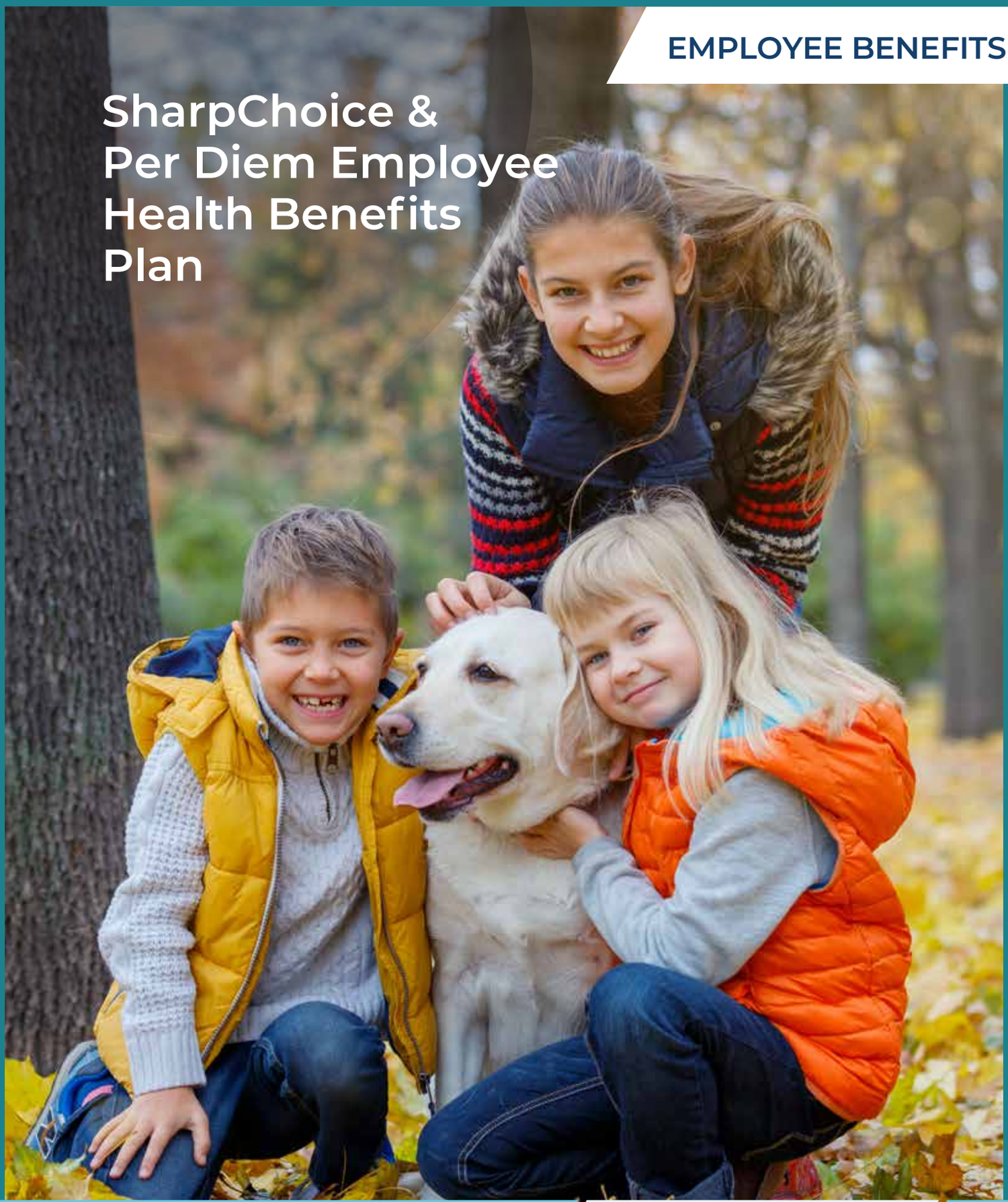
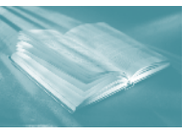
EMPLOYEE BENEFITS

SharpChoice & Per Diem Employee Health Benefits Plan



SUMMARY PLAN DESCRIPTION
Effective January 1, 2026

SHARP



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About THIS BOOK

This book serves as your blueprint to Sharp HealthCare's Per Diem Employee Health Benefits Plan. The more you understand the various elements of your coverage, the better prepared you will be to take advantage of the coverage Sharp HealthCare provides for you and your eligible child(ren) under age 26.

NOTE:
This book contains a summary of your rights and benefits as a participant in the SharpChoice *and group voluntary benefit plans. If you cannot read any part of this book, please contact the Employee Benefits Department.*

This book is divided into the following sections:

- SharpChoice Health Benefits
  - How SharpChoice Works
  - Group Health (Medical) Benefits
  - Vision Benefits
  - Employee Assistance Program
- Definitions
- Administrative Information
- Health Plan Notices

"Sharp HealthCare" as referred to in this book means Sharp HealthCare and its affiliated entities that have adopted the particular plan.

The summary plan descriptions herein are intended to describe the Per Diem Employee Health Benefits Plan. They are based on official documents that may include policies, contracts, plans, and trust agreements. The descriptions herein are intended to be accurate; however, if any conflict arises between this summary and the official plan documents and/or contracts, the plan documents or contracts prevail. These documents will be amended from time to time. This summary may not be amended until some time after the amended plan or contract provisions are effective. In addition, because this is only a summary, all situations will not be covered or described. Sharp reserves the right to correct any errors in this summary.

ABOUTTHISBOOK

It is important for you to read this book to understand what is covered under the Per Diem Employee Health Benefits Plan and when you are entitled to benefits from the plan. Additionally, please make note of the following legal provisions:

- Participation in the plan is not a guarantee of continued employment with Sharp HealthCare or its affiliated employers.
- There are no guarantees that participation in the plan for per diem employees or eligible child(ren) under age 26 will exist or remain unchanged in future years. Sharp HealthCare intends to continue the plan but reserves the right to change it at any time, including the right to change any amounts contributed toward the cost of providing benefits by Sharp HealthCare or employees, the level of benefits provided, and the class or classes of employees eligible for benefits.
- Coverage under the plan is not a guarantee of employment, and Sharp HealthCare reserves the sole right to terminate the plan at any time, either in its entirety or with respect to any covered class or classes of employees.
- All changes will be promptly communicated to you. If the plan is discontinued, benefits will be paid for covered expenses prior to that date.
- Many of the benefits described in this book fall under the jurisdiction of the Employee Retirement Income Securities Act of 1974, as amended (ERISA). Your legal rights under ERISA are described at the end of this book, along with legal and administrative information (such as plan numbers and plan administrators).

This is your book to use as an active resource guide. It will answer many questions that you may have about your health benefits. If you have additional questions concerning your coverage that are not answered in this book, your local Human Resources Office and/or the Employee Benefits Department is always available to help you.

From time to time, Sharp HealthCare may give you other benefits booklets, reports, and statements. You should keep these materials with your Summary Plan Description so that all your medical benefits information remains current and in one place.

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How SHARPCHOICE WORKS

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How SHARPCHOICE WORKS

You are able to select your plan from among three HMO medical plans to meet your individual needs.

SharpChoice offers flexibility, employee involvement, and cost management. It's a program that not only fits with Sharp HealthCare's strategy of remaining competitive from a business standpoint, but also focuses on meeting the diverse needs of Sharp HealthCare employees and their families.

Your Benefits & Options

The next page summarizes the benefits offered under the ***SharpChoice*** Health Plan. You will find detailed information about this plan in the sections throughout this book.

Benefit Plan Contributions & Funding Methods

The sources of funding for the benefit plans described herein are employee contributions. Medical/vision insurance premiums for you and your eligible child(ren) under age 26 are paid by you directly to Sharp Health Plan on a monthly basis.

Eligibility

ELIGIBLE EMPLOYEES

Per Diem employees are eligible to participate in the Per Diem Employee Health Benefits Plan the first of the month following 30 days of continuous employment.

Following is a schedule of effective dates for 2026:

HIRE DATE	EFFECTIVE DATE
■ January 1 to January 3	February 1
■ January 4 to January 31	March 1
■ February 1 to March 3	April 1
■ March 4 to April 2	May 1
■ April 3 to May 3	June 1
■ May 4 to June 2	July 1
■ June 3 to July 3	August 1
■ July 4 to August 3	September 1
■ August 4 to September 2	October 1
■ September 3 to October 3	November 1
■ October 4 to November 2	December 1
■ November 3 to December 3	January 1
■ December 4 to December 31	February 1

ELIGIBLE DEPENDENTS

The following children are eligible to be enrolled under ***SharpChoice***:

Child – Your biological child, stepchild, legally adopted child or another child for whom you are currently the legal guardian or have physical legal custody of, pursuant to a court order that is currently in force, under the age of 26.

Disabled Child Age 26 or Older – Your dependent child who is mentally or physically incapable of self support, is enrolled prior to his or her 26th birthday, and is determined to be totally disabled before his or her 26th birthday.

A child who has been legally placed for adoption with you is considered a legally adopted child on the date of placement. For purposes of this provision, placement for adoption occurs on the date you or you and your spouse/domestic partner have physical legal custody of the child or has assumed responsibility for the child's care and well-being for an indefinite period of time, and shall be determined in the sole discretion of Sharp HealthCare based on objective evidence supplied by you.

A covered child who is both incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and chiefly dependent upon the subscriber for support and maintenance (totally disabled) is eligible to continue to be enrolled under the plan provided the child is otherwise eligible for coverage under the plan and you continue to be covered under the plan. Proof of such total disability must be submitted to the plan prior to the child's 26th birthday.

It is your responsibility to notify Sharp HealthCare if a dependent ceases to meet the eligibility requirements, following the guidelines in the "IRS Qualified Status Changes" section on page 7 and the "Continuation of Coverage (COBRA)" section beginning on page 25.

Dependent Verification Requirement – Sharp has a dependent verification process to ensure that all enrolled dependents receiving benefit coverage are eligible. The verification process helps ensure that the company does not incur increased health care expenses that could negatively impact the future cost of health care benefits for employees and their families. If you are enrolling as a new hire, have experienced a status change, or are participating in open enrollment, and you are adding your legal spouse/certified domestic partner, and/or eligible dependent children to the medical/vision and/or dental plan(s), you will be required to provide verification documents at the time you enroll in benefits. Enrollment for added dependents will only be approved once appropriate documentation is received and verified by Sharp. Coverage for enrolled dependents not meeting the eligibility definition or dependents remaining unverified will not be activated.

IN-AREA COVERAGE FOR NON-RESIDENT EMPLOYEES AND ELIGIBLE CHILDREN

Employees who live outside Sharp Health Plan's service area (San Diego and southern Riverside counties) can be enrolled in medical coverage. Eligible children can also be enrolled if they are not living in Sharp Health Plan's service area. **Coverage is limited to services available within the service area, and emergency and urgent care services outside the service area. It is important to note that your dependent must travel in-area to access non-emergent health care services.**

Enrollment Requirements

When you are first eligible for the health plan, you will make elections regarding your coverage. The elections you make must remain in effect until the end of the plan year, unless you have a qualified family status change. Even then, you may only change your benefit elections to the extent such change is consistent with, and on account of, your change in family status. See the "IRS Qualified Status Changes" on page 7.

Each year, during the annual open enrollment period, you will be given the opportunity to change your coverage elections. Any changes will be effective beginning the next calendar plan year.

COVERAGE EFFECTIVE DATE FOR YOU

As an eligible employee, your medical/vision elections become effective on the first day of the month following 30 days of continuous employment provided you complete the enrollment process and remit the first premium to Sharp Health Plan. If you are not in an "active at work"[1] status on that day due to an illness, injury or disability, your medical/vision coverage will be effective on that day. If you are not in an "active at work" status for reasons other than illness, injury or disability, then your elections will not be effective until the day you return to active work.

1 For purposes of eligibility for the medical/vision plans, you are considered to be actively at work during a Family Medical Leave (FMLA).

COVERAGE EFFECTIVE DATE FOR YOUR ELIGIBLE CHILDREN

Coverage for your enrolled eligible child(ren) under age 26 is subject to the following requirements:

- The effective date is the same as your own coverage (unless enrolled later, due to a qualified status change or open enrollment election or other special enrollment period discussed below).

- Coverage for a newborn child, a newly adopted child or a child newly placed with you or your spouse/domestic partner for adoption is effective retroactive to the date of birth, adoption or placement provided you properly apply for coverage for the child within 31 days from the date of birth, adoption or placement. At this time, you may also enroll yourself and/or other children if he or she is eligible but not enrolled and coverage will be effective as of the date of birth, adoption or placement. Dependents previously eligible may be added at this time; however, their coverage will be effective the first day of the following month.
- You cannot enroll dependents in a plan in which you have not enrolled yourself.

YOUR ENROLLMENT RIGHTS

If you decline benefit coverage for yourself or your eligible child(ren) under age 26 due to other health insurance coverage, you may in the future be able to enroll in the Per Diem Employee Health Plan, provided you request enrollment within 31 days after other coverage ends. Also, if you have a child as a result of marriage/domestic partner certification, birth, adoption or placement for adoption, you may be able to enroll yourself and your child provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. Proper documentation will be required.

LOSS OF OTHER HEALTH CARE COVERAGE

You may enroll yourself and/or any of your eligible children for health plan coverage if all of the following requirements are met:

- You or your child were covered under another health plan as an individual or dependent, including coverage under COBRA;
- You or your child lost coverage under the other health plan or COBRA continuation coverage for you or your child was exhausted (other than due to ineligibility resulting from cause or failure to timely pay any required contributions);
- You properly enroll in coverage under the plan within 31 days from the date on which such other health plan coverage is lost (60 days for CHIP);
- You provide documentation to Sharp HealthCare of the loss of other health plan coverage within 31 days from the date on which such coverage is lost (60 days for CHIP).

Coverage will be effective on the first day of the month following the date the other health care coverage was lost. To enroll, please access Workday within 31 days of the date coverage was lost (60 days for CHIP).

ENROLLMENT DEADLINE

To enroll when you are first eligible, you must enroll yourself and if you choose, your eligible children within 31 days of the initial eligibility date. To enroll during the plan year pursuant to one of the qualified status changes discussed below, you must enroll yourself and any children (as applicable) within 31 days of the date you acquire a new child, within 31 days of the date other health plan coverage was lost, or within 31 days of a qualified status change.

OPEN ENROLLMENT

During the annual open enrollment period, you have the opportunity to change your benefit elections for the upcoming plan year.

REHIRE/REINSTATEMENT

If you recently have been rehired as a Sharp HealthCare per diem employee, it is important that you complete the process to enroll or re-enroll for health coverage. If you have been rehired within 1 year of your termination date, you are eligible to enroll in health coverage upon rehire. **Please note that your former benefit elections will not reinstate automatically.** If you are rehired within 30 days of your termination date, your previous benefit elections are reinstated.

You must complete your enrollment indicating the medical plan you wish to elect. This election must occur within 31 days of your rehire date. Elections will become effective the first day of the month following your rehire date or the date you complete your enrollment and remit the first premium payment to Sharp Health Plan, whichever occurs first.

IRS Qualified Status Changes

You are permitted to make changes in your ***SharpChoice*** benefit elections during the year if you have an IRS "qualified status change," and notify the Human Resources Department within 31 days of the change (60 days if eligible for the Children's Health Insurance Program).

Examples of IRS qualified status changes are:

- Marriage, divorce, legal separation or annulment[1];
- Birth, adoption, placement for adoption, change in physical legal custody or other form of legal guardianship of a dependent child;
- Death of your spouse or dependents;
- Change in employment status by you, your spouse or dependent which affects your/their eligibility for benefits coverage;
- Change in status affecting your eligibility for benefits (i.e., per diem to full-time/part-time);
- Involuntary loss of other benefit coverage for you, your spouse or dependents due to an event that is beyond your control;
- Commencement or return from a leave of absence by you, your spouse or dependents;
- Significant change in benefit coverage for you, your spouse or your dependents such as a significant reduction in benefits coverage, an increase or decrease in premium, or addition or deletion of a benefit option;
- Change in benefit elections for your spouse or dependents during an open enrollment period under another employer's benefit plan;
- Eligibility for and enrollment in MediCare or MediCal by you, your spouse or dependents.

1 IRS regulations do not recognize the declaration or dissolution of a domestic partnership as a qualified status change that would allow a change to a pretax benefit deduction.

- Eligibility or ineligibility and enrollment in the state Children's Health Insurance Program (CHIP). Sixty-day special enrollment/drop period applies.

Termination of Coverage

Except as required under COBRA, ERISA, the IRS Code or other applicable law, health care coverage for you and/or your children ends on the first of the following dates to occur:

- The last day of the month in which your employment with Sharp HealthCare terminates;
- The last day of the month in which you and/or your children (as applicable) change to an ineligible status;
- The last day of the month for which you have not paid the required premiums;
- The date of your death;
- The last day of the plan year following an open enrollment period during which you waive coverage;
- The date the ***SharpChoice*** health plan is amended to terminate the eligibility of any class of eligible employees of which you are a member; or
- The day the ***SharpChoice*** health plan ends.

Family, Medical, and Other Qualified Leaves of Absence

Under the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA) you may be entitled to up to 12 weeks of unpaid leave in any 12-month period. Under the California Pregnancy Disability Leave (PDL) law, which is part of the California Fair Employment and Housing Act (FEHA), you may be entitled to up to 4 months of leave in a 12-month period for disability due to pregnancy, childbirth or related medical conditions. Please refer to Sharp HealthCare's in force LOA Policy. Leave may be available for the birth and care of a newborn child, or placement of a child for adoption or foster care, a serious health condition of a family member (child, spouse or parent), a personal serious illness, or leave related to military service.

You have the option of continuing your health coverage during an approved leave on the same terms and conditions in effect immediately prior to you taking such leave.

Remember, you are responsible for timely payment of your monthly premiums directly to Sharp Health Plan. If you fail to remit your premiums in a timely manner, your coverage will be cancelled retroactive to the end of the month for which your last payment was made.

QUALIFIED STATUS CHANGES

You may be able to change your health coverage provided the changes you want to make are consistent with the commencement or termination of your approved leave of absence. You will also be able to change your elections as a result of a qualified status change that occurs during an approved leave of absence (such as the birth of a child or marriage).

OPEN ENROLLMENT

If you are eligible for benefit coverage and are on an approved leave of absence, you may make changes to your SharpChoice medical/vision benefit elections during the annual open enrollment period. Your changes to medical/vision insurance will be effective with the new calendar plan year following the enrollment period. Benefits continuation described above may apply toward the duration requirements under the Consolidated Omnibus Reconciliation Act (COBRA) as described in the "COBRA" section beginning on page 25.

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Group HEALTH BENEFITS

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Group HEALTH BENEFITS

Sharp Health Plan offers you health benefits through a managed care program, or Health Maintenance Organization (HMO), which helps protect you and your eligible children from high medical costs and the financial burden that could accompany a serious illness or injury.

Managed care is the most effective form of health care, addressing escalating costs while meeting your needs for quality medical care. In a managed care environment, it is essential that you be informed and thoroughly understand how your plan works. The best thing that you can do for yourself is to manage your care – choose and use your benefits wisely. Take the time to be informed about all of your options and how the options you choose will work to your advantage.

You may choose coverage between three Health Maintenance Organization (HMO) options provided through Sharp Health Plan: Value HMO,[1] Basic HMO or Premium HMO option.

Highlights of Value Plan, Basic and Premium HMO Options

All three HMO options use the same provider networks and operate in the same way. The principal provisions of each plan option are highlighted in the chart on the following page.

Please note that the Value HMO Plan option allows you to cover yourself and your eligible dependent children under age 26 while saving on premiums, however coinsurance does apply for certain services beyond routine and preventive care. Carefully review the comparison charts on pages 11-16 to assist you in which HMO plan works best for yourself and your family.

When comparing your HMO coverage options, keep in mind that there are some differences in benefits and costs. You should carefully consider which HMO plan best suits your needs and the needs of your family when reviewing your three options.

1 Please note that the Value HMO Plan is available to cover yourself and your eligible dependent children under the age 26. Spouse/ Domestic Partner are not able to be enrolled in this option.

VALUE PLAN HMO MEDICAL OPTIONS

BENEFIT FEATURE	VALUE PLAN HMO OPTION
Calendar year[1] deductible	$1,500 per individual
Annual Out of Pocket Maximum [1,2]	$6,400 per individual $12,800 per family
Lifetime Maximum	No lifetime maximum
PREVENTIVE SERVICES[3]	
Well baby and Well child (to age 18) physical exams, immunizations and related laboratory services	$0 copayment
Routine adult physical exams, immunizations and related laboratory services	$0 copayment
Laboratory, radiology, and other services for the early detection of disease when ordered by a Physician	$0 copayment
Routine gynecological exams, immunizations and related laboratory services	$0 copayment
Mammography	$0 copayment
Prostate cancer screening	$0 copayment
Colorectal cancer screenings including sigmoidoscopy and colonoscopy	$0 copayment
SHARP BEST HEALTH™ WELLNESS SERVICES	
On-line health education and wellness workshops and other wellness tools	$0 copayment
Telephonic health coaching (weight management, tobacco cessation, stress management, physical activity, nutrition)	$0 copayment
PROFESSIONAL SERVICES	
Primary Care Physician office visit for consultation, treatments, diagnostic testing, etc.	$25/visit
Specialist Physician office visit for consultation, treatments, diagnostic testing, etc.	$50/visit
Medically necessary physician home visit	$50/visit
Laboratory tests and services	$15/visit
Radiology services (x-rays and diagnostic imaging)	$15/visit
Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	$150/visit
Allergy testing	$50/visit
Allergy injections	$25/visit
OUTPATIENT SERVICES (INCLUDING BUT NOT LIMITED TO SURGICAL, DIAGNOSTIC, AND THERAPEUTIC SERVICES)	
Outpatient facility fee	30% coinsurance[4, 7]
Outpatient Physician/Surgeon Fee	30% coinsurance[4, 7]
Infusion Therapy (including but not limited to chemotherapy)	Variable[5]
Dialysis	$0 copayment
Rehabilitation services: physical, occupational and speech therapy	$25/visit
Habilitation services	$25/visit
Radiation therapy	Variable[5]
MATERNITY CARE	
Prenatal and postpartum office visits	$0/visit
Hospitalization and Professional (delivery and all inpatient services)	30% coinsurance[4, 7]
Breastfeeding support, supplies and counseling	$0 copayment
DOULA SUPPORT SERVICES	
Prenatal and postpartum visits	$0 copayment

VALUE PLAN HMO OPTIONS

BENEFIT FEATURE	VALUE PLAN HMO OPTION
FAMILY PLANNING SERVICES	
Contraceptives (including but not limited to all FDA-approved drugs, supplies, devices, implants, injections, and other products).	$0 copayment
Voluntary sterilization – Women	$0 copayment
Voluntary sterilization – Men	$0 copayment
Interruption of pregnancy (including, but not limited to office visits, outpatient surgery, and inpatient services)	$0 copayment
INFERTILITY SERVICES (DIAGNOSIS AND TREATMENT OF UNDERLYING CONDITION) AND FERTILITY SERVICES)	
Primary Care Physician office visit	$25/visit
Specialist Physician office visit	$50/visit
Laboratory tests and services	$15/visit
Radiology services (x-rays and diagnostic imaging)	$15/visit
Outpatient facility fee	30% coinsurance[4, 7]
Outpatient Physician/Surgeon fee	30% coinsurance[4, 7]
Artificial Insemination and Assisted Reproductive Technologies (ART)[9]	Variable[5]
HOSPITALIZATION (INCLUDING BUT NOT LIMITED TO INPATIENT SERVICES, ORGAN TRANSPLANT, AND INPATIENT REHABILITATION)	
Facility fee	30% coinsurance[4, 7]
Physician/surgeon fee	30% coinsurance[4, 7]
EMERGENCY AND URGENT CARE SERVICES	
Emergency room services (waived if admitted to the hospital)	$150/visit[7]
Emergency room physician fee (waived if admitted to the hospital)	$0[7]
Urgent care services	$50/visit
Emergency or non-emergency medical transportation	$150[7]
DURABLE MEDICAL EQUIPMENT AND OTHER SUPPLIES	
Durable medical equipment	50% coinsurance[4, 7]
Diabetic supplies.	20% coinsurance[7]
Prosthetics and orthotics.	$50/visit
MENTAL HEALTH SERVICES[6]	
Office visits	$25/visit
Group Therapy	$25/visit
Other outpatient items and services	30% coinsurance[4, 7]
Inpatient facility fee	30% coinsurance[4, 7]
Inpatient physician fee	30% coinsurance[4, 7]
Emergency services facility fee (waived if admitted)	$150/visit[7]
Emergency services physician fee (waived if admitted)	$0[7]
Emergency and non-emergency psychiatric transportation	$150[7]
Urgent care services	$50/visit
SUBSTANCE USE DISORDER SERVICES[6]	
Office Visits	$25/visit
Group Therapy	$7/visit
Other outpatient items and services	30% coinsurance[4, 7]
Inpatient facility fee	30% coinsurance[4, 7]
Inpatient physician fee	30% coinsurance[4, 7]
Emergency services facility fee for alcohol or drug detoxification (waived if admitted)	$150/visit[7]
Emergency services physician fee for alcohol or drug detoxification (waived if admitted)	$0[7]
Emergency and non-emergency substance use disorder transportation	$150[7]
Urgent care services	$50/visit

VALUE PLAN HMO MEDICAL OPTIONS

BENEFIT FEATURE	VALUE PLAN HMO OPTION
SKILLED NURSING, HOME HEALTH AND HOSPICE SERVICES	
Skilled nursing facility services (maximum of 100 days per calendar year)	40% coinsurance[4, 7]
Home health services (maximum of 100 visits per calendar year)	$25/visit[7]
Hospice care - inpatient	40% coinsurance[4, 7]
Hospice care - outpatient	$40/visit[7]
PRESCRIPTION DRUG COVERAGE[8, 10]	
Preferred Generic/Preferred Brand/Non-preferred medications up to 30 day supply	$10/$25/$50
Preferred Generic/Preferred Brand/Non-preferred medications for a 90 day supply by mail order (maintenance medications only)	$20/$50/$100
Preventative prescription drugs including Preferred Generic and over-the-counter contraceptives	$0 copayment
SUPPLEMENTAL BENEFITS[1]	
Vision services: Eye exam once every 12 months/Frame and Lenses once every 12 months/Frame allowance/Contact allowance	$25/$25/$150/$150

1 Cost sharing payments (deductibles, copayments and coinsurance) made by each individual in a family contribute to the family deductible and out-of-pocket maximums. Once the family out-of-pocket maximum is reached, the plan pays all costs for covered services for all family members. Cost sharing payments for all covered benefits accumulate toward the deductible, if deductible applies to that service, and the out-of pocket maximum.

2 Copayments for supplemental benefits (Chiropractic Services, Adult Vision, etc.) do not apply to the annual out-of-pocket maximum.

3 Includes preventive services with a rating of A or B from the U.S. Preventive Services Task Force; immunizations for children, adolescents, and adults recommended by the Centers of Disease Control; and preventive care and screenings supported by the Health Resources and Services Administration for infants, children, adolescents and women. If preventive care is received at the time of other services, the applicable copayment for such services other .than preventive care may apply.

4 Of contracted rates.

5 Out-of-pocket cost is based on type and location of services (e.g. outpatient surgery costshare for outpatient surgery or specialist office visit cost-share for a service received during a specialist office visit).

6 All medically necessary treatment of mental health and substance abuse disorders is covered under this plan.

7 Deductible applies.

8 Member cost-share will not exceed $250 per individual prescription of up to a 30-day supply of a covered oral anti-cancer drug. 90-day supply cost-share applies to maintenance medications filled by mail order only.

9 For treatment of diagnosed infertility, including by not limited to Assisted Hatching, In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Intracytoplasmic Sperm Injections (ICSI), and Zygote Intrafallopian Transfer (ZIFT). Up to a maximum of three completed oocyte retrievals (egg retrievals) with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine (ASRM), using single embryo transfer when recommended and medically appropriate.

1 O Self-administered outpatient prescription medication for treatment of diagnosed infertility is covered. Refer to the Sharp Health Plan Formulary to determine the tier placement of each prescribed fertility medication.

11 Doula Services are covered at no charge up to the allowable visit limits for members in the Plan's Maternal Mental Health Case Management Program.

BASIC AND PREMIUM HMO MEDICAL OPTIONS

BENEFIT FEATURE	BASIC HMO OPTION	PREMIUM HMO OPTION
Yearly Deductible	None	None
Annual Out of Pocket Maximum including medical and prescription drugs (per individual/per family)[1]	$1,500 per individual $3,000 per family	$1,500 per individual $3,000 per family
Lifetime Maximum	No lifetime maximum	No lifetime maximum
PREVENTIVE SERVICES[2]		
Well baby and Well child (to age 18) physical exams, immunizations and related laboratory services	$0 copayment	$0 copayment
Routine adult physical exams, immunizations and related laboratory services	$0 copayment	$0 copayment
Laboratory, radiology, and other services for the early detection of disease when ordered by a Physician	$0 copayment	$0 copayment
Routine gynecological exams, immunizations and related laboratory services	$0 copayment	$0 copayment
Mammography	$0 copayment	$0 copayment
Prostate cancer screening	$0 copayment	$0 copayment
Colorectal cancer screenings including sigmoidoscopy and colonoscopy	$0 copayment	$0 copayment
SHARP BEST HEALTH™ WELLNESS SERVICES		
On-line health education and wellness workshops and other wellness tools	$0 copayment	$0 copayment
Telephonic health coaching (weight management, tobacco cessation, stress management, physical activity, nutrition)	$0 copayment	$0 copayment
PROFESSIONAL SERVICES		
Primary Care Physician office visit for consultation, treatments, diagnostic testing, etc.	$20/visit	$10/visit
Specialist Physician office visit for consultation, treatments, diagnostic testing, etc.	$30/visit	$15/visit
Medically necessary physician home visit	$35/visit	$25/visit
Laboratory services	$0 copayment	$0 copayment
Radiology services (x-rays)	$0 copayment	$0 copayment
Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	$0/visit	$0/visit
Allergy testing	$30/visit	$15/visit
Allergy injections	$3/visit	$3/visit
OUTPATIENT SERVICES (INCLUDING BUT NOT LIMITED TO SURGICAL, DIAGNOSTIC, AND THERAPEUTIC SERVICES)		
Outpatient surgery	$100/visit	$50/visit
Infusion therapy (including but not limited to chemotherapy)	$0 copayment	$0 copayment
Dialysis	$0 copayment	$0 copayment
Physical, occupational and speech therapy	$30/visit	$15/visit
Radiation therapy	$0 copayment	$0 copayment
MATERNITY CARE		
Prenatal and postpartum office visits	$0/visit	$0/visit
Hospitalization	$250/admission	$150/admission
Breastfeeding support, supplies and counseling	$0 copayment	$0 copayment

1 Copayments for supplemental benefits (Assisted Reproductive Technologies, Acupuncture, Chiropractic Services, and Vision) do not apply to the annual out of pocket maximum.

2 Includes preventive services with a rating of A or B from the US Preventive Services Task Force; immunizations for children, adolescents and adults recommended by the Centers of Disease Control; and preventive care and screenings supported by the Health Resources and Services Administration for infants, children, adolescents and women. If preventive care is received at the time of other services, the applicable copayment for such services other than preventive care may apply.

BASIC AND PREMIUM HMO MEDICAL OPTIONS

BENEFIT FEATURE	BASIC HMO OPTION	PREMIUM HMO OPTION
FAMILY PLANNING SERVICES		
Contraceptives (including but not limited to all FDA-approved drugs, supplies, devices, implants, injections, and other products).	$0 copayment	$0 copayment
Voluntary sterilization – Women	$0 copayment	$0 copayment
Voluntary sterilization – Men	$0 copayment	$0 copayment
Interruption of pregnancy (including, but not limited to office visits, outpatient surgery, and inpatient services)	$0 copayment	$0 copayment
INFERTILITY SERVICES (DIAGNOSIS AND TREATMENT OF UNDERLYING CONDITION)		
Primary Care Physician office visit	$20/visit	$10/visit
Specialist Physician office visit	$30/visit	$15/visit
Laboratory tests and services	$0	$0
Radiology services (x-rays and diagnostic Imaging)	$0	$0
Outpatient facility fee	$100/visit	$50/visit
Outpatient Physician/Surgeon fee	$0	$0
Artificial Insemination and Assisted Reproductive Technologies (ART)	Variable	Variable
HOSPITALIZATION (INCLUDING BUT NOT LIMITED TO INPATIENT SERVICES, ORGAN TRANSPLANT, AND INPATIENT REHABILITATION)		
Inpatient services	$250/admission	$150/admission
EMERGENCY AND URGENT CARE SERVICES		
Emergency room facility fee (waived if admitted to hospital)	$100/visit	$50/visit
Emergency Medical Transportation in connection with hospital admission or emergency services	$100 copayment	$50 copayment
Urgent care services	$30/visit	$15/visit
DURABLE MEDICAL EQUIPMENT AND OTHER SUPPLIES		
Durable medical equipment (copayment applied per rental or purchase, per item, per calendar year)	$50 copayment	$50 copayment
Diabetic supplies.	$0 copayment	$0 copayment
Prosthetics and orthotics	$30/visit	$15/visit
MENTAL HEALTH SERVICES		
Inpatient	$250/admission	$150/admission
Office visits	$20/visit	$10/visit
Group Therapy	$20/visit	$10/visit
Home-based applied behavioral analysis for treatment of pervasive developmental disorder or autism	$0/visit	$0/visit
Other outpatient items and services	$20/visit	$10/visit
Emergency psychiatric transportation	$100 copayment	$50 copayment
Non-emergency psychiatric transportation	$100 copayment	$50 copayment
Urgent care services	$30/visit	$15/visit
SUBSTANCE USE DISORDER[3]		
Emergency services for acute alcohol or drug detoxification	$100/visit	$50/visit
Inpatient	$250/admission	$150/admission
Office Visits	$20/visit	$10/visit
Group Therapy	$7/visit	$7/visit
Emergency Substance use disorder transportation	$100 copayment	$50 copayment
Non-emergency substance use disorder transportation	$100 copayment	$50 copayment
Urgent care services	$30/visit	$15/visit
Other Outpatient Items and Services	$20/visit	$10/visit

3 All medically necessary treatment of mental health and substance use disorders is covered under this plan.

BASIC AND PREMIUM HMO MEDICAL OPTIONS

BENEFIT FEATURE	BASIC HMO OPTION	PREMIUM HMO OPTION
SKILLED NURSING, HOME HEALTH AND HOSPICE SERVICES		
Skilled nursing facility services (maximum of 100 days/calendar year)	$50/admission	$0/admission
Home health services	$0/visit	$0/visit
Hospice care – inpatient or outpatient	$0/visit	$0/visit
PRESCRIPTION DRUG COVERAGE[4]		
Preferred Generic drugs/Preferred Brand drugs/Non-Preferred drugs – medications up to 30 day supply	$10/$25/$50	$10/$20/$40
Preferred Generic drugs/Preferred Brand drugs/Non-Preferred drugs– medications up to 90 day supply by mail order (maintenance medications only)	$20/$50/$100	$20/$40/$80
Preferred Generic and prescribed over-the-counter contraceptives for women.	$0 copayment	$0 copayment
SUPPLEMENTAL RIDERS[5]		
Chiropractic/Acupuncture (combined 20 visits per calendar year)	Not Covered	$10/visit
Hearing Aid Allowance (every 36 months)	$1,000	$1,000
Vision	See Vision Benefits Section of this Booklet on page 29	

4 Copayments for Prescription Drugs apply to the annual out of pocket maximum. Member cost-share for oral anti-cancer drugs will not exceed $250 per 30-day period. Self-administered outpatient prescription medication for treatment of diagnosed fertility is covered. Refer to Sharp Health Plan Formulary to determine the tier placement of each prescribed fertility medication."

5 Copayments for Supplemental Benefits (Assisted Reproductive Technologies, Chiropractic Services, Hearing, and Vision) do not apply to the annual out of pocket maximum.

This section of your booklet is only an overview of the benefits available through the HMO options offered by Sharp Health Plan. **You should consult your Sharp Health Plan Member Handbook for specific information and details of covered services and supplies as well as any limitations and exclusions that apply.**

Visit Sharp Health Plan at www.SharpHealthPlan.com or contact the Customer Care Center at 1-(800) 359-2002 to access the Sharp Health Plan Member Handbook.

Preventive Health Services

The Patient Protection and Affordable Care Act (PPACA) requires group health plans to provide benefits for certain preventive health services without imposing any co-payments, co-insurance, deductibles, or other cost-sharing requirements (often referred to as "first-dollar coverage").

Preventive health services include:

- Evidence-based items or services with an A or B rating recommended by the U.S. Preventive Services Task Force
- Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunizations Practices of the Centers for Disease Control and Prevention
- Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) for infants, children, and adolescents
- Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women, as described below.

PREVENTIVE CARE COVERAGE FOR WOMEN

The U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) issued guidelines pertaining to preventive care and screenings for women. The guidelines include coverage for a broad range of items and services, including contraceptive services, breastfeeding support and supplies, and screening and counseling for interpersonal and domestic violence. First-dollar coverage (no co-pays, co-insurance, deductibles, or other cost-sharing requirements) is provided for the items and services in the chart below:

TYPE OF HEALTH PREVENTIVE SERVICES	DESCRIPTION	FREQUENCY
Well-woman visits	Well-woman preventive care visit annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care.	Annual, although several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.
Screening for gestational diabetes	Screening for gestational diabetes.	In pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
Human papilloma virus testing	High-risk human papilloma virus DNA testing in women with normal cytology results.	Screening should begin at 30 years of age and should occur no more frequently than every 3 years.
Counseling for sexually transmitted infections	Counseling on sexually transmitted infections for all sexually active women.	Annual.
Counseling and screening for human immune-deficiency virus	Counseling and screening for human immune-deficiency virus infection for all sexually active women.	Annual.
Contraceptive methods and counseling1	All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity.	As prescribed.
Breastfeeding support, supplies, and counseling	Comprehensive lactation support and counseling, by a trained provider during pregnancy and/or in the postpartum period, and costs for renting breastfeeding equipment.	In conjunction with each birth.
Screening and counseling for interpersonal and domestic violence	Screening and counseling for interpersonal and domestic violence.	Annual

1 Consistent with the Public Health Service Act, Section 2713 and its implementing regulations, Sharp Health Plan may use reasonable medical management techniques to control costs and promote efficient delivery of care. For example, plans may cover a generic drug without cost sharing and impose cost sharing for equivalent brand name drugs.

What is an HMO?

An HMO is a health maintenance organization which combines comprehensive medical services and preventive care in one managed care plan. You and your family can obtain a wide range of coverage and medical consultations at little out-of-pocket cost. You may pay a deductible depending on which plan you chose to enroll, and only nominal copayments for most services. Most medical services are then covered at 100%. This includes all eligible inpatient services, once the per-hospitalization copayment has been met.

When you enroll in an HMO plan option, you and your eligible children will choose a multi-specialty medical group from Sharp Health Plan's "Choice Provider Network". This is your Plan Medical Group (PMG). You should choose one that is convenient to your home or office. The primary care specialties such as family medicine, internal medicine, and pediatrics are well represented in each PMG. From within the PMG, you will then choose a Primary Care Physician (PCP) who will direct your medical care and refer you to services and specialists when needed. Female subscribers have direct access to OB/GYN care without a referral from their PCP. In-network emergency services are also provided without need for prior authorization. If you select a Sharp Rees-Stealy physician as your

PCP, you should know that the majority of your hospital services will be provided at Sharp Memorial Hospital or Sharp Mary Birch Hospital for Women and outpatient services are generally provided at Sharp Rees-Stealy Medical Center facilities.

To obtain a network provider directory, you may call Sharp Health Plan at (858) 499-8300 or 1-(800) 359-2002, or visit Sharp Health Plan's website at www.sharphealthplan.com.

The HMO Network

Sharp Health Plan is a San Diego-based health care service plan licensed by the State of California. The plan's network of providers are located in San Diego and Southern Riverside counties.

The Sharp Health Plan "Choice" provider network consists of quality medical groups, physicians and facilities contracted with Sharp Health Plan to provide managed care medical services. Sharp Health Plan uses a stringent credentialing process to evaluate physicians' qualifications. Each candidate undergoes a review conducted by a physician advisory or credentials committee. This ensures that each participating physician is qualified by training and experience to deliver care that meets the medical standards of the community.

It is important to note that in order to obtain health care services covered by the plan, you must access providers in the network (except in cases of urgent or emergency situations). If you have children residing out of the service area, the dependent must travel into the service area to access routine, non-emergent services.

How an HMO Works

- You choose a PMG and a PCP from the provider directory for each of your covered children. The physician may be a pediatrician, an internist, a general practitioner or a family practitioner. Women have direct and unlimited access to OB/GYN physicians in their PCP's PMG for obstetrical and gynecological services.
- Your PCP is responsible for coordinating your health care and referring you to an appropriate specialist when you need one.

You may change your PCP/PMG as often as once a month by contacting the Sharp Health Plan Customer Care Department at (858) 499-8300 or 1-(800) 359-2002.

- If you need to see a specialist and one is not available within the network, your PCP will refer you to one outside the network.
- If you use the services of a physician or hospital not in the network, those costs are not covered by the plan and you will be responsible for payment of services (other than emergency and urgent care services). For all care other than emergency and urgent care services, your PCP must be consulted in order for you to receive benefits.
- Each covered child will receive an identification card which should be presented every time medical services are sought.

Obtain Required Authorization
Except for PCP services, Emergency Services, and obstetric and gynecologic services, you are responsible for obtaining valid Authorization before you receive Covered Benefits.

To obtain a valid Authorization:

1. Prior to receiving care, contact your PCP or other approved Plan Provider to discuss your treatment plan.
2. Request prior Authorization for the Covered Benefits that have been ordered by your physician. Your PCP or other Plan Provider is responsible for requesting Authorization from Sharp Health Plan or your Plan Medical Group.
3. If Authorization is approved, obtain the expiration date for the Authorization. You must access care before the expiration date with the Plan Provider identified in the approved Authorization.

You are responsible to pay for all care that is rendered without the necessary Authorization(s).

A decision will be made on the Authorization request within five business days. A letter will be sent to you within two business days of the decision.

If waiting five days would seriously jeopardize your life or health or your ability to regain maximum function or, in your doctor's opinion, it would subject you to severe pain that cannot be adequately managed without the care or treatment that is being requested, you will receive a decision no later than 72 hours after receipt of the Authorization request.

If Sharp Health Plan does not receive enough information to make a decision regarding the Authorization request, the Plan will send you a letter within five days to let you know what additional information is needed. Sharp Health Plan will give you or your provider at least 45 days to provide the additional information. (For urgent Authorization requests, Sharp Health Plan will notify you and your provider by phone within 24 hours and give you or your provider at least 48 hours to provide the additional information.)

If you receive authorization for an ongoing course of treatment, Sharp Health Plan will not reduce or stop the previously authorized treatment before providing you with an opportunity to appeal the decision to reduce or stop the treatment.

EMERGENCY SERVICES AND CARE

Emergency Services are not a substitute for seeing your PCP. Rather, they are intended to provide emergency needed care in a timely manner when you require these services. Emergency Services means those Covered Benefits, including Emergency Services and Care, provided inside or outside the Service Area, which are medically required on an immediate basis for treatment of an Emergency Medical Condition. Sharp Health Plan covers twenty-four hour emergency care. An Emergency Medical Condition is a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable lay person could reasonably expect the absence of immediate attention to result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services and Care means:

1. Medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an Emergency Medical Condition or Active Labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and
2. 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.

WHAT TO DO WHEN YOU REQUIRE EMERGENCY SERVICES

- If you have an Emergency Medical Condition, call "911" or go to the nearest hospital emergency room. It is not necessary to contact your PCP before calling "911" or going to a hospital if you believe you have an Emergency Medical Condition. If you are unsure whether your condition requires Emergency Services, call your PCP (even after normal business hours). Your PCP can help decide the best way to get treatment and can arrange for prompt emergency room care. However, do not delay getting care if your PCP is not immediately available. Members are encouraged to use the "911" emergency response system appropriately when they have an Emergency Medical Condition that requires an emergency response.
- If you go to an emergency room and you do not have an Emergency Medical Condition, you may be responsible for payment.
- If you are hospitalized in an emergency, please notify your PCP or Sharp Health Plan within 48 hours or at the earliest time reasonably possible. This will allow your Plan Physician to share your medical history with the hospital and help coordinate your care. If you are hospitalized outside of the Service Area, your Plan Physician and the Plan may arrange for your transfer to a Plan Hospital if your medical condition is sufficiently stable for you to be transferred.
- Ambulance services are covered (with copayments) when provided in conjunction with Hospital Admissions or Emergency Services.
- Some non-Plan providers may require that you pay for Emergency Services and seek reimbursement from the Plan. On these occasions, obtain a complete bill of all services rendered and a copy of the emergency medical report, and forward them to the Plan right away for reimbursement.
- If you need follow-up care after you receive Emergency Services, call your PCP to make an appointment or for a referral to a specialist. Do not go back to the hospital emergency room for follow-up care, unless you are experiencing an Emergency Medical Condition.

URGENT CARE SERVICES

Urgent conditions are not emergencies, but may need prompt medical attention. Urgent Care Services are not a substitute for seeing your own PCP. They are intended to provide urgently needed care in a timely manner when your PCP has determined that you require these services or you are outside the Plan's Service Area and require Urgent Care Services.

WHAT TO DO WHEN YOU REQUIRE URGENT CARE SERVICES

- Your PCP must Authorize Urgent Care Services if you are in the Plan's Service Areas. If you need Urgent Care Services and are in the Plan's Service Area, you must call your PCP first.
- Out-of-Area Urgent Care Services are considered Emergency Services and do not require an Authorization from your PCP. If you are outside Plan's Service Area and need Urgent Care Services, you should still call your PCP. Your PCP may want to see you when you return in order to follow up with your care.
- If, for any reason, you are unable to reach your PCP, please call Customer Care. You have access to a nurse evenings and weekends for immediate medical advice by calling our toll-free Customer Care telephone number at 1-800-359-2002.

DRUG FORMULARY

The Plan utilizes a drug formulary which is an updated list of medications for Plan physicians to use when prescribing medicines. A drug formulary enhances quality of care by encouraging the use of those prescription medications that are demonstrated to be safe and effective. Medications not listed on the formulary are covered but require a higher copay from you. The drug formulary is reviewed on a regular basis to consider newly developed, frequently requested, and/or provider recommended medicines. Please refer to the Sharp Health Plan HMO Member Handbook for additional information.

PREGNANCY BENEFITS

Benefits for pregnancy are paid in the same way as benefits for other medical conditions.

NEWBORNS AND MOTHERS' HEALTH

If you receive benefits in connection with childbirth, you should know that 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 for the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

BREAST RECONSTRUCTIVE SURGERY

If you receive benefits in connection with a mastectomy and elect breast reconstructive surgery, coverage will be provided for (1) reconstruction of the breast on which the mastectomy was performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and, (3) prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas. These benefits are subject to the Health Plan's regular copayments and deductibles, as described in the Medical Benefits Section on page 9.

MENTAL HEALTH & CHEMICAL DEPENDENCY BENEFITS

If you are a Sharp Health Plan member, you are eligible for mental health and chemical dependency benefits. Sharp Health Plan provides coverage for the diagnosis and medically-necessary treatment of mental illness and chemical dependency. Prior authorization from your Primary Care Physician is not required. For more information or to obtain a Schedule of Benefits, contact Sharp Health Plan toll free at 1 (844) 483-9013 or visit www.sharphealthplan.com. All calls are confidential.

Sharp Best Health™ Wellness Program

Sharp Best Health™ is a wellness program for Sharp employees. It offers free or low-cost programs and tools that can be accessed anywhere, anytime, and are designed to support team members' physical, mental and emotional well-being.

Resources include but not limited to:

- Annual Wellness Assessment
- Physical activity initiatives
- Health coaching programs
- Digital Mindfulness and Yoga app
- Weight management resources
- Discounted gym memberships
- Wellness workshops and webinars
- Daily virtual stretch breaks
- Virtual guided mindfulness sessions
- Healthy recipes

How to File a Claim for Medical Benefits

There are no claim forms or claims processing for in-network services referred by your PCP with the HMO Plan. All expenses and payments are made between the provider and Sharp Health Plan except copayments which you pay to the HMO provider at the time of service. Consult your Sharp Health Plan Member Handbook for the Plan's Claims Appeals and Procedures.

If you receive emergency services from an out-of-network provider, you may be required to pay for services at the time they are rendered. Call Sharp Health Plan Customer Care at 1-(800) 359-2002 for information on how to be reimbursed for covered services.

Appeal Policy and Procedure

Sharp Health Plan has established an appeal process for receiving and resolving plan participant complaints or grievances with Sharp Health Plan and its providers. If you have a complaint regarding your eligibility, coverage, a denial of benefits or any other matter, you may call the Sharp Health Plan Customer Care Department at 1-(800) 359-2002.

You may request a re-evaluation of a specific decision or determination made by the Plan or any of its authorized subcontractors by calling the Plan Customer Care Department at (858) 499-8300 or toll-free at 1-(800) 359-2002 to request assistance with filing an Appeal.

You may also write to Sharp Health Plan with an Appeal at the following address:

Sharp Health Plan
Appeals Department
8520 Tech Way, Suite 200
San Diego, CA 92123-1450

Consult your Sharp Health Plan Member Handbook and Appeal Policy and Procedure for additional information. Member Grievance/Appeal Forms may be obtained from either the Plan or the Member's physician, and are also available on-line at www.sharphealthplan.com.

Other HMO Information

Consult your Sharp Health Plan Member Handbook for more specific information on the following topics:

- Arbitration;
- Coordination of Benefits (COB);
- Recovery from third parties.

Medical Loss Ratio and Premium Refunds

The Affordable Care Act requires health insurers in the large group market to spend at least 85% of the premiums they receive on health care services and activities to improve quality. This is referred to as the Medical Loss Ratio (MLR) rule. A health insurer's Medical Loss Ratio is determined separately for each state's large group markets in which the health insurer offers health coverage. If a health insurer does not meet the MLR, a refund of premiums must be provided to members.

Sharp Health Plan works actively to keep administrative costs below industry average and to allocate as much premium as possible to providing medical services and improving the quality of health care. Sharp Health Plan's MLR is calculated annually and communicated to members by letter in June of each calendar year. In the event the MLR rule is not met, individual members will receive a refund of all (or a portion of) premiums by August 1st following the calendar plan year in which the MLR was not met.

Applying for Medicare While Employed

Medicare is a health insurance program for people age 65 or older and for people with certain disabilities. If you become eligible for Medicare while still employed, you will be able to remain covered under the Sharp Health Plan. How- ever, Medicare requires that you apply for Medi- care Part A (inpatient) when you become eligi- ble. You should contact Medicare at 1-(800) 633-4227, by accessing their website at www.medicare.gov, or by calling the Health Insurance Counseling Aid Advocacy Program at (858) 565-8772, and Sharp Health Plan at 1-(800) 359-2002, or by accessing their website at www.sharpmedicareadvantage.com for eligibility, enrollment and coordination of benefit information.

Coordination of Benefits (COB)

If you are married and both you and your spouse are working, members of your family may be covered under more than one medical/vision plan. Other plans include:

- Group plans covering you or your spouse, sponsored by another employer or professional group; or
- A no-fault plan of automobile insurance (group or individual).

So that the additional coverage does not produce benefits in excess of the actual charges for medical/vision services or supplies, the SharpChoice Medical/Vision Plan, like most other plans, contains a Coordination of Benefits (COB) provision to prevent overpayment. Under the COB provision, one of your plans is deemed primary and the other is deemed secondary. According to standard industry practices, the primary plan pays your expenses first and the secondary plan then pays any remaining balance for which you are eligible. In order to determine which plan is primary and which plan is secondary, rules have been set up which are followed throughout the insurance industry. They are typically used in the following order:

- A plan that does not have a COB provision is automatically considered the primary plan and always pays first.
- A plan that covers the patient as an employee is always the primary plan. Therefore, the SharpChoice Medical/Vision Plan is always primary for you, and your spouse's plan is always primary for your spouse.

  If you have children who are covered under both plans, then your birthday and that of your spouse determines your covered children's primary plan. If your birthday comes first in the calendar year, the SharpChoice Medical, Vision and/or Dental Plan is deemed your children's primary plan. If your spouse's birthday comes first, your spouse's plan is your children's primary plan. If your birthdays are the same, your children's primary coverage is provided by the plan that covered the parent longer. If your spouse's plan does not use the birthday rule, your children's primary coverage is provided by the father's plan.
- If you are separated or divorced, your children's primary medical plan is determined by the following rules:

  a. A plan that covers a child as a dependent of a parent who by court decree must provide health coverage is primary.

  b. When there is no court decree requiring a parent to provide health coverage to a dependent child, then the plan of the parent who has custody of the child is primary. (The plan of the custodial parent's spouse is secondary and the plan of the other natural parent is third.)
- If each of the plans has provisions for layoff situations, the plan of the laid-off individual always pays last for that individual and all dependents.
- If none of the above rules apply, the plan that has covered the patient for the longer period of time will usually be primary.

After the primary plan pays its benefits, the secondary plan may, in some cases, pay the balance of allowable expenses. To ensure you receive the benefits to which you are entitled under both plans, it is important to submit your claims properly. For example, when you file a claim for yourself, be sure to file under your plan first. After you have received payment from your plan, then you can submit the claim to your spouse's plan. When you submit a claim to the secondary plan, be sure to include the Explanation of Benefits (EOB) from the primary plan as well as another copy of the bill.

Remember, if you coordinate your benefits correctly, you will receive payment faster and still have the advantage of coordinated coverage under both plans.

Subrogation and Reimbursement

WORK INJURIES

The plan does not provide covered benefits to you for work-related illnesses or injuries covered by workers' compensation. Sharp Health Plan will advance covered benefits at the time of need, but if you or your dependent receive covered benefits through the plan that are found to be covered by workers' compensation, the plan will pursue reimbursement through workers' compensation. You are responsible to notify Sharp Health Plan of any such occurrences and are required to cooperate to ensure that the Plan is reimbursed for such benefits.

INJURIES CAUSED BY NEGLIGENCE, INTENTIONAL ACT OR OMISSION OF ANOTHER PERSON

If you or your dependent is injured in an event caused by a negligent or intentional act or omission of another person, Sharp Health Plan will advance covered benefits at the time of need subject to an automatic lien by agreement to reimburse the Plan from any recoveries or reimbursement you receive from the person who caused your injury. You are responsible to notify Sharp Health Plan of any such occurrences and are required to cooperate to ensure that Sharp Health Plan is reimbursed for such benefits.

SURROGACY ARRANGEMENTS

A surrogacy arrangement is one in which you agree to become pregnant and to surrender the baby to another person or persons who intend to raise the child. You must pay Sharp Health Plan for any amounts paid for covered benefits you receive related to conception, pregnancy, delivery or newborn care in connection with a surrogacy arrangement ("surrogacy health services"). Your obligation to pay Sharp Health Plan for surrogacy health services is limited to the compensation you are entitled to receive under the surrogacy arrangement.

By accepting surrogacy health services, you automatically assign to Sharp Health Plan your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure their rights, Sharp Health Plan will also have a lien on those payments. Those payments shall first be applied to satisfy Sharp Health Plan's lien. The assignment and the lien will not exceed the total amount of your obligation to Sharp Health Plan under the preceding paragraph.

Within 30 calendar days after entering into a surrogacy arrangement, you must send written notice of the arrangement, including the names and addresses of the other parties to the arrangement, and a copy of any contracts or other documents explaining the arrangement, to:

Sharp Health Plan
Customer Care
Attention: Third Party Liability
8520 Tech Way, Ste. 200
San Diego, CA 92123-1450

You must complete and send Sharp Health Plan all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for Sharp Health Plan to determine the existence of any rights they may have and to satisfy Sharp Health Plan's rights. You must not take any action prejudicial to their rights. If your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate parent, guardian, or conservator shall be subject to Sharp Health Plan's liens and other rights to the same extent as if you had asserted the claim against the third party. Sharp Health Plan may assign their rights to enforce their liens and other rights.

Continuing Your Coverage While on a Medical Leave of Absence (LOA)

If you stop active work because of illness or injury, you may continue your medical coverage during a medical leave of absence by continuing to remit timely premium payments to Sharp Health Plan. Your continuation of coverage because of disability will end at midnight of the last day of the month which coincides with or follows the earliest of the following dates:

- The date that required premiums stop being paid by you;
- The date that you have exhausted the allowable leave time provided by Sharp HealthCare's LOA policy;
- The date you are no longer disabled if proof of disability is not provided within 10 days of receipt of request for proof.

Continuation of Coverage (COBRA)

Sharp HealthCare is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA you and your eligible family members who lose coverage due to certain events may be entitled to continue coverage under COBRA as described in this section.

IMPORTANT TERMS USED IN THIS SECTION

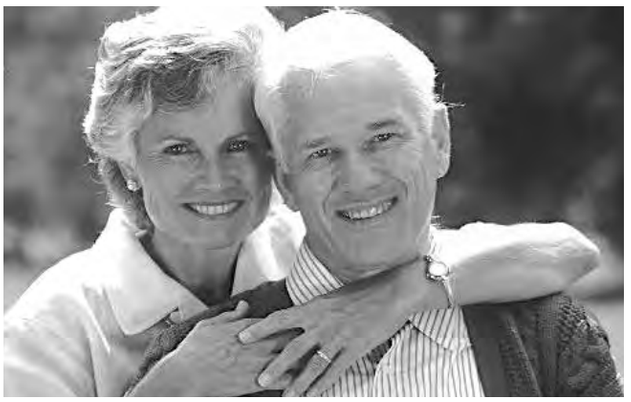
The meanings of key terms used in this section are shown below. Whenever any of the terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this "Important Terms" section.

Initial Enrollment Period is the period of time following the original Qualifying Event.

Qualified Beneficiary means (1) a person who, on the day before a Qualifying Event, was covered under the plan as either an employee or spouse or child of the employee; and (b) an otherwise eligible child who is born to or placed for adoption with the employee during the COBRA continuation period. Qualified Beneficiary includes a spouse or child who is acquired during the COBRA continuation period. Domestic Partners are not recognized as Qualified Beneficiaries under COBRA.

Qualifying Event means any one of the following events which would otherwise result in the termination of coverage for the employee or the employee's spouse or child. These events may be referred to elsewhere in this section by number.

1. For employees, spouses or children:
   a. The employee's termination of employment, for any reason other than gross misconduct; or
   b. Any reduction in the employee's work hours to the point where coverage would be lost.



2. For spouses and children:
   a. The death of the employee;
   b. The spouse's divorce from the employee;
   c. The child's loss of dependency status be cause of age; or
   d. The employee's entitlement to Medicare.

An employee and/or the spouse or child of an employee who is a Qualified Beneficiary may elect COBRA coverage, provided they pay for such coverage as described in this section. COBRA continuation coverage may be chosen for all family members who are otherwise eligible for COBRA coverage, or only for selected family members.

TERMS OF COBRA CONTINUATION COVERAGE

When COBRA Continuation Coverage Begins. COBRA continuation coverage begins on the first day of the month following the date coverage was lost due to the original Qualifying Event.

When COBRA continuation coverage is elected during the Initial Enrollment Period and the required monthly contribution is paid, coverage is reinstated back to the 1st day of the month following the date coverage was lost due to the original Qualifying Event, so that no break in coverage occurs provided the election/enrollment is submitted to the COBRA administrator within 60 days of notification.

Notice. Sharp HealthCare will notify the employee and other eligible family members, as applicable, of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1 or 2, Sharp HealthCare will notify the employee and his or her dependents, as applicable, of the right to continue coverage.

2. For Qualifying Events 2(a) or 2(d), Sharp HealthCare will notify the eligible family member(s) (as applicable) of the right to continue coverage.
3. For Qualifying Events 2(b) and 2(c), the employee or other eligible family member must inform Sharp HealthCare's COBRA Administrator within 60 days of the later of (1) the date of the Qualifying Event; or (2) the date coverage would otherwise end on account of the Qualifying Event, if he or she wishes to continue coverage. Sharp HealthCare will in turn promptly give official notice of the COBRA continuation right to the spouse or other eligible family member, as applicable.

If you and/or an eligible family member elects to continue coverage, he or she must notify Sharp HealthCare within 60 days of the later of (1) the date coverage would otherwise end on account of the Qualifying Event; or (2) the date notice is provided regarding his or her right to elect COBRA continuation coverage. Your coverage will not be effective until you actually elect COBRA continuation coverage at which time your coverage will be retroactively reinstated provided payment is received. The first payment must include premiums retroactive to the date your coverage ended.

If you, an eligible family member, or a designated third party fails to elect COBRA continuation coverage during the Initial Enrollment Period, he or she may not elect COBRA continuation coverage at a later date. The initial required monthly contribution, must be delivered to Sharp HealthCare within 45 days after COBRA coverage is elected. During this time, your coverage will not be effective but will be reinstated when your premiums are paid. The first payment must include premiums retroactive to the date your coverage ceased.

Additional Family Members. The standard enrollment provisions of the plan generally apply to otherwise eligible enrollees during the COBRA continuation coverage period. A spouse or child of a Qualified Beneficiary acquired during the COBRA continuation coverage period may be enrolled as a family member.

Cost of Coverage. Qualified Beneficiaries who properly elect COBRA continuation coverage must pay the entire cost of such coverage (the applicable rate), plus a 2% administrative fee for a total cost of 102% of the applicable rate. This cost is called the "required monthly contribution" and must be paid to Sharp HealthCare, or third party administrator (if applicable), each month during the COBRA continuation period. The applicable rate will vary depending upon the number of covered individuals. Multiple Qualifying Events. Once COBRA continuation coverage begins, it is possible for a second Qualifying Event to occur. If that happens, a Qualified Beneficiary other than the employee may be entitled to an extended period of COBRA continuation coverage. In no event will the total period (for the first and any subsequent Qualifying Event) of COBRA continuation coverage provided to any member exceed 36 months of coverage measured from the first day of the month following the date coverage was lost due to the original Qualifying Event.

For example, an employee's child who was originally eligible for COBRA continuation coverage due to termination of the employee's employment (Qualifying Event 1) and enrolled for COBRA continuation coverage as a Qualified Beneficiary, would be entitled to up to 18 months of coverage. If, during this 18-month period, the child reaches the upper age limit of the plan [a second Qualifying Event – 2(c)], the child may be eligible to extend coverage for up to 36 months from the first day of the month following the date coverage was lost due to the original Qualifying Event (the termination of the employee's employment).

If an employee becomes entitled to Medicare (even if the employee's entitlement to Medicare is not a Qualifying Event) before a termination of employment or reduction in hours (Qualifying Event 1), a Qualified Beneficiary other than the employee may be eligible for COBRA continuation coverage for up to 36 months from the day on which the employee became entitled to Medicare or 18 months from the first day of the month following the date coverage was lost due to the termination or reduction in hours, whichever period is longer.

If an employee becomes entitled to Medicare within the 18-month period following a termination of employment or reduction in hours (Qualifying Event 1), a Qualified Beneficiary other than the employee may be eligible for COBRA continuation coverage for up to 36 months from the first day of the month following the date coverage was lost due to the termination or reduction in hours.

Extension of COBRA Continuation Coverage Due to Total Disability. If during the first 60 days of COBRA continuation coverage due to an employee's termination of employment or reduction in hours (Qualifying Event 1), a Qualified Beneficiary is determined to be disabled for Social Security purposes, the disabled Qualified Beneficiary and all associated Qualified Beneficiaries may be entitled to up to 29 months of COBRA continuation coverage measured from the first day of the month following the employee's loss of coverage due to termination or reduction in hours. In order to elect this extension of COBRA continuation coverage, the disabled Qualified Beneficiary must:

1. Satisfy the legal requirements for being totally an permanently disabled under Title II or Title XVI of the Social Security Act; and
2. Be determined and certified to be disabled by the Social Security Administration.

The disabled Qualified Beneficiary or any other associated Qualified Beneficiary must furnish Sharp HealthCare with proof of the Social Security Administration's determination of disability no later than 60 days after the date of such determination and within the first 18 months of COBRA continuation coverage. For months 19 through 29 of the COBRA continuation coverage period the required monthly contribution for the disabled Qualified Beneficiary may increase from 102% of the applicable rate up to 150% of the applicable rate and must be paid to Sharp HealthCare each month during the extended COBRA continuation coverage period.

Unless coverage terminates on an earlier date as provided below under "When COBRA Continuation Coverage Ends," this period of extended COBRA continuation coverage will end on the earlier of 29 months from the date coverage was lost due to the earlier termination or reduction in hours or the end of the month following a period of 30 days after the Social Security Administration's final determination that the Qualified Beneficiary is no longer disabled. The Qualified Beneficiary must notify Sharp HealthCare of a final determination by the Social Security Administration that he or she is not longer disabled within 30 days of any such determination.

When COBRA Continuation Coverage Ends. COBRA continuation coverage will end on the earliest of:

1. The date the maximum time period (i.e., 18, 29 or 36 months, whichever is applicable) is reached; and/or
2. The date Sharp HealthCare terminates all of its group health plans for all of its employees;
3. The last day of the period for which required monthly contributions are timely paid;
4. The date, after the date of election, upon which the Qualified Beneficiary becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the Qualified Beneficiary; or
5. The date, after the date of the election, upon which the Qualified Beneficiary first becomes entitled to Medicare.

In the case of an individual who is not a Qualified Beneficiary and who is receiving continuation coverage under the plan solely because of the individual's relationship to a Qualified Beneficiary, if the plan's obligation to make COBRA coverage available to the Qualified Beneficiary ceases under this section, the plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

Additional Medical Continuation Coverage Available Under California Law. For Qualifying Events occurring (e.g., loss of coverage) on or after January 1, 2003, an additional continuation period, following COBRA continuation, is available for California employees to the extent that federal COBRA continuation was provided for less than 36 months. In the event that the maximum federal COBRA continuation coverage available was less than 36 months, a Qualified

Beneficiary may elect an additional amount of continuation coverage under Cal-COBRA for an aggregate 36 months of continuation coverage. A Qualified Beneficiary must first exhaust his or her federal COBRA continuation coverage period before becoming eligible for this supplemental Cal-COBRA coverage. Qualified Beneficiaries who properly elect the supplemental Cal-COBRA continuation coverage must pay the entire cost of such supplemental coverage (the applicable rate),plus a 10% administrative fee for a total cost of 110% of the applicable rate."

CAL-COBRA coverage does not include dental.

Health Insurance Certificates

In August 1996, the federal government passed the Health Insurance Portability and Accountability Act (HIPAA). The Act requires that group health plans may not impose pre-existing condition exclusions that exceed 12 months from date of hire (or 18 months for late enrollees). In addition, any pre-existing condition imposed by a plan must be reduced by the period of an individual's creditable coverage under a prior employer's plan, individual insurance, or a government health plan. Credit is granted on a day-for-day basis up to the 12- or 18-month period. An exception to this required reduction in time is if the individual experiences a break in health care coverage between the prior health plan and the new plan.

A break in health care coverage occurs when there is a period of 63 days or more that the individual does not have health care coverage. The period of time prior to the break is not available to reduce the new plan's pre-existing condition exclusion period. Coverage between health care plans may be bridged through COBRA continuation coverage.

In order to comply with this Act, any individual who loses medical coverage under SharpChoice will receive a certificate to show the amount of the individual's creditable previous coverage. The certificate provides you with evidence of your prior health coverage with a SharpChoice plan. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions before you enroll. Certificates will be sent to the individual's last known address. Sharp Health Plan and Sharp HealthCare will coordinate the administration of the health insurance certificates.

COBRA Benefits for Participants Residing Out-of-Area

For the medical plan only, if you or your dependents are COBRA-eligible and you relocate outside of Sharp Health Plan's service area (which is San Diego and South Riverside counties) you may continue medical coverage under COBRA; however, the COBRA coverage provided will be for authorized services rendered by contracted providers within the service area, and for emergency and urgent care services both within and outside the Plan's service area.

Non-emergency services rendered by non-contracted providers or providers outside the Plan's service area are not covered.

In addition, prescription benefit coverage is available; however, you must have your prescriptions filled at a plan pharmacy (e.g., Albertsons®/ Sav-On®, Costco®, CVS Pharmacy® locations including those at Target®, Ralphs®, Rite-Aid®, Vons®, Pavilions®, Walgreens®, Sharp Rees-Stealy Pharmacy, and independently contracted neighborhood pharmacies).

You will not be able to continue your prescription coverage under Cal-COBRA if you move out of area.

SHARP

Vision BENEFITS

SHARP

Vision BENEFITS

When you enroll for medical coverage, you are also automatically enrolled for comprehensive vision benefits through Vision Service Plan (VSP). VSP offers low copayments with no claim forms when you use providers from the VSP Signature Network. You also have the option to use non-network providers but you must file a claim for benefits within six months after completion of services.

How to Obtain Care from a VSP Member Provider

When you want to obtain vision care services, call a VSP doctor to make an appointment. *For details on how you locate a VSP doctor, call VSP at 800-877-7195 to request a VSP doctor listing or visit their website at www.vsp.com. You may elect any provider in the VSP Signature Network.* **Make sure you identify yourself as a VSP member, and be prepared to provide the covered member's social security number.** The VSP doctor will contact VSP to verify your eligibility and plan coverage, and will also obtain authorization for services and materials. VSP will pay the doctor directly for covered services and materials. If you are not currently eligible for services, the VSP doctor is responsible for communicating this to you.

When You Use a Non-VSP Provider

Services and materials obtained from an out-of-network provider will be reimbursed up to amounts on the schedule provided on the following page less any copayments. For out-of-network reimbursement, you pay the entire bill when you receive services, then send your itemized receipts and full patient and member information to VSP. **Claims must be submitted to VSP within six months from your date of service.** Please keep a copy of the information for your records and send the originals to the following address: Vision Service Plan, Out-of-Network Provider Claims, P.O. Box 997105, Sacramento, CA 95899-7105.

Covered Vision Care Benefits

The lens allowances are for two lenses. If only one lens is needed, the allowance will be one-half the pair allowance.

Benefit payments for lenses and frames are based on medical necessity and are limited to certain maximum costs. If you choose a frame style or lens (tinted, oversize, etc.) which costs more than the plan covers, you are responsible for paying the difference in cost.

MEDICALLY NECESSARY CONTACT LENSES

If medically necessary contact lenses are prescribed, they are covered in full (after the co-pay) for the following conditions:

- Following cataract surgery;
- To correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
- Certain conditions of anisometropia;
- Certain conditions of keratoconus.

NOTE: *The Member Doctor must secure prior approval from VSP for medically necessary contacts.*

BENEFIT FEATURE	BASIC VISION PLAN (Available for Value HMO and Basic HMO Plan enrollees.)	PREMIUM VISION PLAN (Available for Premium HMO Plan enrollees.)	
Examination	Once every 12 months	Once every 12 months	BENEFITS
Lenses	Once every 12 months	Once every 12 months	
Frames	Once every 12 months	Once every 12 months	
Examination Copayment	$25.00	$20.00	COPAYMENT
Materials Copayment	$25.00	$20.00	
	FROM A VSP PARTICIPATING PROVIDER[1,4]	**FROM A NON-PARTICIPATING PROVIDER[4]**	COST FOR SERVICES
Examination	Paid-in-Full	Up to $50.00	
Single Vision Lenses	Paid-in-Full	Up to $50.00	
Bifocal Lenses	Paid-in-Full	Up to $75.00	
Trifocal Lenses	Paid-in-Full	Up to $91.00	
Lenticular Lenses	Paid-in-Full	Up to $125.00	
Frame2	$150 Allowance	Up to $70.00	
Necessary Contact Lenses3	Up to $210.00	Up to $210.00	
Elective Contact Lenses3	Up to $150.00	Up to $105.00	
Pediatric Eye Exam (Ages 0-18)	Basic Plan – $25/Visit Premium Plan – $20/Visit	Basic Plan – $50/Visit Premium Plan – $50/Visit	
Pediatric Glasses (Ages 0-18)	Basic Plan – $25 Copayment Premium Plan – $20 Copayment	Basic Plan – $50 Copayment Premium Plan – $50 Copayment	

1 When an exam and/or materials are received from a VSP doctor, the patient will have no out-of-pocket expense other than the copayment, unless optional items are selected. Optional items include, but are not limited to, oversize lenses (61 mm or larger) coated lenses, no-line multifocal lenses, and treatments for cosmetic reasons or a frame that exceeds the plan allowance. VSP doctors offer valuable savings including a 20 percent discount on non-covered pairs of prescription glasses (lenses and frame). Your VSP benefit provides guaranteed savings whether you choose a frame that is covered in full or one that exceeds the plan allowance. If you choose a frame valued at more than the plan's allowance, the difference you will pay is based on VSP's low, discounted member pricing. Have your doctor help you choose the best frame based on your VSP coverage.

2 The allowance is in addition to the 15 percent discount on the contact lens exam. The allowance is applied to both the contact lens exam (fitting and evaluation) and the contact lenses. Any costs exceeding this allowance are the patient's responsibility.

3 The contact lens exam is a special exam for ensuring proper fit of your contacts and evaluating your vision with the contacts. Medically necessary contact lenses must be prescribed by your doctor (as required for certain medical conditions) and approved by VSP.

4 Annual limits shown here do not apply to pediatric (dependents ages 0-18) services or materials.

ELECTIVE CONTACT LENSES

When selecting elective contact lenses (contacts that are not medically necessary) from a Member Doctor, the standard eye examination will be covered in full (after the co-pay). An allowance, as shown, will be provided toward the contact lens evaluation fee, fitting costs and materials. The contact lens allowance is approximately equal to the average cost of spectacle lenses and a frame under the VSP program. Any additional costs exceeding the allowance are your responsibility.

LASER VISION CORRECTION

VSP's Laser VisionCare℠ program is also available to those covered under the VSP WellVision® Plan. It is designed to provide members with a discount off laser surgery when obtained through VSP contracted doctors, surgeons and laser centers. This program includes the two most common laser vision correction procedures, laser-assisted in-situ keratomileusis (LASIK) and photorefractive keratectomy (PRK). Call your VSP doctor to check if he or she is participating in the program. Doctors can also be located on VSP's website at www.vsp.com or by calling 1-(800) 877-7195.

Plan Limitations

The VSP program is designed to cover your visual needs rather than cosmetic materials. If you select any of the following options, there will be an extra charge:

- Blended lenses;
- Contact lenses (except as noted elsewhere in this section);
- Oversize lenses;
- Progressive multifocal lenses;
- Photochromic or tinted lenses other than Pink 1 or 2;
- Coated or laminated lenses;
- A frame that costs more than the plan allowance;
- Cosmetic lenses;
- Optional cosmetic processes;
- UV protected lenses.

Vision Services Not Covered

VSP will not provide benefits for professional services or materials in connection with:

- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses (non-prescription);
- Two pair of glasses in lieu of bifocals;
- Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes;
- Any eye examination, or any corrective eye wear, required by an employer as a condition of employment; or
- Corrective vision services, treatments, ad materials of an experimental nature.

How to File a Claim for Vision Benefits

You do not need to file a claim if you go to a VSP Member Provider.

If you go to a non-VSP provider, you'll have to pay for services and then submit an itemized statement of services received. You'll be reimbursed for costs up to the plan's benefit limits. **You have six months from the date of service to submit such claims to:**

Vision Service Plan
P.O. Box 997105
Attn: Out of Network Provider Claims
Sacramento, CA 95899-7105
Phone: 1-(800) 877-7195

Appeal Policy and Procedure

Sharp Health Plan has established an appeal process for receiving and resolving plan participant complaints or grievances with Sharp Health Plan and its providers. If you have a complaint regarding your eligibility, coverage, a denial of benefits or any other matter, you may call Sharp Health Plan Customer Care Department at 1-(800) 359-2002.

You may request a re-evaluation of a specific decision or determination made by the Plan or any of its authorized subcontractors by calling the Plan Customer Care Department at (858) 499-8300 or toll-free at 1-(800) 359-2002 to request assistance with filing an Appeal.

You may also write to Sharp Health Plan with an Appeal at the following address:

Sharp Health Plan
Appeals Department
8520 Tech Way, Suite 200
San Diego, CA 92123-1450

Consult your Sharp Health Plan member Handbook and Appeal Policy and Procedure for additional information. Member Grievance/Appeal Forms may be obtained from either the Plan or the Member's physician, and are also available on-line at www.sharphealthplan.com.

Coordination of Benefits (COB)

If you are married and both you and your spouse are working, members of your family may be covered under more than one vision plan. For an explanation of Coordination of Benefits (COB), refer to page 23.

Continuation of Coverage (COBRA)

Federal law requires the plan to offer covered employees and eligible dependents the opportunity to continue group health coverage when it ends for certain reasons. For an explanation of how to continue your medical coverage (which includes vision) under the plan, see the Section "Continuation of Coverage (COBRA)" beginning on page 25.

SHARP

Employee ASSISTANCE PROGRAM

SHARP

Employee ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) is a free service provided by Sharp HealthCare to all employees, eligible dependents and household members. The EAP provides professionaland confidential, short-term,problem-focused counseling.

Highlights of the EAP

A broad range of issues and concerns are dealt with including but not limited to:

- Work-life services
- Individual problems
- Family life
- Couples and marital issues
- Substance use and abuse
- Life changes

In addition, the EAP has referral resources to help employees deal with issues of childcare and/or elder care as well as other needs. A variety of training programs and management consultations are also available.

Through the EAP program, Sharp HealthCare pays the cost of up to eight counseling sessions per calendar year per issue. The EAP benefit may be utilized by you as the employee, your family members/eligible dependents and your household members, as appropriate.

Employees are served through the Employee Assistance Program for issues not considered “medically necessary.” If the problem requires possible medical intervention, the EAP Counselor will assist you in coordinating care with your medical provider.

Confidentiality is maintained at all times. All counselors are state licensed and their code of ethics and the law require that no information is shared without the signed release by the employee. Sharp respects employees’ rights for confidentiality, and thus, will not attempt to compromise employee privacy.

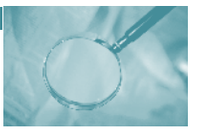
If you are unsure about whom to contact about a problem or wish to make an appointment with a counselor, please feel free to call the EAP anytime and get connected with the right resource or professional.

Call Employee Assistance Program:
1-877-230-5294
or visit their website at
member.magellanhealthcare.com

NOTE: *This program is not designed to handle specific on-the-job problems with managers, such as raises, transfers and promotions, etc.*

Continuation of Coverage under the Employee Assistance Program (EAP)

Federal law requires the plan to offer covered employees and eligible dependents the opportunity to continue group health coverage when it ends for certain reasons. For an explanation of how to continue your EAP coverage under the plan if your employment with Sharp HealthCare ends, see the Section “Continuation of Coverage (COBRA)” beginning on page 25.



SHARP

Definitions

SHARP

Definitions

The following definitions will provide explanations for some of the key terms used throughout this book.

Active work, actively at work means the employee is present at work with the intent and ability of working the scheduled hours and doing the normal duties of his or her job on that day.

Annual Open Enrollment Period means a period of time before the beginning of each calendar plan year when you have the opportunity to change your benefit elections.

Child means your biological child, stepchild, legally adopted child, or a child for whom you are currently the legal guardian or have physical legal custody of, pursuant to a court order that is currently in force, and is under the age of 26. Child also includes your dependent child who is mentally or physically incapable of self support, is enrolled prior to his or her 26th birthday, and is determined to be totally disabled before his or her 26th birthday.

Co-payment means the amount you or your covered dependents must pay before the plan pays benefits.

Deductible means the amount you pay in a calendar year for certain covered benefits before Sharp Health Plan will start to pay for those covered benefits in that calendar year.

Employer means Sharp HealthCare, and its affiliated, participating entities.

Leave of Absence means you are temporarily absent from active employment for a period of time that has been agreed to in advance in writing by Sharp HealthCare outside of your normal vacation time.

Medically Necessary means any services or supplies provided to a covered person that, in the judgment of the plan sponsor and/or claims administrator are appropriate and consistent with the diagnosis and treatment of the illness, accidental injury, or pregnancy; and customarily and reasonably recognized as appropriate throughout the doctor's profession; and could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

Out-of-Pocket Maximum means the most you have to pay for covered services in a calendar year. After you spend this amount on deductibles, copayments and coinsurance,your health plan pays 100% of the costs of covered benefits.

Participant means any employee who is eligible for and enrolls in the Plan(s) desired.

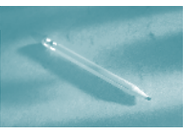
Plan Medical Group or PMG means a group of physicians, organized as or contracted through a legal entity that has met Sharp Health Plan's criteria for participation and has entered into an agreement with the Plan to provide and make available professional services and to provide or coordinate the provision of other covered benefits.

Plan Providers means the physicians, hospitals, skilled nursing facilities, home health agencies, pharmacies, medical transportation companies, laboratories, X-ray facilities, durable medical equipment suppliers and other licensed health care entities or professionals which or who provide covered benefits through an agreement with the Plan(s).

Primary Care Physician or PCP means a Plan physician, possibly affiliated with a PMG, who is chosen by you or your dependents and who is primarily responsible for supervising, coordinating, and providing initial care, for maintaining the continuity of care, and providing or initiating referrals for covered benefits. Primary care physicians include general and family practitioners, internists, pediatricians, and qualified OB-GYNs who have the ability to deliver and accept the responsibility for delivering primary care services.

Protected Health Information or PHI means information, including demographic information collected from an individual, that is created or received by a plan and that is transmitted or maintained in any medium (including orally) that 1) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present or future payment for the provision of health care to an individual; and 2) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. Protected Health Information also includes genetic information. Genetic information is information about an individual's genetic tests, genetic tests of the individual's family members, and the manifestation of a disease or disorder in the individual's family members. Family members include dependents and any other individual who is a first, second, third or fourth-degree relative of the individual or the individual's dependents. Protected Health Information shall not include information that is de-identified in accordance with HHS Reg. §164.51 4(a).

Provider Directory means a listing of Plan approved physicians, hospitals and other plan providers, as updated from time to time.



SHARP

Administrative INFORMATION

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Administrative INFORMATION

This section provides some general information about the health plan described in this booklet as well as information required to be given to you under the Employee Retirement Income Security Act of 1974 (ERISA).

Basic Plan Information

PLAN SPONSOR

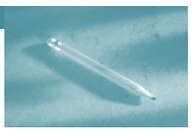
Sharp HealthCare
8695 Spectrum Center Boulevard
San Diego, CA 92123

PLAN ADMINISTRATOR

Sharp HealthCare
8695 Spectrum Center Boulevard
San Diego, CA 92123

PLAN YEAR

Medical/Vision	January 1 - December 31



Plan Identification

Sharp HealthCare is required by law to file information about this benefit plan with the government. The Internal Revenue Service assigns an "employer identification number" (EIN) to benefit plan sponsors. Sharp HealthCare's employer identification number (EIN) is 95-6077327. Sharp HealthCare assigns a plan number (PN) to each of its plans, as follows:

PLAN NAME	PLAN NUMBER	POLICY/GROUP NUMBER	TYPE OF ADMINISTRATION
▪ Medical	510	SHP/1004075	Medical – benefits fully insured under an insurance contract with Sharp Health Plan.
▪ Vision		1003	Vision – benefits are fully insured under an insurance contract with Sharp Health Plan and Vision Service Plan.

Claims Administration

CLAIMS ADMINISTRATORS

The claims administrators for the health plan are:

- HMO Medical Plan

  Sharp Health Plan
  8520 Tech Way, Suite 200
  San Diego, CA 92123-1450
  1-(800) 359-2002

- Vision Plan

  VSP Network Claims:
  Vision Service Plan
  P.O. Box 254500
  Sacramento, CA 95865
  1-(800) 622-7444
  1-(800) 877-7195 Provider Directory

  Out-of-Network Claims:
  Vision Service Plan
  P.O. Box 997105
  Sacramento, CA 95899-7105

AGENT FOR SERVICE OF LEGAL PROCESS

Legal process regarding any of Sharp HealthCare's benefit plans may be served on:

Sharp HealthCare
8695 Spectrum Center Boulevard
San Diego, CA 92123
Attn: Employee Benefits Department

Your Rights Under ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) provides certain rights and protection to participants of the SharpChoice Health, Welfare and Group Voluntary Employee Benefit Plans.

ERISA provides that all plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- You may examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration;
- You may obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The administrator may make a reasonable charge for the copies;
- You will receive a summary of the Plans' annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

You may continue health care coverage for yourself or eligible children if there is a loss of coverage under the plan as a result of a qualifying event. You or your children may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights;

You will be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer if/when you lose coverage under the plan, if/when you become entitled to elect COBRA continuation coverage, if/when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may terminate your employment or otherwise discriminate against you in any way to prevent you from obtaining a health benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

If your claim for health benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and you do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day (not to exceed $1,100) until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that the plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or at www.dol.gov/EBSA, or the Secretary of Participant Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Suite N-5623, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-(866) 444-3272 (EBSA).

NOTE:
The plan described in this book is not to be construed as conditions of employment. Sharp HealthCare reserves the right to modify, revoke, suspend, terminate, or change the plan in whole or in part, at any time, without notice. The language used in this book is not intended to create, nor is it to be construed to create, a contract between Sharp HealthCare and any one of its employees. Nothing herein shall be construed to give any person the right to be retained in the employ of Sharp HealthCare or otherwise restrain Sharp HealthCare's right to deal with its employees. Both Sharp HealthCare and any of its employees may terminate the employment relationship, at will, at any time.

SHARP

HealthCare BENEFIT PLAN NOTICES

SHARP

HealthCare BENEFIT PLAN NOTICES

This section provides special notices regarding your rights and obligations as an eligible employee and/or participant of Sharp HealthCare's Per Diem Employee Health Plan.

The plan does not discriminate on the basis of race, color, national origin, age, disability, or sex. See this page and next for details.

If you and/or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page 55 for more details.

Discrimination is Against the Law

Sharp Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Sharp Health Plan:

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

If you need these services, contact Customer Care at 1-800-359-2002.

If you believe that Sharp Health Plan 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 with:

Sharp Health Plan Appeal/Grievance Department
8520 Tech Way, Suite 200
San Diego, CA 92123-1450
Toll-free: 1-800-359-2002 (TTY:711)
Fax: (619) 740-8572

You can file a grievance in person or by mail, fax, or you can also complete the online Grievance/Appeal form on the Plan's website sharphealthplan.com. If you need help filing a grievance, the Sharp Health Plan Customer Care Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at:

https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,

or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW., Room 509F,
HHH Building, Washington, DC 20201,
1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at:

http://www.hhs.gov/ocr/office/file/index.html.

Right to Designate Primary Care Provider, Pediatrician and/or OB/GYN

Sharp Health Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Sharp Health Plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Sharp Health Plan at (800) 359-2002 or (858) 499-8300 or visit their website at: www.sharphealthplan.com. For children, you may designate a pediatrician as the primary care provider.

Women have direct and unlimited access to OB/GYNs as well as PCPs (family practice, internal medicine, etc.) in their Primary Care Physician's PMG for obstetric and gynecologic services. You will not be required to obtain prior Authorization for sexual and reproductive health services in your Plan Network. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Sharp Health Plan at (800) 359-2002 or (858) 499-8300 or visit their website at www.sharphealthplan.com.

Special Enrollment Rights

If you decline enrollment for yourself or your eligible dependents (including your spouse) because of other group medical coverage, you may be able to enroll yourself and your eligible dependents in Sharp Health Plan if you involuntarily lose eligibility for that other coverage. However, you must request enrollment within 31 days after your or your dependents other coverage ends. You will be required to submit documentation indicating the coverage termination date.

You and your eligible dependents may also be able to enroll in Sharp Health Plan if you or your dependent becomes eligible for a Premium assistance subsidy under Medi-Cal or Healthy Families. You must request enrollment within 60 days after the date that eligibility for premium assistance is determined.

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents outside of your employer's open enrollment period. However, you must request enrollment within 31 calendar days after the marriage, birth, adoption or placement for adoption. If notification of the status change is not received by your employer within the 31-day period, your dependent(s) will not be covered and you will be responsible for payment of any services received.

To add a new eligible dependent (including your spouse) to your coverage, you must complete the qualifying event task in Workday self-service within 31-days of the qualifying event.

To enroll or elect additional coverage because of a special enrollment qualifying event, you must access Workday Self-Service. To request further information or if you have questions or need assistance please contact your local Human Resources Talent Hub at (858) 499-2051 or the Employee Benefits Department Hotline at (858) 499-4336. You must submit your changes within 30 calendar days of the date you lost other coverage or you gained a new dependent. Even if you are enrolled in family coverage, you must make the changes for any new dependent within 30 calendar days of gaining a new dependent. To request more information, contact the Human Resources Talent Hub at (858) 499-2051 office or the Employee Benefits Department Hotline at (858) 499-4336.

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 had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. Coverage will be provided in a manner determined in consultation with you and your doctor, 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;
- treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles, copayments and coinsurance applicable to other medical and surgical benefits provided under your plan.

If you would like more information on WHCRA benefits, contact your local Human Resources office or the Employee Benefits Department at (858) 499-4336.

Your Rights Under the Uniformed Services Employment and Reemployment Rights Act of 1994

A. The Uniformed Services Employment and Reemployment Rights Act

USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services, and applicants to the uniformed services.

B. Reemployment Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- You ensure that your employer receives advance written or verbal notice of your service;
- You have five years or less of cumulative service in the uniformed services while with that particular employer;
- You return to work or apply for reemployment in a timely manner after conclusion of service; and
- You have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

C. Right to be Free from Discrimination and Retaliation

If you:

- Are a past or present member of the uniformed service;
- Have applied for membership in the uniformed service; or
- Are obligated to serve in the uniformed service, then an employer may not deny you –
  - Initial employment;
  - Reemployment;
  - Retention in employment;
  - Promotion; or
  - Any benefit of employment, because of this status.

In addition, an employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

D. Health Insurance Protection

- If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
- Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

E. Enforcement

- The U.S. Department of Labor, Veterans' Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.
- For assistance in filing a complaint, or for any other information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its Web site at http://www.dol.gov/agencies/vets. An interactive online USERRA Advisor can be viewed at https://webapps.dol.gov/elaws/vets/userra/
- If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice for representation.

You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

The rights listed here may vary depending on the circumstances. The text of this notice was prepared by VETS, and may be viewed on the Internet at this address:

https://www.dol.gov/agencies/vets/programs/userra/resources

Sharp HealthCare Health & Dental Plan Notice of Privacy Practices

For further information regarding this notice, contact your local Human Resources office or the Privacy Officer at the Employee Benefits Department at (858) 499-4336.

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

You have the right to:

- Ask us not to use or share your personal health care information in the ways described in this notice. We may not be able to agree to your request.
- Access any medical records related to care delivered by a third-party Telehealth provider and the right to object to the sharing of those records with your PCP.
- Receive Sensitive Services or to submit a claim for Sensitive Services if you have the right to consent to care.

- Have communications containing medical information related to Sensitive Services communicated to you at an alternative mail or email address or telephone number without the authorization of the Subscriber or another policyholder. You can update your contact information on Sharp Connect or by contacting Customer Care at 1-855-995-5004.
    - If you have not designated an alternative mailing address, email address, or telephone number, we will send or make all communications related to your receipt of Sensitive Services in your name at the address or telephone number on file. Such communications include written, verbal, or electronic communications, including:
    - Bills and attempts to collect payment.
    - A notice of adverse benefits determinations.
    - An explanation of benefits notice.
    - A health care service plan's request for additional information regarding a claim.
    - A notice of a contested claim.
    - The name and address of a provider, description of services provided, and other information related to a visit.
    - Any written, oral, or electronic communication from a health care service plan that contains protected health information.
- Have Sharp Health Plan not disclose medical information related to your receipt of Sensitive Services to the policyholder, primary subscriber, or any plan enrollees, absent your express written authorization.
- Request confidential communication in a certain form and format if it is readily producible in the requested form and format, or at alternative locations. The confidential communication request shall be valid until you submit a revocation of the request or a new confidential communication request is submitted. If you pay for a service or a health care item out-of-pocket in full, you can ask your provider not to share that information with us or with other health insurers.
- Ask us to contact you only in writing or at a different address, post office box, or by telephone. We will accept reasonable requests when necessary to protect your safety.
- Get a copy of your health information. You will be sent a form to fill out and may be charged a fee for the costs of copying and mailing records. (We may keep you from seeing certain parts of your records for reasons allowed by law.)
- Ask that information in your records be amended if it is not correct or complete. We may refuse your request if: (i) the information is not created or kept by Sharp Health Plan, or (ii) we believe it is correct and complete. If we do not make the changes you ask, you may ask that we review our decision. You also may send a statement saying why you disagree with our records, and that statement will be kept with your records. Important: Sharp Health Plan does not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.
- Request a list of what information we share, with whom we shared it, when we shared it and for what reasons. This list will not include when we share information:
    - With you;
    - With your permission;
    - For treatment, payment or health plan operations; or as required by law.
- Receive written notification if we discover a breach of your unsecured PHI, and determine through a risk assessment that notification is required.
- Authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing, for most uses or disclosures of psychotherapy notes, or if we intend to sell your PHI.
- Revoke an authorization, at any time, in writing, except to the extent that we have taken an action in reliance on the use or disclosure indicated in the authorization.
- Request a copy of this Notice of Privacy Practices. You also can find this notice on our website at: sharphealthplan.com.
- Complain about any aspect of our health information practices

See the following pages of this notice for more information on these rights and how to exercise them.

YOUR CHOICES

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information.

See the following pages of this notice for more information on these choices and how to exercise them.

OUR USES AND DISCLOSURES

Sharp Health Plan may use or share your information for reasons directly connected to your treatment, payment for that treatment or health plan operations. The information we use and share includes, but is not limited to: your name, address, personal facts, medical care given to you and your medical history.

Some actions we take as a health plan include: checking your eligibility and enrollment; approving and paying for health care services; investigating or prosecuting fraud; checking the quality of care that you receive; and coordinating the care you receive. Some examples include:

- For treatment: You may need medical treatment that requires us to approve care in advance. We will share information with doctors, hospitals and others in order to get you the care you need.
- For payment: Sharp Health Plan reviews, approves and pays for health care claims sent to us for your medical care. When we do this, we share information with the doctors, clinics and others who bill us for your care. And we may forward bills to other health plans or organizations for payment.
- For health care operations: We may use information in your health record to judge the quality of the health care you receive. We also may use this information in audits, fraud and abuse programs, planning, and general administration. We do not use or disclose PHI that is genetic information for underwriting purposes.

OTHER USES FOR YOUR HEALTH INFORMATION

- Sometimes a court will order us to give out your health information. We also will give information to a court, investigator or lawyer under certain circumstances. This may involve fraud or actions to recover money from others.
- You or your doctor, hospital and other health care providers may appeal decisions made about claims for your health care. Your health information may be used to make these Appeal decisions.
- We also may share your health information with agencies and organizations that check how our health plan is providing services.
- We must share your health information with the federal government when it is checking on how we are meeting privacy rules.
- We may share your information with researchers when an Institutional Review Board (IRB) has reviewed and approved the reason for the research, and has established appropriate protocols to ensure the privacy of the information.
- We may disclose health information, when necessary, to prevent a serious threat to your health or safety, or the health and safety of another person, or the public. Such disclosures would be made only to someone able to help prevent the threat.
- We provide Employers only with the information allowed under the federal law. This information includes summary data about their group and information concerning Premium and enrollment data. The only other way that we would disclose your Protected Health Information to your Employer is if you authorized us to do so.

If we want to use your information for any purpose not listed in this notice, we must get your written permission. If you give us your permission, you may take it back in writing at any time.

See the following pages of this notice for more information on these uses and disclosures.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information:

- Marketing purposes
- Sale of your information

Our Responsibilities

- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Effective Date
This notice is effective October 1, 2025.

Important Notice from Sharp HealthCare About Your Prescription Drug Coverage and Medicare[1]

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Sharp Health Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Sharp HealthCare has determined that the prescription drug coverage offered by Sharp Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

WHAT HAPPENS TO YOUR CURRENT COVERAGE IF YOU DECIDE TO JOIN A MEDICARE DRUG PLAN?

If you decide to join a Medicare drug plan, your current Sharp Health Plan coverage will not be affected. If you are currently enrolled in coverage with Sharp Health Plan, the plan pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive your current Sharp Health Plan health and prescription drug benefits. The prescription drug coverage provided by Sharp Health Plan includes coverage for outpatient generic and brand formulary medications with co-pays from you. The plan utilizes a drug formulary which is an updated list of medications or plan physicians to use when prescribing medicines. Medications not listed on the formulary are covered but require higher co-pays from you.

Your coverage options include:

- You may retain your existing coverage with Sharp Health Plan and choose not to enroll in Medicare Part D at this time. You may enroll in Part D at a later date (and without penalty if you enroll within 63 days of the loss of creditable coverage).
- You may retain your existing coverage with Sharp Health Plan and enroll in Medicare Part D coverage. Sharp Health Plan will coordinate with Medicare Part D coverage.
- You may enroll in Medicare Part D in lieu of other coverage. If you decide to enroll in the Medicare Part D prescription drug plan and drop your current Sharp Health Plan coverage, you may not be able to get this coverage back until the next open enrollment. You and your dependents may re-enroll into Sharp Health Plan only once each calendar year during the open enrollment under the Sharp HealthCare Benefits Program.

- See pages 7-9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/Creditable Coverage), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

WHEN WILL YOU PAY A HIGHER PREMIUM (PENALTY) TO JOIN A MEDICARE DRUG PLAN?

You should also know that if you drop or lose your current coverage with Sharp Health Plan and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

FOR MORE INFORMATION ABOUT THIS NOTICE OR YOUR CURRENT PRESCRIPTION DRUG COVERAGE

For information about your current prescription drug coverage contact Sharp Health Plan at (858) 499-8300 or (800) 359-2002. For further information about this notice, contact Sharp HealthCare's Employee Benefits Department Hotline at (858) 499-4336 or the Employee Benefits Department at (858) 499-5292.

NOTE:
You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan, and if this coverage through Sharp Health Plan changes. You also may request a copy of this notice at any time.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

REMEMBER:
Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	October 1, 2025
Name of Entity/Sender:	Sharp HealthCare
Contact-Position/Office:	Employee Benefits Department
Address:	8695 Spectrum Center Blvd. San Diego, CA 92123
Phone Number:	(858) 499-4336 or (858) 499-5292

Translation Services Available

Español (Spanish)	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY: 1-800-735-2929).
繁體中文 (Chinese)	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-800-359-2002 (TTY: 1-800-735-2929）。
Tiếng Việt (Vietnamese)	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY: 1-800-735-2929).
Tagalog (Filipino)	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY: 1-800-735-2929).
한국어 (Korean)	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY: 1-800-735-2929) 번으로 전화해 주십시오.
Հայերեն (Armenian)	ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY: (հեռատիպ)՝ 1-800-735-2929):
فارسی (Persian/Farsi)	**توجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-359-2002 -1: (TTY) 800-735-2929-1 تماس بگیرید.
Русский (Russian)	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-359-2002 (телетайп: (TTY:1-800-735-2929).
日本語 (Japanese)	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-359-2002 (TTY: 1-800-735-2929）まで、お電話にてご連絡ください。
العربية (Arabic)	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-359-2002 -1 (رقم هاتف الصم والبكم: 800-735-2929-1.
ਪੰਜਾਬੀ (Panjabi/Punjabi)	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY: 1-800-735-2929) 'ਤੇ ਕਾਲ ਕਰੋ।
ខ្មែរ (Mon-Khmer/ Cambodian)	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-359-2002 (TTY: 1-800-735-2929)។
Hmoob (Hmong)	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY: 1-800-735-2929).
हिंदी (Hindi)	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY: 1-800-735-2929) पर कॉल करें।
ภาษาไทย (Thai)	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-359-2002 (TTY: 1-800-735-2929).

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