2023

Sutter Health Plus

Large Group Evidence of Coverage and Disclosure Form

Plan Name: Vista HD26 HDHP HMO

Effective January 1, 2023

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

Sutter Health Plus

2700 Gateway Oaks Drive, Suite 1200

Sacramento, CA 95833

Member Services

8 a.m. to 7 p.m.

Monday through Friday

1-855-315-5800 (TTY 1-855-830-3500)

www.sutterhealthplus.org

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Sutter Health Plus
P.O. Box 160307
Sacramento, CA 95816
855-315-5800
sutterhealthplus.org

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

Sutter Health Plus:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:

  Qualified sign language interpreters

  Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:

  Qualified interpreters

  Information written in other languages

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

If you believe that Sutter Health Plus has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender ide

INTRODUCTION

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

Throughout this *EOC*, Sutter Health Plus is referred to as ñSHP,ò ñus,ò ñweò or ñyour health planò while Members are referred to as ñyou.ò The capitalized terms used have specific meanings which are defined in the Definitions chapter. Also, please note that all times listed throughout this *EOC* are Pacific Time.

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

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

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

Confidentiality of Medical Records

SHP is committed to protecting the confidentiality of our Membersô records.

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

Confidential Communication of Medical Information

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

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

Privacy Practices

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

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

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

Language Assistance

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

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

SHP

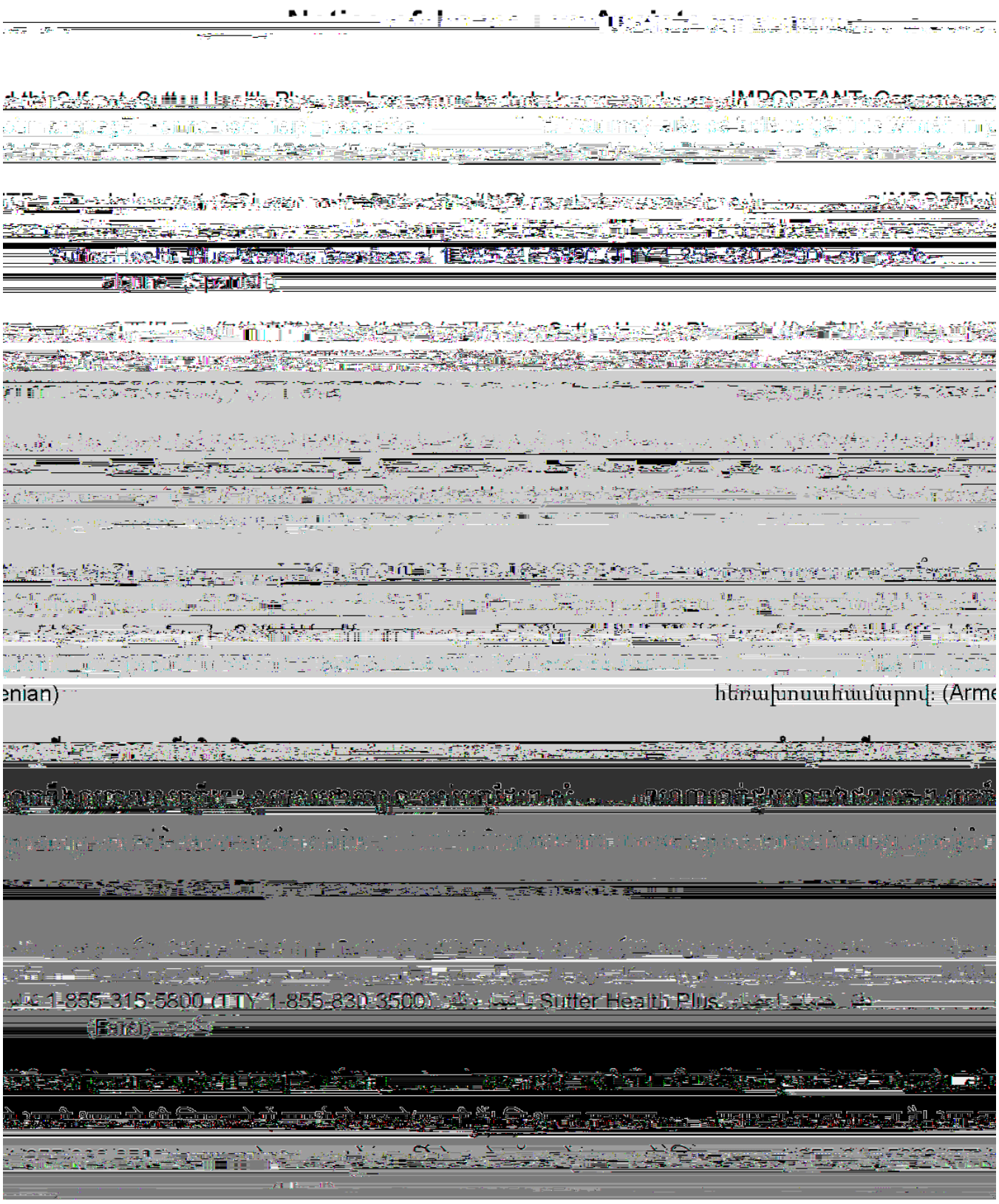
1-855-315-5800 (TTY 1-855-830-3500)

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



SHP Contact Information

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

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

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

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

Other SHP Contacts:

- Appeals and Grievances: **1-855**

USBHPC maintains a network of Participating Practitioners, which includes facilities and behavioral health professionals, to provide you with these services. SHP and USBHPC are committed to assuring that the services provided by the USBHPC network are properly coordinated with the services provided by the SHP network

- CVS Caremark, part of the CVS Health family, provides pharmacy benefit management (PBM) services for Outpatient Prescription Drug benefits. CVS Caremark maintains one of the largest networks of Participating Pharmacies with retail, mail order delivery and Specialty Drug distribution channels
- Vision Service Plan, or VSP, provides core refractive eye exams for all Members, and, when an employer Group has purchased optional vision benefits, VSP also provides comprehensive vision services for all Members
- Delta Dental provides

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

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

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

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

In some cases, a non-Participating Provider may provide Covered Services at an SHP network facility where SHP or your PCP's Medical Group has authorized the services. You are not responsible for

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

Your Choice of Doctors and Providers—Your SHP Provider Directory

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

The SHP website and Provider Directory lists all physicians, hospitals, clinics, Skilled Nursing Facilities, and other facilities in the SHP network. You must receive all of your care from the providers in your PCP's Medical Group, which is a subset of the SHP network, unless you need Emergency Services or Urgent Care or you receive Prior Authorization from your Medical Group or SHP to visit an out-of-network

- 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

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

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

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

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

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

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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 doctorís Medical Group. Your Medical Group may refer you to any Specialist in the SHP network outside of the Medical Group

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

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

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

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

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

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

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

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

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

Emergency Services

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

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

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

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

PCP. Allergy testing and treatment also require Prior Authorization by the PCP's Medical Group.

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

Ambulance Services

Emergency

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

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

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

Nonemergency

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

Ambulance Services Exclusion

SHP does not cover transportation by TJETTf1 0 0 1dand on by TJETTf1 0 0 1dand on by TJETTf1 0 0 14.024 649.0 g0 G[q8

- Outpatient imaging, laboratory, and special procedures (refer to the Outpatient Imaging, Laboratory, and Therapeutic Procedures section)
- Outpatient

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

  Artificial insemination

  Services related to the transfer of embryos into a uterus

  Thawing of any cryopreserved reproductive material

This exclusion does not apply if your employer Group elected infertility treatment as an optional benefit. If elected, please refer to the separate Infertility Services Benefit Rider for details on Covered Services.

Health Education

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

You pay the following for these Covered Services:

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

Health Education Limitations and Exclusions

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

Hearing Services

SHP covers the following:

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

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

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

Hearing Services Exclusions

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

Home Health Care

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

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- SHP covers services rendered by midwives when the provider is within the SHP network and is supervised by a Participating SHP Physician

Infertility Treatment

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

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

Medically Administered Drugs

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

Medically administered drugs include:

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

SHP covers the prescribed,12 0 612 792 reW* BT/F7 [3078] TJETQq0.00000912 0 612 792 reW* nBT/F3 10.08 TETQq4(a)-14

months by the Qualified Autism Service Provider and modified whenever appropriate

The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to USBHPC upon request

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

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

Substance Use Disorder (SUD) Services

SUD inpatient services are covered as follows:

- Inpatient services are inpatient hospitalization and professional services rendered by a Participating Practitioner and provided at a participating facility, such as a hospital or Residential Treatment Center. These services are covered when Prior Authorized by USBHPC and are inclusive of, but not limited to, the following:

  Inpatient chemical dependency hospitalization, including medical detoxification and medical treatment for withdrawal symptoms

  Treatment at a Residential Treatment Center

- Inpatient prescription drugs are covered only when prescribed by a USBHPC Participating Practitioner for the Medically Necessary treatment of a SUD while the Member is confined to a hospital or inpatient treatment center.

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

SUD outpatient services are covered as follows:

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

  Multidisciplinary intensive treatment programs such as:

  Intensive outpatient program day treatment

  Partial hospitalization day treatment

- Outpatient Prescription Drugs are covered when prescribed by a USBHPC Participating Practitioner or SHP Participating Provider. They are covered as Outpatient Prescription Drugs

- 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

Covered Outpatient Prescription Drugs are covered up to a 30-day supply from a CVS Health National

UHTXLUHV 3ULRU $XWKRUL]DWLRQ 7KH 0HPEHU¶V QHZ Participating Physician must submit a Prior $XWKRUL]DWLRQ UHTXHVW WKDW VSHFLILHV ³FRQWLQXLW\ RI FDUH´ ,I WK-day prescription is documented by the prior provider or pharmacy, then SHP may cover up to a 90-day supply of the drug. Additional refills or requests for supplies of the drug require additional review for medical necessity and the prescribing Provider must submit a Prior Authorization request.

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

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

Exigent circumstances are when one of the following is true:

- A Member is suffering from a health condition that may seriously jeopardize their life, health, or

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

General Exclusions

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

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

arrangement. A Surrogate Pregnancy is one in which a woman (the surrogate) has agreed to become pregnant with the intention of surrendering custody of the child to another person. If the Surrogate is a Member, she is entitled to maternity services, but in the event pregnancy services are rendered to a woman in a Surrogate arrangement, the Plan or its Medical Group has the right to impose a lien against any amount received by the Surrogate/Member for reasonable costs incurred by SHP or its contracted Medical Groups

31) Travel and lodging expenses. This exclusion does not apply to reimbursement for travel and lodging expenses provided under the Bariatric Surgery section in the Your Benefits chapter

32) Exercise equipment, gym memberships, fitness trainers, and fitness classes

33) Dietary supplements or replacement foods used to promote weight loss, such as all liquid diets, purified foods, protein shake diets, vitamin and mineral supplements

34) Commercially available weight loss programs that offer group support or specific meals, such as Weight Watchers®, Jenny Craig®, or Nutrisystems®

35) Complementary, alternative and integrative medicine:

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determine if the Dependent continues to be eligible as a disabled Dependent

- If the Dependent is not a Member and the Subscriber is requesting enrollment of the Dependent, the Subscriber must provide SHP with documentation of the Dependent's incapacity and dependency within 60 days after SHP requests the documentation so that SHP may determine if the Dependent is eligible to enroll as a disabled Dependent. If SHP determines that the Dependent is eligible as a disabled Dependent, the Subscriber must provide SHP with documentation of the Dependent's incapacity and dependency within 60 days after requested so that SHP can determine if the Dependent continues to be eligible as a disabled Dependent

When You Can Enroll and When Coverage Begins

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

New Employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a SHP enrollment application to your Group within your *URXS¶V UHTXLUHG WLPHIUDPH IRU QHZ HPSOR\HHV DV permitted by law or regulation.

Effective Date of Coverage

Your coverage effective date is based on the date provided to SHP by your Group. 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 10.08 TJ ET Q q 0.00000

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

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

Termination Due to Loss of Eligibility

If at any time you lose eligibility, your membership will end at 11:59 p.m. on the last day o

Option 1 ±Right to Submit a Grievance to SHP

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

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

You may want to submit your grievance to SHP first if you believe your cancellation, rescission or

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 ²continuation of health coverage ´or ²continuation 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 employee's job ends
- 7KH HPSOR\HH¶V KRXUV RI HPSOR\PHQW 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

x 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

x 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

x 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:

x 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:

x You are age 60 or older at the time your employment ends, and

x 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:

x You do not pay your Premiums on the due date or within the grace period of at least 30 days

x You move outside the SHP Service Area

x Your former Employer no longer offers any health plan

x You sign up for or become eligible for Medicare

x You sign up for another health plan

x You commit fraud or intentional misrepresentation of material fact

x You sign up for or become eligible for federal COBRA

x You do not submit your election notice

x You qualify for another federal program such as the Federal Employees Health Benefits Program

You must contact SHP if:

x You move outside the SHP Service Area

x You or your Dependent(s) sign up for or become eligible for Medicare

x You sign up for another health plan

x You or your Dependent(s) sign up for or become eligible for federal COBRA

x You qualify for another federal program such as the Federal Employees Health Benefits Program

Cal-COBRA Termination and Premature Termination of Continuation Coverage

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

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

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

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

Uniformed Covered Services Employment and Reemployment Rights Act (USERRA)

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

Coverage for a Disabling Condition

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

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

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

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

Important Definitions for Disabling Condition

- Totally disabled f or Subscriber s and adult Dependent s 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

SHP will reimburse travel expenses for covered, medically necessary bariatric (metabolic) surgery performed at a facility that is 50 miles or more from W K H 0 H P E H U ¶ V K R P H D V R X W O L Q H G L Q W K H % D U L D W U L F Surgery subsection of the Your Benefits chapter.

To obtain reimbursement for eligible travel expenses, please submit the following items to Sutter Health plus, Attn: Claims Department, at the P.O. Box listed on the back of your Member ID card:

- A completed claim form
- A copy of the written Prior Authorization from the 3 & 3 ¶ V 0 H G L F D O * U R X S
- Documentation of the expenses incurred, including itemized bills and receipts

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

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

Grievances

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

- You are not satisfied with the quality of care you received
- You received a written denial of Covered Services that require Prior Authorization from either the Medical Group or SHP or a Notice of Non-Coverage and you want SHP to cover the services
- You received a Notice of Adverse Determination from CVS Caremark and you want to appeal the decision
- A Participating Provider determines that Covered Services are not Medically Necessary and you want SHP to cover the services
- You were told that services are not covered and you believe that the services are Covered Services
- You received care from a non-Participating Provider or a Participating Provider that is outside \RXU 3&3¶V 0HGLFDO*URXS without Prior Authorization (other than Emergency Services, Post-Stabilization Care, Out-of

- By calling USBHPC Grievances and Appeals:
  1-800-985-2410
- By faxing:
  1-855-312-1470
- Online:
  liveandworkwell.com

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

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

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

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

Grievance Handled by Phone Within One Business Day

If you

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

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

What Are My Rights?

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

- To be provided information about the SHP organization and its services, providers and practitioners, managed care requirements, processes us

SHP Public Policy Participation Committee

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

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

What Are My Responsibilities?

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

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

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

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

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

Reporting Suspected Fraud and Abuse

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

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

There are many examples of fraud and abuse which include:

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

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

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

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

If sending an email please include the following information:

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

Your Benefits chapter, excluding mental health and substance use disorder services provided by USBHPC Participating Practitioners, and subject to the Exclusions And Limitations chapter of this *EOC*.

Medically Necessary (Medical Necessity): Means that which SHP determines:

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

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

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.

Post-Stabilization Care: Medically Necessary services related to your Emergency Medical related to you

pregnant with the intention of surrendering custody of the child to another person.

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