgery

SHP covers the following reconstructive surgery services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease, if a Participating Provider determines that it is necessary to improve function or to the extent possible, create a normal appearance
- Following Medically Necessary removal of all or part of a breast, reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas, in accordance with the Women's Health and Cancer Rights Act
- Surgical treatments as part of sex or gender reassignment that change primary and/or secondary sex characteristics for transsexual, transgender and gender-non-conforming Members, in accordance with the World Professional Association for Transgender Health's (WPATH's) Standards of Care

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

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

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

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

Reconstructive Surgery Exclusions

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

Services Associated With Clinical Trials

SHP covers services associated with approved clinical trials based on the following criteria:

- 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 conducted in relation to the prevention, detection or treatment of cancer or another Life-threatening disease or condition
- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
 - The National Institutes of Health (NIH)
 - The FDA

- The Centers for Disease Control and Prevention
- The Agency for Health Care Research and Quality
- The Centers for Medicare & Medicaid Services
- A cooperative group or center of any of the previously identified entities listed above or the Department of Defense or the Department of Veterans Affairs
- A qualified non-governmental research entity identified in the guidelines issued by the NIH for center support grants
- The Department of Veteran Affairs, The Department of Defense or The Department of Energy, if the study or investigation has been reviewed or approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) it is comparable to the National Institute of Health system of peer review of studies and investigations and (2) it assured unbiased review of the highest scientific standard by qualified people who have no interest in the outcome

- The services would be covered under this EOC if they were not provided in connection with a clinical trial
- The referring Participating Provider or a non-Participating Provider has received Prior Authorization from SHP or your Medical Group and has concluded that your participation in such trial would be appropriate based upon your meeting the conditions previously described
- You provide medical and scientific information establishing that your participation in such trial would be appropriate based upon your meeting the conditions described previously and it is authorized by SHP or your Medical Group

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

Services Associated with Clinical Trials Exclusions

SHP does not cover:

- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management

- Health care services that are customarily provided by the research sponsors free of charge
- Travel, hospital and meals associated with participation in a clinical trial

SHP Nurse Advice Line and USBHPC Intake Services Line

SHP's Nurse Advice Line offers all Members round-the-clock access to registered nurses who help answer questions about medical problems, including caring for minor injuries and illnesses at home, seeking the most appropriate help based on the medical concern, identifying and addressing emergency medical concerns and finding the appropriate access to care or SHP Participating Providers. You can access the Nurse Advice Line 24 hours a day, seven days a week by calling 1-855-836-3500 or SHP Member Services.

USBHPC maintains a toll-free and confidential Intake Services Line available 24 hours a day, seven days a week. You may call USBHPC's toll-free telephone line 1-855-202-0984 to answers questions about your coverage, speak with a behavioral health professional for crisis intervention and to obtain a referral for mental health and substance use disorder services.

Skilled Nursing Facility Care

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

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

SHP covers the following services:

- Physician and nursing services
- Room and board
- Drugs prescribed by a Participating Provider as part of your plan of care in the SNF in accord with SHP's drug formulary guidelines if they are administered to you in the SNF by a medical professional
- DME in accordance with SHP's DME policy
- Imaging and laboratory services that SNFs ordinarily provide
- Medical social services

- Blood, blood products and their administration
- Medical supplies
- Physical, occupational and speech therapy
- Behavioral Health Treatment for autism spectrum disorder
- Respiratory therapy

Telehealth Services

SHP covers services considered to be telehealth or telemedicine services when provided by a Participating Provider for a service that would be considered a covered benefit when provided in person. The Cost Sharing you pay for telehealth services will be equal to or less than, and will never exceed, the Cost Sharing you pay for an equivalent, in-person service. Telehealth services are subject to the same maximum deductible (if applicable to your plan design) and annual OOPM as equivalent in-person services. As required by law, Participating Providers who render telehealth services will be reimbursed on the same basis and to the same extent they are reimbursed for equivalent, in-person services.

Transplant Services

SHP covers transplants of organs, tissue or bone marrow if the Medical Group provides a written referral for care to a transplant facility as described under the Referrals to Specialists and the Prior Authorization sections in the Seeing A Doctor And Other Providers chapter. After the referral to a transplant facility, the following applies:

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, SHP will only cover services you receive before that determination is made
- SHP, Participating Hospitals, the Medical Group and Participating Providers are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue or bone marrow donor
- SHP provides certain donation-related services for a living donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These services must be directly related to a covered transplant for you, which shall include services for harvesting the organ, tissue, bone marrow or stem cell and for treatment of complications in accordance with the following guidelines:
 - The services are directly related to a covered transplant service for you or are required to evaluate a potential donor, harvest the organ, bone marrow or stem cells or treat complications

- SHP provides or pays for donation-related services for actual or potential donors (whether or not they are Members)
- Donor receives Covered Services no later than 90 days following the harvest or evaluation service
- Donor receives services inside the United States, with the exception that geographic limitations do not apply to treatment of stem cell harvesting
- Donor receives written authorization for evaluation and harvesting services
- For services to treat complications, the donor either receives non-Emergency Services after written authorization, or receives Emergency Services SHP would have covered if the enrollee had received them
- In the event the enrollee's plan membership terminates after the donation or harvest, but before the expiration of the 90 day time limit for services to treat complications, the plan shall continue to pay for Medically Necessary services for donor for 90 days following the harvest or evaluation service

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

Transplant Services Exclusions

SHP does not cover:

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

Vision Services – Adult

SHP does not cover adult vision services unless your employer Group has elected an additional optional benefit for comprehensive adult vision services. This optional benefit is provided through VSP to Members 19 years of age and older. If elected, the comprehensive adult vision benefit is described in the SHP Vision Benefit Rider – Small Group addendum, a separate document available on

request to SHP. Coverage for medical and surgical treatment of the eyes is described elsewhere in this Your Benefits chapter, including, but not limited to, the Hospital Inpatient Care and Outpatient Care sections.

Vision Services – Pediatric

This section describes only your pediatric vision benefit provided through VSP. Pediatric Vision Services are provided to pediatric Members through the end of the month in which the Member turns 19 years of age. Coverage for medical and surgical treatment of the eyes is described elsewhere in this Your Benefits chapter, including, but not limited to, the Hospital Inpatient Care and Outpatient Care sections.

SHP contracts with VSP to provide the following Pediatric Vision Services:

- Annual preventive refractive eye exam and dilation; complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated; routine preventive annual refractive exams thereafter
- A complete pair of glasses or contact lenses to correct vision every 12 months:
 - Lenses covered in full:
 - Single vision, lined bifocal, lined trifocal or lenticular lenses
 - Polycarbonate lenses
 - Plastic or glass optional
 - Scratch and UV coatings
 - Frames covered in full:
 - Frames from the pediatric benefit collection (a collection equal to the Exchange collection)
 - Elective contact lens materials in lieu of eyeglasses:
 - Standard (one pair every 12 months) = one contact lens per eye (total two lenses)
 - Monthly (six-month supply) = six lenses per eye (total 12 lenses)
 - Bi-weekly (three-month supply) = six lenses per eye (total 12 lenses)
 - Dailies (one month supply) = 30 lenses per eye (total 60 lenses)
 - Medically Necessary contact lenses are covered in full for Members who have specific conditions for which contact lenses provide better visual correction

- Low vision benefits are included for Members who have severe visual problems that are not correctable with regular lenses
 - Low vision exam - Comprehensive exam, once every 12 months is covered in full (Prior Authorization required)
 - Low vision aids - Approved low vision aids are covered in full once every 12 months (Prior Authorization required)

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

Pediatric Vision Services Benefit Limitations and Exclusions

- Pediatric Vision Services are only covered when provided by a VSP member doctor
- Orthoptics or vision training and any associated supplemental testing are excluded
- Medical or surgical treatment of the eyes is not covered under this pediatric vision benefit provided through VSP. Medically necessary medical or surgical treatment of the eyes may be Covered Services when provided to treat an Emergency Medical Condition, or by your PCP, or upon Prior Authorization and referral to an SHP Participating Provider. Refer to the Emergency Services And Urgent Care chapter and the Outpatient Care and Hospital Inpatient Care sections in this Your Benefits chapter

How to Access Your Pediatric Vision Benefit

To obtain your vision benefit, you must first call a VSP member doctor and schedule an appointment. Be sure to tell the provider you have VSP coverage under SHP and that provider will confirm your eligibility and obtain any Prior Authorization necessary for services.

A directory of VSP member doctors is available online at vsp.com or by calling VSP Member Services at 1-800-877-7195.

If you have a problem with VSP or any VSP member doctor, please contact VSP Member Services to request assistance or to submit a complaint or grievance.

EXCLUSIONS AND LIMITATIONS

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

General Exclusions

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

SHP does not cover (excludes) the following:

- 1) Any services or supplies obtained before the Member's effective date of coverage or after the Member's coverage has ended
- 2) Services, supplies and treatments which are not Medically Necessary
- 3) Non-emergent services and supplies rendered by non-Participating Providers unless prior authorized by the PCP's Medical Group or SHP
- 4) Any services or supplies provided by a person who lives in the Member's home, or by an immediate relative of the Member
- 5) Personal comfort or convenience items (e.g., television, radio), home or automobile modifications or improvements (e.g., chair lifts, purifiers)
- 6) Penile prostheses, unless prescribed by an SHP Participating Physician or USBHPC Participating Practitioner and part of the Medically Necessary treatment of a mental health disorder (e.g., gender affirming surgery) or medical condition (e.g., secondary to penile trauma, tumor, physical disease to the circulatory system or nerve supply)
- 7) Vitamins and mineral supplements, except those noted in the Preventive Care Drugs and Supplies subsection of the Outpatient Prescription Drugs, Supplies, Equipment and Supplements section in the Your Benefits chapter
- 8) Over-the-counter (OTC) drugs, supplies or equipment that may be obtained without a prescription are excluded; this may not apply to specific items for which OTCs are mentioned in the Your Benefits chapter when accompanied by a written prescription, including but not limited to, the Preventive Care Services section
- 9) Services related to the treatment of infertility, as defined in California Health and Safety Code section 1374.55, including all services related to artificial insemination and conception by artificial means, such as: Ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and services related to their procurement and storage), in vitro fertilization (IVF) and zygote intrafallopian transfer (ZIFT). This exclusion does not apply to the standard fertility preservation services included in the Outpatient Care section of the Your Benefits chapter. This exclusion also does not apply if your employer Group has purchased a Plus Plan
- 10) Home birth delivery
- 11) SHP does not cover routine physical exams when the purpose of the exam is to satisfy requirements for obtaining or maintaining insurance, licensing or employment, or for entering school, camp or athletic programs. A routine physical exam is:
 - Obtained for the purposes of checking a Member's general health in the absence of symptoms
 - Obtained at the Member's request (not requested by a Participating Provider)
 - Not Medically Necessary, and
 - Not part of a periodic preventive wellness exam or other preventive purpose
- 12) Aquatic therapy and other water therapy. This exclusion does not apply to therapy services that are part of a Prior Authorized physical therapy treatment plan
- 13) Chiropractic services and the services of a chiropractor. (This exclusion does not apply if optional chiropractic benefits are elected by the Group subscriber, provided through ACN and described in a separate ACN Evidence of Coverage and Schedule of Benefits)
- 14) Cosmetic services intended primarily to alter or reshape normal structures of the body in order to improve your appearance. This exclusion does not apply to Medically Necessary reconstructive surgery services, as described in the Reconstructive Surgery section of the Your Benefits chapter, and includes, but is not limited to, surgical treatments for gender dysphoria to

change primary and/or secondary sex characteristics

- 15) Custodial care that is not provided by or under the supervision of licensed and trained medical professionals and provides assistance with activities of daily living, including, but not limited to, walking, getting in and out of bed, bathing, dressing, cooking, toileting and managing drug prescriptions or their self-administration

16) Dental care, including:

- a) Items or services in connection with the care, treatment, filling, removal, replacement, or artificial restoration of the teeth or structures directly supporting the teeth;
- b) Treatment of dental abscesses;
- c) Orthodontia (dental services to correct irregularities or malocclusion of the teeth), for any reason other than reconstructive treatment of cleft palate, including treatment to alleviate temporomandibular joint disease (TMJ);
- d) Any procedure intended to prepare the mouth for dentures or for the more comfortable use of dentures;
- e) Bridges, dental plates, dental prostheses and dental orthoses, including anesthetic agents or drugs used for the purpose of dental care

Note: these dental exclusions do not apply to the covered Pediatric Dental Services described in the Pediatric Dental Addendum at the end of this EOC. If Subscriber Group has elected to purchase an optional, comprehensive adult dental benefit provided by Delta Dental, please see the Delta Dental EOC for additional information on dental benefits

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

has been authorized by law for use in testing or other studies on human patients)

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

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

- 19) Items and services that are not considered Medically Necessary for the promotion, prevention, or other treatment of hair loss or hair growth. This exclusion does not apply to the Medically Necessary treatment of a MH/SUD, such as gender dysphoria, for services and items including, but not limited to, hair removal and drugs for the treatment of hair loss
- 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 you how to read, (whether or not you or a Dependent has dyslexia)
 - d) Educational testing
 - e) Teaching skills for employment or vocational purposes
 - f) The following are also excluded unless the services are authorized as part of the Medically Necessary treatment of a MH/SUD, including Behavioral Health Treatment, and provided by persons acting within the scope of their licensure or as authorized by California law:

- i. Teaching and support services to increase intelligence
 - ii. Teaching art, dance, horse riding, music or swimming
 - iii. Aquatic therapy and other water therapy
 - iv. Play therapy
- 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 the pediatric vision benefit or to covered services described in the SHP Vision Benefit Rider if your employer Group has elected to purchase optional adult vision benefits
- 22) Massage therapy. This exclusion does not apply to Medically Necessary massage therapy services that are part of a Prior Authorized physical therapy treatment plan
- 23) Food supplements or infant formulas, except when Medically Necessary and covered in the Your Benefits chapter
- 24) Residential and long-term care in a facility where you stay overnight. This exclusion does not apply when the overnight stay is part of Medically Necessary Medical Services received in a hospital, a Skilled Nursing Facility (SNF) or as part of inpatient respite hospice care as described in the Your Benefits chapter of this EOC. This exclusion also does not apply when the overnight stay is part of the Medically Necessary treatment of a MH/SUD as described in the Mental Health and Substance Use Disorder Services section of the Your Benefits chapter
- 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 FDA approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside the U.S. This exclusion does not apply to any of the following:
- a) Services covered under the Emergency Services And Urgent Care chapter that you receive outside the United States
 - b) Experimental or investigational services when an investigational application has been filed with the FDA and the manufacturer or other source makes the services available to you or SHP through an FDA-authorized procedure, except that SHP does cover not services that are customarily provided by research sponsors at no cost to enrollees in a clinical trial or other investigational treatment protocol
- c) Services covered under the Services Associated with Clinical Trials section in the Your Benefits chapter
- Refer to the If You Have A Concern Or Dispute With SHP chapter for information about Independent Medical Review related to denied requests for experimental or investigational services.
- 27) Services provided by people who are not licensed or certified by the state to provide health care services. This exclusion does not apply to behavioral health professionals authorized under California law to provide the Medically Necessary treatment of a MH/SUD or to administer Behavioral Health Treatment for ASD, including, but not limited to, a Qualified Autism Service Paraprofessional
- 28) When a service is not covered, all services related to the non-Covered Service are excluded, except for services SHP would otherwise cover to treat complications of the non-Covered Service. For example, if you have a non-covered cosmetic surgery, SHP will not cover services you receive in preparation for the surgery or for follow-up care. If you later suffer a Life-threatening complication such as a serious infection, this exclusion would not apply and SHP would cover any services that we would otherwise cover to treat that complication
- 29) All services involved in Surrogacy, including but not limited to embryo transfers, services and supplies related to donor sperm or sperm preservation for artificial insemination. Surrogacy is pregnancy under a Surrogate arrangement. A Surrogate Pregnancy is one in which a woman (the surrogate) has agreed to become pregnant with the intention of surrendering custody of the child to another person. If the Surrogate is a Member, she is entitled to maternity services, but in the event pregnancy services are rendered to a woman in a Surrogate arrangement, the Plan or its Medical Group has the right to impose a lien against any amount received by the Surrogate/Member for reasonable costs incurred by SHP or its contracted Medical Groups
- 30) Travel and lodging expenses. This exclusion does not apply to reimbursement for travel and lodging expenses provided under the Bariatric Surgery section in the Your Benefits chapter
- 31) Exercise equipment, gym memberships, fitness trainers, and fitness classes
- 32) Dietary supplements or replacement foods used to promote weight loss, such as all liquid diets,

purified foods, protein shake diets, vitamin and mineral supplements

- 33) Commercially available weight loss programs that offer group support or specific meals, such as Weight Watchers®, Jenny Craig®, or Nutrisystems®
- 34) Complementary, alternative and integrative medicine:
- “Complementary” generally refers to use of a non-mainstream approach together with conventional medicine. This includes non-physician practitioners who prescribe “natural products” and “mind and body practices” which are not considered health plan benefits
 - “Alternative” refers to use of a non-mainstream approach in place of conventional medicine
 - “Integrative” refers to healing-oriented medicine that takes account of the whole person, including all aspects of lifestyle
- Note: this exclusion does not apply to acupuncture benefits included in your benefit plan as an Essential Health Benefit (EHB) or elected as an optional benefit by your employer Group (refer to your optional benefit plan documents for your plan’s acupuncture coverage information)
- 35) Immunizations required for foreign travel or occupational purposes, unless otherwise described in the Preventive Services subsection in the Your Benefits chapter
- 36) Private duty nursing or shift care
- 37) Services and supplies associated with the donation of organs when the recipient is not a Member of SHP

38) Services and supplies in connection with the reversal of voluntary sterilization

39) Circumcisions performed more than 30 days after the birth of the newborn are not covered unless Medically Necessary and Prior Authorized by the PCP’s Medical Group

Pre-existing Conditions and Health Assessments

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

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

Limitations

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

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

ENROLLING IN SHP AND ADDING NEW DEPENDENTS

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

Non-Discrimination

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

Who Is Eligible

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

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

A Dependent may be:

- Your Spouse
- Child of a Subscriber or Spouse

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

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

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

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

or your Spouse has assumed a parent-Child relationship (refer to the definition of a Child)

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

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

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

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

When You Can Enroll and When Coverage Begins

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

New Employees

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

Effective Date of Coverage

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

Waiting and Affiliation Periods

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

Adding New Dependents to an Existing Account

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

Effective Date of Coverage for New Dependents

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

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

Open Enrollment

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

Late Enrollee

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

Special Enrollment

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

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

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

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

Special Enrollment Due to Loss of Other Coverage

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

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

- Loss of coverage due to discontinuation of your benefit plan by another carrier or because that carrier has withdrawn from your service area

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

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

Special Enrollment Due to New Dependents

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

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

Special Enrollment Due to Court or Administrative Order

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

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

Special Enrollment Due to Release From Incarceration

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

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

If you (or a Dependent) received coverage from an issuer who has substantially violated a material provision of a health coverage contract, you will be

eligible for a 60-day special enrollment period following such violation.

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

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

Special Enrollment Due to Completion of Covered Services

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

Special Enrollment Due to Eligibility or Premium Assistance

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

Special Enrollment Due to Misinformation Regarding Coverage

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

Special Enrollment Due to Reemployment After Military Service

If you terminated your health care coverage because you were called to active duty in the military service, you may be able to reenroll in your Group's health plan if required by state or federal law. Please ask your Group for more information.

Renewal Provisions

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

WHEN YOUR SHP HEALTH COVERAGE ENDS (TERMINATION OF BENEFITS)

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

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (e.g., if your termination date is January 1, 2023, your last minute of coverage was on December 31, 2022 at 11:59 p.m.). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Covered Services you receive after your membership terminates, **even if you are hospitalized or undergoing treatment for an ongoing condition.** SHP and Participating Providers have no further liability or responsibility under this *Evidence of Coverage and Disclosure Form (EOC)* after your membership terminates, except as provided under the Payments after Termination section of this chapter.

Termination Due to Loss of Eligibility

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

Termination of Group Subscriber Contract

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

Termination for Cause

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

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

Termination of a Product or all Products

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

Payments After Termination

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

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

State Review of Membership Termination

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

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

SHP makes the Grievance Form available on its website at sutterhealthplus.org, in the Forms section.

Option 1 – Right to Submit a Grievance to SHP

You may submit a grievance to SHP using one of the following methods:

- By writing:

Sutter Health Plus
Attn: Appeals and Grievances Department
P.O. Box 160305
Sacramento, CA 95816

- By calling:
SHP Member Services
1-855-315-5800
TTY 1-855-830-3500
- By faxing:
1-855-759-8755
1-916-736-5422
- Online:
sutterhealthplus.org

You may want to submit your grievance to SHP first if you believe your cancellation, rescission or nonrenewal is the result of a mistake. You should submit a grievance as soon as possible, but no longer than 180 days, after you receive the Notice of End of Coverage for your grievance to be considered timely.

SHP will resolve your grievance or provide a pending status within three calendar days. If SHP upholds your cancellation, rescission or nonrenewal, SHP will notify you of SHP's decision and immediately transmit your grievance to the DMHC. If you do not receive a response within three calendar days, or if you are not satisfied with the response, you may submit a grievance to the DMHC as detailed under Option 2, below.

Option 2 – Right to Submit a Grievance to DMHC

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

You may submit grievances to the DMHC using one of the following methods:

- By writing:
Help Center
Department of Managed Health Care
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
- By calling:
1-888-466-2219
TDD: 1-877-688-9891
- By faxing:
1-916-255-5241
- Online:
www.dmhc.ca.gov

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

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

Continuation of Group Coverage

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

COBRA

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

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

Notification of qualifying event:

- Employers must notify SHP within 30 days after the following qualifying events:
 - The employee’s job ends
 - The employee’s hours of employment are reduced
 - The employee becomes eligible to receive Medicare benefits
 - The employee dies
- Employers must notify SHP within 60 days after any of the following qualifying events:
 - You become divorced or legally separated

- A child or other Dependent no longer qualifies as a Dependent under plan rules

Election notice:

- Generally, you must be sent an election notice by your employer Group or their designated COBRA administrator no later than 14 days after your employer or the COBRA administrator receives notice that a Qualifying Event has occurred

Election period:

- You have 60 days to notify your employer Group or their designated COBRA administrator that you want to elect/enroll continuation coverage. The 60 days starts on the later of the following two dates:
 - The date you receive the election notice
 - The date your coverage ended

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

Premium payment:

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

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

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

You will lose COBRA if:

- You move outside the SHP Service Area
- Your former employer no longer offers any health plan
- You become eligible for Medicare
- You sign up for another health plan
- You commit fraud or intentional misrepresentation of material fact

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

Cal-COBRA

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

Important Definitions for Cal-COBRA:

- **Continuation Coverage** means extended coverage under the Group Health Plan in which an Eligible Employee or eligible Dependent is currently enrolled, or, in the case of a termination of the Group Health Plan or an Employer open enrollment period, extended coverage under the Group Health Plan currently offered by the Employer
- **Core Coverage** means coverage of basic health care services, as defined in subdivision (b) of Section 1345, and other hospital, medical, or surgical benefits provided by the Group Health Plan that a Qualified Beneficiary was receiving immediately prior to the Qualifying Event, other than Noncore Coverage
- **Employer** for the purposes of Cal-COBRA means a Small Employer that:
 - Employed two to 19 Eligible Employees on at least 50 percent of its working days during the preceding calendar year, or, if the Employer was not in business during any part of the preceding calendar year, employed two to 19 Eligible Employees on at least 50 percent of its working days during the preceding calendar quarter
 - Has contracted for health care coverage through a Group Health Plan offered by a health care service plan
 - Is not subject to Section 4980B of the United States Internal Revenue Code or Chapter 18 of the Employee Retirement Income Security Act, 29 U.S.C. Section 1161 et seq.
- **Group Health Plan** means any health care service plan contract provided pursuant to Article 3.1 of the Knox-Keene Act to an Employer with two to 19 Eligible Employees
- **Noncore Coverage** means coverage for adult vision or dental care that was elected as an optional benefit by the employer Group and provided as part of the Group Health Plan that a Qualified Beneficiary was receiving immediately prior to the Qualifying Event (Pediatric Vision

Services and Pediatric Dental Services are considered part of Core Coverage)

- **Qualified Beneficiary** means any individual who, on the day before the Qualifying Event, is an enrollee in a Group Health Plan offered by a health care service plan pursuant to Article 3.1 of the Knox-Keene Act and has a Qualifying Event. This may include a child who is born to or placed for adoption with a Qualified Beneficiary during the Cal-COBRA Continuation Coverage period and who is enrolled in Cal-COBRA Continuation Coverage within 30-days of the date of the birth of placement for adoption
- **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 Health Plan to a Qualified Beneficiary:
 - The death of the covered employee
 - The termination of employment or reduction in hours of the covered employee's employment, except that termination for gross misconduct does not constitute a Qualifying Event
 - The divorce or legal separation of the covered employee from the covered employee's spouse
 - The loss of Dependent status by a Dependent enrolled in the Group Health Plan
 - With respect to a covered Dependent only, the covered employee's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare)
 - Exhaustion of Federal COBRA
 - Birth or adoption of Child
- **Small Employer** means any of the following:
 - 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.

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

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

- **Notification of Qualifying Event:**
 - Employers must notify SHP within 30 days after the following Qualifying Events:
 - The employee's job ends
 - The employee's hours of employment are reduced
 - You or your Dependent must notify SHP within 60 days after any of the following Qualifying Events:
 - The employee dies
 - The employee divorces or legally separates
 - A Child or other Dependent no longer qualifies as a Dependent under plan rules
 - The employee becomes eligible to receive Medicare benefits
- **Election notice:**
 - Generally, you must be sent an election notice no later than 14 days after SHP receives notice that a Qualifying Event has occurred
- **Election period:**
 - You have 60 days to notify SHP that you want to elect/enroll in Cal-COBRA Continuation Coverage. The 60 days starts on the later of the following two dates:
 - The date you receive the election notice
 - The date your coverage ended
- **Premium payment:**
 - You must pay the Premiums for your Cal-COBRA coverage to SHP
 - SHP must receive your first Premium within 45 days after you enroll in Cal-COBRA. Your first payment must cover at least all monthly Premiums from the date your coverage ended (due to a Qualifying Event) up to the last day of the month in which you make your first payment
 - Following your enrollment in Cal-COBRA and payment of the first Premium, you must then pay all subsequent monthly Premiums on the due date or within the grace period of at least 30 days, for as

long as you are eligible to stay on Cal-COBRA

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

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

You may be eligible for an extension of Cal-COBRA if you are between the ages of 60 and 65 if:

- You are age 60 or older at the time your employment ends, and
- You worked for that employer for at least 5 years prior to the date of termination of employment

If both criteria are met, you may be eligible for Cal-COBRA coverage beyond the maximum of 36 months, up to reaching age 65 and you become eligible for Medicare.

You will lose Cal-COBRA if:

- You do not pay your Premiums on the due date or within the grace period of at least 30 days
- You move outside the SHP Service Area
- Your former Employer no longer offers any health plan
- You sign up for or become eligible for Medicare
- You sign up for another health plan
- You commit fraud or intentional misrepresentation of material fact
- You sign up for or become eligible for federal COBRA
- You do not submit your election notice
- You qualify for another federal program such as the Federal Employees Health Benefits Program

You must contact SHP if:

- You move outside the SHP Service Area
- You or your Dependent(s) sign up for or become eligible for Medicare
- You sign up for another health plan
- You or your Dependent(s) sign up for or become eligible for federal COBRA
- You qualify for another federal program such as the Federal Employees Health Benefits Program

Cal-COBRA Termination and Premature Termination of Continuation Coverage

Prior to the exhaustion of Cal-COBRA Continuation Coverage, SHP will notify the member 180 days in advance of the pending exhaustion and termination of coverage. The Cal COBRA Ending notice specifies the date that coverage will end and provides other coverage options.

When Cal-COBRA coverage is exhausted, SHP sends a Notice of End of Coverage to Subscribers. This notice specifies the reason for termination and the effective date of the termination.

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

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

Uniformed Covered Services Employment and Reemployment Rights Act (USERRA)

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

Coverage for a Disabling Condition

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

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

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

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

Important Definitions for Disabling Condition

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

PAYMENT AND REIMBURSEMENT

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

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

How to File a Claim

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

- Send us a completed claim form for reimbursement and attach itemized bills from the non-Participating Provider, including receipts
- Complete and return any information requested by SHP to process your claim, such as claim forms, consents for the release of medical records, assignments and claims for any other benefits to which you may be entitled
- Mail the completed request and information, as well as any additional information requested by SHP as soon as possible after receiving the care and no later than 365 days from the date of service. Send to Sutter Health Plus, Attn: Claims Operations, at the P.O. Box listed on the back of your Member ID card.

Please note that the 365 days timeframe to submit a claim applies to Medical Services. For Outpatient Prescription Drugs, refer to the Pharmacy Payment and Reimbursement section of this Payment And Reimbursement chapter

SHP will respond to your claim as follows:

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

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

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

Pharmacy Payment and Reimbursement

If you have a situation in which you paid the full price for a prescription at a Participating Pharmacy, you may submit a Direct Member Reimbursement (DMR) request to CVS Caremark. To complete this process, you must complete and submit a Paper Claims Reimbursement Form with your receipt, within 90 days of the date of service. The form can be found on the CVS Caremark member portal under the Plan & Benefits tab, in the "Print Plan Forms" section.

All requests must be for covered Outpatient Prescription Drugs as specified in the Outpatient Prescription Drugs, Supplies, Equipment and Supplements section of the Your Benefits chapter. If a Drug requires Prior Authorization or step therapy, it may not be reimbursed.

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

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

Travel Expense Reimbursement

SHP will reimburse travel expenses for covered, medically necessary bariatric (metabolic) surgery performed at a facility that is 50 miles or more from the Member's home, as outlined in the Bariatric Surgery subsection of the Your Benefits chapter.

To obtain reimbursement for eligible travel expenses, please submit the following items to

Sutter Health plus, Attn: Claims Department, at the P.O. Box listed on the back of your Member ID card:

- A completed claim form
- A copy of the written Prior Authorization from the PCP's Medical Group
- Documentation of the expenses incurred, including itemized bills and receipts

IF YOU HAVE A CONCERN OR DISPUTE WITH SHP

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

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

Grievances

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

- You are not satisfied with the quality of care you received
- You received a written denial of Covered Services that require Prior Authorization from either the Medical Group or SHP or a Notice of Non-Coverage and you want SHP to cover the services
- You received a Notice of Adverse Determination from CVS Caremark and you want to appeal the decision
- A Participating Provider determines that Covered Services are not Medically Necessary and you want SHP to cover the services
- You were told that services are not covered and you believe that the services are Covered Services
- You received care from a non-Participating Provider or a Participating Provider that is outside your PCP's Medical Group without Prior Authorization (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care or emergency Ambulance Services) and you want SHP to pay for the care
- SHP did not decide fully in your favor on a claim for Covered Services described in the Emergency Services And Urgent Care chapter of this *EOC* and you want to appeal the decision
- You are dissatisfied with how long it took to receive Covered Services, including scheduling

an appointment and time in the waiting or exam rooms

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

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

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

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

You may submit grievances to USBHPC for mental health and substance use disorder services provided through SHP's contract with USBHPC as follows:

- By writing:
OptumHealth Behavioral Solutions of California
Attn: Grievances and Appeals Department
P.O. Box 30512
Salt Lake City, UT 84130-0512
- By calling USBHPC Grievances and Appeals: 1-800-985-2410
- By faxing: 1-855-312-1470
- Online: liveandworkwell.com

You may submit grievances to ACN for optional acupuncture and/or chiropractic benefits only if elected as an optional benefit by your employer Group as part of your benefit plan, provided through SHP's contract with ACN.

- By writing:
ACN, dba OptumHealth Physical Health of California
Attn: Grievance Coordinator
P.O. Box 880009
San Diego, CA 92168-0009
- By calling: OptumHealth Customer Service at 1-800-428-6337
- Online: myoptumhealthphysicalhealthofca.com

You may submit grievances to VSP for Pediatric Vision Services (and for optional adult vision benefits only if elected as an optional benefit by your employer Group as part of your benefit plan), provided through SHP's contract with VSP.

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

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

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

Grievance Handled by Phone Within One Business Day

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

Expedited Grievances

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

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

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

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

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

You may also submit expedited grievances to USBHPC for mental health and substance use disorder services provided through SHP's contract with USBHPC as follows:

- By writing:
OptumHealth Behavioral Solutions of California
Attn: Grievances and Appeals Department
P.O. Box 30512
Salt Lake City, UT 84130-0512
- By calling USBHPC Grievances and Appeals: 1-800-985-2410
- By faxing:

1-855-312-1470

- Online: liveandworkwell.com

You may submit expedited grievances to ACN in a similar manner. Expedited grievances submitted to ACN are for optional acupuncture and/or chiropractic benefits only if elected as an optional benefit by your employer Group as part of your benefit plan, provided through SHP's contract with ACN.

- By writing:
ACN, dba OptumHealth Physical Health of California
Attn: Grievance Coordinator
P.O. Box 880009
San Diego, CA 92168-0009
- By calling: OptumHealth Customer Service at 1-800-428-6337
- Online: myoptumhealthphysicalhealthofca.com

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

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

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

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

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe

pain or potential loss of life, limb or major bodily function), you may contact the DMHC directly prior to filing a grievance with SHP at any time by calling **1-888-466-2219 (TDD 1-877-688-9891)**.

Supporting Documents

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

Who May File

The following persons may file a grievance:

- You may file for yourself
- You may appoint someone as your authorized representative, including your physician, by completing SHP's authorization form, which is available by calling SHP Member Services (your completed authorization form must accompany the grievance)
- You may file for your Dependent under age 18, except that they must appoint you as their authorized representative if they have 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 they must appoint you as their authorized representative if they have the legal right to control release of information that is relevant to the grievance
- You may file for your conservatee if you are a court-appointed conservator
- You may file for your principal if you are an agent under a currently effective health care proxy, to the extent provided under state law

Department of Managed Health Care Complaints

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

1-855-315-5800 (TTY 1-855-830-3500) and use SHP's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies

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

You may request that SHP participate in voluntary mediation before you submit a grievance to the DMHC. The use of mediation services shall not prevent you from submitting a grievance to the DMHC after mediation. Refer to the upcoming section on Voluntary Mediation.

Independent Medical Review (IMR) Process

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

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

- One of these situations applies to you:
 - You have a recommendation from a provider requesting Medically Necessary Covered Services
 - You have received Emergency Services, emergency Ambulance Services or Urgent Care from a provider who determined the Covered Services to be Medically Necessary
 - You have been seen by a Participating Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Covered Services has been denied, modified, or delayed based in whole or in part on a decision that the Covered Services are not Medically Necessary

- You have filed a grievance and SHP has denied it or we haven't made a decision about your grievance within 30 calendar days (or three calendar days for expedited grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function

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

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

Experimental or Investigational Denials

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

- A written statement from your treating physician that you have a Life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy SHP covers than the therapy being requested. ("Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity)
- If your treating physician is a Participating Provider, that they 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 their 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 their recommendation; SHP does not cover the services of the non-Participating Provider

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

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

Voluntary Mediation

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

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

Sutter Health Plus
Member Services – Voluntary Mediation
2700 Gateway Oaks, Suite 1200
Sacramento, CA 95833

Binding Arbitration

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

As a condition of your membership, you agree that any and all disputes between yourself (including any heirs or assigns) and SHP, including claims of medical malpractice (that is as to whether any

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

This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter. SHP's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties.

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

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

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

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

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

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

and binding on all parties except to the extent that state or federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Member, SHP may assume all or a portion of the Member's share of the fees and expenses associated with the arbitration. Upon written notice by the Member requesting a hardship application, SHP will forward the request to an independent, professional dispute resolution organization for a determination. Such a request for hardship should be submitted to the address provided previously. Effective July 1, 2002, Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. §1001 et seq., a federal law regulating benefit plans, are not required to submit to mandatory binding arbitration any disputes about certain "adverse benefit determinations" made by SHP. Under ERISA, an "adverse benefit determination" means a decision by SHP to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and SHP may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

MEMBER RIGHTS AND RESPONSIBILITIES

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

What Are My Rights?

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

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

SHP Public Policy Participation Committee

SHP has a Public Policy Participation committee of the health plan's Board of Directors. The committee includes providers, members, and employer clients who advise on ways to improve member and employer client experience. This may include reviewing materials and programs and providing candid feedback and suggestions for improvement.

If you would like to be considered for this committee, please write to SHP at:

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

What Are My Responsibilities?

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

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

- To know, understand and abide by the terms, conditions, and provisions set forth by SHP as your health plan. (The *Evidence of Coverage and Disclosure Form (EOC)* contains this information)
- To supply SHP and its providers and practitioners (to the extent possible) the information they need to provide care and service to you. This includes informing SHP's Member Services when a change in residence occurs or other circumstances arise that may affect entitlement to coverage or eligibility
- To select a PCP who will have primary responsibility for coordination of your care and to establish a relationship with that PCP
- To learn about your medical condition and health problems and to participate in developing mutually agreed upon treatment goals with your practitioner, to the degree possible
- To follow preventive health guidelines, prescribed treatment plans and guidelines/instructions that you have agreed to with your health care Professionals and to provide to those Professionals information relevant to your care
- To schedule appointments as needed or indicated, to notify the Participating Provider when it is necessary to cancel an appointment and to reschedule cancelled appointments if indicated
- To show consideration and respect to the providers and their staff and to other patients
- To express Grievances regarding SHP, or the care or service received through one of SHP's providers, to SHP Member Services for investigation through SHP's Grievance process
- To ensure SHP is notified within 24 hours of receiving the care or as soon as is reasonably possible when you are admitted to non-

Participating Hospitals or for Post-Stabilization Care authorization.

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

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

Reporting Suspected Fraud and Abuse

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

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

There are many examples of fraud and abuse which include:

- Billing for services or items that were not provided
- Billing for services or equipment that are more expensive than what was supplied
- Members allowing someone else to use their SHP ID card
- A provider paying a Member to obtain care or services
- Identity theft
- Falsifying medical records

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

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

If sending an email please include the following information:

- Date suspected fraud occurred
- Date suspected fraud was discovered

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

DEFINITIONS

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

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

Behavioral Health Treatment: Means professional services and treatment programs, including applied behavior analysis and other evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with autism spectrum disorder (ASD), including, but not limited to, pervasive developmental disorder (PDD).

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

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

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

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

Coinsurance: A percentage of Charges that you must pay when you receive a Covered Service as

described in the What You Pay chapter and in the *Benefits and Coverage Matrix*.

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

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

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

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

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

Eligible Employee: 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 at least 30 hours, at the Small Employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term does not include sole proprietors or the spouses of those sole proprietors, partners of a partnership or the spouses of those partners, or 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)

(2) Any member of a guaranteed association

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

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

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

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

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

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

- A medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the

Emergency Medical Condition, within the capability of the facility

- 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
 - 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 general acute care hospital or to an acute psychiatric hospital
- 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)

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

Evidence of Coverage and Disclosure Form

(EOC): This EOC document, which describes the health care coverage under SHP's Group Subscriber Contract with your Group.

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

Family: A Subscriber and all of their Dependents.

Generic Drug/Drugs: As defined by the US Food and Drug Administration (FDA), a Generic Drug is identical – or bioequivalent - to a brand name drug in dosage, safety, strength, how it is taken, quality, performance, and intended use. Before approving a Generic Drug product, FDA requires many rigorous tests and procedures to assure that the Generic Drug can be substituted for the brand name drug. The FDA bases evaluations of substitutability, or "therapeutic equivalence," of Generic Drugs on scientific evaluations. By law, a Generic Drug product must contain the identical amounts of the same active ingredient(s) as the brand name product. Drug products evaluated as "therapeutically equivalent" can be expected to have equal effect and no difference when substituted for the brand name product. A Generic Drug typically costs less than the brand name drug.

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

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

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

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

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

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

Medical Services: Means benefits with respect to items or services for conditions or procedures provided by Participating Providers included in the Your Benefits chapter, excluding mental health and substance use disorder services provided by USBHPC Participating Practitioners, and subject to the Exclusions And Limitations chapter of this *EOC*.

Medically Necessary (Medical Necessity): 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.

For the definition of Medically Necessary treatment of a mental health and substance use disorder, refer to the Mental Health and Substance Use Disorder Services section of the Your Benefits chapter.

Medicare: The federal health insurance program for people aged 65 or older, some people under age 65

with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

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

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

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

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

Out-of-Pocket Maximum: The annual Out-of-Pocket Maximum is the total Cost Sharing amount a Member is liable to pay each year for most Covered Services. When the Member reaches the applicable Out-of-Pocket Maximum, the Member is not required to pay any additional Cost Sharing, such as Copayments, Coinsurance or Deductibles, for the remainder of the Benefit Year. Refer to your *Benefits and Coverage Matrix (BCM)* for the applicable Out-of-Pocket Maximum for each Member.

Outpatient Prescription Drugs: This includes self-administered drugs, supplies, equipment and supplements approved by the Federal Food and Drug Administration for sale to the public through retail or mail order pharmacies. "Self-administered" means those drugs that need not be administered in a clinical setting or by a licensed health care provider. This also includes Specialty Drugs for sale to the public through a Specialty Pharmacy. All covered drugs, supplies, equipment and supplements require a prescription and are not provided for use on an inpatient basis.

Participating Hospital: Means a duly licensed hospital which, at the time care is provided to a Member, has a contract in effect with SHP or a Contracted Medical Group to provide hospital services to Members. The Covered Services which some Participating Hospitals may provide to

Members are limited by SHP's utilization review and quality assurance policies or by SHP's contract with the hospital.

Participating Pharmacy: Means a pharmacy under contract with SHP through CVS Caremark®, authorized to dispense covered Outpatient Prescription Drugs to Members.

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

Participating Practitioner: A health care facility or provider who has entered into a written agreement with USBHPC to provide mental health disorder services, including Behavioral Health Treatment, or substance use disorder services to Members. These behavioral health professionals are qualified and duly licensed, certified or otherwise authorized under California law to practice their profession. Behavioral health professionals may include, but are not limited to, a psychiatrist, a marriage and family therapist, a Qualified Autism Service Provider/Professional/Paraprofessional, a clinical social worker, a professional clinical counselor or a psychologist.

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 their 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.

Pediatric Dental Services: Pediatric Dental Services are Essential Health Benefits provided to pediatric Members through the end of the month in which the Member turns 19 years of age. Pediatric Dental Services are arranged by Delta Dental and provided through a DeltaCare USA Dental HMO product embedded in your SHP plan. These services do not require a PCP referral and are described further in the Pediatric Dental Addendum at the end of this EOC.

Pediatric Vision Services: Pediatric Vision Services are Essential Health Benefits provided to pediatric Members through the end of the month in which the Member turns 19 years of age. Pediatric Vision Services are arranged through VSP and provided through a VSP Choice Plan product embedded in your SHP plan. These services do not require a PCP referral and are described further in the Vision Services – Pediatric section of the Your Benefits chapter in this EOC.

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

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

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

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

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

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

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

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

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

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

- Is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice
- Provides treatment and implements services pursuant to a treatment plan developed and

approved by the Qualified Autism Service Provider

- Meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan

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

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

Qualified Autism Service Provider: Means either of the following:

- A person who is certified by a national entity, such as the Behavior Analyst Certification Board, with a certification that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for autism spectrum disorder (ASD), including pervasive developmental disorder (PDD), provided the services are within the experience and competence of the person who is nationally certified

- A person licensed as a Physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and Family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the California Business and Professions Code, who designs, supervises, or provides treatment for ASD, including PDD, provided the services are within the experience and competence of the licensee

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

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

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

Small Employer: 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.

For purposes of determining eligibility, the size of a Small Employer shall be determined annually. For plan years commencing on or after January 1, 2016, the definition of small employer, for purposes of determining employer eligibility in the small employer market, shall be determined using the method for counting full-time employees and full-time equivalent

employees set forth in Section 4980H(c)(2) of the Internal Revenue Code.¹

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

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

- Therapy of chronic or complex disease
- Specialized patient training and provider coordination of care (services, supplies, or devices) required prior to therapy initiation and/or during therapy
- Unique patient compliance and safety monitoring requirements
- Unique requirements for handling, shipping and storage
- Have restricted distribution by the U.S. Food and Drug Administration

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

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

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

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

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

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

¹ Calculating the number of FTEs: The number of FTEs for each calendar month in the preceding calendar year is determined by calculating the aggregate number of hours of service for that calendar month for employees who were not fulltime employees (but not more than 120 hours of

service for any employee) and dividing that number by 120. In determining the number of FTEs for each calendar month, fractions are taken into account; an employer may round the number of FTEs for each calendar month to the nearest one hundredth.

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PEDIATRIC DENTAL ADDENDUM TO EVIDENCE OF COVERAGE

INTRODUCTION

This document is an addendum to your SHP Evidence of Coverage to add coverage for pediatric dental Essential Health Benefits as described in this Dental Evidence of Coverage.

SHP contracts with Delta Dental of California (“Delta Dental”) to make the DeltaCare[®] USA network of Contract Dentists available to you. You can obtain covered Benefits from your Contract Dentist without a referral from a Participating Provider. When you visit your Contract Dentist your Copayment is due and you pay only the applicable Copayment of Benefits up to the Plan Out-of-Pocket Maximum. These pediatric dental Benefits are for children through the end of the month in which the Enrollee turns 19 years of age, who meet the eligibility requirements specified in your SHP Evidence of Coverage.

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a Contract Dentist may charge you their usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered Benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. To fully understand your coverage, you may wish to carefully review this Amendment.

Additional information about your pediatric dental Benefits is available by calling Delta Dental’s Customer Care at 1-800-422-4234 5 a.m. – 6 pm. Pacific Time, Monday through Friday.

Eligibility under this Dental Evidence of Coverage is determined by SHP.

Using This Dental Evidence of Coverage

This Addendum discloses the terms and conditions of your pediatric dental coverage and is designed to help you make the most of your dental plan. It will help you understand how the dental plan works and how to obtain dental care. Please read this Dental Evidence of Coverage completely and carefully.

Persons with Special Health Care Needs should read the section entitled “Special Health Care Needs.” A Matrix describing this plan’s major Benefits and coverage can be found on the last page of this Dental EOC (“Schedule C”).

DEFINITIONS

In addition to the terms defined in the “Definitions” section of your SHP Evidence of Coverage, the following terms, when capitalized and used in any part of this Dental Evidence of Coverage have the following meanings:

Administrator: Delta Dental Insurance Company or other entity designated by Delta Dental, operating as an Administrator in the state of California. Certain functions described throughout this Addendum may be performed by the Administrator, as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 1-800-422-4234.

Authorization: the process by which Delta Dental determines if a procedure or treatment is a referable Benefit under this dental plan.

Benefits: covered dental services provided under the terms of this Amendment.

Calendar Year: the 12 months of the year from January 1 through December 31.

Contract Dentist: a DeltaCare USA Dentist who provides services in general dentistry and who has agreed to provide Benefits to Enrollees under this dental plan. Enrollees must obtain a referral from their Contract Dentist to obtain Specialist Services.

Contract Orthodontist: a DeltaCare USA Dentist who specializes in orthodontics and who has agreed to provide Benefits to Enrollees under this dental plan which covers medically necessary orthodontics. Enrollees must obtain a referral from their Contract Dentist to obtain services from a Contract Orthodontist.

Contract Specialist: a DeltaCare USA Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under this dental plan. Enrollees must obtain a referral from their Contract Dentist to obtain services from a Contract Specialist.

Copayment/Cost of Share: the amount listed in the Schedules and charged to an Enrollee by a Contract Dentist, Contract Specialist or Contract Orthodontist for the Benefits provided under this dental plan. Copayments must be paid at the time treatment is received.

Delta Dental Service Area: all geographic areas in the state of California in which Delta Dental is licensed as a

specialized health care service plan.

Dentist: a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Department of Managed Health Care: a department of the California Health and Human Services Agency which has charge of regulating specialized health care service plans. Also referred to as the “Department” or “DMHC.”

Emergency Dental Condition: dental symptoms and/or pain that are so severe that a reasonable person would believe that, without immediate attention by a Dentist, they could reasonably be expected to result in any of the following:

- placing the patient's health in serious jeopardy
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part
- death

Emergency Dental Services: a dental screening, examination and evaluation by a Dentist, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Dentist, to determine if an Emergency Dental Condition exists and, if it does, the care, treatment and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Dental Condition, within the capability of the facility.

Optional: any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure but is chosen by the Enrollee, and is subject to the limitations and exclusions described in the Schedules attached to this Dental Evidence of Coverage.

Out-of-Network: treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits to Enrollees under the terms of this Dental Evidence of Coverage.

Pediatric Enrollee: an Eligible Pediatric Individual enrolled under this Policy to receive Benefits. Coverage for Pediatric Enrollees is through the end of the month in which the Pediatric Enrollee turns 19 years of age.

Procedure Code: the Current Dental Terminology (CDT[®]) number assigned to a Single Procedure by the American Dental Association.

Single Procedure: a dental procedure that is assigned a separate Procedure Code.

Special Health Care Need: a physical or mental impairment, limitation or condition that substantially interferes with an Enrollee's ability to obtain Benefits. Examples of such a Special Health Care Need are: 1) the Enrollee's inability to obtain access to the Contract Dentist's facility because of a physical disability; and 2) the Enrollee's inability to comply with their Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

Specialist Services: services performed by a Contract Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics (if medically necessary) or pediatric dentistry. Specialist Services must be authorized by Delta Dental.

Treatment in Progress: any Single Procedure, as defined by the CDT code that has been started while the Enrollee was eligible to receive Benefits and for which multiple appointments are necessary to complete the procedure whether or not the Enrollee continues to be eligible for Benefits under this dental plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established, full or partial dentures for which an impression has been taken and orthodontics when bands have been placed and tooth movement has begun.

Urgent Dental Services: medically necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

OVERVIEW OF DENTAL BENEFITS

This section provides information that will give you a better understanding of how this dental plan works and how to make it work best for you.

What is the DeltaCare USA Plan?

The DeltaCare USA plan provides Pediatric Benefits through a convenient network of Contract Dentists in the state of California. These Dentists are screened to ensure that our standards of quality, access and safety are

maintained. The network is composed of established dental professionals. When you visit your Contract Dentist, you pay only the applicable Cost Share for Benefits. There are no deductibles, lifetime maximums or claim forms.

Benefits, Limitations and Exclusions

This plan provides the Benefits described in the Schedules that are a part of this Dental Evidence of Coverage. Benefits are only available in the state of California. The services are performed as deemed appropriate by your Contract Dentist.

Cost Share and Other Charges

You are required to pay any Copayments listed in the Schedule A attached to this Dental Evidence of Coverage. Your Cost Share is paid directly to the Dentist who provides treatment. Charges for broken appointments and visits after normal visiting hours are listed in the Schedules attached to this Dental Evidence of Coverage.

In the event that we fail to pay a Contract Dentist, you will not be liable to that Contract Dentist for any sums owed by us. By statute, the DeltaCare USA Dentist contract contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental. Except for the provisions in the "Emergency Dental Services" section, if you have not received Authorization for treatment from an Out-of-Network Dentist, and we fail to pay that Out-of-Network Dentist, you may be liable to that Out-of-Network Dentist for the cost of services received. For further clarification, see the "Emergency Dental Services" and "Specialist Services" provisions in this Dental Evidence of Coverage.

HOW TO USE THE DELTACARE USA PLAN/CHOICE OF CONTRACT DENTIST

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW HOW TO OBTAIN DENTAL SERVICES. YOU MUST OBTAIN DENTAL BENEFITS FROM, OR BE REFERRED FOR SPECIALIST SERVICES BY YOUR CONTRACT DENTIST.

Delta Dental will provide Contract Dentists to Enrollees at convenient locations during the term of this Dental Evidence of Coverage. The Enrollee may request changes to the assigned Contract Dentist facility by contacting Delta Dental's Customer Care at 1-800-422-4234. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. The change must be requested prior to the 15th of the month to become effective on the first day of the following month.

You will be provided with written notice if: 1) a requested facility is closed to further enrollment; 2) a chosen Contract Dentist facility withdraws from the plan; or 3) a facility requests, for good cause, that the Enrollee be re-assigned to another Contract Dentist facility.

All Treatment in Progress must be completed before you change to another Contract Dentist facility. For example, this would include: 1) partial or full dentures for which final impressions have been taken; 2) completion of root canals in progress; or 3) delivery of crowns when teeth have been prepared.

All services which are Benefits will be rendered at the Contract Dentist facility. Specialist Services obtained from a Contract Orthodontist or Contract Specialist must be referred by the Enrollee's Contract Dentist. Delta Dental will have no obligation or liability with respect to services rendered by Out-of-Network Dentists, with the exception of Emergency Dental Services or Specialist Services recommended by a Contract Dentist and authorized by Delta Dental. All authorized Specialist Services claims will be paid by Delta Dental less any applicable Copayments. A Contract Dentist may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services.

If your Contract Dentist facility terminates participation in the DeltaCare USA network, that Contract Dentist facility will complete all Treatment in Progress as described above. If for any reason the Contract Dentist is unable to complete treatment, Delta Dental shall make reasonable and appropriate provisions for the completion of such treatment by another Contract Dentist.

Delta Dental shall give written notice to the Enrollee within a reasonable time of any termination or breach of contract, or inability to perform by any Contract Dentist if the Enrollee will be materially or adversely affected.

Emergency Dental Services

Emergency Dental Services are used for palliative relief, controlling of dental pain, and/or stabilizing the Enrollee's condition. The Enrollee's Contract Dentist's facility maintains a 24-hour emergency dental services system, 7 days a week. If the Enrollee is experiencing an Emergency Dental Condition, they can call 911 (where available) or obtain Emergency Dental Services from any Dentist without a referral.

After Emergency Dental Services are provided, further non-emergency treatment is usually needed. Non-emergency treatment must be obtained at the Enrollee's Contract Dentist facility.

The Enrollee is responsible for any Copayment(s) for Emergency Dental Services received. Non-covered procedures will be the Enrollee's financial responsibility and will not be paid by this plan.

Benefits for Emergency Dental Services not provided by the Enrollee's Contract Dentist are limited to a maximum of \$100.00 per emergency, per Enrollee, less the applicable Cost Share. If the maximum is exceeded or if the conditions in the "Timely Access to Care" section are not met, the Enrollee is responsible for any charges for services received by a Dentist other than from their Contract Dentist.

Urgent Dental Services

Inside the Delta Dental Service Area

An Urgent Dental Service requires prompt dental attention but it is not an Emergency Dental Condition. If an Enrollee thinks that they may need Urgent Dental Services, the Enrollee can call their Contract Dentist during normal business hours or after hours.

Outside the Delta Dental Service Area

If an Enrollee needs Urgent Dental Services due to an unforeseen dental condition or injury, this plan covers medically necessary dental services when prompt attention is required from an Out-of-Network Dentist if all of the following are true:

- The Enrollee receives the Urgent Dental Services from an Out-of-Network Dentist while temporarily outside the Delta Dental Service Area.
- A reasonable person would have believed that the Enrollee's health would seriously deteriorate if they delayed treatment until they returned to the Delta Dental Service Area.

Enrollees do not need prior Authorization from Delta Dental to receive Urgent Dental Services outside the Delta Dental Service Area. Any Urgent Dental Services an Enrollee receives from Out-of-Network Dentists outside the Delta Dental Service Area are covered if the Benefits would have been covered if the Enrollee had received them from Contract Dentists.

We do not cover follow-up care from Out-of-Network Dentists after the Enrollee no longer needs Urgent Dental Services. To obtain follow-up care from a Dentist, the Enrollee can call their Contract Dentist.

The Enrollee is responsible for any Cost of Share amount(s) for Urgent Dental Services received.

Timely Access to Care

Contract Dentists, Contract Orthodontists and Contract Specialists have agreed waiting times to Enrollees for appointments for care which will never be greater than the following timeframes:

- for emergency care, 24 hours a day, 7 day days a week;
- for any urgent care, 72 hours for appointments consistent with the Enrollee's individual needs;
- for any non-urgent care, 36 business days; and
- for any preventative services, 40 business days.

During non-business hours, the Enrollee will have access to their Contract Dentist's answering machine, answering service, cell phone or pager for guidance on what to do and whom to contact for Urgent Dental Services or if they are experiencing an Emergency Dental Condition including while outside the Delta Dental Service Area.

If the Enrollee calls our Customer Care, a representative will answer their call within 10 minutes during normal business hours.

Should the Enrollee need interpretation services when scheduling an appointment with any of our Contract Dentists, Contract Orthodontists or Contract Specialists' facilities, they may call our Customer Care at 1-800-422-4234 for assistance.

Language Assistance Services

Delta Dental offers qualified interpretation services to limited-English proficient Enrollees at no cost to the Enrollee at all points of contact, in any modern language, including when an Enrollee is accompanied by a family member or friend who can provide language interpretation services.

If you need language interpretation services, materials translated into your preferred language or into an alternative format, please call Customer Care at 888-282-8528 or 800-735-2929 (TTY). You may also visit the provider directory on our website which includes self-reported languages by DeltaCare USA Dentists.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics, orthodontics (if medically necessary) or pediatric dentistry must be: 1) referred by your Contract Dentist; and 2) authorized by Delta Dental. You pay the specified Copayment(s). (Refer to the Schedules attached to this Dental Evidence of Coverage.)

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the Schedules attached to this Dental Evidence of Coverage to determine Benefits.

If you require Specialist Services and a Contract Specialist or Contract Orthodontist is not within 35 miles of your home address to provide these services, your Contract Dentist must receive prior Authorization from Delta Dental to refer you to an Out-of-Network specialist or Out-of-Network orthodontist to provide these Specialist Services. Specialist Services performed by an Out-of-Network specialist or Out-of-Network orthodontist that are not authorized by Delta Dental may not be covered.

If an Enrollee is referred to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

Claims for Reimbursement

Claims for covered Emergency Dental Services or authorized Specialist Services should be sent to us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one (1) year of the treatment date. The address for claims submission is Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Dentist Compensation

A Contract Dentist is compensated by Delta Dental through monthly capitation, and by Enrollees through required Cost Share amounts for treatment received. A Contract Specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Cost Share paid by the Enrollee. In no event does Delta Dental pay a Contract Dentist or a Contract Specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number shown in this Dental Evidence of Coverage.

Processing Policies

The dental care guidelines for this dental plan explain to Contract Dentists what services are covered under this Dental Evidence of Coverage. Contract Dentists, Contract Orthodontists and Contract Specialists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist, Contract Orthodontist and Contract Specialist that fall under the scope of Benefits of this dental plan are provided subject to any Cost Share. If a Contract Dentist believes that an Enrollee should seek treatment from a Contract Specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered Benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a Contract Specialist. An Enrollee may contact Delta Dental's Customer Care at 1-800-422-4234 for information regarding the dental care guidelines for this plan.

A covered Benefit appropriately provided through teledentistry is covered on the same basis and to the same extent that the covered Benefit is provided through in-person diagnosis, consultation or treatment.

Renewal and Termination of Coverage

Please refer to your SHP Evidence of Coverage for further information regarding renewal and termination of this dental plan.

Second Opinions

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by the Contract Dentist. You may also be requested to obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of the Enrollee's condition. Requests involving an Emergency Dental Condition will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Care at 1-800-422-4234 or write to Delta Dental.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Delta Dental. A second opinion by an Out-of-Network Dentist will be authorized if an appropriately qualified Contract Dentist is not available. Only second opinions which have been approved or authorized will be paid. You will be sent a written notification if your request for a second opinion is not authorized. If you disagree with this determination, you may file a grievance. Refer to the "Enrollee Complaint Procedure" section of this Dental Evidence of Coverage for more information.

Special Health Care Needs

If you believe you have a Special Health Care Need, you should contact Delta Dental's Customer Care at 1-800-422-4234. Delta Dental will confirm whether such a Special Health Care Need exists and what arrangements can be made to assist you in obtaining Benefits. Delta Dental will not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a contract Dentist treating Enrollees with Special Health Care Needs.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Care at 1-800-422-4234.

ENROLLEE COMPLAINT PROCEDURE

If you have any complaint regarding, eligibility, the denial of dental services or claims, the policies, procedures or operations of Delta Dental, or the quality of dental services performed by a Contract Dentist, you may call the Customer Care at 1-800-422-4234, or the complaint may be addressed in writing to:

Delta Dental of California
Quality Management Department
P.O. Box 997330 Sacramento, CA 95899

Written communication must include: 1) the name of the patient; 2) the name, address, telephone number and ID number of the Pediatric Enrollee; and 3) the Dentist's name and facility location.

"Grievance" means a written or oral expression of dissatisfaction regarding this dental plan and/or Dentist, including quality of care concerns, and will include a complaint, dispute, request for reconsideration or appeal made by Pediatric Enrollee or the Enrollee's representative. Where this plan is unable to distinguish between a grievance and an inquiry, it will be considered a grievance.

"Complaint" is the same as "grievance."

"Complainant" is the same as "grievant" and means the person who filed the grievance including the Enrollee, a representative designated by the Enrollee, or other individual with authority to act on behalf of the Enrollee.

Within five (5) calendar days of the receipt of any complaint, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a Dentist for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 days of receipt of a complaint or shall provide a written explanation if additional time is required to report on the complaint. If the complaint involves an Emergency Dental Condition, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the grievance within three (3) days.

Delta Dental's grievance system allows Enrollees to file grievances for at least 180 calendar days following any incident or action that is the subject of the Enrollee's dissatisfaction. Delta Dental does not discriminate against any Enrollee on the grounds that the complainant filed a grievance.

If you have completed Delta Dental's grievance process or if you have been involved in Delta Dental's grievance procedure for more than 30 calendar days, you may file a complaint with the Department. You may seek assistance or file a grievance immediately with the Department in cases involving an imminent and serious threat to your health including, but not limited to, severe pain, potential loss of life, limb or major bodily function. In such case, Delta Dental will provide you with a written statement on the disposition or pending status of your grievance no later than three (3) calendar days from the date of our receipt of your grievance. You may file a complaint with the Department immediately if you are experiencing an Emergency Dental Condition.

The Department is responsible for regulating health care service plans. If you have a grievance against Delta Dental, you should first telephone us at **1-800-422-4234** and use our grievance process above 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 Dental Condition, 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.

Independent Medical Review (“IMR”)

You may also be eligible for an 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 for disputes for your Emergency Dental Condition or urgent medical services. The Department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department’s internet website (**www.dmhc.ca.gov**) has complaint forms, IMR application forms and instructions online.

Complaints Involving an Adverse Benefit Determination

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim), an Enrollee may file a requested review (a complaint) with Delta Dental for at least 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review will be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide the enrollee with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination.

If the review of a denial is based, in whole or in part, on a lack of medically necessity, experimental treatment, or a clinical judgment in applying the terms of this Plan, Delta Dental will consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

GENERAL PROVISIONS

Third Party Administrator (“TPA”)

Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under this Dental Evidence of Coverage. Any TPA providing such services or receiving such information will enter into a separate business associate agreement with Delta Dental providing that the TPA will meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

Organ and Tissue Donation

Donating organs and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital, when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

Non-Discrimination

Delta Dental complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. Delta Dental does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Delta Dental:

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

If you need these services, contact Delta Dental’s Customer Care at 1-800-422-4234.

If you believe that Delta Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance electronically online, over the phone with a Customer Service representative, or by mail.

Delta Dental
P.O. Box 997330
Sacramento, CA 95899-7330
Telephone Number: 1-800-422-4234
Website Address: deltadentalins.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

SCHEDULE A

Description of Benefits and Cost Shares for Pediatric Enrollees (Under Age 19)

The Benefits shown below are performed as needed and deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the DeltaCare® USA Plan ("Plan"). Please refer to Schedule B for further clarification of Benefits. Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under this Plan and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2022 Procedure Codes, descriptors or nomenclature which is under copyright by the American Dental Association® ("ADA"). The ADA may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
<i>D0100–D0999 I. DIAGNOSTIC</i>			
D0999	Unspecified diagnostic procedure, by report	No charge	<i>Includes office visit, per visit (in addition to other services); In addition, shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.</i>
D0120	Periodic oral evaluation - established patient	No charge	<i>1 per 6 months per Contract Dentist</i>
D0140	Limited oral evaluation - problem focused	No charge	<i>1 per Enrollee per Contract Dentist</i>
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge	<i>1 per 6 months per Contract Dentist, included with D0120, D0150</i>
D0150	Comprehensive oral evaluation - new or established patient	No charge	<i>Initial evaluation, 1 per Contract Dentist</i>
D0160	Detailed and extensive oral evaluation - problem focused, by report	No charge	<i>1 per Enrollee per Contract Dentist</i>
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No charge	<i>6 per 3 months, not to exceed 12 per 12 month period</i>
D0171	Re-evaluation - post-operative office visit	No charge	
D0180	Comprehensive periodontal evaluation - new or established patient	No charge	<i>Included with D0150</i>
D0210	Intraoral - complete series of radiographic images	No charge	<i>1 series per 36 months per Contract Dentist</i>
D0220	Intraoral - periapical first radiographic image	No charge	<i>20 images (D0220, D0230) per 12 months per Contract Dentist</i>
D0230	Intraoral - periapical each additional radiographic image	No charge	<i>20 images (D0220, D0230) per 12 months per Contract Dentist</i>
D0240	Intraoral - occlusal radiographic image	No charge	<i>2 per 6 months per Contract Dentist</i>
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	No charge	<i>1 per date of service</i>
D0251	Extra-oral posterior dental radiographic image	No charge	<i>4 per date of service</i>
D0270	Bitewing - single radiographic image	No charge	<i>1 of (D0270, D0273) per date of service</i>
D0272	Bitewings - two radiographic images	No charge	<i>1 of (D0272, D0273) per 6 months per Contract Dentist</i>

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D0273	Bitewings - three radiographic images	No charge	1 of (D0270, D0273) per date of service; 1 of (D0272, D0273) per 6 months per Contract Dentist
D0274	Bitewings - four radiographic images	No charge	1 of (D0274, D0277) per 6 months per Contract Dentist
D0277	Vertical bitewings - 7 to 8 radiographic images	No charge	1 of (D0274, D0277) per 6 months per Contract Dentist
D0310	Sialography	No charge	
D0320	Temporomandibular joint arthrogram, including injection	No charge	Limited to trauma or pathology; 3 per date of service
D0322	Tomographic survey	No charge	2 per 12 months per Contract Dentist
D0330	Panoramic radiographic image	No charge	1 per 36 months per Contract Dentist
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	No charge	2 per 12 months per Contract Dentist
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No charge	For the diagnosis and treatment of the specific clinical condition not apparent on radiographs; 4 per date of service
D0351	3D photographic image	No charge	1 per date of service
D0460	Pulp vitality tests	No charge	
D0470	Diagnostic casts	No charge	For the evaluation of orthodontic Benefits only; 1 per Contract Dentist unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment)
D0502	Other oral pathology procedures, by report	No charge	Performed by an oral pathologist
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge	1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge	1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge	1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office
D0701	Panoramic radiographic image - image capture only	No charge	
D0702	2D cephalometric radiographic image - image capture only	No charge	
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No charge	
D0704	3D photographic image - image capture only	No charge	
D0705	Extra-oral posterior dental radiographic image - image capture only	No charge	
D0706	Intraoral - occlusal radiographic image - image capture only	No charge	
D0707	Intraoral - periapical radiographic image - image capture only	No charge	
D0708	Intraoral - bitewing radiographic image - image capture only	No charge	
D0709	Intraoral - complete series of radiographic images - image capture only	No charge	
D1000-D1999 II. PREVENTIVE			
D1110	Prophylaxis - adult	No charge	Cleaning; 1 of (D1110, D1120, D4346) per 6 months
D1120	Prophylaxis - child	No charge	Cleaning; 1 of (D1110, D1120, D4346) per 6 months
D1206	Topical application of fluoride varnish	No charge	1 of (D1206, D1208) per 6 months

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D1208	Topical application of fluoride - excluding varnish	No charge	1 of (D1206, D1208) per 6 months
D1310	Nutritional counseling for control of dental disease	No charge	
D1320	Tobacco counseling for the control and prevention of oral disease	No charge	
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	No charge	
D1330	Oral hygiene instructions	No charge	
D1351	Sealant - per tooth	No charge	1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	No charge	1 per tooth per 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position
D1353	Sealant repair - per tooth	No charge	The original Contract Dentist or dental office is responsible for any repair or replacement during the 36-month period
D1354	Interim caries arresting medicament application - per tooth	No charge	1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"
D1355	Caries preventive medicament application - per tooth	No charge	1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"
D1510	Space maintainer - fixed, unilateral - per quadrant	No charge	1 per quadrant; posterior teeth
D1516	Space maintainer - fixed - bilateral, maxillary	No charge	1 per arch; posterior teeth
D1517	Space maintainer - fixed - bilateral, mandibular	No charge	1 per arch; posterior teeth
D1520	Space maintainer - removable, unilateral - per quadrant	No charge	1 per quadrant; posterior teeth
D1526	Space maintainer - removable - bilateral, maxillary	No charge	1 per arch, through age 17; posterior teeth
D1527	Space maintainer - removable - bilateral, mandibular	No charge	1 per arch, through age 17; posterior teeth
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No charge	1 per Contract Dentist, per quadrant or arch, through age 17
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No charge	1 per Contract Dentist, per quadrant or arch, through age 17
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No charge	1 per Contract Dentist, per quadrant or arch, through age 17
D1556	Removal of fixed unilateral space maintainer - per quadrant	No charge	Included in case by Contract Dentist or dental office who placed appliance
D1557	Removal of fixed bilateral space maintainer - maxillary	No charge	Included in case by Contract Dentist or dental office who placed appliance
D1558	Removal of fixed bilateral space maintainer - mandibular	No charge	Included in case by Contract Dentist or dental office who placed appliance
D1575	Distal shoe space maintainer - fixed, unilateral - per quadrant	No charge	1 per quadrant, age 8 and under; posterior teeth

D2000-D2999 III. RESTORATIVE

- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.

- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years (60+ months) old.

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D2140	Amalgam - one surface, primary or permanent	\$25	<i>1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth</i>
D2150	Amalgam - two surfaces, primary or permanent	\$30	<i>1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth</i>
D2160	Amalgam - three surfaces, primary or permanent	\$40	<i>1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth</i>
D2161	Amalgam - four or more surfaces, primary or permanent	\$45	<i>1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth</i>
D2330	Resin-based composite - one surface, anterior	\$30	<i>1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth</i>
D2331	Resin-based composite - two surfaces, anterior	\$45	<i>1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth</i>
D2332	Resin-based composite - three surfaces, anterior	\$55	<i>1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth</i>
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	\$60	<i>1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth</i>
D2390	Resin-based composite crown, anterior	\$50	<i>1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth</i>
D2391	Resin-based composite - one surface, posterior	\$30	<i>1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth</i>
D2392	Resin-based composite - two surfaces, posterior	\$40	<i>1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth</i>
D2393	Resin-based composite - three surfaces, posterior	\$50	<i>1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth</i>
D2394	Resin-based composite - four or more surfaces, posterior	\$70	<i>1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth</i>
D2710	Crown - resin-based composite (indirect)	\$140	<i>1 per 60 months, permanent teeth; age 13 through 18</i>
D2712	Crown - 3/4 resin-based composite (indirect)	\$190	<i>1 per 60 months, permanent teeth; age 13 through 18</i>
D2721	Crown - resin with predominantly base metal	\$300	<i>1 per 60 months, permanent teeth; age 13 through 18</i>
D2740	Crown - porcelain/ceramic substrate	\$300	<i>1 per 60 months, permanent teeth; age 13 through 18</i>
D2751	Crown - porcelain fused to predominantly base metal	\$300	<i>1 per 60 months, permanent teeth; age 13 through 18</i>
D2781	Crown - 3/4 cast predominantly base metal	\$300	<i>1 per 60 months, permanent teeth; age 13 through 18</i>
D2783	Crown - 3/4 porcelain/ceramic	\$310	<i>1 per 60 months, permanent teeth; age 13 through 18</i>
D2791	Crown - full cast predominantly base metal	\$300	<i>1 per 60 months, permanent teeth; age 13 through 18</i>
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	\$25	<i>1 per 12 months per Contract Dentist</i>
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	\$25	
D2920	Re-cement or re-bond crown	\$25	<i>Recommendation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.</i>
D2921	Reattachment of tooth fragment, incisal edge or cusp	\$45	<i>1 per 12 months</i>
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	\$120	<i>1 per 36 months</i>
D2929	Prefabricated porcelain/ceramic crown - primary tooth	\$95	<i>1 per 12 months</i>

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D2930	Prefabricated stainless steel crown - primary tooth	\$65	1 per 12 months
D2931	Prefabricated stainless steel crown - permanent tooth	\$75	1 per 36 months
D2932	Prefabricated resin crown	\$75	1 per 12 months for primary teeth; 1 per 36 months for permanent teeth
D2933	Prefabricated stainless steel crown with resin window	\$80	1 per 12 months for primary teeth; 1 per 36 months for permanent teeth
D2940	Protective restoration	\$25	1 per 6 months per Contract Dentist
D2941	Interim therapeutic restoration - primary dentition	\$30	1 per tooth per 6 months per Contract Dentist
D2949	Restorative foundation for an indirect restoration	\$45	
D2950	Core buildup, including any pins when required	\$20	
D2951	Pin retention - per tooth, in addition to restoration	\$25	1 per tooth regardless of the number of pins placed; permanent teeth
D2952	Post and core in addition to crown, indirectly fabricated	\$100	Base metal post; 1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth
D2953	Each additional indirectly fabricated post - same tooth	\$30	Performed in conjunction with D2952
D2954	Prefabricated post and core in addition to crown	\$90	1 per tooth; a Benefit only in conjunction with covered crowns on root canal treated permanent teeth
D2955	Post removal	\$60	Included in case fee by Contract Dentist or dental office who performed endodontic and restorative procedures. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.
D2957	Each additional prefabricated post - same tooth	\$35	Performed in conjunction with D2954
D2971	Additional procedures to customize a crown to fit under an existing partial denture framework	\$35	Included in the fee for laboratory processed crowns. The listed fee applies for service provided by a Contract Dentist other than the original treating Dentist/dental office.
D2980	Crown repair necessitated by restorative material failure	\$50	Repair during the 12 months following initial placement or previous repair is included, no additional charge to the Enrollee or plan is permitted by the original treating Contract Dentist/dental office.
D2999	Unspecified restorative procedure, by report	\$40	Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.
D3000-D3999 IV. ENDODONTICS			
D3110	Pulp cap - direct (excluding final restoration)	\$20	
D3120	Pulp cap - indirect (excluding final restoration)	\$25	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$40	1 per primary tooth
D3221	Pulpal debridement, primary and permanent teeth	\$40	1 per tooth

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	\$60	1 per permanent tooth
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$55	1 per tooth
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$55	1 per tooth
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	\$195	Root canal
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	\$235	Root canal
D3330	Endodontic therapy, molar tooth (excluding final restoration)	\$300	Root canal
D3331	Treatment of root canal obstruction; non-surgical access	\$50	
D3333	Internal root repair of perforation defects	\$80	
D3346	Retreatment of previous root canal therapy - anterior	\$240	Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.
D3347	Retreatment of previous root canal therapy - bicuspid	\$295	Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.
D3348	Retreatment of previous root canal therapy - molar	\$365	Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$85	1 per permanent tooth
D3352	Apexification/recalcification - interim medication replacement	\$45	1 per permanent tooth
D3410	Apicoectomy - anterior	\$240	1 per 24 months by the same Contract Dentist or dental office; permanent teeth only
D3421	Apicoectomy - bicuspid (first root)	\$250	1 per 24 months by the same Contract Dentist or dental office; permanent teeth only
D3425	Apicoectomy - molar (first root)	\$275	1 per 24 months by the same Contract Dentist or dental office; permanent teeth only
D3426	Apicoectomy (each additional root)	\$110	1 per 24 months by the same Contract Dentist or dental office; permanent teeth only; a benefit for 3rd molar if it occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.
D3430	Retrograde filling - per root	\$90	
D3471	Surgical repair of root resorption - anterior	\$160	1 per 24 months by the same Contract Dentist or dental office
D3472	Surgical repair of root resorption - premolar	\$160	1 per 24 months by the same Contract Dentist or dental office
D3473	Surgical repair of root resorption - molar	\$160	1 per 24 months by the same Contract Dentist or dental office

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D3910	Surgical procedure for isolation of tooth with rubber dam	\$30	
D3999	Unspecified endodontic procedure, by report	\$100	<i>Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.</i>
D4000-D4999 V. PERIODONTICS			
<i>- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.</i>			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	\$150	<i>1 per quadrant per 36 months, age 13+</i>
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	\$50	<i>1 per quadrant per 36 months, age 13+</i>
D4249	Clinical crown lengthening - hard tissue	\$165	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	\$265	<i>1 per quadrant per 36 months, age 13+</i>
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	\$140	<i>1 per quadrant per 36 months, age 13+</i>
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	\$80	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	\$55	<i>1 per quadrant per 24 months; age 13+</i>
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	\$30	<i>1 per quadrant per 24 months; age 13+</i>
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	\$40	<i>Cleaning; 1 of (D1110, D1120, D4346) per 6 months</i>
D4355	Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	\$40	<i>1 treatment per 12 consecutive months</i>
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	\$10	
D4910	Periodontal maintenance	\$30	<i>1 per 3 months; service must be within the 24 months following the last scaling and root planing</i>
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	\$15	<i>1 per Contract Dentist; age 13+</i>
D4999	Unspecified periodontal procedure, by report	\$350	<i>Enrollees age 13+. Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.</i>

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D5000-D5899 VI. PROSTHODONTICS (removable)			
<i>- For all listed dentures and partial dentures, Cost Share includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.</i>			
<i>- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.</i>			
<i>- Replacement of a denture or a partial denture requires the existing denture to be 5+ years (60+ months) old.</i>			
D5110	Complete denture - maxillary	\$300	1 per 60 months
D5120	Complete denture - mandibular	\$300	1 per 60 months
D5130	Immediate denture - maxillary	\$300	1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.
D5140	Immediate denture - mandibular	\$300	1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.
D5211	Maxillary partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	\$300	1 per 60 months
D5212	Mandibular partial denture - resin base (including, retentive/clasping materials, rests, and teeth)	\$300	1 per 60 months
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	\$335	1 per 60 months
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests, and teeth)	\$335	1 per 60 months
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$275	1 per 60 months
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	\$275	1 per 60 months
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$330	1 per 60 months
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	\$330	1 per 60 months
D5410	Adjust complete denture - maxillary	\$20	1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months
D5411	Adjust complete denture - mandibular	\$20	1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months
D5421	Adjust partial denture - maxillary	\$20	1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months
D5422	Adjust partial denture - mandibular	\$20	1 per day of service per Contract Dentist; up to 2 per 12 months per Contract Dentist after the initial 6 months
D5511	Repair broken complete denture base, mandibular	\$40	1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months
D5512	Repair broken complete denture base, maxillary	\$40	1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D5520	Replace missing or broken teeth - complete denture (each tooth)	\$40	Up to 4 per arch per date of service after the initial 6 months; up to 2 per arch per 12 months per Contract Dentist
D5611	Repair resin partial denture base, mandibular	\$40	1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months
D5612	Repair resin partial denture base, maxillary	\$40	1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months
D5621	Repair cast partial framework, mandibular	\$40	1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months
D5622	Repair cast partial framework, maxillary	\$40	1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months
D5630	Repair or replace broken retentive clasping materials - per tooth	\$50	3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist
D5640	Replace broken teeth - per tooth	\$35	4 per arch per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist
D5650	Add tooth to existing partial denture	\$35	Up to 3 per date of service per Contract Dentist; 1 per tooth after the initial 6 months
D5660	Add clasp to existing partial denture - per tooth	\$60	3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist
D5730	Reline complete maxillary denture (direct)	\$60	Included for the first 6 months after placement by the Contract Dentist or dental office where the appliance was originally delivered; 1 per 12 month period after the initial 6 months
D5731	Reline complete mandibular denture (direct)	\$60	1 per 12 month period after the initial 6 months
D5740	Reline maxillary partial denture (direct)	\$60	1 per 12 month period after the initial 6 months
D5741	Reline mandibular partial denture (direct)	\$60	1 per 12 month period after the initial 6 months
D5750	Reline complete maxillary denture (indirect)	\$90	1 per 12 month period after the initial 6 months
D5751	Reline complete mandibular denture (indirect)	\$90	1 per 12 month period after the initial 6 months
D5760	Reline maxillary partial denture (indirect)	\$80	1 per 12 month period after the initial 6 months
D5761	Reline mandibular partial denture (indirect)	\$80	1 per 12 month period after the initial 6 months
D5850	Tissue conditioning, maxillary	\$30	2 per prosthesis per 36 months after the initial 6 months
D5851	Tissue conditioning, mandibular	\$30	2 per prosthesis per 36 months after the initial 6 months
D5862	Precision attachment, by report	\$90	Included in the fee for prosthetic and restorative procedures by the Contract Dentist or dental office where the service was originally delivered. The listed fee applies for service provided by a dentist other than the original treating Contract Dentist or dental office.
D5863	Overdenture - complete maxillary	\$300	1 per 60 months
D5864	Overdenture - partial maxillary	\$300	1 per 60 months
D5865	Overdenture - complete mandibular	\$300	1 per 60 months
D5866	Overdenture - partial mandibular	\$300	1 per 60 months

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D5899	Unspecified removable prosthodontic procedure, by report	\$350	<i>Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.</i>
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS			
<i>- All maxillofacial prosthetic procedures require prior Authorization.</i>			
D5911	Facial moulage (sectional)	\$285	
D5912	Facial moulage (complete)	\$350	
D5913	Nasal prosthesis	\$350	
D5914	Auricular prosthesis	\$350	
D5915	Orbital prosthesis	\$350	
D5916	Ocular prosthesis	\$350	
D5919	Facial prosthesis	\$350	
D5922	Nasal septal prosthesis	\$350	
D5923	Ocular prosthesis, interim	\$350	
D5924	Cranial prosthesis	\$350	
D5925	Facial augmentation implant prosthesis	\$200	
D5926	Nasal prosthesis, replacement	\$200	
D5927	Auricular prosthesis, replacement	\$200	
D5928	Orbital prosthesis, replacement	\$200	
D5929	Facial prosthesis, replacement	\$200	
D5931	Obturator prosthesis, surgical	\$350	
D5932	Obturator prosthesis, definitive	\$350	
D5933	Obturator prosthesis, modification	\$150	<i>2 per 12 months</i>
D5934	Mandibular resection prosthesis with guide flange	\$350	
D5935	Mandibular resection prosthesis without guide flange	\$350	
D5936	Obturator prosthesis, interim	\$350	
D5937	Trismus appliance (not for TMD treatment)	\$85	
D5951	Feeding aid	\$135	
D5952	Speech aid prosthesis, pediatric	\$350	
D5953	Speech aid prosthesis, adult	\$350	
D5954	Palatal augmentation prosthesis	\$135	
D5955	Palatal lift prosthesis, definitive	\$350	
D5958	Palatal lift prosthesis, interim	\$350	
D5959	Palatal lift prosthesis, modification	\$145	<i>2 per 12 months</i>
D5960	Speech aid prosthesis, modification	\$145	<i>2 per 12 months</i>
D5982	Surgical stent	\$70	
D5983	Radiation carrier	\$55	
D5984	Radiation shield	\$85	
D5985	Radiation cone locator	\$135	
D5986	Fluoride gel carrier	\$35	
D5987	Commissure splint	\$85	
D5988	Surgical splint	\$95	
D5991	Vesiculobullous disease medicament carrier	\$70	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D5999	Unspecified maxillofacial prosthesis, by report	\$350	<i>Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.</i>
D6000-D6199 VIII. IMPLANT SERVICES			
<i>- A Benefit only under exceptional medical conditions. Prior Authorization is required. Refer also to Schedule B.</i>			
D6010	Surgical placement of implant body: endosteal implant	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6011	Surgical access to an implant body (second stage implant surgery)	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6013	Surgical placement of mini implant	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6040	Surgical placement: eosteal implant	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6050	Surgical placement: transosteal implant	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6055	Connecting bar - implant supported or abutment supported	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6056	Prefabricated abutment - includes modification and placement	\$135	<i>A Benefit only under exceptional medical conditions</i>
D6057	Custom fabricated abutment - includes placement	\$180	<i>A Benefit only under exceptional medical conditions</i>
D6058	Abutment supported porcelain/ceramic crown	\$320	<i>A Benefit only under exceptional medical conditions</i>
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	\$315	<i>A Benefit only under exceptional medical conditions</i>
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	\$295	<i>A Benefit only under exceptional medical conditions</i>
D6061	Abutment supported porcelain fused to metal crown (noble metal)	\$300	<i>A Benefit only under exceptional medical conditions</i>
D6062	Abutment supported cast metal crown (high noble metal)	\$315	<i>A Benefit only under exceptional medical conditions</i>
D6063	Abutment supported cast metal crown (predominantly base metal)	\$300	<i>A Benefit only under exceptional medical conditions</i>
D6064	Abutment supported cast metal crown (noble metal)	\$315	<i>A Benefit only under exceptional medical conditions</i>
D6065	Implant supported porcelain/ceramic crown	\$340	<i>A Benefit only under exceptional medical conditions</i>
D6066	Implant supported crown - porcelain fused to high noble alloys	\$335	<i>A Benefit only under exceptional medical conditions</i>
D6067	Implant supported crown - high noble alloys	\$340	<i>A Benefit only under exceptional medical conditions</i>
D6068	Abutment supported retainer for porcelain/ceramic FPD	\$320	<i>A Benefit only under exceptional medical conditions</i>
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	\$315	<i>A Benefit only under exceptional medical conditions</i>
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	\$290	<i>A Benefit only under exceptional medical conditions</i>
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	\$300	<i>A Benefit only under exceptional medical conditions</i>
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	\$315	<i>A Benefit only under exceptional medical conditions</i>

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	\$290	<i>A Benefit only under exceptional medical conditions</i>
D6074	Abutment supported retainer for cast metal FPD (noble metal)	\$320	<i>A Benefit only under exceptional medical conditions</i>
D6075	Implant supported retainer for ceramic FPD	\$335	<i>A Benefit only under exceptional medical conditions</i>
D6076	Implant supported retainer for FPD - porcelain fused to high noble alloys	\$330	<i>A Benefit only under exceptional medical conditions</i>
D6077	Implant supported retainer for metal FPD - high noble alloys	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	\$30	<i>A Benefit only under exceptional medical conditions</i>
D6081	Scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	\$30	<i>A Benefit only under exceptional medical conditions</i>
D6082	Implant supported crown - porcelain fused to predominantly base alloys	\$335	<i>A Benefit only under exceptional medical conditions.</i>
D6083	Implant supported crown - porcelain fused to noble alloys	\$335	<i>A Benefit only under exceptional medical conditions</i>
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	\$335	<i>A Benefit only under exceptional medical conditions</i>
D6085	Provisional implant crown	\$300	<i>A Benefit only under exceptional medical conditions</i>
D6086	Implant supported crown - predominantly base alloys	\$340	<i>A Benefit only under exceptional medical conditions</i>
D6087	Implant supported crown - noble alloys	\$340	<i>A Benefit only under exceptional medical conditions</i>
D6088	Implant supported crown - titanium and titanium alloys	\$340	<i>A Benefit only under exceptional medical conditions</i>
D6090	Repair implant supported prosthesis, by report	\$65	<i>A Benefit only under exceptional medical conditions</i>
D6091	Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment	\$40	<i>A Benefit only under exceptional medical conditions</i>
D6092	Re-cement or re-bond implant/abutment supported crown	\$25	<i>A Benefit only under exceptional medical conditions</i>
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	\$35	<i>A Benefit only under exceptional medical conditions</i>
D6094	Abutment supported crown - titanium and titanium alloys	\$295	<i>A Benefit only under exceptional medical conditions</i>
D6095	Repair implant abutment, by report	\$65	<i>A Benefit only under exceptional medical conditions</i>
D6096	Remove broken implant retaining screw	\$60	<i>A Benefit only under exceptional medical conditions</i>
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	\$315	<i>A Benefit only under exceptional medical conditions</i>
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	\$330	<i>A Benefit only under exceptional medical conditions</i>
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	\$330	<i>A Benefit only under exceptional medical conditions</i>
D6100	Surgical removal of implant body	\$110	<i>A Benefit only under exceptional medical conditions</i>
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	\$350	<i>A Benefit only under exceptional medical conditions</i>

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	\$330	<i>A Benefit only under exceptional medical conditions</i>
D6121	Implant supported retainer for metal FPD - predominantly base alloys	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6122	Implant supported retainer for metal FPD - noble alloys	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6190	Radiographic/surgical implant index, by report	\$75	<i>A Benefit only under exceptional medical conditions</i>
D6191	Semi-precision abutment - placement	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6192	Semi-precision attachment - placement	\$350	<i>A Benefit only under exceptional medical conditions</i>
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	\$265	<i>A Benefit only under exceptional medical conditions</i>
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	\$315	<i>A Benefit only under exceptional medical conditions</i>
D6199	Unspecified implant procedure, by report	\$350	<i>Implant services are a Benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Written documentation shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.</i>
<i>D6200-D6999 IX. PROSTHODONTICS, fixed</i>			
<i>- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge).</i>			
<i>- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years (60+ months) old.</i>			
D6211	Pontic - cast predominantly base metal	\$300	<i>1 per 60 months; age 13+</i>
D6241	Pontic - porcelain fused to predominantly base metal	\$300	<i>1 per 60 months; age 13+</i>
D6245	Pontic - porcelain/ceramic	\$300	<i>1 per 60 months; age 13+</i>
D6251	Pontic - resin with predominantly base metal	\$300	<i>1 per 60 months; age 13+</i>
D6721	Retainer crown - resin with predominantly base metal	\$300	<i>1 per 60 months; age 13+</i>

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D6740	Retainer crown - porcelain/ceramic	\$300	1 per 60 months; age 13+
D6751	Retainer crown - porcelain fused to predominantly base metal	\$300	1 per 60 months; age 13+
D6781	Retainer crown - 3/4 cast predominantly base metal	\$300	1 per 60 months; age 13+
D6783	Retainer crown - 3/4 porcelain/ceramic	\$300	1 per 60 months; age 13+
D6784	Retainer crown - 3/4 titanium and titanium alloys	\$300	1 per 60 months; age 13+
D6791	Retainer crown - full cast predominantly base metal	\$300	1 per 60 months; age 13+
D6930	Re-cement or re-bond fixed partial denture	\$40	<i>Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.</i>
D6980	Fixed partial denture repair necessitated by restorative material failure	\$95	
D6999	Unspecified fixed prosthodontic procedure, by report	\$350	<i>Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment. Not a Benefit within 12 months of initial placement of a fixed partial denture by the same Contract Dentist/office.</i>
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY			
<i>- Prior Authorization required for procedures performed by a Contract Specialist. Medical necessity must be demonstrated for procedures D7340 - D7997. Refer also to Schedule B.</i>			
<i>- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic. Post-operative services include exams, suture removal and treatment of complications.</i>			
D7111	Extraction, coronal remnants - deciduous tooth	\$40	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$65	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	\$120	
D7220	Removal of impacted tooth - soft tissue	\$95	
D7230	Removal of impacted tooth - partially bony	\$145	
D7240	Removal of impacted tooth - completely bony	\$160	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$175	
D7250	Removal of residual tooth roots (cutting procedure)	\$80	
D7260	Oroantral fistula closure	\$280	
D7261	Primary closure of a sinus perforation	\$285	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$185	1 per arch regardless of number of teeth involved; permanent anterior teeth
D7280	Exposure of an unerupted tooth	\$220	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D7283	Placement of device to facilitate eruption of impacted tooth	\$85	<i>For active orthodontic treatment only</i>
D7285	Incisional biopsy of oral tissue-hard (bone, tooth)	\$180	<i>1 per arch per date of service; regardless of number of areas involved</i>
D7286	Incisional biopsy of oral tissue-soft	\$110	<i>3 per date of service</i>
D7290	Surgical repositioning of teeth	\$185	<i>1 per arch, for permanent teeth only; applies to active orthodontic treatment</i>
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	\$80	<i>1 per arch; applies to active orthodontic treatment</i>
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$85	
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$50	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	\$120	
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	\$65	
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	\$350	<i>1 per arch per 60 months</i>
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)	\$350	<i>1 per arch</i>
D7410	Excision of benign lesion up to 1.25 cm	\$75	
D7411	Excision of benign lesion greater than 1.25 cm	\$115	
D7412	Excision of benign lesion, complicated	\$175	
D7413	Excision of malignant lesion up to 1.25 cm	\$95	
D7414	Excision of malignant lesion greater than 1.25 cm	\$120	
D7415	Excision of malignant lesion, complicated	\$255	
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	\$105	
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	\$185	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$180	
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$330	
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$155	
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$250	
D7465	Destruction of lesion(s) by physical or chemical method, by report	\$40	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D7471	Removal of lateral exostosis (maxilla or mandible)	\$140	1 per quadrant
D7472	Removal of torus palatinus	\$145	1 per lifetime
D7473	Removal of torus mandibularis	\$140	1 per quadrant
D7485	Reduction of osseous tuberosity	\$105	1 per quadrant
D7490	Radical resection of maxilla or mandible	\$350	
D7510	Incision and drainage of abscess - intraoral soft tissue	\$70	1 per quadrant per date of service
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$70	1 per quadrant per date of service
D7520	Incision and drainage of abscess - extraoral soft tissue	\$70	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$80	
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	\$45	1 per date of service
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	\$75	1 per date of service
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	\$125	1 per quadrant per date of service
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	\$235	
D7610	Maxilla - open reduction (teeth immobilized, if present)	\$140	
D7620	Maxilla - closed reduction (teeth immobilized, if present)	\$250	
D7630	Mandible - open reduction (teeth immobilized, if present)	\$350	
D7640	Mandible - closed reduction (teeth immobilized, if present)	\$350	
D7650	Malar and/or zygomatic arch - open reduction	\$350	
D7660	Malar and/or zygomatic arch - closed reduction	\$350	
D7670	Alveolus - closed reduction, may include stabilization of teeth	\$170	
D7671	Alveolus - open reduction, may include stabilization of teeth	\$230	
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	\$350	
D7710	Maxilla - open reduction	\$110	
D7720	Maxilla - closed reduction	\$180	
D7730	Mandible - open reduction	\$350	
D7740	Mandible - closed reduction	\$290	
D7750	Malar and/or zygomatic arch - open reduction	\$220	
D7760	Malar and/or zygomatic arch - closed reduction	\$350	
D7770	Alveolus - open reduction stabilization of teeth	\$135	
D7771	Alveolus, closed reduction stabilization of teeth	\$160	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D7780	Facial bones - complicated reduction with fixation and multiple approaches	\$350	
D7810	Open reduction of dislocation	\$350	
D7820	Closed reduction of dislocation	\$80	
D7830	Manipulation under anesthesia	\$85	
D7840	Condylectomy	\$350	
D7850	Surgical discectomy, with/without implant	\$350	
D7852	Disc repair	\$350	
D7854	Synovectomy	\$350	
D7856	Myotomy	\$350	
D7858	Joint reconstruction	\$350	
D7860	Arthrotomy	\$350	
D7865	Arthroplasty	\$350	
D7870	Arthrocentesis	\$90	
D7871	Non-arthroscopic lysis and lavage	\$150	
D7872	Arthroscopy - diagnosis, with or without biopsy	\$350	
D7873	Arthroscopy: lavage and lysis of adhesions	\$350	
D7874	Arthroscopy: disc repositioning and stabilization	\$350	
D7875	Arthroscopy: synovectomy	\$350	
D7876	Arthroscopy: discectomy	\$350	
D7877	Arthroscopy: debridement	\$350	
D7880	Occlusal orthotic device, by report	\$120	
D7881	Occlusal orthotic device adjustment	\$30	<i>1 per date of service per Contract Dentist; 2 per 12 months per Contract Dentist</i>
D7899	Unspecified TMD therapy, by report	\$350	
D7910	Suture of recent small wounds up to 5 cm	\$35	
D7911	Complicated suture - up to 5 cm	\$55	
D7912	Complicated suture - greater than 5 cm	\$130	
D7920	Skin graft (identify defect covered, location and type of graft)	\$120	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	\$80	
D7940	Osteoplasty - for orthognathic deformities	\$160	
D7941	Osteotomy - mandibular rami	\$350	
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	\$350	
D7944	Osteotomy - segmented or subapical	\$275	
D7945	Osteotomy - body of mandible	\$350	
D7946	LeFort I (maxilla - total)	\$350	
D7947	LeFort I (maxilla - segmented)	\$350	
D7948	LeFort II or LeFort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	\$350	
D7949	LeFort II or LeFort III - with bone graft	\$350	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	\$190	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	\$290	

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D7952	Sinus augmentation via a vertical approach	\$175	
D7955	Repair of maxillofacial soft and/or hard tissue defect	\$200	
D7961	Buccal/labial frenectomy (frenulectomy)	\$120	<i>1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted</i>
D7962	Lingual frenectomy (frenulectomy)	\$120	<i>1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted</i>
D7963	Frenuloplasty	\$120	<i>1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted</i>
D7970	Excision of hyperplastic tissue - per arch	\$175	<i>1 per arch per date of service</i>
D7971	Excision of pericoronal gingiva	\$80	
D7972	Surgical reduction of fibrous tuberosity	\$100	<i>1 per quadrant per date of service</i>
D7979	Non-surgical sialolithotomy	\$155	
D7980	Sialolithotomy	\$155	
D7981	Excision of salivary gland, by report	\$120	
D7982	Sialodochoplasty	\$215	
D7983	Closure of salivary fistula	\$140	
D7990	Emergency tracheotomy	\$350	
D7991	Coronoidectomy	\$345	
D7995	Synthetic graft - mandible or facial bones, by report	\$150	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	\$60	<i>Removal of appliances related to surgical procedures only; 1 per arch per date of service; the listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.</i>
D7999	Unspecified oral surgery procedure, by report	\$350	<i>Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.</i>
D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees ONLY			
<i>- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a Benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when prior Authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health.</i>			
<i>- Pediatric Enrollee must continue to be eligible, Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.</i>			
<i>- Comprehensive orthodontic treatment procedure (D8080) includes all appliances, adjustments, insertion, removal and post treatment stabilization (retention). The Enrollee must continue to be eligible during active treatment. No additional charge to the Enrollee is permitted from the original treating Contract Orthodontist or dental office who received the comprehensive case fee. A separate fee applies for services provided by a Contract Orthodontist other than the original treating Contract Orthodontist or dental office.</i>			
<i>- Cost Share payment for medically necessary orthodontics applies to course of treatment, not individual benefit years within a multi-year course of treatment. This Cost Share applies to the course of treatment as long as the Pediatric Enrollee remains enrolled in this Plan.</i>			
<i>- Refer to Schedule B for additional information on medically necessary orthodontics.</i>			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$1,000	<i>1 per Enrollee per phase of treatment; included in comprehensive case fee</i>
D8210	Removable appliance therapy		<i>1 per lifetime; age 6 through 12; included in comprehensive case fee</i>
D8220	Fixed appliance therapy		<i>1 per lifetime; age 6 through 12; included in comprehensive case fee</i>

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D8660	Pre-orthodontic treatment examination to monitor growth and development		<i>1 per 3 months when performed by the same Contract Dentist or dental office; up to 6 visits per lifetime; included in comprehensive case fee</i>
D8670	Periodic orthodontic treatment visit		<i>Included in comprehensive case fee</i>
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		<i>1 per arch for each authorized phase of orthodontic treatment; included in comprehensive case fee</i>
D8681	Removable orthodontic retainer adjustment		<i>Included in comprehensive case fee</i>
D8696	Repair of orthodontic appliance - maxillary		<i>1 per appliance; included in comprehensive case fee</i>
D8697	Repair of orthodontic appliance - mandibular		<i>1 per appliance; included in comprehensive case fee</i>
D8698	Re-cement or re-bond fixed retainer - maxillary		<i>1 per Contract Dentist; included in comprehensive case fee</i>
D8699	Re-cement or re-bond fixed retainer - mandibular		<i>1 per Contract Dentist; included in comprehensive case fee</i>
D8701	Repair of fixed retainer, includes reattachment - maxillary		<i>1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.</i>
D8702	Repair of fixed retainer, includes reattachment - mandibular		<i>1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.</i>
D8703	Replacement of lost or broken retainer - maxillary		<i>1 per arch; within 24 months following the date of service for orthodontic retention (D8680); included in comprehensive case fee</i>
D8704	Replacement of lost or broken retainer - mandibular		<i>1 per arch; within 24 months following the date of service for orthodontic retention (D8680); included in comprehensive case fee</i>
D8999	Unspecified orthodontic procedure, by report		<i>Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment; included in comprehensive case fee.</i>
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES			
D9110	Palliative (emergency) treatment of dental pain - minor procedure	\$30	<i>1 per date of service per Contract Dentist; regardless of the number of teeth and/or areas treated</i>
D9120	Fixed partial denture sectioning	\$95	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	\$10	<i>1 per date of service per Contract Dentist; for use to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state</i>
D9211	Regional block anesthesia	\$20	
D9212	Trigeminal division block anesthesia	\$60	
D9215	Local anesthesia in conjunction with operative or surgical procedures	\$15	
D9222	Deep sedation/general anesthesia - first 15 minutes	\$45	<i>Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service</i>
D9223	Deep sedation/general anesthesia - each subsequent 15 minute increment	\$45	<i>Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service</i>

Code	Description	Pediatric Enrollee Pays	Clarification/Limitations for Pediatric Enrollees
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	\$15	<i>(Where available)</i>
D9239	Intravenous moderate (conscious) sedation/analgesia - first 15 minutes	\$60	<i>Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service</i>
D9243	Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment	\$60	<i>Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service</i>
D9248	Non-intravenous conscious sedation	\$65	<i>Where available; 1 per date of service per Contract Dentist</i>
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	\$50	
D9311	Consultation with a medical health care professional	No charge	
D9410	House/extended care facility call	\$50	<i>1 per Enrollee per date of service</i>
D9420	Hospital or ambulatory surgical center call	\$135	
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$20	<i>1 per date of service per Contract Dentist</i>
D9440	Office visit - after regularly scheduled hours	\$45	<i>1 per date of service per Contract Dentist</i>
D9610	Therapeutic parenteral drug, single administration	\$30	<i>4 of (D9610, D9612) injections per date of service</i>
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	\$40	<i>4 of (D9610, D9612) injections per date of service</i>
D9910	Application of desensitizing medicament	\$20	<i>1 per 12 months per Contract Dentist; permanent teeth</i>
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	\$35	<i>1 per date of service per Contract Dentist within 30 days of an extraction</i>
D9950	Occlusion analysis - mounted case	\$120	<i>Prior Authorization is required; 1 per 12 months for diagnosed TMJ dysfunction; permanent teeth; age 13+</i>
D9951	Occlusal adjustment - limited	\$45	<i>1 per 12 months for quadrant per Contract Dentist; age 13+</i>
D9952	Occlusal adjustment - complete	\$210	<i>1 per 12 months following occlusion analysis - mounted case (D9950) for diagnosed TMJ dysfunction; permanent teeth; age 13+</i>
D9997	Dental case management - patients with special health care needs	No charge	
D9999	Unspecified adjunctive procedure, by report	No charge	<i>Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a Benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.</i>

Endnotes:

If services for a listed procedure are performed by the Contract Dentist, the Enrollee pays the specified Cost Share. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Cost Share specified for such services.

Optional or upgraded procedure(s) are defined as any alternative procedure(s) presented by the Contract Dentist and formally agreed upon by financial consent that satisfies the same dental need as a covered procedure. Enrollee

may elect an Optional or upgraded procedure, subject to the limitations and exclusions of this Plan. The applicable charge to the Enrollee is the difference between the Contract Dentist's regularly charged fee (or contracted fee, when applicable) for the Optional or upgraded procedure and the covered procedure, plus any applicable Cost Share for the covered procedure.

Examples of Optional Services:

- If the Enrollee chooses an Optional or upgraded procedure presented by the Contract Dentist,
 - Where noble (D6061, D6064, D6071, D6074, D6083, D6087, D6099, D6122); high noble (precious) (D6059, D6062, D6066, D6067, D6069, D6072, D6076, D6077); or titanium (D6084, D6088, D6094, D6097, D6194, D6195, D6784) metals are used for an implant/abutment supported crown or fixed bridge retainer,
 - And an additional laboratory fee is charged by the Contract Dentist.

Then the Enrollee will be responsible for the fee charged by the laboratory which equals the difference between the higher cost of the Optional service and the lower cost of the customary service or standard procedure.

Additional Endnotes to Covered California's 2023 Dental Standard Benefit Plan Designs

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan or Family Dental Plan)

Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment ("EPSDT") benefit.

SCHEDULE B

Limitations and Exclusions of Benefits for Pediatric Enrollees (Under age 19)

Limitations of Benefits for Pediatric Enrollees

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Cost Shares for Pediatric Benefits ("Schedule A")*. Additional requests, beyond the stated frequency limitations, for prophylaxis, fluoride and scaling procedures (D1110, D1120, D1206, D1208 and D4346) shall be considered for prior Authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.
2. A filling [D2140-D2161, D2330-D2335, D2391-D2394] is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
3. A crown [D2390 and covered codes only between D2710-D2791] is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five+ year (60+ months) limitation.
4. The replacement of an existing crown [D2390 and covered codes only between D2710-D2791], fixed partial denture (bridge) [covered codes only between D6211-D6245, D6251, D6721-D6791] or a removable full [D5110, D5120] or partial denture [covered codes only between D5211-D5214, D5221-D5224] is covered when:
 - a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, and
 - b. Either of the following:
 - The existing non-functional restoration/bridge/denture was placed five or more years (60+ months) prior to its replacement, or
 - If an existing partial denture is less than five years old (60 months), but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.
5. Coverage for the placement of a fixed partial denture (bridge) [covered codes only between D6211-D6245, D6251, D6721-D6791] or removable partial denture [covered codes only between D5211-D5214, D5221-D5224]:
 - a. Fixed partial denture (bridge):
 - A fixed partial denture is a Benefit only when medical conditions or employment preclude the use of a removable partial denture.
 - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, or
 - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics, or
 - Each abutment tooth to be crowned meets Limitation #3.
 - b. Removable partial denture:
 - Cast metal (D5213, D5214, D5223, D5224), one or more teeth are missing in an arch.
 - Resin based (D5211, D5212, D5221, D5222), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease.
6. Immediate dentures [D5130, D5140, D5221-D5224] are covered when one or more of the following conditions are present:
 - a. Extensive or rampant caries are exhibited in the radiographs, or
 - b. Severe periodontal involvement indicated, or
 - c. Numerous teeth are missing resulting in diminished chewing ability adversely affecting the Enrollee's health.
7. Maxillofacial prosthetic services [covered codes only between D5911-D5999] for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.

8. All maxillofacial prosthetic procedures [covered codes only between D5911-D5999] require prior Authorization for medically necessary procedures.
9. Implant services [covered codes only between D6010-D6199] are a Benefit only under exceptional medical conditions. Exceptional medical conditions include, but are not limited to:
 - a. Cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prosthesis.
 - b. Severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures [D7340, D7350] or osseous augmentation procedures [D7950], and the Enrollee is unable to function with conventional prosthesis.
 - c. Skeletal deformities that preclude the use of conventional prosthesis (such as arthrogryposis, ectodermal dysplasia, partial anodontia and cleidocranial dysplasia).
10. Temporomandibular joint ("TMJ") dysfunction procedure codes [covered codes only between D7810-D7880] are limited to differential diagnosis and symptomatic care and require prior Authorization.
11. Certain listed procedures performed by a Contract Specialist may be considered to be primary under the Enrollee's medical coverage. Dental Benefits will be coordinated accordingly.
12. Deep sedation/general anesthesia [D9222, D9223] or intravenous conscious sedation/analgesia [D9239, D9243] for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.

Exclusions of Benefits for Pediatric Enrollees

1. Any procedure that is not specifically listed under *Schedule A*, except as required by state or federal law.
2. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
3. Lost or theft of full or partial dentures [covered codes only between D5110-D5140, D5211-D5214, D5221-D5224], space maintainers [D1510-D1575], crowns [D2390 and covered codes only between D2710-D2791], fixed partial dentures (bridges) [covered codes only between D6211-D6245, D6251, D6721-D6791] or other appliances.
4. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
5. Dental expenses incurred in connection with any dental procedure before the Enrollee's eligibility in this Plan. Examples include: teeth prepared for crowns, partials and dentures, root canals in progress.
6. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.) unless included in *Schedule A*.
7. Dispensing of drugs not normally supplied in a dental facility unless included in *Schedule A*.
8. Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:
 - a. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, or
 - b. is inconsistent with generally accepted standards for dentistry.
9. Dental services received from any dental facility other than the Contract Dentist including the services of a dental specialist, unless expressly authorized or as cited under the "Emergency Dental Services" and "Urgent Dental Services" sections of the EOC. To obtain written Authorization, the Enrollee should call Delta Dental's Customer Care at 800-471-9925.
10. Consultations [D9310, D9311] or other diagnostic services [covered codes only between D0120-D0999], for non-covered Benefits.

11. Single tooth implants [covered codes only between D6000–D6199].
12. Restorations [covered codes only between D2330-D2335, D2391-D2394, D2710-D2791, D6211-D6245, D6251, D6721-D6791] placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.
13. Preventive [covered codes only between D1110-D1575], endodontic [covered codes only between D3110-D3999] or restorative [covered codes only between D2140-D2999] procedures are not a Benefit for teeth to be retained for overdentures.
14. Partial dentures [covered codes only between D5211-5214, D5221-D5224] are not a Benefit to replace missing 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for a partial denture with cast clasps or rests.
15. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth [covered codes only between D8000-D8999], periodontal splinting [D4320-D4321], gnathologic recordings, equilibration [D9952] or treatment of disturbances of the TMJ [covered codes only between D0310-D0322, D7810-D7899], unless included in *Schedule A*.
16. Porcelain denture teeth, precision abutments for removable partials [D5862] or fixed partial dentures (overlays, implants, and appliances associated therewith) [D6940, D6950] and personalization and characterization of complete and partial dentures.
17. Extraction of teeth [D7111, D7140, D7210, D7220-D7240], when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars.
18. TMJ dysfunction treatment modalities that involve prosthodontia [D5110-D5224, D6211-D6245, D6251, D6721-D6791], orthodontia [covered codes only between D8000-D8999], and full or partial occlusal rehabilitation or TMJ dysfunction procedures [covered codes only between D0310-D0322, D7810-D7899] solely for the treatment of bruxism.
19. Vestibuloplasty / ridge extension procedures [D7340, D7350] performed on the same date of service as extractions [D7111-D7250] on the same arch.
20. Deep sedation/general anesthesia [D9222, D9223] for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for intravenous conscious sedation/analgesia [D9239, D9243].
21. Intravenous conscious sedation/analgesia [D9239, D9243] for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for deep sedation/general anesthesia [D9222, D9223].
22. Inhalation of nitrous oxide [D9230] when administered with other covered sedation procedures.
23. Cosmetic dental care [exclude covered codes in this list if done for purely cosmetic reasons: D2330-D2394, D2710–D2751, D2940, D6211-D6245, D6251, D6721-D6791, D8000-D8999].

Medically Necessary Orthodontics for Pediatric Enrollees

1. Orthodontic Services are limited to the following automatic qualifying conditions:
 - a. Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior authorization request,
 - b. Craniofacial anomaly. Written documentation from a credentialed specialist shall be submitted, on their professional letterhead, with the prior Authorization request,
 - c. A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate,
 - d. A crossbite of individual anterior teeth causing destruction of soft tissue,

- e. An overjet greater than 9 mm or reverse overjet greater than 3.5 mm,
 - f. Severe traumatic deviation.
2. The following documentation must be submitted with the request for prior Authorization of services by the Contract Orthodontist:
 - a. ADA 2006 or newer Claim Form with service code(s) requested;
 - b. Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
 - c. Cephalometric radiographic image or panoramic radiographic image;
 - d. HLD score sheet completed and signed by the Contract Orthodontist; and
 - e. Treatment plan.
 3. Coverage for comprehensive orthodontic treatment [D8080] requires acceptable documentation of a handicapping malocclusion as evidence by a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form and pre-treatment diagnostic casts [D0470]. Comprehensive orthodontic treatment [D8080]:
 - a) is limited to Enrollees who are between 13 through 18 years of age with a permanent dentition without a cleft palate or craniofacial anomaly; but
 - b) may start at birth for patients with a cleft palate or craniofacial anomaly.
 4. Removable appliance therapy [D8210] or fixed appliance therapy [D8220] is limited to Enrollee between 6 to 12 years of age, once in a lifetime, to treat thumb sucking and/or tongue thrust.
 5. The Benefit for a pre-orthodontic treatment examination [D8660] includes needed oral/facial photographic images [D0350, D0351, D0703, D0704]. Neither the Enrollee nor the plan may be charged for D0350, D0351, D0703 or D0704 in conjunction with a pre-orthodontic treatment examination.
 6. The number of covered periodic orthodontic treatment [D8670] visits and length of covered active orthodontics is limited to a maximum of up to:
 - a. handicapping malocclusion - eight (8) quarterly visits;
 - b. cleft palate or craniofacial anomaly - six (6) quarterly visits for treatment of primary dentition;
 - c. cleft palate or craniofacial anomaly - eight (8) quarterly visits for treatment of mixed dentition; or
 - d. cleft palate or craniofacial anomaly - ten (10) quarterly visits for treatment of permanent dentition.
 - e. facial growth management - four (4) quarterly visits for treatment of primary dentition;
 - f. facial growth management - five (5) quarterly visits for treatment of mixed dentition;
 - g. facial growth management - eight (8) quarterly visits for treatment permanent dentition.
 7. Orthodontic retention [D8680] is a separate Benefit after the completion of covered comprehensive orthodontic treatment [D8080] which:
 - a. includes removal of appliances and the construction and place of retainer(s) [D8680]; and
 - b. is limited to Enrollees under age 19 and to one per arch after the completion of each phase of active treatment for retention of permanent dentition unless treatment was for a cleft palate or a craniofacial anomaly.
 8. Cost Share is payable to the Contract Orthodontist who initiates banding in a course of prior authorized orthodontic treatment [covered codes only between D8000-D8999]. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:
 - a. will not be entitled to a refund of any amounts previously paid, and
 - b. will be responsible for all payments, up to and including the full Cost Share, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.
 9. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment [covered codes only between D8000-D8999], the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

If an Enrollee is receiving ongoing orthodontic treatment at the time of termination, Delta Dental will continue to provide orthodontic Benefits for:

 - a. 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or

- b. until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

At the end of 60 days (or at the end of the quarter), the Enrollee's obligation shall be based on the Contract Orthodontist's submitted fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

- 10. Orthodontics, including oral evaluations and all treatment, [covered codes only between D8000-D8999] must be performed by a licensed dentist or his or her supervised staff, acting within the scope of applicable law.
- 11. The removal of fixed orthodontic appliances [D8680] for reasons other than completion of treatment is not a covered Benefit.

SCHEDULE C

Information Concerning Benefits Under The DeltaCare® USA Program

THIS MATRIX IS INTENDED TO BE USED TO COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THIS AMENDMENT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PROGRAM BENEFITS AND LIMITATIONS.

(A) Deductibles	None																																																
(B) Lifetime Maximums	None																																																
(C) Out-of-Pocket Maximum	Covered pediatric dental services apply to the out-of-pocket maximum in your Health Plan <EOC NAME>. See your Health Plan <i>Membership Agreement and Evidence of Coverage</i> for information about your out-of-pocket maximum.																																																
(D) Professional Services	<p>An Enrollee may be required to pay a Cost Share amount for each procedure as shown in the Description of Benefits and Cost Share, subject to the limitations and exclusions of the program.</p> <p>Cost Share ranges by category of service. Examples are as follows:</p> <table> <tr> <td>Diagnostic Services</td> <td>No Charge</td> <td></td> <td></td> </tr> <tr> <td>Preventive Services</td> <td>No Charge</td> <td></td> <td></td> </tr> <tr> <td>Restorative Services</td> <td>\$ 20.00</td> <td>-</td> <td>\$ 310.00</td> </tr> <tr> <td>Endodontic Services</td> <td>\$ 20.00</td> <td>-</td> <td>\$ 365.00</td> </tr> <tr> <td>Periodontic Services</td> <td>\$ 10.00</td> <td>-</td> <td>\$ 350.00</td> </tr> <tr> <td>Prosthodontic Services, (removable)</td> <td>\$ 20.00</td> <td>-</td> <td>\$ 350.00</td> </tr> <tr> <td>Maxillofacial Prosthetics</td> <td>\$ 35.00</td> <td>-</td> <td>\$ 350.00</td> </tr> <tr> <td>Implant Services (medically necessary only)</td> <td>\$ 25.00</td> <td>-</td> <td>\$ 350.00</td> </tr> <tr> <td>Prosthodontic Services, (fixed)</td> <td>\$ 40.00</td> <td>-</td> <td>\$ 350.00</td> </tr> <tr> <td>Oral and Maxillofacial Surgery</td> <td>\$ 30.00</td> <td>-</td> <td>\$ 350.00</td> </tr> <tr> <td>Orthodontic Services (medically necessary only)</td> <td>\$1,000.00</td> <td>-</td> <td>\$ 1,000.00</td> </tr> <tr> <td>Adjunctive General Services</td> <td>No Charge</td> <td>-</td> <td>\$ 210.00</td> </tr> </table> <p>NOTE: Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to one in a 6-month period.</p>	Diagnostic Services	No Charge			Preventive Services	No Charge			Restorative Services	\$ 20.00	-	\$ 310.00	Endodontic Services	\$ 20.00	-	\$ 365.00	Periodontic Services	\$ 10.00	-	\$ 350.00	Prosthodontic Services, (removable)	\$ 20.00	-	\$ 350.00	Maxillofacial Prosthetics	\$ 35.00	-	\$ 350.00	Implant Services (medically necessary only)	\$ 25.00	-	\$ 350.00	Prosthodontic Services, (fixed)	\$ 40.00	-	\$ 350.00	Oral and Maxillofacial Surgery	\$ 30.00	-	\$ 350.00	Orthodontic Services (medically necessary only)	\$1,000.00	-	\$ 1,000.00	Adjunctive General Services	No Charge	-	\$ 210.00
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Adjunctive General Services	No Charge	-	\$ 210.00																																														
(E) Outpatient Services	Not Covered																																																
(F) Hospitalization Services	Not Covered																																																
(G) Emergency Dental Coverage	Benefits for Emergency Pediatric Dental Services by an Out-of-Network Dentist are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.																																																
(H) Ambulance Services	Not Covered																																																
(I) Prescription Drug Services	Not Covered																																																
(J) Durable Medical Equipment	Not Covered																																																
(K) Mental Health Services	Not Covered																																																
(L) Chemical Dependency Services	Not Covered																																																
(M) Home Health Services	Not Covered																																																
(N) Other	Not Covered																																																

Each individual procedure within each category listed above, and that is covered under the plan, has a specific Cost Share that is shown in the *Description of Benefits and Cost Share for Pediatric Benefits* in this Amendment.

CALIFORNIA*CHOICE* SUPPLEMENT TO EVIDENCE OF COVERAGE

WELCOME TO CALIFORNIA*CHOICE*

Your Employer has chosen to offer your health coverage to you and your fellow Employees through the California*Choice* Program. This Supplement is to Sutter Health Plus's ("PLAN") Evidence of Coverage, into which this California*Choice* Supplement is inserted. All of the provisions of that Evidence of Coverage are applicable to your health coverage. This Supplement explains certain details specific to the California*Choice* Program and may duplicate what is already stated in that document. In the case of inconsistencies between the attached Evidence of Coverage and this document, the provisions of this document will control.

WHAT IS THE CALIFORNIA*CHOICE* PROGRAM?

The California*Choice* Program is a program through which a number of California health care service plans and insurance carriers together offer various health benefits plans to employers for their employees' coverage. You as an Employee have the opportunity to select to receive your health benefits from one of these health plans or, in some circumstances, an insurance carrier. This gives you the sort of choice of health plans that typically has been enjoyed by only a few.

You have selected PLAN as the health care service plan from which you wish to receive your employer-sponsored medical benefits and you and your eligible Dependents have become members of PLAN.

IMPORTANT FEATURES OF THE CALIFORNIA*CHOICE* PROGRAM

Some of the important features of the California*Choice* Program which impact you as an Enrollee in PLAN are listed below.

1. Participation Requirements

At least seventy percent (70%) of your fellow Employees will receive their medical coverage from one of the health plans or the insurance carrier participating in the California*Choice* Program.

2. Eligibility Requirements

a. Employee Eligibility

An Eligible Employee is one who lives or works in PLAN's Service Area, who is permanently and actively employed for compensation an average of 30 hours per week over the course of a month, at the small employer's regular place of business, and who has met any applicable waiting period requirements.

- Provided that GROUP has been determined to be a "small employer" without counting them for purposes of making such determination, the term includes sole proprietors or partners of a partnership and their respective spouses, 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.
- Permanent employees who work at least 20 hours but not more than 29 hours are eligible if all four of the following conditions apply:
 - They otherwise meet the definition of an Eligible Employee except for the number of hours worked

- The employer offers the employees health coverage under a health benefit plan
- All similarly situated employees are offered coverage under the health benefit plan
- The employee must have worked at least 20 hours per normal work week for at least 50% of the weeks in the previous calendar quarter (documentation required upon request). Individuals who work on a part-time, temporary or substitute basis are not eligible. If you are accepted for enrollment in PLAN, your coverage will become effective on the first day of the month following your Employer's designated waiting period of 30 days.

b. Dependent Eligibility

A Dependent claiming eligibility hereunder as a spouse must be legally married to an Eligible Employee. A spouse may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of the Employer or following a proven triggering event as described in Paragraph (3.a) below.

A Dependent claiming eligibility hereunder as a domestic partner must be personally related to an Eligible Employee by a domestic partnership as defined below. A domestic partner may be added to coverage at the time of initial enrollment of the Employee, at each open enrollment period of the Employer or following a proven triggering event as described in Paragraph (3.a) below.

Eligible Employee agrees to notify California*Choice* Benefit Administrators immediately upon termination of the marriage or domestic partnership.

A Dependent child claiming eligibility hereunder must be born to, a step-child of, a legal ward of, or adopted by the Eligible Employee or the Eligible Employee's spouse or domestic partner or is a child for whom the Eligible Employee has assumed a parent-child relationship, as indicated by intentional assumption of parental status or assumption of parental duties by the Eligible Employee, as certified by the Eligible Employee at the time of enrollment of the child and annually thereafter (but not to include foster children), subject to the following condition:

- Under age 26 (unless disabled, disability diagnosed prior to age 26)
- This "child" profile describes herein an "eligible dependent child."

A Dependent child who exceeds the age limit for Dependent children and is disabled, that is, who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition diagnosed as such by competent health care professionals prior to such Dependent's 26th birthday, and has remained continuously dependent on the Employee for at least 50% of his/her economic support since he/she became disabled, shall be eligible for coverage hereunder until such disability ceases. Proof of Dependent's disability must be received within 60 days after California*Choice* Benefit Administrators requests it.

California*Choice* Benefit Administrators will provide subscriber a 90-day notice that a dependent is about to reach the age limit for dependent children and will lose coverage unless subscriber provides written certification from a competent health care

professional, within 60 days of receiving this 90-day warning notice, that the dependent meets the above conditions of being disabled.

California*Choice* Benefit Administrators or PLAN will determine if the child meets the conditions above prior to the child reaching the age limit. After two years following the child's reaching the limiting age, California*Choice* Benefit Administrators or PLAN may request proof of continuing incapacity and dependency, but not more often than yearly. If the Employee is enrolling a disabled child for new coverage, California*Choice* Benefit Administrators or PLAN may request initial proof of incapacity/dependency and then yearly, and the Employee must provide the requested information within 60 days of receipt of request.

If you are enrolling Dependents, they must also enroll in the same plan you have selected. Enrollees and their Dependents are, however, able to select different primary care physicians.

Formal proof of the required eligibility and existence of the relationship of any Dependent to the Employee may be requested at the time of enrollment, time of service authorization request or claim submission, but not more frequently than annually after the two-year period following a child's attainment of the limiting age.

New Dependents

(i) New Dependent - Spouse

An individual who becomes a new Dependent by virtue of marriage is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request form is submitted to the Employer within 45 days after such marriage, allowing the Employer sufficient time to submit the request to the California*Choice* Program within 60 days after such marriage. If California*Choice* Benefit Administrators receives all required documentation before the 16th day of the month of marriage, Premium is charged for the full month and coverage is effective as of the date of marriage. If California*Choice* Benefit Administrators receives all required documentation on or after the 16th day of the month of marriage, the new spouse will be enrolled as of the 1st of the month following the date of receipt. The Employee enrollee requesting coverage for such new Dependent must provide a stamped copy of the marriage certificate. The Employee must agree to notify California*Choice* Benefit Administrators immediately upon termination of marriage.

(ii) New Dependent - Birth/Adoption/Legal Guardian

An individual who becomes a new Dependent by virtue of birth, adoption or placement for adoption or legal guardianship or is a child for whom the Eligible Employee has assumed a parent-child relationship is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request is submitted to the Employer within 45 days after such birth, adoption or placement for adoption or effective date of a guardianship order, or arrival at status of eligible dependent child, for coverage effective as of effective date of such event, allowing the Employer sufficient time to submit the request to the California*Choice* Program within 60 days after such birth, adoption or placement for adoption or legal guardianship or arrival at status of eligible dependent child, with coverage to be effective upon the date of the event. The first 30 days of coverage for such new or adopted child is automatic, regardless of whether the child is enrolled or not after this 30-day period. If the birth, adoption or placement for adoption or legal guardianship effective date occurs between the 1st and the 15th day of the month,

Premiums are charged for the full month. If the birth, adoption or placement for adoption or legal guardianship effective date occurs between the 16th day and the end of the month, no Premiums are charged (copy of legal documentation may be required).

(iii) New Dependent - Stepchild

A child who comes to be the stepchild of an Enrollee is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request is submitted to the Employer within 45 days following marriage or establishment of a registered domestic partnership to the parent or legal guardian of the stepchild, allowing the Employer sufficient time to submit the request to the California*Choice* Program within 60 days following the date of the Enrollee's marriage to or establishment of a registered domestic partnership with the parent or legal guardian of the stepchild (actual adoption by the stepparent Enrollee is not required, although a copy of the marriage certificate to, or a State-stamped copy of the Certificate of Registered Domestic Partnership with, the parent of the new stepchild may be required). If the marriage or creation of the domestic partnership occurs before the 16th day of the month, Premium is charged for the full month and coverage is effective as of the date of marriage or creation of the domestic partnership. If the marriage or creation of the domestic partnership occurs on or after the 16th day of the month, the stepchild will be enrolled effective as of the 1st of the month following the date of receipt.

(iv) New Dependent - Domestic Partner

In order for an Employee's domestic partner to be eligible for coverage, at the time of Employee eligibility for enrollment, the Employee and domestic partner must:

- Not be married under either statutory or common law or part of another domestic partnership;
- Both be 18 years of age or older and of the same or different sex;
- If of opposite sexes one or the other must be over age 62, and one or both must meet the Social Security eligibility requirements referenced in California Family Code Section 297 (b)(4)(B);
- If one is under 18 years of age meet the requirements and follow the procedures prescribed in California Family Code Section 297.1;
- Share an intimate and committed relationship of mutual caring;
- Both be mentally competent;
- Not related by blood to a degree of closeness that would prevent them from being married in this state;
- Agree to notify California*Choice* Benefit Administrators immediately upon termination of the domestic partnership.

The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State and at the time of filing both partners meet all of the requirements above.

An individual who becomes a new Dependent by virtue of becoming a registered domestic partner of the Employee is eligible for coverage at other than the Employer's annual open enrollment, provided the appropriate request form is submitted to the Employer within 45 days after such domestic partnership is created, allowing the Employer sufficient time to submit the request to the CaliforniaChoice Benefit Administrators within 60 days after such event. If CaliforniaChoice Benefit Administrators receives all required documentation before the 16th day of the month in which the domestic partnership was established, Premium is charged for the full month and coverage is effective as of the date of the event. If CaliforniaChoice Benefit Administrators receives all required documentation on or after the 16th day of the month in which the domestic partnership was established, the new domestic partner will be enrolled as of the 1st of the month following the date of receipt. The Employee Enrollee requesting coverage for such new Dependent must provide a State-stamped copy of the Certificate of Registered Domestic Partnership within 45 days after such domestic partnership is created, allowing the Employer sufficient time to submit the request and Certificate to the CaliforniaChoice Benefit Administrators within 60 days of its issuance. For purposes of this provision only, the domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State. The Employee must agree to notify CaliforniaChoice Benefit Administrators immediately upon termination of the domestic partnership.

3. Special and Late Enrollment

a. Special Enrollment

Employees who did not enroll during the initial enrollment period or at the Employer's annual open enrollment may add newly acquired Dependents and themselves to the contract by submitting an application within 60 days from the date of acquisition of the Dependent:

- to add Employee and spouse or domestic partner following the birth of a newborn, adoption or placement for adoption of a child or arrival at status of eligible dependent child, coverage effective on the date of such event;
- to add Employee and spouse or registered domestic partner after marriage or creation of a domestic partnership. If all required documentation is received before the 16th day of the month of marriage/creation of domestic partnership, coverage for Employee and spouse or domestic partner is effective on the date of marriage or creation of the domestic partnership; If all required documentation is received on or after the 16th day of the month of marriage/creation of domestic partnership, coverage is effective on the 1st of the month following the date of receipt.
- to add Employee and Employee's newborn, eligible dependent child, or child placed for adoption, following birth, adoption or placement for adoption or arrival at status of eligible dependent child, coverage effective on effective date of such event;

- to add Employee and Employee's stepchild, if marriage or domestic partner registration occurs before the 16th day of the month, coverage effective as of the date of marriage or domestic partner registration; if marriage or domestic partner registration occurs on or after the 16th day of the month, stepchild will be enrolled effective as of the 1st of the month following date of receipt.

If an Employee did not enroll himself or herself or a Dependent at initial enrollment or at the Employer's annual open enrollment because the Employee or Dependent had coverage under another employer health plan, please see the "Late Enrollment" section below and the "Eligibility" section above for further information regarding rights to request enrollment at a later time.

b. Late Enrollment

Late enrollees (as defined in California Health & Safety Code section 1357.500(f)) must wait until open enrollment to be enrolled unless covered above under the "Special Enrollment" provisions. However, pursuant to H&S section 1357.500(f) and as further articulated in PLAN's Evidence of Coverage, if an Employee did not enroll, or enroll a Dependent, at initial enrollment or at annual open enrollment because Employee:

- or dependent loses minimum essential coverage, as described in California H&S Section 1399.849(d)(1)(A);
- gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption or arrival at status of eligible dependent child;
- is mandated to be covered as a dependent pursuant to a valid state or federal court order;
- has been released from incarceration;
- health coverage issuer substantially violated a material provision of the health coverage contract;
- gains access to new health benefit plans as a result of a permanent move;
- was receiving services from a contracting provider under another health benefit plan, for one of the conditions described in subdivision (c) of H&S Section 1373.96 and that provider is no longer participating in the health benefit plan;
- is a member of the reserve forces of the United States military returning from active duty or a member of the California National Guard returning from active duty service; and
- demonstrates that he or she did not enroll in a health benefit plan during the immediately preceding enrollment period because he or she was misinformed that he or she was covered under minimum essential coverage.

then if such a triggering event occurs, the Employee may enroll in PLAN by submitting an enrollment application to CaliforniaChoice Benefit Administrators within 60 days of loss of other coverage or within 60 days of another triggering event listed immediately above, pursuant to H&S section 1357.500(f) and as articulated further in PLAN's EOC.

Coverage with PLAN through California*Choice* Benefit Administrators to become effective 1st day of month following receipt of completed enrollment application.

4. Waiting Period

The waiting period for coverage, which shall be applicable for all Employees, is 0, 30 or 60 days plus the days until the first of the following month, not to exceed 90 days.

5. Benefits

Under the federal “Patient Protection and Affordable Care Act,” your Employer is required to select one of four (4) “metal tier” options of benefits offered by PLAN, keyed to their “actuarial value” (“Bronze,” “Silver,” “Gold,” “Platinum”). However, by participating in the California*Choice* Program, your Employer is able and may decide to offer to you two (2) neighboring metal tiers of benefits (Bronze/Silver, Silver/Gold, or Gold/Platinum) for you to choose from or even to offer three (3) neighboring metal tiers of benefits (Silver/Gold/Platinum) from which you could choose. Employees will then have the option to choose from the health plans and benefit plans offered within such metal tier options. The benefits you will have chosen to receive from PLAN are described in the Evidence of Coverage to which this Supplement is attached. You may not change your benefit plan within PLAN other than during its open enrollment period unless you experience a “triggering event” (see Paragraph 3 above). PLAN will make all benefit and coverage dispute determinations, although these determinations are subject to PLAN’s grievance procedures.

a. Cal-COBRA and COBRA

PLAN has agreed to provide coverage for you if you are Cal-COBRA-eligible or COBRA-eligible, at rates which you can receive by requesting them from your employer. Please examine your options carefully before declining this coverage.

b. Co-payments

As noted in the attached Evidence of Coverage, certain covered services and benefits are subject to co-payments which you will be required to make.

c. Plan Materials

PLAN will provide you with an identification card and its Evidence of Coverage (“EOC”) and this Supplement, and will distribute its federally-required “Summary of Benefits and Coverage” (“SBC”). California*Choice* Benefit Administrators will post on its website a copy of PLAN's current SBC. (In lieu of hard copies, PLAN may notify Enrollee of where to obtain electronic copies of the EOC and California*Choice* EOC Supplement.)

6. Termination for Nonpayment of Premiums

On the first day of the month prior to the coverage month, the Premium Notice that is sent to your Employer by California*Choice* Benefit Administrators will include the mandated regulatory statement contained in Rule 1300.65(a)(2), which states: “Your Health Plan is billing you for the cost of your health coverage. You must pay all amounts listed in this bill by the due date. If you do not pay this amount by the due date, your health coverage can be cancelled. You will receive a grace period before your Plan can cancel your coverage for not paying the amount due. You can file a complaint with your PLAN and with the California Department of Managed Health Care if you think there is a mistake. Learn more about your health care rights and responsibilities in your Plan Evidence of Coverage.” Premium payments are due on or before the 20th day of the month prior to the month of coverage. If your Employer fails to pay the required Premiums when due, PLAN (or California*Choice* Benefit Administrators on behalf of PLAN)

will mail your Employer a “Notice of Start of Grace Period” stating that the Employer has until the end of the Grace Period, which lasts at least 30 consecutive days, in which to pay the Premiums due before any cancellation of unpaid coverage contracts will take effect. This Notice will provide information to your Employer regarding the reason for cancellation(s), the effective date of cancellation(s), the dollar amount(s) due to PLAN, the date of the last day of paid coverage, the date the grace period begins and expires, any obligations of your Employer during the grace period, including your Employer’s responsibility to promptly send you a copy of the Notice of Start of Grace Period, consequences for nonpayment of Premiums due within that timeframe, as well as the right of your Employer to submit a grievance to the PLAN and/or the California Department of Managed Health Care if your Employer believes coverage has been or will be improperly cancelled.

The Notice shall also inform your Employer that coverage will continue during a 30-day grace period that begins on the day the Notice of Start of Grace period is dated and lasts at least 30 consecutive days. For California*Choice* Program Plans, the Notice of Start of Grace Period will be dated and sent the first calendar day after the last day of paid coverage. If the Premium remains unpaid by the 14th day of the coverage month, California*Choice* Benefit Administrators on behalf of PLAN will send your Employer a “Second Notice of Grace Period” repeating the need to pay the Premium(s) and the consequences for not doing so. If Premium payment(s) is/are not received by the effective date of cancellation*, PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will cancel the membership agreement and coverage for you and all your Dependents will end on such date as is contained in the “Notice of End of Coverage” sent to your Employer . It is your Employer’s responsibility to promptly send you a copy of the Notice of End of Coverage. (*The 30-day grace period begins the day the Notice of Start of Grace period is dated and lasts at least 30 consecutive days. If the affected premium(s) is(are) not paid by the last day of the Grace Period, coverage under the Agreement will be terminated prospectively, which in most cases occurs on the last day of the coverage period. Since the month of February consists of only 28/29 days, Employers who do not pay February’s premium(s) by the end of the 30-day grace period will have their coverage contacts(s) terminated on the last day of March).

PLAN (or California*Choice* Benefit Administrators on behalf of PLAN) will mail a separate Notice of End of Coverage to its affected individual Members that includes similar information provided in the Notice of End of Coverage that is sent to your employer. The Notice that is sent to your Employer would provide your Employer with the following information: (1) that the agreement for coverage has been cancelled for non-payment of premiums; (2) the specific date and time when the coverage ended; (3) how and when coverage may be reinstated; (4) the responsibility of the Employer to pay all Premiums due, including for coverage during the 30-day grace period provided; (5) the right of your Employer to submit a grievance to the PLAN and /or the California Department of Managed Health Care if your Employer believes coverage has been improperly cancelled and the right to reinstatement of the membership agreement if the Department rules in favor of the Employer in any such review; (6) the California*Choice* telephone number Members can call to obtain additional information, including whether your Employer obtained reinstatement of the Agreement; and (7) GROUP is responsible for notifying each affected individual Member of his or her right to purchase continuation coverage and that you would be sent a similar Notice of End of Coverage, which would include a State-approved notice regarding the possibility that you could secure coverage either through the “Covered California” State Exchange or in the State’s Medi-Cal Program and also providing you toll-free contact telephone numbers and an Internet website where you could obtain additional information about these opportunities.

7. Partial Payment Protocol

If your Employer has subscribed to more than one health Plan or Carrier for your healthcare coverage through the CaliforniaChoice Program and fails to make premium payments for every one of its coverage contracts, the application of such Partial Premium Payment as is submitted will be made to specific coverage contracts according to a priority articulated in the Group Service Agreement Supplement that is part of your Employer’s contract with each Plan. If the Partial Payment is adequate to cover all the Medical coverage contracts the Employer has, then they will be maintained in place and the remainder of the Partial Payment will be applied to any Specialty coverage contracts your Employer may have through the Program, in a priority that goes dental-vision-chiropractic/acupuncture-life until the Partial Payment funds run out. If your Employer’s Partial Payment is insufficient to cover certain of the Specialty contract premiums then those contracts will terminate at the end of the grace period. If there is not sufficient Partial Payment to cover the Medical premiums due, then that coverage will terminate at the end of the grace period and the Partial Payment will be applied to any Specialty coverage contracts the Employer has through the Program, in the above priority until the Partial Payment funds run out. In either scenario, the premium-paid Specialty coverage contracts will terminate at the end of the contract period.

By way of illustration only, if a Group has two separate dental coverage options, Partial Payment shall be applied to the dental contract with the highest membership count first, unless the Partial Payment amount is insufficient to cover that dental contract’s due premium. Whether it is sufficient to cover the first dental contract premium or not, Choice Administrators shall then apply the Partial Payment amount or the remainder of the Partial Payment amount to the dental contract premium with the next highest membership count. If at this point of application there remains a Partial Payment amount then that amount shall be applied to any remaining dental coverage contract premiums due, ranked by membership count. If after application to dental premiums due there remains a Partial Payment amount, then it shall be applied to the vision contract with the highest membership count, and any remaining Partial Payment amount shall then be applied to the premium due for the vision contract with the next highest membership. This progression of Partial Payment amount application shall continue down through the premiums due for additional vision coverage contracts, and then in similar fashion to premiums due for chiropractic/acupuncture coverage and then for life insurance coverage. If two contracts within the same line of coverage (e.g., dental) have the same membership count, Choice Administrators shall first apply available Partial Payment amounts to the coverage contract with the highest premium due.

Partial Payment Hierarchy:
1) All Medical contract(s) (all must be paid in full or all terminate)
2) Dental contract with highest membership count
3) Dental contract with next highest membership count (repeated through all dental contracts)
4) Vision contract with highest membership count
5) Vision contract with next highest membership count (repeated through all vision contracts)
6) Chiropractic/acupuncture contract with highest membership count
7) Chiropractic/acupuncture contract with next highest membership count (repeated through all chiropractic contracts)
8) Life contract with the highest membership count
9) Life contract with the next highest membership count (repeated through all life contracts)

Your Employer is required to inform you in the event it becomes involved in such a Partial Premium Payment situation so that you may plan for desired alternate coverage. If you have questions regarding this Partial Payment Protocol, you may contact your employer or the California*Choice* Program at 800-558-8003.

RENEWAL

If your Employer wishes to renew in PLAN through the California*Choice* Program upon the anniversary date of its contract with PLAN, your Employer must have a minimum of at least two (2) Eligible Employees (or such number as may come to be used in the Small Group Act to define a Small Group Employer) and seventy percent (70%) of those not covered elsewhere by a plan sponsored by your Employer must be enrolled in a health care service plan or insurance program participating in the California*Choice* Program. If your Employer does not meet such renewal requirements, it may renew at such later date as it meets such renewal qualification requirements.

THE REST IS THE SAME!

This Supplement merely describes the particular features of your coverage from PLAN because of PLAN's participation in the California*Choice* Program. You should refer to the Evidence of Coverage to which this is merely a Supplement for all other details regarding your membership in and receipt of health care services from PLAN.]

HEALTH PLAN BENEFITS AND COVERAGE MATRIX

THIS BENEFITS AND COVERAGE MATRIX (BCM) IS INTENDED TO HELP YOU COMPARE COVERAGE AND BENEFITS AND IS A SUMMARY ONLY. THIS BCM SHOWS THE AMOUNT YOU WILL PAY FOR COVERED SERVICES. FOR A DETAILED DESCRIPTION OF COVERAGE, BENEFITS AND LIMITATIONS, THE EVIDENCE OF COVERAGE AND DISCLOSURE FORM (EOC) SHOULD BE CONSULTED. PLEASE CONTACT SUTTER HEALTH PLUS (SHP) FOR ADDITIONAL INFORMATION.

(Important disclaimer regarding optional benefits: Cost Sharing and benefit information for optional benefits that may be elected by your employer group are not reflected on this Benefits and Coverage Matrix. Most optional benefits do not accrue to your Deductible, if applicable, and to your Out-of-Pocket Maximum. Please refer to the separate plan documents for elected optional benefits to determine Cost Sharing, Covered Services and any limitations or exclusions.)

BENEFIT PLAN NAME: Gold CC83 HMO

Annual Deductible for Certain Medical Services	
For self-only enrollment (Subscriber-only)	\$250
For any one Member in a Family	\$250
For an entire Family	\$500
Separate Annual Deductible for Prescription Drugs	
For self-only enrollment (Subscriber-only)	None
For any one Member in a Family	None
For an entire Family	None
Annual Out-of-Pocket Maximum (OOPM) (Combined Medical and Pharmacy)	
You will not pay any more Cost Sharing if the amount you paid for Copayments, Coinsurance and Deductibles for Covered Services in a calendar year totals one of the following amounts:	
For self-only enrollment (Subscriber-only)	\$7,800
For any one Member in a Family	\$7,800
For an entire Family	\$15,600
Lifetime Maximum	
Lifetime benefit maximum	None

Benefits	Member Cost Sharing
<p>Preventive Care Services</p> <p>If you receive a non-Preventive Care Service during a preventive care visit, then you may be responsible for the Cost Sharing of the additional non-Preventive Care Service. In addition, if abnormalities are found during a preventive care exam or screening, such as a mammogram for breast cancer screening or a colonoscopy for colorectal cancer screening, then follow-up testing or procedures may be considered non-Preventive Care Services and Cost Sharing may apply. Please refer to the EOC for more information on Preventive Care Services.</p>	
Family planning counseling and services, including preconception care visits (see Endnotes)	No charge
Routine preventive immunizations/vaccines	No charge
Routine preventive visits (e.g., well-child and well-woman visits), inclusive of routine preventive counseling, physical exams, procedures and screenings (e.g., screenings for diabetes and cervical cancer)	No charge
Routine preventive imaging and laboratory services	No charge
Preventive care drugs, supplies, equipment and supplements (refer to the SHP formulary for a complete list)	No charge
<p>Outpatient Services</p>	
Primary Care Physician (PCP) office visit to treat an injury or illness	\$35 copay per visit
Other practitioner office visit (see Endnotes)	\$35 copay per visit
Acupuncture services (see Endnotes)	\$35 copay per visit
Chiropractic services	Not covered
Sutter Walk-in Care visit, where available	\$35 copay per visit
Specialist office visit	\$55 copay per visit
<p>Allergy services provided as part of a Specialist visit (includes testing, injections and serum)</p> <p>There is no Cost Sharing for serum billed separately from the Specialist office visit or for allergy injections that are provided when the Specialist is not seen and no other services are received.</p>	\$55 copay per visit
Medically administered drugs dispensed to a Participating Provider for administration	No charge

Outpatient rehabilitation services	\$35 copay per visit
Outpatient habilitation services	\$35 copay per visit
Outpatient surgery facility fee	\$300 copay per visit after deductible
Outpatient surgery Professional fee	\$35 copay per visit
Outpatient non-office visit (see Endnotes)	20% coinsurance
Non-preventive laboratory services	\$35 copay per visit
Radiological and nuclear imaging (e.g., MRI, CT and PET scans)	\$250 copay per procedure after deductible
Diagnostic and therapeutic imaging and testing (e.g., X-ray, mammogram, ultrasound, EKG/ECG, cardiac stress test and cardiac monitoring)	\$55 copay per procedure
Hospitalization Services	
Inpatient facility fee (e.g., hospital room, medical supplies and inpatient drugs including anesthesia)	\$600 copay per day up to maximum of 5 days per admission after deductible
Inpatient Professional fees (e.g., surgeon and anesthesiologist)	No charge
Emergency and Urgent Care Services	
Emergency room facility fee	\$250 copay per visit after deductible
Emergency room Professional fee	No charge
This emergency room Cost Sharing does not apply if admitted directly to the hospital as an inpatient for Covered Services. If admitted directly to the hospital for an inpatient stay, the Cost Sharing for "Hospitalization Services" will apply.	
Urgent Care visit	\$35 copay per visit
Ambulance Services	
Medical transportation (including emergency and non-emergency)	\$250 copay per trip after deductible
Outpatient Prescription Drugs, Supplies, Equipment and Supplements	

Covered Outpatient Prescription Drugs obtained at a Participating Pharmacy through retail, mail order or Specialty Pharmacy services and in accordance with SHP's drug formulary guidelines:	
Tier 1 - Most Generic Drugs and low-cost preferred brand name drugs	<u>Retail-30</u> : \$15 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$30 copay per prescription for up to a 100-day supply
Tier 2 - Preferred brand name drugs, non-preferred Generic Drugs and drugs recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost	<u>Retail-30</u> : \$40 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$80 copay per prescription for up to a 100-day supply
Tier 3 - Non-preferred brand name drugs or drugs that are recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost <i>(These generally have a preferred and often less costly therapeutic alternative at a lower tier)</i>	<u>Retail-30</u> : \$70 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$140 copay per prescription for up to a 100-day supply
Tier 4 - Drugs that are biologics, drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$250 per prescription for up to a 30-day supply
Durable Medical Equipment, Prosthetics, Orthotics and Supplies	
Durable medical equipment for home use	20% coinsurance
Ostomy and urological supplies; prosthetic and orthotic devices	20% coinsurance
Mental Health & Substance Use Disorder (MH/SUD) Services	
MH/SUD inpatient facility fee (see Endnotes)	\$600 copay per day up to a maximum of 5 days per admission after deductible
MH/SUD inpatient Professional fees (see Endnotes)	No charge

MH/SUD individual outpatient office visit (e.g., evaluation and treatment services)	\$35 copay per visit
MH/SUD group outpatient office visit (e.g., evaluation and treatment services)	\$17.50 copay per visit
MH/SUD other outpatient services (see Endnotes)	\$35 copay per visit
Maternity Care	
Routine prenatal care visits, after confirmation of pregnancy, and the first postnatal care visit Maternity care provided at office visits or other outpatient locations may include diagnostic tests and services described elsewhere in this BCM that result in Cost Sharing (e.g., see “Diagnostic and therapeutic imaging and testing” for ultrasounds and “Non-preventive laboratory services” for lab tests).	No charge
Breastfeeding counseling, services and supplies (e.g., double electric or manual breast pump)	No charge
Labor and delivery inpatient facility fee (e.g., anesthesia and delivery services for all inpatient childbirth methods)	\$600 copay per day up to a maximum of 5 days per admission after deductible
Labor and delivery inpatient Professional fees (e.g., anesthesiologist, nurse midwife and obstetrician)	No charge
Abortion Services	
Abortion (e.g., medication or procedural abortions) Abortion-related services, including pre-abortion and follow-up services	No charge
Other Services for Special Health Needs	
Skilled Nursing Facility services (up to 100 days per benefit period)	\$300 copay per day up to a maximum of 5 days per admission after deductible
Home health care (up to 100 visits per calendar year)	\$30 copay per visit
Hospice care	No charge

Pediatric Dental and Vision Services (Provided through the end of the month in which the Member turns 19 years of age)	
Diagnostic and preventive Pediatric Dental Services (e.g., cleanings, exams, fluoride, sealants, space maintainers and X-rays)	No charge
Basic Pediatric Dental Services (e.g., periodontal maintenance services and restorative procedures)	See Pediatric Dental Addendum in EOC
Major Pediatric Dental Services (e.g., crowns and casts, endodontics, oral surgery, other periodontal services and prosthodontics)	See Pediatric Dental Addendum in EOC
Medically Necessary orthodontic Pediatric Dental Services	\$1,000
Pediatric Vision Services: eye exam	No charge
Pediatric Vision Services: eyewear (one pair of glasses or contact lenses in lieu of glasses)	No charge

Endnotes:

1. Family Deductibles (when applicable) and Out-of-Pocket Maximums (OOPM) are equal to two times the “self-only” values. In a Family plan, a Member is only responsible for the “one Member in a Family” Deductible and OOPM. Deductibles and other Cost Sharing payments made by each Member in a Family contribute to the “entire Family” Deductible and OOPM. Once the “entire Family” Deductible amount is satisfied by any combination of Member Deductible payments, plan Copayment or Coinsurance amounts apply until the “entire Family” OOPM is reached, after which the plan pays all costs for Covered Services for all Family Members.

2. Cost Sharing for all Essential Health Benefits, including that which accumulates toward an applicable Deductible, accumulates toward the OOPM.

3. Outpatient Prescription Drugs, when prescribed, are Medically Necessary generic or brand-name drugs in accordance with SHP’s formulary guidelines. All Medically Necessary prescription drug Cost Sharing contributes toward your Deductible, if applicable, and OOPM.

Outpatient Prescription Drugs are available for up to a 30-day supply through a retail Participating Pharmacy. Maintenance Drugs are available for up to a 100-day supply through the CVS Health Retail-90 Network or through the CVS Caremark Mail Service Pharmacy. Specialty Drugs are only available for up to a 30-day supply through CVS Specialty. Specialty Drugs are not exclusive to Tier 4 and, regardless of tier placement, have the same fill requirements.

FDA-approved, self-administered hormonal contraceptives that are dispensed at one time for a Member by a provider, pharmacist or other location licensed or authorized to dispense drugs or supplies, may be covered at up to a 12-month supply. For a 12-month supply of contraceptives, applicable Cost Sharing will be up to four times the retail Cost Share.

4. The “Other practitioner office visit” benefit includes therapy visits and other office visits not provided by either PCPs or Specialists or visits not specified in another benefit.
5. The “Family planning counseling and services” benefit does not include male sterilization procedures which are covered under the “Outpatient surgery” benefits listed above. This benefit also does not include the termination of pregnancy which is covered under the “Abortion Services” benefit category listed above.
6. Acupuncture is typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.
7. The “Outpatient non-office visit” benefit includes, but is not limited to, services such as outpatient chemotherapy, outpatient dialysis, outpatient radiation therapy, outpatient infusion therapy, sleep studies and similar outpatient services performed in a non-office setting. This benefit also includes storage of cryopreserved reproductive materials included in the fertility preservation services benefit. Storage of cryopreserved materials is not a per visit service and is typically billed on an annual basis at the “Outpatient non-office visit” Cost Sharing.
8. The “MH/SUD inpatient” benefits include, but are not limited to: inpatient psychiatric hospitalization, including inpatient psychiatric observation; inpatient Behavioral Health Treatment for autism spectrum disorder; treatment in a Residential Treatment Center; inpatient chemical dependency hospitalization, including medical detoxification and treatment for withdrawal symptoms; and prescription drugs prescribed in an inpatient setting, excluding a Residential Treatment Center. Refer to the Outpatient Prescription Drug benefit for coverage details for prescription drugs prescribed in a Residential Treatment Center.
9. “MH/SUD other outpatient services” include, but are not limited to: psychological testing; multidisciplinary intensive day treatment programs such as partial hospitalization and intensive outpatient programs; outpatient psychiatric observation for an acute psychiatric crisis; outpatient Behavioral Health Treatment for autism spectrum disorder delivered in any outpatient setting, including the home; and other outpatient intermediate services that fall between inpatient care and outpatient office visits.
10. Cost Sharing for services with Copayments is the lesser of the Copayment amount or allowed amount.
11. In order to be covered, most non-preventive care medical services require a referral from your PCP. Many of these services also require Prior Authorization by your PCP’s medical group or SHP. Please consult the EOC for complete details on referral and Prior Authorization requirements for all Covered Services.
12. For this Benefit Year, this benefit plan provides eligible Medicare beneficiaries with prescription drug coverage that is expected to pay on average as much as the standard Medicare Part D coverage in accordance with Centers for Medicare and Medicaid Services. The coverage is at least as good as the Medicare drug benefit and therefore considered “creditable coverage”. Refer to [Medicare.gov](https://www.medicare.gov) for complete details.