# Small Group Evidence of Coverage and Disclosure Form

# Plan Name:

*Effective [Group Effective Date]*

Sutter Health Plan Customer Service
8 a.m. to 7 p.m.
Monday through Friday
855-315-5800 (TTY 855-830-3500)
**sutterhealthplan.org**

# TABLE OF CONTENTS

# NONDISCRIMINATION POLICY

Sutter Health Plan complies with applicable Federal and California civil rights laws and does not exclude people, treat them differently or otherwise discriminate against them for reasons including but not limited to race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, pregnancy, age or disability.

Sutter Health Plan:

- 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 Plan Customer Service at 855-315-5800.

If you believe that Sutter Health Plan has failed to provide these services or discriminated in another way for reasons including but not limited to race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, pregnancy, age or disability, you can file a grievance with Sutter Health Plan by telephone, mail or fax, or online at:

| | | |
|---|---|---|
| Sutter Health Plan | Telephone: | 855-315-5800 |
| Attn: Appeals & Grievances | TTY: | 855-830-3500 |
| P.O. Box 160305 | Fax: | 916-736-5422 |
| Sacramento, CA 95816 | Toll-Free Fax: | 855-759-8755 |
| | Online: | **sutterhealthplan.org**<br>**shplan.org/memberportal** |

If you need help filing a grievance, call Sutter Health Plan Customer Service at **855-315-5800**.

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

If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent

medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, if there is a concern of discrimination based on race, color, national origin, age, disability or sex. You can file 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<br>200 Independence Avenue, SW<br>Room 509F, HHH Building<br>Washington, D.C. 20201 | Telephone: 800-368-1019<br>TDD: 800-537-7697 |

Complaint forms are available at:
**https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html**

# INTRODUCTION

Welcome to Sutter Health Plan! 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 healthcare 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 Plan 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 healthcare 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 healthcare services, associated costs, any limitations and exclusions, how to file a complaint or grievance, and other important features about your plan.

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

### 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 Sutter Health Plan Customer Service. You may also find valuable information about your coverage and the SHP Provider Network at **sutterhealthplan.org**. Please see the Health Plan Benefits 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 **sutterhealthplan.org** and follow the instructions or you can call Sutter Health Plan Customer Service. Sutter Health Plan 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 Plan 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 healthcare 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 Sutter Health Plan Customer Service toll-free at 855-315-5800 or TTY users call 855-830-3500, 8 a.m. to 7 p.m., Monday through Friday, or you may access our website at **sutterhealthplan.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 Sutter Health Plan Customer Service 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.

Sutter Health Plan

# Notice of Language Assistance

IMPORTANT: Can you read this? If not, Sutter Health Plan 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 Plan Customer Service at 855-315-5800 (TTY 855-830-3500). (English)

IMPORTANTE: ¿Puede leer esto? Si no puede, Sutter Health Plan puede proporcionarle a alguien que lo ayude a leerlo. También puede obtener este documento en su idioma. Llame al Servicio de Atención al Cliente de Sutter Health Plan al 855-315-5800 (TTY 855-830-3500). (Spanish)

重要事項：您能閱讀這些內容嗎？如果不能閱讀，Sutter Health Plan 可以安排人員幫助您閱讀。您還可能可以獲得以您的語言編寫的這些內容。如需免費幫助，請致電 Sutter Health Plan 客戶服務部，電話號碼：855-315-5800 (TTY 855-830-3500)。(Chinese)

ملاحظة مُهِمَّة: هل بمقدورك قراءة هذا؟ إذا لم تكُن قادرًا على ذلك، يُمكن لخطّة Sutter Health Plan أن تأتي بشخص يُساعدك على قراءته. كذلك قد يكون من المُمكن تزويدك بنُسخة منه مكتوبة بلُغتك. للحصول على مُساعدة مجّانية، يُرجى الاتصال بخدمة العُملاء التابعة لخطّة Sutter Health Plan على هاتف 855-315-5800 (أو بخط الكتابة عن بُعد [TTY] 855-830-3500). (Arabic)

ԿԱՐԵՎՈՐ Է. Կարո՞ղ եք սա կարդալ: Եթե ոչ, Sutter Health Plan-ը կարող է տրամադրել մեկին, ով կօգնի Ձեզ կարդալ այն: Դուք կկարողանաք նաև ստանալ այն գրված Ձեր լեզվով: Անվճար օգնության համար զանգահարեք Sutter Health Plan-ի Հաճախորդների սպասարկման բաժին՝ 855-315-5800 (TTY 855-830-3500) հեռախոսահամարով: (Armenian)

សំខាន់៖ តើអ្នកអាចអានដាច់ទេ? បើអានមិនដាច់ទេ Sutter Health Plan អាចឱ្យគេជួយអ្នកអានបាន។ អ្នកក៏ប្រហែលជាអាចទទួលបានឯកសារនេះសរសេរជាភាសារបស់អ្នកផងដែរ។
សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទៅកាន់ផ្នែកសេវាអតិថិជន Sutter Health Plan តាមលេខ 855-315-5800 (TTY 855-830-3500)។ (Cambodian)

**نکته مهم:** آیا می‌توانید این مطلب را بخوانید؟ اگر نمی‌توانید، Sutter Health Plan می‌تواند از فردی کمک بگیرد تا آن را برایتان بخواند. همچنین امکان دریافت این مطالب به زبان شما وجود دارد. برای دریافت کمک به صورت رایگان، لطفاً با خدمات مشتریان Sutter Health Plan از طریق شماره تلفن 855-315-5800 (TTY 855-830-3500) تماس بگیرید. (Farsi)

महत्वपूर्ण: क्या आप इसे पढ़ सकते/ती हैं? यदि नहीं, तो सट्टर हेल्थ प्लान (Sutter Health Plan) इसे पढ़ने में किसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा में भी लिखवा सकते/ती हैं। निःशुल्क सहायता के लिए, कृपया Sutter Health Plan ग्राहक सेवा को 855-315-5800 (TTY 855-830-3500) पर कॉल करें। (Hindi)

TSEEM CEEB: Koj puas tuaj yeem nyeem qhov no tau? Yog tias tsis tau, Sutter Health Plan tuaj yeem kom ib tus neeg pab koj nyeem nws. Tsis tas li ntawd, tej zaum koj kuj tseem tuaj yeem tau txais qhov no sau ua koj hom lus thiab. Yog xav tau kev pab dawb, thov hu rau Sutter Health Plan Lub Chaw Pab Cuam Qhua ntawm 855-315-5800 (TTY 855-830-3500). (Hmong)

重要：こちらの文書が読めますか? 読むのが難しいときは、サッター ヘルス プランが読むのをお手伝いするスタッフを手配します。また、これを日本語で書いてもらうこともできます。無料でのサポートをご利用いただくには、電話 855-315-5800（TTY 855-830-3500）、サッター ヘルス プラン カスタマー サービスにご連絡ください。(Japanese)

중요 사항: 이것을 읽으실 수 있습니까? 만약 읽으실 수 없는 경우, Sutter Health Plan 은 귀하가 읽으실 수 있도록 다른 사람을 시켜 도와 드릴 수 있습니다. 또한 이 내용을 자신이 사용하는 언어로 작성하도록 하실 수도 있습니다. 비용 부담 없이 도움을 받으시려면 Sutter Health Plan 고객 서비스에 전화를 하십시오. 전화: 855-315-5800 (TTY 855-830-3500). (Korean)

ສຳຄັນ: ທ່ານສາມາດອ່ານຂໍ້ຄວາມນີ້ໄດ້ບໍ? ຖ້າບໍ່ໄດ້, Sutter Health Plan ສາມາດໃຫ້ຄົນຊ່ວຍທ່ານອ່ານຂໍ້ຄວາມນີ້. ນອກຈາກນີ້, ທ່ານຍັງອາດຈະສາມາດຂໍໃຫ້ຂຽນເປັນພາສາຂອງທ່ານໄດ້. ຫາກຕ້ອງການການຊ່ວຍເຫຼືອໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ, ກະລຸນາໂທຫາຝ່າຍບໍລິການລູກຄ້າຂອງ Sutter Health Plan ທີ່ເບີ 855-315-5800 (TTY 855-830-3500). (Laotian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਸੱਟਰ ਹੈਲਥ ਪਲਾਨ (Sutter Health Plan) ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਬਿਨਾਂ ਲਾਗਤ ਦੇ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਸੱਟਰ ਹੈਲਥ ਪਲਾਨ ਦੀ ਗਾਹਕ ਸੇਵਾ ਨੂੰ 855-315-5800 (TTY 855-830-3500) 'ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ВАЖНО. Вы можете это прочитать? Если нет, Sutter Health Plan может предоставить вам того, кто сможет помочь вам прочитать это. Вы также можете получить этот документ в письменной форме на своём языке. Для бесплатной помощи позвоните в отдел обслуживания клиентов Sutter Health Plan по телефону 855-315-5800 (TTY 855-830-3500). (Russian)

MAHALAGA: Nababasa mo ba ito? Kung hindi, maaari kang bigyan ng Sutter Health Plan ng taong makakatulong sa iyo na basahin ito. Maaari mo ring hilingin na ipasulat ito sa iyong wika. Para sa walang bayad na tulong, mangyaring tumawag sa Sutter Health Plan Customer Service sa 855-315-5800 (TTY 855-830-3500). (Tagalog)

หมายเหตุ: คุณอ่านข้อความนี้ออกหรือไม่ ถ้าหากคุณอ่านไม่ออก Sutter Health Plan สามารถให้คนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถขอรับเนื้อหานี้เป็นภาษาของคุณได้อีกด้วย หากคุณต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย กรุณาติดต่อ Sutter Health Plan Customer Service ได้ที่ 855-315-5800 (TTY 855-830-3500) (Thai)

QUAN TRỌNG: Quý vị có thể đọc thông tin này không? Nếu không, Sutter Health Plan có thể yêu cầu ai đó đọc giúp cho quý vị. Quý vị cũng có thể nhận được thông tin này dưới dạng văn bản bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi cho ban Dịch Vụ Khách Hàng của Sutter Health Plan theo số 855-315-5800 (TTY 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 healthcare issue, have questions about your benefits, need a new Primary Care Physician (PCP) or need to replace your membership cards. For important updates please visit **sutterhealthplan.org**. You can also find information on our Member Portal at **shplan.org/memberportal** (registration required).

**Sutter Health Plan Customer Service:** 855-315-5800
(TTY 855-830-3500), Monday through Friday,
8 a.m. to 7 p.m.

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

**Mailing Address:** P.O. Box 160307 Sacramento, CA 95816

**Other SHP Contacts:**

- Appeals and Grievances: **855-315-5800**
- Fraud and Abuse: 855-315-5800
- Health and Wellness: 855-315-5800
- Language Assistance: 855-315-5800
- Customer Service: 855-315-5800
- Website: **sutterhealthplan.org**

## Contact Information for SHP Health Plan Partners

**Mental Health and Substance Use Disorder (MH/SUD) Benefits: Carelon Behavioral Health of California, Inc. (Carelon)**

- Carelon Member Services: 844-398-0314 (TTY 711)
- Website: **carelonbh.com/sutterhealthplan**

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

- Delta Dental Member Services: 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: 844-740-0635
- Mail Order Pharmacy (CVS Caremark® Mail Service Pharmacy): 844-740-0635
- Specialty Pharmacy (CVS Specialty®):
  800-237-2767
- Website: **caremark.com**
- Prior Authorization for non-Specialty Drugs:

  Verbal Requests: 800-294-5979

  Fax Line: 888-836-0730
- Prior Authorization for Specialty Drugs:

Verbal Requests: 866-814-5506

Fax Line: 866-249-6155

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

- VSP Member Services: 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

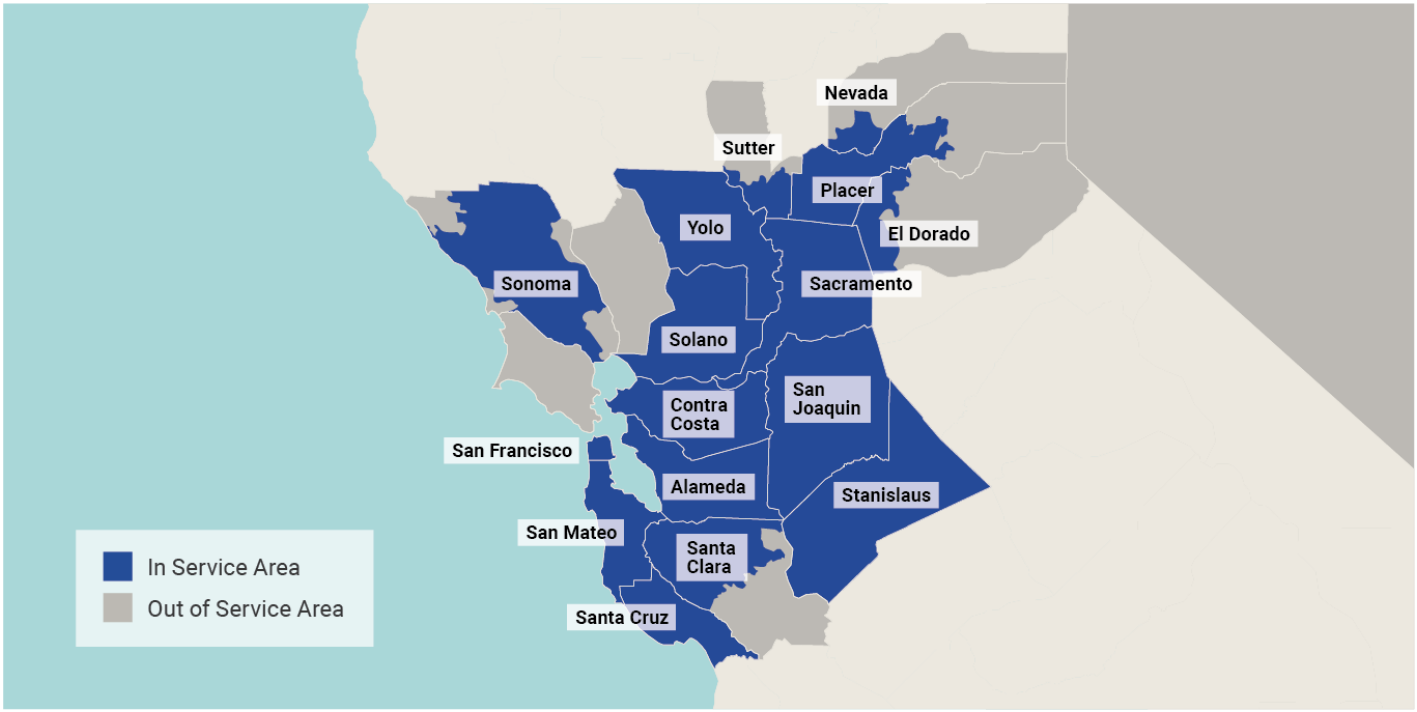
**Acupuncture-Chiropractic Benefits: ACN Group of California, Inc. dba OptumHealth Physical Health (ACN)**

- Member Services: 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**

# SHP SERVICE AREA MAP

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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 | | | | | | | | | | | | | | |

# 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 Plan's (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 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 Sutter Health Plan Customer Service or the SHP Member portal at **shplan.org/memberportal** or print a temporary membership card from the SHP Member website at **sutterhealthplan.org**.

## The SHP Service Area

SHP provides healthcare 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 be eligible for coverage with SHP. 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 Out-of-Area 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 **shplan.org/memberportal** or by calling Sutter Health Plan Customer Service . 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 healthcare 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 And 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 **sutterhealthplan.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, you required Emergency Services, you required Out-of-Area Urgent Care, or you received Covered Services from a noncontracting ground or air ambulance provider. COVID-19 diagnostic and screening testing; therapeutics; and preventive services do not require Prior Authorization when provided by a non-Participating Provider. If you are a new Member or your provider's contract ends, in some cases you may continue to see your current healthcare provider. This process is detailed in the Continuity of Care section.

Geographic and timely access standards are in the Timely Access to Care section of the How To Use The Plan chapter of this EOC. If MH/SUD services are not available to you in accordance with geographic and timely access standards, SHP or Carelon will offer and schedule Medically Necessary MH/SUD services from an out-of-network provider or providers. If SHP or Carelon do not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from an appropriate licensed provider, even if the provider is not in SHP or Carelon's network. To be covered by SHP or Carelon, your first appointment with the provider must be within 90 calendar days of the date you, your representative or your provider first asked SHP or Carelon for the MH/SUD services. If an appointment or admission to a provider is not available within 90 calendar days of initially submitting a request, you may arrange an appointment or admission for the earliest possible date outside the 90-day window so long as the appointment or

admission was confirmed within 90 days. If you see an out-of-network provider, you do not have to pay anything other than your ordinary in-network Cost Sharing.

If out-of-network coverage is arranged as described above, SHP or Carelon will reimburse the provider for the entire course of Medically Necessary services to treat your MH/SUD, unless there is an in-network, timely and geographically accessible provider available to deliver MH/SUD services, transfer to the new provider would not harm you, and transfer is within the standard of care for your MH/SUD condition.

Before SHP or Carelon may transition you to an in-network provider, SHP or Carelon will provide you, your representative, if any, and the provider(s) treating you with at least 90 calendar days' notice. The notice shall inform you of the name and contact information of the in-network provider to which SHP or Carelon intends to transition you and information about how you may file a complaint with SHP or Carelon if you, your representative, or your provider believes transitioning you to an in-network provider will harm you or is not within the standard of care.

## 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 healthcare 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:

- Carelon Behavioral Health of California, Inc., or Carelon, administers and coordinates benefits for mental health disorder services, including Behavioral Health Treatment for autism spectrum disorder, and substance use disorder services. Carelon maintains a network of Participating Practitioners, which includes facilities and behavioral health professionals, to provide you with these services. SHP and Carelon are committed to assuring that the services provided by the Carelon 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. Carelon, 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 Healthcare When You Need It

Call your PCP for Medical Services or Carelon 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 Carelon Participating Practitioner and Prior Authorization from your Medical Group, SHP or Carelon for many Covered Services. See the Authorization, Modification and Denial of Healthcare 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 Carelon 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 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 are in-area and need Urgent Care, please contact your PCP, contact the SHP Nurse Advice Line or visit your Medical Group's contracted Urgent Care facility. If you need Out-of-Area Urgent Care, 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 nonurgent 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<br>PCP provides appropriate after-hours emergency instructions |
| Access to non-Urgent Care appointments with a Specialist, including a Specialist for MH/SUD services | 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 nonurgent 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 nonurgent follow-up 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 |
| Nonurgent appointments for ancillary services for the diagnosis or treatment of an injury, illness or other heath condition | Appointment is offered within 15 business days from time of request |

If Covered Services are not available with an in-network physician within the geographic and timely access standards set by law or regulation, Members may be provided with a one-time letter of agreement with Practitioners as needed to provide members with Medically Necessary care within required standards. Members may also be referred to providers outside of their assigned Medical Group for delivery of Medically Necessary care and any Medically Necessary follow-up services. If SHP arranges coverage for an out-of-network provider, then the Member will pay the same Cost Sharing for Covered Services as they would pay if the same Covered Services were received from a Participating Practitioner.

Interpreter services shall be coordinated with scheduled appointments for healthcare services to ensure the provision of interpreter services at the time of the appointment without delay to the scheduled appointment.

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 855-836-3500 or Sutter Health Plan Customer Service.

Carelon maintains a toll-free and confidential Intake Services Line available 24 hours a day, seven days a week. You may call Carelon's toll-free number 844-398-0314 to answer 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.

## Mental Health/Substance Use Disorder Care

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

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

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

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

# 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 Sutter Health Plan Customer Service.

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 an SHP Participating Provider, by a non-Participating Provider when services have been Prior Authorized, provided as Emergency Services, or Out-of-Area Urgent Care.

Additionally, you are not responsible for any amounts beyond your Cost Sharing when the services are provided by a non-Participating provider and the services are required or recommended in a Community Assistance, Recovery, and Empowerment (CARE) agreement or CARE plan approved by a court or for Behavioral Health Crisis Services provided to an enrollee by a 988 center, mobile crisis team, or other provider of Behavioral Health Crisis Services.

If out-of-network MH/SUD coverage is arranged as described in "The SHP Network" or "Timely Access to Care" sections, SHP or Carelon will reimburse the provider for the entire course of medically necessary services to treat your MH/SUD. If you see an out-of-network provider because an in-network provider is not available within geographic and timely access standards you do not have to pay anything other than your ordinary in-network Cost Sharing.

## 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

If you have a Family High Deductible Health Plan (HDHP), linked to a Health Savings Account (HSA), the IRS sets minimum Deductible amounts. In a Family HDHP, each individual Family Member is responsible for the greater of the IRS minimum amount or the individual Deductible amount. For 2026, the IRS requires Family Deductibles of at least $3,400 to qualify as an HSA. So each individual Family Member is responsible for the greater of:

- The individual Deductible amount (indicated on the BCM as “self-only enrollment”); or
- $3,400

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 $3,400 self-only Deductible and a $4,000 Family maximum Deductible. When you have paid $3,400 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 $600 (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 Sutter Health Plan Customer Service. 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 Sutter Health Plan Customer Service 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 Carelon Member Services or Sutter Health Plan Customer Service.

**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 Sutter Health Plan Customer Service. 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 Sutter Health Plan Customer Service.

## Premiums

A Premium is the dollar amount due to SHP each month for healthcare 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 and 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.

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, please refer to your optional benefit documents for more information. 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 Sutter Health Plan Customer Service .

## 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 Out-of-Area Urgent Care, please ask the provider to bill SHP (or Carelon 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 healthcare service plan. COB ensures that duplicate payments are not made for the same Covered Services. All insurers and healthcare 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, and each Participating Provider, 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 to all of the following:

- 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.
- 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 Plan 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 noncapitated 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 healthcare providers. Your Primary Care Physician (PCP) will partner with you on your healthcare 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 healthcare.

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 one of the following circumstances apply: you require Emergency Services or Out-of-Area Urgent Care, you receive Covered Services from a noncontracting ground or air ambulance provider, you receive Prior Authorization from your Medical Group or SHP to visit an out-of-network provider, or you receive Prior Authorization from your Medical Group to visit an SHP provider that is outside of your PCP's Medical Group. Additionally, Prior Authorization is not required for services that are required or recommended in a CARE agreement or CARE plan approved by a court or for Behavioral Health Crisis Services provided by a 988 center, mobile crisis team or other provider of Behavioral Health Crisis Services.

Additionally, you also have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If SHP or Carelon fails to arrange those services for you with a provider who is in network, SHP or Carelon will cover and arrange needed services for you from an out-of-network provider. If SHP or Carelon do not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from an appropriately licensed provider as described in The SHP Network section in the How To Use The Plan chapter.

You can request a current copy of the Provider Directory by contacting Sutter Health Plan Customer Service at 855-315-5800 (TTY 855-850-3500), or you may view SHP's online Provider Directory at **sutterhealthplan.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 an 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. Despite the foregoing, the following are situations where you will not be billed by a provider for more than your in-network cost share:

- You receive Behavioral Health Crisis Services from a 988 center, mobile crisis team or other provider of Behavioral Health Crisis Services. A 988 center, mobile crisis team, or other provider of Behavioral Health Crisis Services shall not bill or collect an amount from you for services except for your in-network Cost Sharing amount. If you are billed differently than stated in this section, you may report receipt of the bill to SHP and the Department of Managed Health Care.
- You receive Covered Services from a noncontracting ground or air ambulance provider. In this situation, you will not pay any more than the Cost Sharing amount you would pay for the same Covered Service received from a contracting ground or air ambulance provider. Unless otherwise agreed to by the noncontracting ground ambulance provider and SHP, SHP will directly reimburse a contracting ground ambulance provider for ground ambulance services the difference between the in-network Cost Sharing amount and an amount described, as follows:
    - The rate established and approved by a local government or if there is no established or approved rate, the amount established by Section 1300.71 (a)(3)(B) of Title 28 of the California Code of Regulations

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 Sutter Health Plan Customer Service.

**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 Plan Customer Service at 855-315-5800 (TTY 855-830-3500) to ensure that you can obtain the healthcare 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/an:

- **Doctor of internal medicine**
- **Family practice doctor**
- **General practitioner**
- **Pediatrician**
- **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 healthcare. 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 Sutter Health Plan Customer Service or visit **shplan.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 3 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 Sutter Health Plan Customer Service to make the request, or use the Continuity of Care Request Form available on the Member portal at **shplan.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 in-network Urgent Care facility. SHP encourages you to call your PCP, SHP's nurse advice line or Customer Service 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. If you are out-of-area and need Urgent Care, visit the nearest Urgent Care facility.
- 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 Sutter Health Plan Customer Service 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 Carelon 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). You also have a right to receive timely and geographically accessible MH/SUD services when you need them. If Carelon or SHP fails to arrange those services for you with an appropriate provider who is in Carelon or SHP's network, Carelon or SHP must cover and arrange needed services for you from an out-of-network provider. If SHP or Carelon do not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from an appropriately licensed provider as described in The SHP Network section in the How To Use The Plan chapter.
- Reproductive or sexual healthcare services for the following:
  - The prevention or treatment of pregnancy, including birth control, emergency contraceptive services, pregnancy tests, prenatal care, and outpatient abortion and abortion-related services, including pre-abortion and follow-up 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
- Behavioral Health Crisis Services provided by a 988 center or mobile crisis team, or other providers of Behavioral Health Crisis Services, regardless of whether the service is provided by a Participating Provider or out-of-network provider
- Covered Services from a contracting or non-contracting ground or air ambulance provider for an Emergency Medical Condition

- Services required or recommended by a CARE agreement or a CARE plan.

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 **sutterhealthplan.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 a Food and Drug Administration (FDA) approved therapy for advanced or metastatic stage 3 or 4 cancer
- Durable medical equipment
- Elective (nonemergency) inpatient admissions
- Standard Fertility Preservation 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
- Non-emergent observation services
- 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 or a subspecialist
- Second opinion consultations for care from a Specialist or other licensed health provider outside the Member's selected Medical Group

Contact Sutter Health Plan Customer Service 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 nonroutine outpatient services, including, but not limited to:

- Behavioral Health Treatment for autism spectrum disorder
- Intensive outpatient program day treatment
- Partial hospitalization program day treatment
- Non-emergent observation services
- Transcranial magnetic stimulation

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

Prior Authorization is not required for the following:

- Behavioral Health Crisis Services provided by a 988 center, mobile crisis team or other provider of Behavioral Health Crisis Services
- Services required or recommended by a CARE agreement or a CARE plan

SHP, your Medical Group or Carelon 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 Healthcare Services

When a Member or a Participating Provider/Practitioner requests healthcare services, SHP, your Medical Group, CVS Caremark and Carelon 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 healthcare 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, Carelon 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 healthcare 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 healthcare provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the 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 the following information upon request, and at no cost, to you, your representatives and Participating Providers:

- All UM criteria used to deny, delay, or modify requested services in your specific case.
- Education program materials used to educate SHP or Carelon staff and contracted or affiliated third parties that conduct UM review for MH/SUD services

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 healthcare services, or the criteria or guidelines related to a particular condition, you may contact Sutter Health Plan Customer Service.

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 **sutterhealthplan.org/members**.

If you would like a copy of Carelon's description of the processes utilized for the authorization or denial of MH/SUD services, then you may contact Carelon Member Services or visit the Carelon website at **carelonbh.com/sutterhealthplan** . 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 **https://www.carelonbehavioralhealthca.com/providers/medical-necessity-criteria/**. Upon request, Carelon 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, Carelon will coordinate with the school district or regional center to provide case management of your treatment program. Upon Carelon'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 Carelon 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 (nonurgent) 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 nonurgent 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 Carelon will notify requesting Participating Providers of decisions to deny or modify Prior Authorization of requested healthcare 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 Carelon 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 Carelon, 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 nonurgent (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 nonurgent 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 855-315-5800 (TTY 855-830-3500)
- Send your written request to:

  Sutter Health Plan
  Attn: Utilization Management – Expedited Review
  P.O. Box 160305
  Sacramento, CA 95816
- Fax your written request to 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 Carelon Participating Practitioner may submit a request for a second opinion to Carelon either in writing or verbally through Carelon 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 Carelon 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, Carelon 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 Carelon, 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, Carelon 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 Carelon Second Opinion policy or to request a second opinion from Carelon, you may contact Carelon Member Services:

- By telephone:
  844-398-0314
- In writing:
  Carelon Behavioral Health of California, Inc.
  P.O. Box 1852
  Hicksville, NY 11802

# 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 Plan (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.

If you experience a Psychiatric Emergency Medical Condition, dial 9-8-8, the U.S. national suicide prevention and mental health crisis hotline, for immediate assistance. Prior Authorization is not required for Behavioral Health Crisis Services provided by a 988 center or mobile crisis team, or other providers of Behavioral Health Crisis Services, regardless of whether the service is provided by a Participating Provider or out-of-network provider. The cost for these services from an out-of-network provider will be no more than if the services were received from an in-network provider.

## 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 Carelon 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 healthcare 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 Carelon's contracted network, the hospital will contact your assigned Medical Group, SHP or Carelon, 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 Carelon.

**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 Carelon 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 855-315-5800 (TTY 855-830-3500); or Carelon at 844-398-0314, 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 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.

A noncontracting hospital will not bill you for Post-Stabilization Care for an Emergency Medical Condition unless one of the following conditions are met:

- You, your spouse or legal guardian refuses to consent to your transfer to the contracting hospital as requested and arranged for by SHP, or
- The noncontracting hospital is unable to obtain the name and contact information for SHP

SHP will not cover unauthorized Post-Stabilization Care or related transportation provided by non-Participating Providers, except as stated above or as described in the “Authorization for Post-Stabilization Services for Behavioral Health Crisis Services” section below.

**Authorization for Post-Stabilization Services for Behavioral Health Crisis Services**

If SHP or Carelon is contacted by a 988 center, mobile crisis team, or other provider of Behavioral Health Crisis Services, SHP or Carelon will, within 30 minutes of the time the provider makes the initial contact, either:

- Authorize Post-Stabilization Care or
- Inform the provider it will arrange for the prompt transfer of your care to another provider

SHP or Carelon will reimburse the 988 center, mobile crisis team, or other provider of Behavioral Health Crisis Services for Post-Stabilization Care to you if any of the following occur:

- SHP or Carelon authorizes the 988 center, mobile crisis team, or other provider of behavioral health crisis services to provide Post-Stabilization Care
- SHP or Carelon does not respond to the 988 center, mobile crisis team, or other provider of Behavioral Health Crisis Services provider’s initial contact or make a decision regarding whether to authorize Post-Stabilization Care or to promptly transfer your care within 30 minutes of the time the provider makes the initial telephone call requesting information
- There is an unreasonable delay in the transfer of your care to another provider and the provider determines the enrollee requires Post-Stabilization Care

## 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)
- SHP covers emergency room medical care and follow-up healthcare treatment for a Member who is treated following a rape or sexual assault. Follow-up healthcare treatment includes medical or surgical services for the diagnosis, prevention, or treatment of medical conditions

arising from an instance of rape or sexual assault.

SHP covers follow-up health care treatment by non-Participating Providers and SHP will arrange for the provision of follow-up health care treatment required from providers outside SHP's network if those services are unavailable within the network to ensure timely access to covered health care services consistent with Section 1367.03.

Coverage is not dependent upon the enrollee filing a police report, pressing charges against the assailant, or securing a conviction. For non-HDHPs, members will not pay a Deductible or any other Cost-Sharing for these services for the first nine months after treatment is initiated. For HDHPs, after a Member meets their Deductible, they will not pay any other Cost-Sharing for these services for the first nine months after treatment is initiated.

If you feel that you were improperly billed for services that you received from a non-Participating Provider/Practitioner, contact SHP at 855-315-5800 for Medical Services, or contact Carelon at 844-398-0314 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 Sutter Health Plan Customer Service 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

Carelon 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 Carelon 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 Carelon Participating Practitioner, if you have one. If you are calling during nonbusiness hours, and your Carelon Participating Practitioner is not immediately available, or you do not yet have a Carelon Participating Practitioner, call Carelon Member Services for assistance in finding a Participating Practitioner near your area. If your Carelon Participating Practitioner or Carelon 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 Carelon.

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

Failure to transfer or to obtain approval from Carelon 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 Plan (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/**
- 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 **https://www.cdc.gov/vaccines/?CDC_AAref_Val=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**

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 6 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:
  - Voluntary tubal ligation and other similar sterilization procedures
  - Patient education and counseling
  - Follow up services related to covered drugs, devices, products and procedures including, but not limited to, management of side effects, counseling for continued adherence and device insertion and removal
  - All contraceptive drugs, devices and other products that are FDA-approved, including all FDA-approved contraceptive drugs, devices and products available as OTC, 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. Approved contraceptive methods include, but are not limited to, barrier methods, hormonal methods and implanted devices
  - If there is no therapeutic equivalent generic substitute available in the market, coverage will be provided without Cost Sharing for the original, brand name contraceptive
  - Over-the-counter (OTC) FDA-approved contraceptive drugs, devices and products are covered without a prescription
  - 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
  - Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling
- 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
  - Maternal mental health screenings, including at least one maternal mental health screening during pregnancy, at least one additional screening during the first six weeks of the postpartum period, and additional postpartum screenings if determined to be Medically Necessary and clinically appropriate in the judgment of the treating provider
  - Alpha-fetoprotein testing
  - Lactation support services including breastfeeding equipment and supplies (e.g. double electric breast pumps), consultations, counseling, and education
  - Medically Necessary pasteurized donor human milk obtained from a licensed tissue bank
  - 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
  - Doula care services
- 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 ages 40 to 74
  - 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, including at-home 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.

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

Emergency ambulance services include services provided by one of the following programs developed by a local Emergency Medical Services (EMS) agency and approved by the Emergency Medical Services Authority:

- Community paramedicine program
- Mobile integrated health program
- Triage to alternate destination program

If you receive Covered Services from a noncontracting ground or air ambulance provider, including a noncontracting community paramedicine program, triaged to alternate destination program, or mobile integrated health program, you will pay no more than the Cost Sharing amount you would pay for the same Covered Services received from a contracting ground or air ambulance provider, including a contracting community paramedicine program, triaged to alternate destination program, or mobile integrated health program. Additionally, a noncontracting ground or air ambulance provider cannot send you to collections for anything more than the in-network Cost Sharing amount if you fail to pay.

### Nonemergency

SHP covers nonemergency 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.

If you receive nonemergency services from a noncontracting ground or air ambulance provider, you will pay no more than the same Cost Sharing amount you would pay for the same Covered Services received from a contracting ground or air ambulance provider.

**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 presurgical 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 presurgical 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. Chiropractic services 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 associated facility charges for dental procedures rendered in a hospital or surgery center setting.

  These services are covered when the clinical status or underlying medical condition of the patient requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting. These services are covered only if the above conditions are met and one of the following is true:

  - The Member is under age seven
  - The Member is developmentally disabled
  - The Member's health is compromised, and general anesthesia is Medically Necessary
- 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 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 nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel
- Routine (nonemergency) 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.

## Standard Fertility Preservation Services

SHP covers Medically Necessary 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. Standard Fertility Preservation Services are covered if either of the following is true:

- Your provider has recommended that you receive a covered medical treatment within the next 12 months that may cause infertility and you attest that you plan to undergo such treatment in the next 12 months. SHP will accept an attestation from you or your provider contained in a request for services.
- You received a covered medical treatment that may cause infertility; your condition was such that you were unable to either undergo fertility preservation or complete your fertility preservation cycle(s); and you face an ongoing risk for infertility due to reproductive damage caused by those treatments

For purposes of this benefit, Standard Fertility Preservation Services means any services consistent with the current established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine including, but not limited to:

- Consultations, exams and fertility preservation counseling with reproductive specialists
- Retrieval of gametes as follows:
  - A lifetime limit of up to two cycles for oocyte retrieval for members with ovaries
  - A lifetime limit of up to two attempts to collect sperm for members with testicles
- A lifetime limit of up to two attempts of embryo creation.
- A lifetime limit of up to two attempts to retrieve gonadal tissue
- Cryopreservation and storage of sperm, oocytes, gonadal tissue, and embryos as follows:
  - Until the member reaches age 26 for a member who is under the age 18 on the date the member's genetic material is first cryopreserved.
  - Until the member reaches age 26 or for three years, whichever period is longer, for a member who is 18 years or older but not yet 26 years old on the date the member's genetic material is first cryopreserved.
  - For a period of three years for a member who is 26 years or older at the time the member's genetic material is first cryopreserved.
- Gonadal shielding or transposition during a procedure or treatment

SHP will not deny a coverage request for Medically Necessary Standard Fertility Preservation Services based solely upon the following: a prior diagnosis of infertility, where medical evaluation indicates that you would have a reasonable chance of responding to such services; your age, where medical evaluation indicates that you would have a reasonable chance of responding to such services; your gender; your gender identity; your sexual orientation; your gender expression; your marital status; or your disability.

### Standard Fertility Preservation Limitations and Exclusions

Iatrogenic infertility does not include infertility caused by a medical treatment performed for the purpose of preventing pregnancy, including vasectomy or tubal ligation.

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, and thawing of any

cryopreserved genetic material are not Standard Fertility Preservation Services. If you have a Plus Plan, please refer to the Infertility and Fertility Services section in this Your Benefits chapter for details on Covered 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 any costs associated with the retrieval of gametes from anyone other than the member undergoing the medical treatment that may cause iatrogenic infertility.

SHP has the right to select a storage vendor of its choosing for cryopreservation and storage of genetic material. If you change health care service plans during the covered storage period and the new health care service plan deems it necessary to transport the genetic material to a different storage facility, your new health care service plan shall be responsible for transportation costs of genetic material to a storage facility selected by the new health care service plan and is required to cover storage for the remainder of the applicable storage timeframe to the extent required by law.

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

**If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days for primary care and 15 business days for specialist care from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).**

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

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

### Gender Dysphoria

SHP or Carelon covers all treatment for gender dysphoria identified in the most recent edition of the Standards of Care developed by the World Professional Association for Transgender Health.

### Doula Care Services

SHP contracts with Mahmee to administer in-person and virtual doula support. Doulas are non-clinical birth professionals who provide physical, emotional, and psychosocial support and advocacy throughout pregnancy, labor, and postpartum.

You may obtain more information or enroll in the 12-month doula support program by visiting the Mahmee website at www.mahmee.com, calling

Mahmee at 818-431-1118 or emailing Mahmee at **hello@mahmee.com**.

## 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 healthcare 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
- Services for PANDAS and PANS as described in the Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) section in the Your Benefits chapter

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

## Infertility and Fertility Services

If your employer Group has purchased a Plus Plan, SHP covers the Medically Necessary services, supplies and drugs for the diagnosis and treatment of infertility and fertility services, in accordance with the guidelines of the American Society for Reproductive Medicine. For covered infertility and fertility 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.

For purposes of this benefit, "infertility" means a condition or status characterized by any of the following:

- A licensed physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors.
- A person's inability to reproduce either as an individual or with their partner without medical intervention.
- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this benefit, regular, unprotected sexual intercourse means either of the following:
  - No more than 12 months of unprotected sexual intercourse for a person under 35 years of age
  - No more than 6 months of unprotected sexual intercourse for a person 35 years of age or older

- This definition does not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

Covered services include, but are not limited to:

- Consultations, exams, diagnostic tests, procedures, and drug therapy to diagnose and treat infertility
- A lifetime maximum of three completed oocyte retrievals
- Unlimited embryo transfers, using single embryo transfer when recommended and medically appropriate
- Cryopreservation and storage of sperm, oocytes, gonadal tissue, and embryos as follows:
  - Storage of cryopreserved genetic material for a period of three years.
  - SHP has the right to select a storage vendor of its choosing. If the Member changes health care service plans during the covered storage period and the new health care service plan deems it necessary to transport the genetic material to a different storage facility, the Member's new health care service plan shall be responsible for transportation costs of genetic material to a storage facility selected by the new health care service plan and is required to cover storage for the remainder of the applicable storage timeframe to the extent required by law.

**Infertility and Fertility Services Limitations and Exclusions**

Coverage for the treatment of infertility and fertility services is provided without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation.

SHP does not cover:

- Services for any individual who is not a covered Member, including any costs associated with the retrieval, cryopreservation, and storage of genetic material from anyone other than a covered Member.
- Services and supplies to reverse voluntary infertility including, but not limited to, reversals of vasectomy, tubal ligation or other surgically-induced infertility, or to treat infertility following reversal procedures.
- Experimental and investigational diagnostic studies, procedures and drugs used to determine the cause of infertility or to treat infertility.

## 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. Certain medically administered drugs may require Prior Authorization from CVS Caremark and must be obtained from a Participating Pharmacy.

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)
- Drugs for the Medically Necessary treatment of a mental health or substance use disorder, including but not limited to injectable antipsychotic drugs

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 covers Medically Necessary treatment of mental health and substance use disorders and contracts with Carelon Behavioral Health of California, Inc. (Carelon) to administer the majority of 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 Carelon's Member Services toll-free number 844-398-0314, available 24 hours a day 7 days a week, visit Carelon's website at **carelonbh.com/sutterhealthplan** or

contact Sutter Health Plan Customer Service. To request language interpreter services from Carelon, provided at no cost to Members, call 844-398-0314.

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). Benefits and coverage for MH/SUD are not limited to short-term or acute treatment.

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 healthcare provider

Covered Services include inpatient and outpatient benefits that are Prior Authorized by Carelon, SHP or your Medical Group, as needed, are typically rendered by a Participating Practitioner or Provider and provide the following Medically Necessary treatment of a MH/SUD:

- Basic healthcare services as defined in subdivision (a)(1) of Section 1300.74.42.01 of the California Health and Safety Code. Basic healthcare services include the following:
    - Emergency Services
    - Urgent Care
    - Physician services, including but not limited to consultation and referral to other health care providers and prescription drugs when furnished or administered by a health care provider or facility
    - Hospital inpatient services, including services of general acute care, acute psychiatric, and chemical dependency recovery hospitals
    - Ambulatory care services, including but not limited to physical therapy, occupational therapy, speech therapy, and infusion therapy
    - Diagnostic laboratory services, diagnostic and therapeutic radiologic services and other diagnostic and therapeutic services
    - Home health care services
    - Preventive health care services, regardless of whether you have been diagnosed with a mental health condition or substance use disorder. Preventive health care services include the following:
        - Screening, brief intervention and referral to treatment, primary care-based interventions, and specialty services for persons with hazardous, at-risk or harmful substance use who do not meet the diagnostic criteria for a substance use disorder, or persons for whom there is not yet sufficient information to document a substance use or addictive disorder, as described in ASAM level of care 0.5 (3rd edition), or the most recent version of the ASAM Criteria
        - Basic services for prevention and health maintenance, including: screening for mental health and developmental disorders and adverse childhood experiences; multidisciplinary assessments; expert evaluations; referrals; consultations and counseling by mental health clinicians; emergency evaluation, brief intervention and disposition; crisis intervention and stabilization; community outreach prevention and intervention programs; mental health first aid for victims of trauma or disaster; and health maintenance and violence prevention education, as described in LOCUS and CALOCUS-CASII level of care zero (version 2020), or the most recent versions of LOCUS and CALOCUS-CASII
        - Preventive Care Services for an MH/SUD

- Hospice care that is at a minimum, equivalent to hospice care provided by the federal Medicare Program

- 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
- Withdrawal management services, including all the following ASAM levels (3rd edition) or as described in the most recent version of *The ASAM Criteria:*
  - 1-WM, ambulatory withdrawal management without extended on-site monitoring
  - 2-WM, ambulatory withdrawal management with extended on-site monitoring
  - 3.2 WM, clinically managed residential withdrawal management
  - 3.7- WM, clinically monitored inpatient withdrawal management
  - 4-WM, medically managed intensive inpatient withdrawal management
- Services that are Medically Necessary and furnished or delivered by, or under the direction of, a health care provider or facility acting within the scope of practice of the provider's or facility's license or certification under applicable state law are covered for a MH/SUD.
- Emergency health care services that are furnished or delivered by, or under the direction of, a health care provider or facility acting within the scope of practice of the provider's or facility's license or certification under applicable state law, including by or at a licensed or certified health care provider or facility owned or operated by, employed by, or contracted with, a political subdivision to provide emergency health care services or Behavioral Health Crisis Services, regardless of whether SHP or Carelon are contracted with the health care provider, facility, or political subdivision to furnish emergency health care services or Behavioral Health Crisis Services to SHP enrollees.
- Home health care services, including the following:
  - Part-time skilled nursing care, including by a registered nurse, licensed practical nurse under the supervision of a registered nurse, or psychiatrically trained nurse. Part-time means both skilled nursing services and home health aide services furnished any number of days per week, provided that the skilled nursing services and home health aide services, combined, are furnished less than eight hours per day and 35 hours per week.
  - Part time home health aide services for personal care
  - Physical therapy
  - Speech-language pathology
  - Occupational therapy
  - Medical social services
  - Medical supplies provided by a home health agency while an enrollee is under a home health plan or care
  - Durable medical equipment while an enrollee is under a home health plan of care

  Home health care services are covered when all of the following conditions are satisfied:
  - You are confined to the home except for infrequent or relatively short duration absences, or when absences are attributable to the need to receive medical treatment due to a MH/SUD disorder
  - Skilled nursing care on an intermittent basis, physical therapy, occupational therapy, or speech-language pathology services are Medically Necessary for the evaluation or treatment of an MH/SUD or its symptoms
  - Your physician, physicians assistant, nurse practitioner or clinical nurse specialist attests that you meet the above two criteria and periodically reviews no less frequently than every 60 days, a plan of care that includes the home health care services listed above and the frequency and duration of visits

Covered Services also include Behavioral Health Crisis Services provided to a Member by a 988 center, mobile crisis team, or other providers of Behavioral Health Crisis Services, regardless of whether the Behavioral Health Crisis Service is provided by a Participating Provider or an out-of-network provider. The cost for these Behavioral Health Crisis Services from an out-of-network provider will be no more than the services would be if received from an in-network provider, and prior authorization is not required.

If services for the Medically Necessary treatment of a MH/SUD are not available within Carelon's network of Participating Practitioners within the geographic and timely access standards set by law or regulation, then Carelon will provide for and 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

Carelon 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. If SHP or Carelon fail to arrange coverage for you, you or your representative may arrange for you to obtain care from any appropriately licensed provider regardless of whether the provider contracts with SHP or Carelon. Please see The SHP Network section in the How To Use The Plan chapter for information about arranging appointments, the timeframes for appointments and Cost Sharing for these services.

**Mental Health Disorder Services**

Mental health disorder inpatient services are covered as follows:

- Inpatient psychiatric observation for an acute psychiatric crisis. This service does not require Prior Authorization.
- 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 Carelon and are inclusive of, but not limited to, the following:
    - Inpatient Behavioral Health Treatment for ASD
    - Inpatient psychiatric hospitalization
    - Treatment in a crisis residential program
- Inpatient services, including but not limited to all the following:
    - ASAM inpatient levels of care (3rd edition) for substance use disorder rehabilitation and withdrawal management, or as described in the most recent version of the ASAM criteria
    - High intensity acute medically managed residential programs (LOCUS and CALOCUS-CASII level 6A (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).
    - Medically managed extended care residential programs (LOCUS and CALOCUS-CASII level 6B
- Inpatient prescription drugs are covered only when prescribed by a Carelon 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:

- Coordinated specialty care for the treatment of first episode psychosis
- Intensive home-based treatment
- Outpatient psychiatric observation for an acute psychiatric crisis. This service does not require Prior Authorization.
- Behavioral therapies to manage neuropsychiatric symptoms for the treatment of PANDAS and PANS as described in the Your Benefits chapter
- Medication management
- Intensive community-based treatment, including assertive community treatment and intensive case management
- Polysomnography
- Psychological and neuropsychological testing
- Schoolsite services
- Outpatient electroconvulsive therapy, including anesthesia services and necessary monitoring
- Psychiatric health facility services, including structured outpatient services as described in Health and Safety Code section 1250.2
- 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 outpatient monitoring of drug therapy. This includes outpatient professional services, including but not limited to individual, group, and family substance use and mental health counseling
- Outpatient other items and services require Prior Authorization by Carelon, 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:
    - Multidisciplinary intensive psychiatric treatment programs such as:
        - 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 ASD, including pervasive developmental disorder (PDD), requires Prior Authorization by Carelon, 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 Carelon 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 through SHP's pharmacy benefit, not through Carelon's MH/SUD benefit, and may require Prior Authorization from CVS Caremark. Coverage includes Outpatient Prescription Drugs prescribed for MH/SUD pharmacotherapy, including office-based opioid treatment.

**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 Carelon and are inclusive of, but not limited to, the following:
    - Inpatient chemical dependency hospitalization, including medical detoxification and medical treatment for withdrawal symptoms
- Narcotic (opioid) treatment programs
- Drug testing, both presumptive and definitive, including for initial ongoing patient assessment during SUD treatment
- Inpatient services, including but not limited to all the following:
    - ASAM inpatient levels of care (3rd edition) for substance use disorder rehabilitation and withdrawal management, or as described in the most recent version of the ASAM criteria
    - High intensity acute medically managed residential programs (LOCUS and CALOCUS-CASII level 6A (version 2020), or as described in the most recent versions of LOCUS and CALOCUS-CASII).
    - Medically managed extended care residential programs (LOCUS and CALOCUS-CASII level 6B
- Medication management
- Schoolsite services
- Treatment at a Residential Treatment Center
- Inpatient prescription drugs are covered only when prescribed by a Carelon 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. This

includes outpatient professional services, including but not limited to individual, group, and family substance use and mental health counseling.

- Other outpatient items and services require Prior Authorization by Carelon, 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 through SHP's pharmacy benefit, not through Carelon's MH/SUD benefit, and may require Prior Authorization from CVS Caremark.
- Coverage includes Outpatient Prescription Drugs prescribed for MH/SUD pharmacotherapy, including office-based opioid treatment
- Intensive community-based treatment, including assertive community treatment and intensive case management
- Psychological and neuropsychological testing

**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, and psychological testing, not Prior Authorized by Carelon or SHP (except in the event of Emergency Services, Urgent Care, healthcare services when required or recommended in a CARE agreement or CARE plan, or Behavioral Health Crisis Services from a 988 center, mobile crisis team, or other provider of Behavioral Health Crisis Services)
- 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
- 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

- Experimental and investigational services. A service is experimental or investigational if Carelon determines that one of the following is true:

    a) Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)

    b) It requires government approval that has not been obtained when the service is to be provided

    This exclusion does not apply to any of the following:

    a) 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, Carelon 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

**Children and Youth Behavioral Health Initiative (CYBHI) School Site Behavioral Health Services**

CYBHI School Site Behavioral Health Services include, outpatient non-specialty mental health and substance use disorder services (e.g., psychoeducation, screening and assessments, therapy, case management) provided to Members 25 years of age or younger at a school site, including on-campus, off-campus and mobile clinic locations, when the services are provided or arranged by a local educational agency (LEA) or public institution of higher education (IHE) that participate in the CYBHI Fee Schedule Program. These services are covered without Prior Authorization or Cost Share, except as authorized by the Department of Health Care Services (DHCS) or Department of Managed Health Care (DMHC). Please refer to the BCM for Cost Sharing details. The scope of services can be found in the CYBHI Fee Schedule available on the DHCS website at https://www.dhcs.ca.gov/CYBHI/Pages/Fee-Schedule.aspx.

**Community Assistance, Recovery, and Empowerment (CARE) Program**

The CARE Act allows certain people to file a petition in civil court to seek behavioral health treatment on behalf of an individual diagnosed with a schizophrenia spectrum disorder and/or a psychotic disorder. Eligible individuals will receive a court-ordered treatment plan (called a CARE agreement or CARE plan), which may include a requirement to receive services from county behavioral health departments (CBHDs). SHP will cover the cost of developing an evaluation and the provision of all healthcare services when required or recommended in a CARE agreement or a CARE plan approved by a court regardless of whether the service is provided by an in- or out-of-network provider. Members are not required to obtain Prior Authorization or pay any Cost Sharing other than for prescription drugs.

## 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, including but not limited to vasectomy services and procedures. For non-HDHPs, male sterilization procedures are covered with no cost share. For HDHPs, male sterilization procedures are covered at no cost share after the minimum deductible is met for the plan year. Male sterilization procedures do not require Prior Authorization.
- Nurse midwife services are covered when medically appropriate and the nurse midwife is a Participating Provider in your PCP's medical group
- Outpatient services for the prophylaxis, diagnosis, and treatment of PANDAS and PANS as described in the Your Benefits chapter
- 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. For non-HDHPs, members will not pay a Deductible, Coinsurance or any other Cost-Sharing for these services. For HDHPs, after a Member meets their Deductible, they will not pay a Coinsurance, Copayment or any other Cost-Sharing for these 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
  - Biomarker testing for purposes of diagnosis, treatment, appropriate management or ongoing monitoring of a Member's disease or condition to guide treatment decisions
  - All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available) when:
    - Determined to be Medically Necessary
    - Test is not experimental/investigational
    - Results are used to modify treatment for the Member

- Therapeutic procedures
  - Radiation therapy
  - Ultraviolet light treatments

## Outpatient Prescription Drugs, Supplies, Equipment and Supplements

SHP contracts with CVS Caremark® to administer the Outpatient Prescription Drug benefit as part of your covered healthcare 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 a CVS Caremark contracted Specialty Pharmacy, unless the item is obtained as part of the Covered Services described in the Emergency Services and Urgent Care chapter or the prescription drug is prescribed for Behavioral Health Crisis Services or dispensed as part of a CARE agreement or CARE plan approved by a court.

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 or if you are seeing a Non-Participating Provider for MH/SUD services because a Participating Provider is not available to you in accordance with geographic and timely access standards.
  - 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 Caremark contracted retail network 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/sutterhealthplan**, click on Find a Pharmacy and use the Pharmacy Locator tool or call CVS Caremark Customer Care at 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 Caremark Retail-90 Network. 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 800-378-5697
    2. Fax: Your prescribing provider can fax a prescription using the FastStart® New Prescription Fax Form to 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 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 844-740-0635 or on the Sutter Health Plan website at **sutterhealthplan.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 because of CVS Caremark, please contact CVS Caremark Customer Care at 844-740-0635 to arrange for expedited delivery through an alternative method at no additional cost.

**Specialty Prescription Drugs**

Specialty Drugs are typically used to treat complex or rare chronic conditions, they often require close supervision and therapy monitoring. Most Specialty Drugs must be obtained through a CVS Caremark contracted Specialty Pharmacy, including but not limited to CVS Specialty. Certain Specialty Drugs may be obtained through a CVS Caremark contracted retail network location.

For more information on where to obtain your Specialty Drug:

- Visit the SHP CVS Caremark website at **caremark.com/oe/sutterhealthplan** to access the Check Drug Cost tool
- Call CVS Caremark Customer Care at 844-740-0635

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 through CVS Specialty:

- Visit the CVS Specialty website at **cvsspecialty.com**
- Call CVS Specialty Customer Care at 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/sutterhealthplan** or the SHP website at **sutterhealthplan.org/pharmacy**. The formulary is also available upon request by calling Sutter Health Plan Customer Service.

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, nonpreferred 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 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. This amount will apply to your Deductible, if any, and Out-of-Pocket Maximum.
- If there is a generic equivalent to a brand name drug, you will pay the lowest Cost Sharing that would be applied, whether or not the generic equivalent and the brand name drug are on the formulary.
- 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.

  For High Deductible Health Plans (HDHPs), oral anticancer drugs on any tier are subject to the annual Deductible and the Cost Sharing maximum will not apply until after the Deductible is met.
- Dispense-As-Written (DAW) Penalty: If brand drugs are dispensed at the prescriber's or Member's request when an 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 ***sutterhealthplan.org*** or within the SHP Member Portal For members on a High

Deductible Health Plan (HDHP), please note that this Cost Share assistance is not considered a qualifying medical expense by the IRS and not self-reporting copay card use may render your HDHP not compatible with an HSA.

**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 are 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 **https://www.cdc.gov/vaccines/?CDC_AAref_Val=https://www.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 OTC agents
  - Contraceptive drugs and devices that are FDA-approved, 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 inadvisable 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

- OTC FDA-approved contraceptive drugs, devices and products are covered without a prescription.
- 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 Asthma**

SHP covers the following Outpatient Prescription Drugs for the management and treatment of diabetes and 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
- Prescription 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 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.

**Medication-Assisted Treatment**

For medication-assisted treatment, SHP covers at least one FDA-approved medication in each of the following categories without Prior Authorization, step therapy, or utilization review:

- Medication for the reversal of opioid overdose, including a naloxone product or other opioid antagonist
- Medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product
- A long-acting buprenorphine product
- A long-acting injectable naltrexone product

**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 844-740-0635 for assistance

Situations requiring Prior Authorization 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)
- **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
- **Nonformulary Drugs:** When self-administered, FDA-approved drugs are not listed on the SHP formulary (i.e. "nonformulary drugs"), your prescribing Provider may request Prior Authorization for a Medically Necessary nonformulary prescription drug. Please note that if CVS Caremark approves the Prior Authorization request of a nonformulary 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 for new Members who have an active prescription. If the active prescription is documented by the prior provider or pharmacy, then SHP may cover up to a 90-day supply of the drug if filled at a Participating Pharmacy. Ongoing coverage may require 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 nonurgent 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 nonformulary 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 nonurgent, 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 Sutter Health Plan Customer Service.

**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. Standard Cost Sharing applies.

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 Sutter Health Plan Customer Service 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 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 healthcare Professional (refer to the Medically Administered Drugs section)

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

1. Prescription drugs that have an available 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, asthma and Preventive Care Services, or prescription drugs on the SHP Formulary
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 drugs 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. This does not apply to drugs that are FDA approved. For drugs that are FDA-approved, refer to the Off-Label Use subsection of the Prior Authorization for Outpatient Prescription Drugs section above

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 OTC 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. 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, supplies or equipment 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. 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, 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, infant/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 healthcare 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 healthcare 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) 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

## Special Footwear and Orthotic Coverage

SHP covers special footwear, inserts, services and supplies medically necessary to accommodate foot disfigurement caused by motor impairment, paralysis or bone deformity. This includes, but is not limited to, foot abnormalities associated with the following conditions:

- Arthritis
- Diabetes
- Cerebral palsy
- Congenital disfigurement such as clubfoot deformity or leg length discrepancy
- Disfigurement of the bones of the foot or ankle
- Motor disorder
- Partial or full amputation of foot
- Polio
- Spina bifida

The following items are Covered Benefits when prescribed by a Participating Provider, authorized by your PCP's Medical Group and medically necessary:

- Custom Foot Orthotics
- Shoe Modifications to standard non-orthopedic shoes – E.g., rockersoles, shoe buildups, metatarsal bars, shoe stretching, Thomas heels, tongue pads, velcro closures, modified lacers, etc.
- Depth Inlay Shoes – Considered medically necessary when shoe modifications will not accommodate the foot deformity and determined that an insole or additional space is needed
- Custom-made Orthopedic Shoes
- Casting, fitting and consultation required to assess the foot deformity, prepare the custom orthotic or shoe, fabricate the orthotic, and ensure proper fit of the orthotic

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

SHP provides coverage for the prophylaxis, diagnosis and treatment of PANDAS and PANS that is prescribed or ordered by the treating physician and surgeon and are Medically Necessary, as defined by current nationally recognized clinical practice guidelines by expert treating physicians published in peer-reviewed medical literature. The following treatment for PANDAS and PANS is covered:

- Antibiotics
- Medication and behavioral therapies to manage neuropsychiatric symptoms
- Immunomodulating medicines
- Plasma exchange, and
- Intravenous immunoglobulin therapy

Coverage for PANDAS or PANS therapies will not be denied or delayed if you previously received treatment, including the same or similar treatment, for PANDAS or PANS, or if you were diagnosed with or received treatment for your condition under a different diagnostic name, including autoimmune encephalopathy. Coverage will be provided in a timely manner that is appropriate for the severity of your condition, .

SHP will not limit coverage of immunomodulating therapies for PANDAS or PANS and will not require a trial of therapies that treat only neuropsychiatric symptoms before authorizing coverage of immunomodulating therapies. Coverage for PANDAS and PANS shall adhere to the treatment recommendations delineated in current clinical practice guidelines published in peer-reviewed medical literature or put forth by organizations composed of expert treating clinicians.

Coverage of PANDAS and PANS is not subject to a copayment, coinsurance, deductible or other cost sharing that is greater than any other benefit provided by SHP under this EOC.

SHP will provide a required authorization for PANDAS and PANS prophylaxis, diagnosis, or treatment in a timely manner that is appropriate for the severity of an enrollee's condition.

## 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
- For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which you identify, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.
- 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
- Healthcare 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 Carelon 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 855-836-3500 or Sutter Health Plan Customer Service.

Carelon maintains a toll-free and confidential Intake Services Line available 24 hours a day, seven days a week. You may call Carelon's toll-free telephone line 844-398-0314 to answer 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 nonemergency 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 calendar year:
  - 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 calendar year) = one contact lens per eye (total two lenses)
    - Monthly (six-month supply) = six lenses per eye (total 12 lenses/2 boxes)
    - Biweekly (three-month supply) = six lenses per eye (total 12 lenses/2 boxes)
    - Dailies (three month supply) = 30 lenses per eye (total 180 lenses/2 boxes)
  - 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 visual impairments not correctable by conventional prescription eyeglasses, contact lenses, surgery, or medication Low vision supplemental exam - Once every calendar year is covered in full (Prior Authorization required)
  - Low vision aids - Approved low vision aids are covered in full once every calendar year (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 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 Plan (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.

   This exclusion does not apply in the following circumstances:

   - MH/SUD services are not available to you in accordance with geographic and timely access standards, and SHP or Carelon provides and arranges for coverage for medically necessary MH/SUD services from an out-of-network provider or providers. Please see The SHP Network section in the How To Use The Plan chapter for details about coverage for these services, and timing for the appointments or admissions, as well as Cost Sharing for these services.
   - You receive Behavioral Health Crisis Services provided by a 988 center or mobile crisis team, or other providers of Behavioral Health Crisis Services, regardless of whether the service is provided by a Participating Provider or out-of-network provider
   - You receive healthcare services that are required or recommended in a CARE agreement or CARE plan.

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 Carelon 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) OTC drugs, supplies or equipment that may be obtained without a prescription are excluded; this may not apply to specific items mentioned in the Your Benefits chapter, including but not limited to, the Preventive Care Services section. This exclusion does not apply to OTC FDA-approved contraceptive drugs, devices and products.

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 Standard Fertility Preservation Services 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 healthcare 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 healthcare 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 autism spectrum disorder (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 nonmainstream approach together with conventional medicine. This includes nonphysician practitioners who prescribe "natural products" and "mind and body practices" which are not considered health plan benefits.
- "Alternative" refers to use of a nonmainstream 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 to determine if your plan has acupuncture coverage).

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.

## Preexisting Conditions and Health Assessments

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

You (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 or 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 for Sutter Health Plan (SHP) coverage, all Subscribers must live, physically work or reside within SHP's Service Area, which is comprised of specific ZIP codes in Northern California. Subscribers must notify SHP if they no longer live, physically work or reside in SHP's Service Area.

## Nondiscrimination

**Sutter Health Plan 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 an 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 healthcare in anticipation of adoption.
  - For purposes of this requirement, “legal right to control healthcare” 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 healthcare
- 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 healthcare 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 healthcare 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 Healthcare Benefit Plans as a Result of a Permanent Move**

If you (or a Dependent) have gained access to new healthcare 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 healthcare 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 healthcare coverage because you were called to active duty in the military service, you may be able to reenroll in your Group's health plan if required by state or federal law. Please ask your Group for more information.

## Renewal Provisions

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

# WHEN YOUR SHP HEALTH COVERAGE ENDS (TERMINATION OF BENEFITS)

Your membership with Sutter Health Plan (SHP) may end for several reasons. If your membership is terminated, you may be able to continue your healthcare 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 1st, your last minute of coverage was on December 31st 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 **sutterhealthplan.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 Plan
  Attn: Appeals and Grievances Department
  P.O. Box 160305
  Sacramento, CA 95816

- By calling:

  Sutter Health Plan Customer Service
  855-315-5800
  TTY: 855-830-3500

- By faxing:

  916-736-5422
  855-759-8755

- Online:

  **sutterhealthplan.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:

  888-466-2219
  TDD: 877-688-9891

- By faxing:

  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 Plan (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 Sutter Health Plan Customer Service 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 healthcare 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 healthcare coverage through a Group Health Plan offered by a healthcare 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 healthcare 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 healthcare 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 Jan. 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% 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 healthcare 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

### Terminating Cal-COBRA Coverage

Cal-COBRA subscribers may voluntarily terminate their membership by emailing the completed Cal-COBRA or Individual and Family Plan Termination Form to: **SHPServiceTeam@sutterhealth.org** or faxing securely to (916) 736-5090 (the form must be signed by the Subscriber).

> The Cal-COBRA or Individual and Family Plan Termination Form can be accessed at: **sutterhealthplan.org/about/forms**, or by contacting Sutter Health Plan Customer Service.

If we receive the notice on or before the last day of the month, the termination date will be the first of the following month. For example, if we received the termination notice on December 31, 2024, the last moment of coverage was at 11:59 p.m. Pacific Time on December 31, 2024 and the termination date was January 1, 2025. Also, the subscriber must include with their notice all amounts payable related to this Agreement, including Premium, for the period prior to the termination effective date. SHP does not process requests for retroactive termination.

### 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 healthcare 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 Sutter Health Plan Customer Service 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 may pay the provider and file a claim for reimbursement with Sutter Health Plan (SHP), unless the provider agrees to bill SHP or the services are provided by a non-contracting ground or air ambulance that must bill SHP for the covered service. If you receive a bill or other demand from a noncontracting ground ambulance provider that is greater than the in-network Cost Sharing, SHP will take appropriate action to assist you in resolving the issue. 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 Plan, 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:

- 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 30 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 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 Plan, 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 Plan (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 Sutter Health Plan Customer Service by calling toll-free at **855-315-5800 (TTY 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 Sutter Health Plan Customer Service 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 Plan
  Attn: Appeals & Grievances Department
  P.O. Box 160305
  Sacramento, CA 95816
- By calling: Sutter Health Plan Customer Service at
  **855-315-5800 (TTY 855-830-3500)**
- By faxing: 855-759-8755 or 916-736-5422
- Online: **sutterhealthplan.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 also submit grievances to SHPfor mental health and substance use disorder services as follows:

- By writing:

  Sutter Health Plan
  Attn: Appeals & Grievances Department
  P.O. Box 160305
  Sacramento, CA 95816
- By calling: Sutter Health Plan Customer Service at
  **855-315-5800 (TTY 855-830-3500)**
- By faxing:

- 855-759-8755 or 916-736-5422
- Online: **sutterhealthplan.org**

If your employer Group has purchased acupuncture or chiropractic coverage, 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 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 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 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 Sutter Health Plan Customer Service 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).

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: Sutter Health Plan Customer Service at **855-315-5800 (TTY 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 Plan
  Attn: Appeals & Grievances Department
  P.O. Box 160305
  Sacramento, CA 95816

- By faxing: 855-759-8755 or 916-736-5422
- Online: **sutterhealthplan.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 SHP for mental health and substance use disorder services as follows:

- By writing:

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

- By calling: Sutter Health Plan Customer Service at **855-315-5800 (TTY 855-830-3500)**

- By faxing:
- 855-759-8755 or 916-736-5422
- Online: **sutterhealthplan.org**

If your employer Group has purchased acupuncture or chiropractic coverage, 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 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 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 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 Sutter Health Plan Customer Service (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 healthcare 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 your health plan, you should first telephone your health plan toll

free at
**1-855-315-5800 (TTY 1-855-830-3500)** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent Medical Services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

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 the following address:

Sutter Health
Office of the General Counsel
2200 River Plaza Dr.
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 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 Plan's (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 Sutter Health Plan Customer Service, or you may download a copy at **sutterhealthplan.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 healthcare, 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 healthcare 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 healthcare 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 healthcare

## 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 Plan
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 Sutter Health Plan Customer Service 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 healthcare 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 Sutter Health Plan Customer Service 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 healthcare 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 healthcare 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 healthcare 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: Sutter Health Plan Customer Service at
  855-315-5800 (TTY 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 Plan (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 Crisis Services:** means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a mental health or substance use disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis stabilization services.

**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 healthcare 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 healthcare 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 healthcare 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 healthcare 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 Information:** Means any individually identifiable information, in electronic or physical form, in possession of or derived from a provider of health care, health care service plan, pharmaceutical company, or contractor regarding a patient's medical history, mental health application information, reproductive or sexual health application information, mental or physical condition, or treatment.

**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 Carelon 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.

Medically Necessary services include maternity services necessary to prevent serious deterioration of the health of Member or the Member's fetus, based on the Member's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns 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 healthcare 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 healthcare facility or provider who has entered into a written agreement with Carelon 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:** Means healthcare provided for the prevention and early detection of disease, illness, injury, or other health conditions and includes all of the healthcare services required by sections 1345(b)(5), 1367.002, 1367.3, and 1367.35 of the Knox-Keene Act, and Rule 1300.67(f).

**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 Plan, Medical Groups or SHP's health plan partners to review a request for specified healthcare 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 either of the following:
    - 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
    - A psychological associate, an associate marriage and family therapist, an associate clinical social worker, or an associate professional clinical counselor, as defined and regulated by the Board of Behavioral Sciences or the Board of Psychology
- 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:** Means the geographical area and population points contained therein where the plan is approved by the DMHC to arrange healthcare services consistent with network adequacy requirements. "Population points" shall mean a representation of where people live and work in the state of California based on United States Census

Bureau population data and United States Postal Service (USPS) delivery route data, and made available annually by the DMHC on the web portal accessible at **dmhc.ca.gov**.

**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 healthcare 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).

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

**Subscriber:** 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

[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.

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, including pregnancy. Urgent Care services includes maternity services necessary to prevent serious deterioration of the health of Member or the Member's fetus, based on the Member's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed.

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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 ("Dental EOC" or "Addendum").

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. See your SHP EOC and medical copayment summary for further information about your Plan Out -of-Pocket Maximum.

**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. If you would like more information about dental coverage options, you may call Customer Care at 888-282-8528. 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 888-282-8528 5 a.m.– 6 p.m. Pacific Time, Monday through Friday.

Eligibility under this Dental EOC is determined by SHP.

### Using This Dental EOC

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 EOC 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 EOC, the following terms, when capitalized and used in any part of this Dental EOC 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 EOC.

**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 EOC.

**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 EOC. 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 EOC. You 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 EOC.

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 EOC.

**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 EOC. The Enrollee may request changes to the 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 this dental plan, 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.

**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 (TTY: 711). 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 EOC.)

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in the Schedules attached to this Dental EOC 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 EOC.

**Processing Policies**

The dental care guidelines for this dental plan explain to Contract Dentists what services are covered under this Dental EOC. 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 Orthodontists and Contract Specialists that fall under the scope of Benefits of this dental plan are provided subject o 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.

**Teledentistry Services**

Teledentistry services are when a Dentist delivers dental services through telehealth or telecommunications to diagnose dental issues, offer dental care advice or determine appropriate dental treatment. It can be a convenient alternative option to an in-person dental appointment.

There are two types of Teledentistry services:

Synchronous is real-time interaction such as a video call with Your Contract Dentist.

Asynchronous is when a video or photo of Your dental issue is sent to Your Contract Dentist and a reply is sent later.

We cover Teledentistry services at the diagnostic oral evaluation cost share amount shown in Schedule A subject to the limitations and exclusions in Schedule B. A Teledentistry appointment is covered on the same basis and to the same extent that the Benefit is covered through in-person diagnosis, consultation or treatment and is inclusive in the overall patient management care and not a separately payable service. Although the fees for Teledentistry are included in the fees that may apply to other dental services received, there are no frequency limitations imposed for Teledentistry access.

Please note that not all Contract Dentists offer Teledentistry services and that not all dental conditions can be treated through Teledentistry visits. We recommend contacting Your Contract Dentist and Delta Dental Customer Care for additional information.

If You are experiencing a life-threatening emergency, immediately call 911.

**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 EOC 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 1860
Alpharetta, GA 30023

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 up on 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 EOC. 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 Disclosure

### Discrimination is Against the Law

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, sexual orientation, pregnancy or related conditions and gender identity. Delta Dental does not exclude people or treat them differently because of their race, color, national origin, age, disability or sex.

Delta Dental:

- Provide people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Delta Dental provide free language assistance services to people whose primary language is not English, which may include:
- Qualified interpreters
- Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, for language assistance services, please call 866-530-9675 (TTY:711).

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 or by email, over the phone with a Customer Care representative, or by mail.

Delta Dental Insurance Company

Appeals and Grievances Dept.

P.O. Box 1860

Alpharetta, GA 30023-1860

866-530-9675

Deltadentalins.com

1557coordinator@delta.org

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 *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-2025 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 |
|---|---|---|---|
| D0100–D0999 | I. DIAGNOSTIC | | |
| D0999 | Unspecified diagnostic procedure, by report | No charge | *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.* |
| D0120 | Periodic oral evaluation - established patient | No charge | *1 per 6 months per Contract Dentist* |
| D0140 | Limited oral evaluation - problem focused | No charge | *1 per Enrollee per Contract Dentist* |
| D0145 | Oral evaluation for a patient under three years of age and counseling with primary caregiver | No charge | *1 per 6 months per Contract Dentist, included with D0120, D0150* |
| D0150 | Comprehensive oral evaluation - new or established patient | No charge | *Initial evaluation, 1 per Contract Dentist* |
| D0160 | Detailed and extensive oral evaluation - problem focused, by report | No charge | *1 per Enrollee per Contract Dentist* |
| D0170 | Re-evaluation - limited, problem focused (established patient; not post-operative visit) | No charge | *6 per 3 months, not to exceed 12 per 12 month period* |
| D0171 | Re-evaluation - post-operative office visit | No charge | |
| D0180 | Comprehensive periodontal evaluation - new or established patient | No charge | *Included with D0150* |
| D0210 | Intraoral - comprehensive series of radiographic images | No charge | *1 series per 36 months per Contract Dentist* |
| D0220 | Intraoral - periapical first radiographic image | No charge | *20 images (D0220, D0230) per 12 months per Contract Dentist* |
| D0230 | Intraoral - periapical each additional radiographic image | No charge | *20 images (D0220, D0230) per 12 months per Contract Dentist* |
| D0240 | Intraoral - occlusal radiographic image | No charge | *2 per 6 months per Contract Dentist* |
| D0250 | Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector | No charge | *1 per date of service* |
| D0251 | Extra-oral posterior dental radiographic image | No charge | *4 per date of service* |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| D0270 | Bitewing - single radiographic image | No charge | *1 of (D0270, D0273) per date of service* |
| D0272 | Bitewings - two radiographic images | No charge | *1 of (D0272, D0273) per 6 months per Contract Dentist* |
| 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* |
| D0396 | 3D printing of a 3D dental surface scan | No charge | |
| 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 | |
| | | | |
| 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 | |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| D0709 | Intraoral - comprehensive series of radiographic images - image capture only | No charge | |
| D0801 | 3D intraoral surface scan - direct | No charge | *1 per date of service* |
| D0802 | 3D dental surface scan - indirect | No charge | *1 per date of service* |
| D0803 | 3D facial surface scan - direct | No charge | *1 per date of service* |
| D0804 | 3D facial surface scan - indirect | No charge | *1 per date of service* |
| 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* |
| 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 | Application of caries arresting medicament - 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* |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| 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.* | | | |
| D2140 | Amalgam - one surface, primary or permanent | $25 | *1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth* |
| D2150 | Amalgam - two surfaces, primary or permanent | $30 | *1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth* |
| D2160 | Amalgam - three surfaces, primary or permanent | $40 | *1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth* |
| D2161 | Amalgam - four or more surfaces, primary or permanent | $45 | *1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth* |
| D2330 | Resin-based composite - one surface, anterior | $30 | *1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth* |
| D2331 | Resin-based composite - two surfaces, anterior | $45 | *1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth* |
| D2332 | Resin-based composite - three surfaces, anterior | $55 | *1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth* |
| D2335 | Resin-based composite - four or more surfaces (anterior) | $60 | *1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth* |
| D2390 | Resin-based composite crown, anterior | $50 | *1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth* |
| D2391 | Resin-based composite - one surface, posterior | $30 | *1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth* |
| D2392 | Resin-based composite - two surfaces, posterior | $40 | *1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth* |
| D2393 | Resin-based composite - three surfaces, posterior | $50 | *1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth* |
| D2394 | Resin-based composite - four or more surfaces, posterior | $70 | *1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth* |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| D2710 | Crown - resin-based composite (indirect) | $140 | *1 per 60 months, permanent teeth; age 13 through 18* |
| D2712 | Crown - 3/4 resin-based composite (indirect) | $190 | *1 per 60 months, permanent teeth; age 13 through 18* |
| D2721 | Crown - resin with predominantly base metal | $300 | *1 per 60 months, permanent teeth; age 13 through 18* |
| D2740 | Crown - porcelain/ceramic | $300 | *1 per 60 months, permanent teeth; age 13 through 18* |
| D2751 | Crown - porcelain fused to predominantly base metal | $300 | *1 per 60 months, permanent teeth; age 13 through 18* |
| D2781 | Crown - 3/4 cast predominantly base metal | $300 | *1 per 60 months, permanent teeth; age 13 through 18* |
| D2783 | Crown - 3/4 porcelain/ceramic | $310 | *1 per 60 months, permanent teeth; age 13 through 18* |
| D2791 | Crown - full cast predominantly base metal | $300 | *1 per 60 months, permanent teeth; age 13 through 18* |
| D2910 | Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration | $25 | *1 per 12 months per Contract Dentist* |
| D2915 | Re-cement or re-bond indirectly fabricated or prefabricated post and core | $25 | |
| D2920 | Re-cement or re-bond crown | $25 | *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.* |
| D2921 | Reattachment of tooth fragment, incisal edge or cusp | $45 | *1 per 12 months* |
| D2928 | Prefabricated porcelain/ceramic crown - permanent tooth | $120 | *1 per 36 months* |
| D2929 | Prefabricated porcelain/ceramic crown - primary tooth | $95 | *1 per 12 months* |
| 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 | Placement of interim direct restoration | $25 | *1 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* |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| 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.* |
| D2976 | Band stabilization- per tooth | $40 | |
| 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.* |
| D2989 | Excavation of a tooth resulting in the determination of non-restorability | $50 | |
| D2991 | Application of hydroxyapatite regeneration medicament- per tooth | No charge | *2 per tooth per 12 months* |
| 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* |
| 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* |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| 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 - premolar | $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 | $350 | *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 - premolar (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.* |
| D3428 | Bone graft in conjunction with periradicular surgery - per tooth, single site | $350 | |
| D3429 | Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site | $350 | |
| D3430 | Retrograde filling - per root | $90 | |
| D3431 | Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery | $80 | |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| 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* |
| D3910 | Surgical procedure for isolation of tooth with rubber dam | $30 | |
| D3999 | Unspecified endodontic procedure, by report | $100 | *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.* |
| D4000-D4999 V. PERIODONTICS | | | |
| *- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic.* | | | |
| D4210 | Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant | $150 | *1 per quadrant per 36 months, age 13+* |
| D4211 | Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant | $50 | *1 per quadrant per 36 months, age 13+* |
| 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 | *1 per quadrant per 36 months, age 13+* |
| D4261 | Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant | $140 | *1 per quadrant per 36 months, age 13+* |
| 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 | *1 per quadrant per 24 months; age 13+* |
| D4342 | Periodontal scaling and root planing - one to three teeth per quadrant | $30 | *1 per quadrant per 24 months; age 13+* |
| D4346 | Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation | $40 | *Cleaning; 1 of (D1110, D1120, D4346) per 6 months* |
| D4355 | Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit | $40 | *1 treatment per 12 consecutive months* |
| D4381 | Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth | $10 | |
| D4910 | Periodontal maintenance | $30 | *1 per 3 months; service must be within the 24 months following the last scaling and root planing* |
| D4920 | Unscheduled dressing change (by someone other than treating dentist or their staff) | $15 | *1 per Contract Dentist; age 13+* |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| D4999 | Unspecified periodontal procedure, by report | $350 | *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.* |
| D5000-D5899 VI. PROSTHODONTICS (removable) | | | |
| *- 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.* | | | |
| *- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.* | | | |
| *- Replacement of a denture or a partial denture requires the existing denture to be 5+ years (60+ months) old.* | | | |
| 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* |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| 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* |
| D5520 | Replace missing or broken teeth - complete denture - per 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 missing or broken teeth - partial denture - 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 - per tooth | $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* |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| 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* |
| D5899 | Unspecified removable prosthodontic procedure, by report | $350 | *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.* |
| D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS | | | |
| *- All maxillofacial prosthetic procedures require prior Authorization.* | | | |
| 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 | *2 per 12 months* |
| D5934 | Mandibular resection prosthesis with guide flange | $350 | |
| D5935 | Mandibular resection prosthesis without guide flange | $350 | |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| 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 | *2 per 12 months* |
| D5960 | Speech aid prosthesis, modification | $145 | *2 per 12 months* |
| 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 | |
| D5999 | Unspecified maxillofacial prosthesis, by report | $350 | *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.* |
| D6000-D6199 VIII. IMPLANT SERVICES | | | |
| *- A Benefit only under exceptional medical conditions. Prior Authorization is required. Refer also to Schedule B.* | | | |
| D6010 | Surgical placement of implant body: endosteal implant | $350 | *A Benefit only under exceptional medical conditions* |
| D6011 | Surgical access to an implant body (second stage implant surgery) | $350 | *A Benefit only under exceptional medical conditions* |
| D6012 | Surgical placement of interim implant body for transitional prosthesis: endosteal implant | $350 | *A Benefit only under exceptional medical conditions* |
| D6013 | Surgical placement of mini implant | $350 | *A Benefit only under exceptional medical conditions* |
| D6040 | Surgical placement: eposteal implant | $350 | *A Benefit only under exceptional medical conditions* |
| D6050 | Surgical placement: transosteal implant | $350 | *A Benefit only under exceptional medical conditions* |
| D6055 | Connecting bar - implant supported or abutment supported | $350 | *A Benefit only under exceptional medical conditions* |
| D6056 | Prefabricated abutment - includes modification and placement | $135 | *A Benefit only under exceptional medical conditions* |
| D6057 | Custom fabricated abutment - includes placement | $180 | *A Benefit only under exceptional medical conditions* |
| D6058 | Abutment supported porcelain/ceramic crown | $320 | *A Benefit only under exceptional medical conditions* |
| D6059 | Abutment supported porcelain fused to metal crown (high noble metal) | $315 | *A Benefit only under exceptional medical conditions* |
| D6060 | Abutment supported porcelain fused to metal crown (predominantly base metal) | $295 | *A Benefit only under exceptional medical conditions* |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| D6061 | Abutment supported porcelain fused to metal crown (noble metal) | $300 | *A Benefit only under exceptional medical conditions* |
| D6062 | Abutment supported cast metal crown (high noble metal) | $315 | *A Benefit only under exceptional medical conditions* |
| D6063 | Abutment supported cast metal crown (predominantly base metal) | $300 | *A Benefit only under exceptional medical conditions* |
| D6064 | Abutment supported cast metal crown (noble metal) | $315 | *A Benefit only under exceptional medical conditions* |
| D6065 | Implant supported porcelain/ceramic crown | $340 | *A Benefit only under exceptional medical conditions* |
| D6066 | Implant supported crown - porcelain fused to high noble alloys | $335 | *A Benefit only under exceptional medical conditions* |
| D6067 | Implant supported crown - high noble alloys | $340 | *A Benefit only under exceptional medical conditions* |
| D6068 | Abutment supported retainer for porcelain/ceramic FPD | $320 | *A Benefit only under exceptional medical conditions* |
| D6069 | Abutment supported retainer for porcelain fused to metal FPD (high noble metal) | $315 | *A Benefit only under exceptional medical conditions* |
| D6070 | Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal) | $290 | *A Benefit only under exceptional medical conditions* |
| D6071 | Abutment supported retainer for porcelain fused to metal FPD (noble metal) | $300 | *A Benefit only under exceptional medical conditions* |
| D6072 | Abutment supported retainer for cast metal FPD (high noble metal) | $315 | *A Benefit only under exceptional medical conditions* |
| D6073 | Abutment supported retainer for cast metal FPD (predominantly base metal) | $290 | *A Benefit only under exceptional medical conditions* |
| D6074 | Abutment supported retainer for cast metal FPD (noble metal) | $320 | *A Benefit only under exceptional medical conditions* |
| D6075 | Implant supported retainer for ceramic FPD | $335 | *A Benefit only under exceptional medical conditions* |
| D6076 | Implant supported retainer for FPD - porcelain fused to high noble alloys | $330 | *A Benefit only under exceptional medical conditions* |
| D6077 | Implant supported retainer for metal FPD - high noble alloys | $350 | *A Benefit only under exceptional medical conditions* |
| D6080 | Implant maintenance procedures when a full arch fixed hybrid prosthesis is removed and reinserted, including cleansing of prosthesis and abutments | $30 | *A Benefit only under exceptional medical conditions* |
| D6081 | Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure | $30 | *A Benefit only under exceptional medical conditions* |
| D6082 | Implant supported crown - porcelain fused to predominantly base alloys | $335 | *A Benefit only under exceptional medical conditions.* |
| D6083 | Implant supported crown - porcelain fused to noble alloys | $335 | *A Benefit only under exceptional medical conditions* |
| D6084 | Implant supported crown - porcelain fused to titanium and titanium alloys | $335 | *A Benefit only under exceptional medical conditions* |
| D6085 | Interim implant crown | $300 | *A Benefit only under exceptional medical conditions* |
| D6086 | Implant supported crown - predominantly base alloys | $340 | *A Benefit only under exceptional medical conditions* |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| D6087 | Implant supported crown - noble alloys | $340 | *A Benefit only under exceptional medical conditions* |
| D6088 | Implant supported crown - titanium and titanium alloys | $340 | *A Benefit only under exceptional medical conditions* |
| D6089 | Accessing and retorquing loose implant screw- per screw | $60 | *1 per 24 months* |
| D6090 | Repair of implant/abutment supported prosthesis | $65 | *A Benefit only under exceptional medical conditions* |
| D6091 | Replacement of replaceable part of semi-precision or precision attachment of implant/abutment supported prosthesis, per attachment | $40 | *A Benefit only under exceptional medical conditions* |
| D6092 | Re-cement or re-bond implant/abutment supported crown | $25 | *A Benefit only under exceptional medical conditions* |
| D6093 | Re-cement or re-bond implant/abutment supported fixed partial denture | $35 | *A Benefit only under exceptional medical conditions* |
| D6094 | Abutment supported crown - titanium and titanium alloys | $295 | *A Benefit only under exceptional medical conditions* |
| D6096 | Remove broken implant retaining screw | $60 | *A Benefit only under exceptional medical conditions* |
| D6097 | Abutment supported crown - porcelain fused to titanium and titanium alloys | $315 | *A Benefit only under exceptional medical conditions* |
| D6098 | Implant supported retainer - porcelain fused to predominantly base alloys | $330 | *A Benefit only under exceptional medical conditions* |
| D6099 | Implant supported retainer for FPD - porcelain fused to noble alloys | $330 | *A Benefit only under exceptional medical conditions* |
| D6100 | Surgical removal of implant body | $110 | *A Benefit only under exceptional medical conditions* |
| D6105 | Removal of implant body not requiring bone removal or flap elevation | $110 | *A Benefit only under exceptional medical conditions* |
| D6110 | Implant/abutment supported removable denture for edentulous arch - maxillary | $350 | *A Benefit only under exceptional medical conditions* |
| D6111 | Implant/abutment supported removable denture for edentulous arch - mandibular | $350 | *A Benefit only under exceptional medical conditions* |
| D6112 | Implant/abutment supported removable denture for partially edentulous arch - maxillary | $350 | *A Benefit only under exceptional medical conditions* |
| D6113 | Implant/abutment supported removable denture for partially edentulous arch - mandibular | $350 | *A Benefit only under exceptional medical conditions* |
| D6114 | Implant/abutment supported fixed denture for edentulous arch - maxillary | $350 | *A Benefit only under exceptional medical conditions* |
| D6115 | Implant/abutment supported fixed denture for edentulous arch - mandibular | $350 | *A Benefit only under exceptional medical conditions* |
| D6116 | Implant/abutment supported fixed denture for partially edentulous arch - maxillary | $350 | *A Benefit only under exceptional medical conditions* |
| D6117 | Implant/abutment supported fixed denture for partially edentulous arch - mandibular | $350 | *A Benefit only under exceptional medical conditions* |
| D6118 | Implant/abutment supported interim fixed denture for edentulous arch - mandibular | $350 | *A Benefit only under exceptional medical conditions* |
| D6119 | Implant/abutment supported interim fixed denture for edentulous arch - maxillary | $350 | *A Benefit only under exceptional medical conditions* |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| D6120 | Implant supported retainer - porcelain fused to titanium and titanium alloys | $330 | *A Benefit only under exceptional medical conditions* |
| D6121 | Implant supported retainer for metal FPD - predominantly base alloys | $350 | *A Benefit only under exceptional medical conditions* |
| D6122 | Implant supported retainer for metal FPD - noble alloys | $350 | *A Benefit only under exceptional medical conditions* |
| D6123 | Implant supported retainer for metal FPD - titanium and titanium alloys | $350 | *A Benefit only under exceptional medical conditions* |
| D6180 | Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments | $30 | *A Benefit only under exceptional medical conditions* |
| D6190 | Radiographic/surgical implant index, by report | $75 | *A Benefit only under exceptional medical conditions* |
| D6191 | Semi-precision abutment - placement | $350 | *A Benefit only under exceptional medical conditions* |
| D6192 | Semi-precision attachment - placement | $350 | *A Benefit only under exceptional medical conditions* |
| D6194 | Abutment supported retainer crown for FPD - titanium and titanium alloys | $265 | *A Benefit only under exceptional medical conditions* |
| D6195 | Abutment supported retainer - porcelain fused to titanium and titanium alloys | $315 | *A Benefit only under exceptional medical conditions* |
| D6197 | Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant | $95 | *A Benefit only under exceptional medical conditions* |
| D6198 | Remove interim implant component | $110 | *A Benefit only under exceptional medical conditions* |
| D6199 | Unspecified implant procedure, by report | $350 | *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.* |
| D6200-D6999 IX. PROSTHODONTICS, fixed | | | |
| *- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge).* | | | |
| *- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years (60+ months) old.* | | | |
| D6211 | Pontic - cast predominantly base metal | $300 | *1 per 60 months; age 13+* |
| D6241 | Pontic - porcelain fused to predominantly base metal | $300 | *1 per 60 months; age 13+* |
| D6245 | Pontic - porcelain/ceramic | $300 | *1 per 60 months; age 13+* |
| D6251 | Pontic - resin with predominantly base metal | $300 | *1 per 60 months; age 13+* |
| D6721 | Retainer crown - resin with predominantly base metal | $300 | *1 per 60 months; age 13+* |
| 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+* |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| 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 | *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.* |
| D6980 | Fixed partial denture repair necessitated by restorative material failure | $95 | |
| D6999 | Unspecified fixed prosthodontic procedure, by report | $350 | *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.* |
| D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY | | | |
| *- Prior Authorization required for procedures performed by a Contract Specialist. medical necessity must be demonstrated for procedures D7340 - D7997. Refer also to Schedule B.* | | | |
| *- Includes pre-operative and post-operative evaluations and treatment under a local anesthetic. Post-operative services include exams, suture removal and treatment of complications.* | | | |
| D7111 | Extraction, coronal remnants - primary 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 | |
| D7252 | Partial extraction for immediate implant placement | $80 | *1 per lifetime per tooth, in conjunction with immediate implant placement* |
| D7259 | Nerve dissection | $280 | |
| 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 | *For active orthodontic treatment only* |
| D7284 | Excisional biopsy of minor salivary glands | $115 | *1 in same day* |
| D7285 | Incisional biopsy of oral tissue-hard (bone, tooth) | $180 | *1 per arch per date of service; regardless of number of areas involved* |
| D7286 | Incisional biopsy of oral tissue-soft | $110 | *3 per date of service* |
| D7290 | Surgical repositioning of teeth | $185 | *1 per arch, for permanent teeth only; applies to active orthodontic treatment* |
| D7291 | Transseptal fiberotomy/supra crestal fiberotomy, by report | $80 | *1 per arch; applies to active orthodontic treatment* |
| 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 | *1 per arch per 60 months* |
| D7350 | Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue) | $350 | *1 per arch* |
| 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 | |
| D7509 | Marsupialization of odontogenic cyst | $180 | |
| 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 | |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| D7771 | Alveolus, closed reduction stabilization of teeth | $160 | |
| 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 | *1 per date of service per Contract Dentist; 2 per 12 months per Contract Dentist* |
| 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 | |
| D7939 | Indexing for osteotomy using dynamic robotic assisted or dynamic navigation | $350 | *1 per tooth per 60 months* |
| 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 | |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| 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 | |
| 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 | *1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted* |
| D7962 | Lingual frenectomy (frenulectomy) | $120 | *1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted* |
| D7963 | Frenuloplasty | $120 | *1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted* |
| D7970 | Excision of hyperplastic tissue - per arch | $175 | *1 per arch per date of service* |
| D7971 | Excision of pericoronal gingiva | $80 | |
| D7972 | Surgical reduction of fibrous tuberosity | $100 | *1 per quadrant per date of service* |
| D7979 | Non-surgical sialolithotomy | $155 | |
| D7980 | Surgical 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 | *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.* |
| D7999 | Unspecified oral surgery procedure, by report | $350 | *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.* |
| D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees ONLY | | | |
| *- 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.* | | | |
| *- Pediatric Enrollee must continue to be eligible, Benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.* | | | |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| *- 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.* | | | |
| *-Limited orthodontic treatment (any dentition) and comprehensive orthodontic treatment (any dentition) are part of comprehensive orthodontic treatment with orthognathic surgery* | | | |
| *- 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.* | | | |
| *- Refer to Schedule B for additional information on medically necessary orthodontics.* | | | |
| D8080 | Comprehensive orthodontic treatment of the adolescent dentition | $1,000 | *1 per Enrollee per phase of treatment; included in comprehensive case fee* |
| D8091 | Comprehensive orthodontic treatment with orthognathic surgery | | *1 per Enrollee per phase of treatment; included in comprehensive case fee* |
| D8210 | Removable appliance therapy | | *1 per lifetime; age 6 through 12; included in comprehensive case fee* |
| D8220 | Fixed appliance therapy | | *1 per lifetime; age 6 through 12; included in comprehensive case fee* |
| D8660 | Pre-orthodontic treatment examination to monitor growth and development | | *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* |
| D8670 | Periodic orthodontic treatment visit | | *Included in comprehensive case fee* |
| D8671 | Periodic orthodontic treatment visit associated with orthognathic surgery | | *Included in comprehensive case fee* |
| D8680 | Orthodontic retention (removal of appliances, construction and placement of retainer(s)) | | *1 per arch for each authorized phase of orthodontic treatment; included in comprehensive case fee* |
| D8681 | Removable orthodontic retainer adjustment | | *Included in comprehensive case fee* |
| D8696 | Repair of orthodontic appliance - maxillary | | *1 per appliance; included in comprehensive case fee* |
| D8697 | Repair of orthodontic appliance - mandibular | | *1 per appliance; included in comprehensive case fee* |
| D8698 | Re-cement or re-bond fixed retainer - maxillary | | *1 per Contract Dentist; included in comprehensive case fee* |
| D8699 | Re-cement or re-bond fixed retainer - mandibular | | *1 per Contract Dentist; included in comprehensive case fee* |
| D8701 | Repair of fixed retainer, includes reattachment - maxillary | | *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.* |
| D8702 | Repair of fixed retainer, includes reattachment - mandibular | | *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.* |
| D8703 | Replacement of lost or broken retainer - maxillary | | *1 per arch; within 24 months following the date of service for orthodontic retention (D8680); included in comprehensive case fee* |
| D8704 | Replacement of lost or broken retainer - mandibular | | *1 per arch; within 24 months following the date of service for orthodontic retention (D8680); included in comprehensive case fee* |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| D8999 | Unspecified orthodontic procedure, by report | | *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.* |
| D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES | | | |
| D9110 | Palliative treatment of dental pain - per visit | $30 | *1 per date of service per Contract Dentist; regardless of the number of teeth and/or areas treated* |
| D9120 | Fixed partial denture sectioning | $95 | |
| D9210 | Local anesthesia not in conjunction with operative or surgical procedures | $10 | *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* |
| D9211 | Regional block anesthesia | $20 | |
| D9212 | Trigeminal division block anesthesia | $60 | |
| D9215 | Local anesthesia in conjunction with operative or surgical procedures | $15 | |
| D9219 | Evaluation for moderate sedation, deep sedation or general anesthesia | $45 | |
| D9222 | Deep sedation/general anesthesia - first 15 minutes | $45 | *Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service* |
| D9223 | Deep sedation/general anesthesia - each subsequent 15 minute increment | $45 | *Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9222, D9223) per date of service* |
| D9230 | Inhalation of nitrous oxide/analgesia, anxiolysis | $15 | *(Where available)* |
| D9239 | Intravenous moderate (conscious) sedation/analgesia - first 15 minutes | $60 | *Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service* |
| D9243 | Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment | $60 | *Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service* |
| D9248 | Non-intravenous conscious sedation | $65 | *Where available; 1 per date of service per Contract Dentist* |
| 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 | *1 per Enrollee per date of service* |
| D9420 | Hospital or ambulatory surgical center call | $135 | |
| D9430 | Office visit for observation (during regularly scheduled hours) - no other services performed | $20 | *1 per date of service per Contract Dentist* |
| D9440 | Office visit - after regularly scheduled hours | $45 | *1 per date of service per Contract Dentist* |
| D9610 | Therapeutic parenteral drug, single administration | $30 | *4 of (D9610, D9612) injections per date of service* |

| Code | Description | Pediatric Enrollee Pays | Clarification/ Limitations for Pediatric Enrollees |
|---|---|---|---|
| D9612 | Therapeutic parenteral drugs, two or more administrations, different medications | $40 | *4 of (D9610, D9612) injections per date of service* |
| D9910 | Application of desensitizing medicament | $20 | *1 per 12 months per Contract Dentist; permanent teeth* |
| D9930 | Treatment of complications (post-surgical) - unusual circumstances, by report | $35 | *1 per date of service per Contract Dentist within 30 days of an extraction* |
| D9950 | Occlusion analysis - mounted case | $120 | *Prior Authorization is required; 1 per 12 months for diagnosed TMJ dysfunction; permanent teeth; age 13+* |
| D9951 | Occlusal adjustment - limited | $45 | *1 per 12 months for quadrant per Contract Dentist; age 13+* |
| D9952 | Occlusal adjustment - complete | $210 | *1 per 12 months following occlusion analysis - mounted case (D9950) for diagnosed TMJ dysfunction; permanent teeth; age 13+* |
| D9995 | Teledentistry - synchronous; real-time encounter | No charge | |
| D9996 | Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review | No charge | |
| D9997 | Dental case management - patients with special health care needs | No charge | |
| D9999 | Unspecified adjunctive procedure, by report | No charge | *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.* |

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 2026 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)**

1. 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.

2. To the extent the dental plans can offer Teledentistry, it would be offered at no charge.

3. These Endnotes do not limit an issuer's obligations to comply with applicable Federal, State, or local laws, rules, or regulations. In the event an issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirements of these Endnotes, an issuer shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these Endnotes exceed requirements imposed by law, an issuer shall comply with the requirements in these Endnotes.

## 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] are 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 anaodontia 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.

13. When performed in conjunction with the removal of an impacted tooth, complete bony with unusual surgical complications, nerve dissection is included with the extraction procedure. Otherwise, nerve dissection is not a Benefit (D7259).

**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. Dispensing of drugs not normally supplied in a dental facility unless included in *Schedule A*.

7. 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.

8. Dental services received from any dental facility other than the assigned 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.

9. Consultations [D9310, D9311] or other diagnostic services [covered codes only between D0120–D0999], for non-covered Benefits.

10. Single tooth implants [covered codes only between D6000–D6199].

11. 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.

12. 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.

13. 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.

14. 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 [D4322-D4323], gnathologic recordings, equilibration [D9952] or treatment of disturbances of the TMJ [covered codes only between D0310-D0322, D7810-D7899], unless included in *Schedule A*.

15. Porcelain denture teeth or fixed partial dentures (overlays, implants, and appliances associated therewith) [D6940, D6950] and personalization and characterization of complete and partial dentures.

16. Extraction of teeth [D7111, D7140, D7210, D7220-D7240, D7241, D7250], when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars.

17. 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.

18. Vestibuloplasty / ridge extension procedures [D7340, D7350] performed on the same date of service as extractions [D7111-D7250] on the same arch.

19. 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].

20. 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].

21. Inhalation of nitrous oxide [D9230] when administered with other covered sedation procedures.

22. 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].

23. Services or supplies for sleep apnea.

24. Administration of neuromodulators is not a Benefit of the plan.

25. Administration of dermal fillers is not a Benefit of the plan.

**Medically Necessary Orthodontic 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, D0703,D0801, D0802, D0803, D0804]. Neither the Enrollee nor the plan may be charged for D0350, D0703, D0801, D0802, D0803 or D0804 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. All orthodontic services, including direct to consumer orthodontics, must be provided by a licensed Dentist authorized to deliver care in Your state. Claims for services that are not provided by a Dentist are not eligible for reimbursement.

9. 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.

10. 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.

11. Orthodontics, including oral evaluations and all treatment, [covered codes only between D8000-D8999] must be performed by a licensed dentist or their supervised staff, acting within the scope of applicable law.

12. 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 Membership Agreement and Evidence of Coverage. See your Health Plan Membership Agreement and Evidence of Coverage for information about your out-of-pocket maximum. |
| (D) Professional Services | 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.<br><br>Cost Share ranges by category of service.<br>Examples are as follows:<br>Diagnostic Services No Charge<br>Preventive Services No Charge<br>Restorative Services $ 20.00 - $ 310.00<br>Endodontic Services $ 20.00 - $ 350.00<br>Periodontic Services $ 10.00 - $ 350.00<br>Prosthodontic Services, (removable) $ 20.00 - $ 350.00<br>Maxillofacial Prosthetics $ 35.00 - $ 350.00<br>Maxillofacial Prosthetics $ 35.00 - $ 350.00<br>Implant Services (medically necessary only) $ 25.00 - $ 350.00<br>Prosthodontic Services, (fixed) $ 40.00 - $ 350.00<br>Oral and Maxillofacial Surgery $ 30.00 - $ 350.00<br>Orthodontic Services (medically necessary only) $1,000.00 - $ 1,000.00<br>Adjunctive General Services No Charge - $ 210.00<br><br>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. |
| (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.