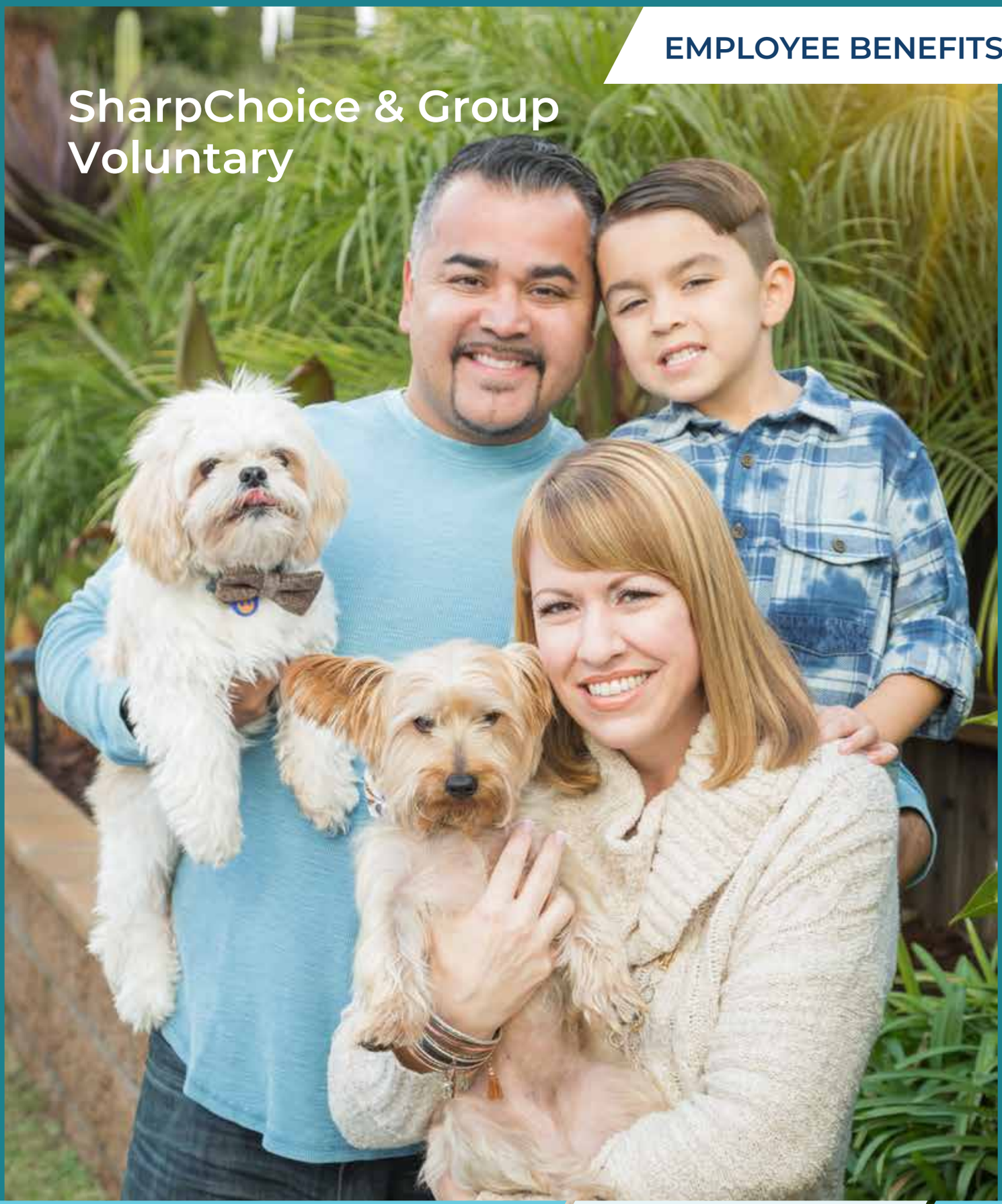
EMPLOYEE BENEFITS

# SharpChoice & Group Voluntary



**SUMMARY PLAN DESCRIPTION**
Effective January 1, 2024

SHARP

SHARP

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# About THIS BOOK

This book serves as your blueprint to Sharp HealthCare's health, welfare and group voluntary benefit plans. The more you understand the various elements of your benefit coverage, the better prepared you will be to take full advantage of the benefits Sharp HealthCare provides for you and your family.

*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 and Welfare Benefits
  - How ***SharpChoice*** Works
  - Group Health (Medical) Benefits
  - Dental Benefits
  - Vision Benefits
  - Employee Assistance Program
  - Flexible Spending Accounts
  - Group Life and AD&D (Accidental Death & Dismemberment) Insurance
  - Personal Accident Insurance
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- Group Voluntary Benefits
  - Critical Illness Insurance
  - Group Accident Insurance
  - Hospital Indemnity Information
  - Group Legal Plan
- Definitions
- Administrative Information
- Health and Dental 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 benefit plans. 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.

It is important for you to read this book to understand what is covered under the various benefit plans and when you are entitled to benefits from the plans. Additionally, please make note of the following legal provisions:

- Participation in the plans is not a guarantee of continued employment with Sharp HealthCare or its affiliated employers.
- There are no guarantees that participation under the plans for employees or other covered persons will exist or remain unchanged in future years. Sharp HealthCare intends to continue the plans but reserves the right to change them 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 any of the plans is not a guarantee of employment, and Sharp HealthCare reserves the sole right to terminate the plans at any time, either in their entirety or with respect to any covered class or classes of employees.
- All changes will be promptly communicated to you. If a plan is discontinued, benefits will be paid for covered expenses prior to that date.
- Sharp HealthCare is not responsible for advising you on the tax effect of your participation in any plan described in this book. It is recommended that you consult a tax advisor if you have any questions about how participation in any of these plans will affect your personal tax situation because tax laws are complicated and constantly changing.
- 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 benefits at Sharp HealthCare. If you have additional questions concerning your benefits 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 benefits information remains current and in one place.

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# How *SHARPCHOICE* WORKS


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SHARP

# How *SHARPCHOICE* WORKS

You are able to select your benefits from among a number of different coverage options in order to meet your individual needs with a flexible benefits program like ***SharpChoice***. One uniform set of benefits rarely fits everyone's circumstances. You may be part of a household with one person working outside the home, you may have a working spouse, a CA Certified Domestic Partner, you may be a single parent, part of a family with stepchildren, or you may be single. Sharp HealthCare employees come from many different backgrounds and have many different needs. ***SharpChoice*** takes this into account and has been designed so that you have the opportunity to build your benefits program around your circumstances.

***SharpChoice*** offers flexibility, employee involvement, tax advantages 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 ***SharpChoice***. You will find detailed information about each plan in the sections throughout this book.

## Benefit Plan Contributions & Funding Methods

The sources of funding for the benefit plans described herein are employee and employer contributions. Medical/vision and dental insurance premiums for you and your family are paid in part by Sharp HealthCare out of its general assets, and in part by your pretax payroll deduction.* Premiums for Basic Life and Basic Long Term Disability (LTD) insurance are paid by Sharp HealthCare. Premiums for optional insurance such as supplemental and dependent life insurance, supplemental LTD insurance, personal accident insurance, and all group voluntary benefits are paid by you. Your payroll deductions are made on an after-tax basis for all optional coverage except personal accident insurance which is paid by your pretax payroll deductions.

* Deductions for medical/vision and dental benefits for domestic partners, and personal accident insurance are post-tax.

## SHARPCHOICE BENEFITS & OPTIONS

| BENEFIT | OPTIONS | | WHO PAYS THE COST |
|---|---|---|---|
| Medical/Vision | Basic HMO Medical Option<br>Premium HMO Medical Option | | You and Sharp HealthCare share the cost of coverage. |
| Dental | Basic PPO Dental Option<br>Premium PPO Dental Option | | You and Sharp HealthCare share the cost of coverage. |
| Flexible Spending Accounts | Health Care Spending Account<br>Dependent Care Spending | | You choose the amount of your contribution. |
| Personal Accident Insurance | Coverage up to $500,000 not to exceed 10 x your annual base earnings for amounts above $300,000. | | You pay the entire cost at group rates. |
| Basic Life and AD&D Insurance | 1 x your annual base earnings up to $1,000,000 for each coverage (e.g., Life and AD&D).[1] | | Sharp HealthCare pays the entire cost of Basic coverage. |
| Optional Life Insurance | 1, 2, 3 or 4 x your annual base earnings up to $1,000,000 (combined with Basic Life Insurance).[2] | | You pay the entire cost at group rates. |
| Dependent Life Insurance | Legal Spouse or Domestic Partner[3]<br>$ 5,000<br>$10,000<br>$25,000<br>$50,000<br>$75,000<br>$100,000[4] | Child(ren) under Age 26<br>$ 5,000<br>$10,000<br>N/A<br>N/A<br>N/A<br>N/A | You pay the entire cost at group rates. |
| Basic Long-Term Disability | 60% of covered base earnings up to $7,500 per month[5] | | Sharp HealthCare pays the entire cost of Basic coverage. |
| Supplemental Long-Term Disability | 6 2/3% of monthly covered base earnings up to $7,500 per month (Staff, Leads, Supervisors) | | You pay the entire cost of Supplemental LTD – 6 2/3% coverage at group rates. |

1 1.5 X for Managers/Directors, 2 X for VPs, and 3 X for SVPs. SVP maximum is $2,000,000 (basic and optional combined).
2 1.5, 2.5, or 3.5 X for Managers/Directors and 1, 2, or 3X for VPs not to exceed $1,000,000 (basic and optional combined). 1,2,3, or 4 X for SVPs not to exceed $2,000,000 (basic and optional combined).
3 Not to exceed 100% of employee's life insurance amount (basic + optional).
4 A health statement is required for Evidence of Insurability for the $100,000 level.
5 Benefit amount for Managers/Directors is 70% of covered base earnings up to $8,750 per month. LTD Benefit for VPs/SVPs is 70% of monthly base earnings up to $20,000 per month.

## Pre-Tax Premium Payment — An Example[1]

Assume you are married with one child. Your annual cost for medical and dental coverage is $3,042. You get the full value of your $3,042 since you do not have to pay taxes on these pre-tax dollars. Your annual savings in the example is $1,174.

| | POST-TAX DOLLARS | PRE-TAX DOLLARS | EXAMPLE |
|---|---|---|---|
| Annual gross pay | $50,000 | $50,000 | |
| Pre-tax Premiums (Medical and Dental) | – $0 | – $3,042 | |
| Adjusted gross pay | $50,000 | $46,958 | |
| Less Taxes (Federal and Social Security) | – $17,467 | – $16,293 | |
| Post-tax Premiums (Medical and Dental) | – $3,042 | $0 | |
| Net pay | $29,491 | $30,665 | |

**AMOUNT YOU SAVE USING PRE-TAX DOLLARS: $1,174**

1 Note: This example is for illustrative purposes only. The exact amount of your tax savings will depend on the tax rate and deductions for your personal situation. Deductions for domestic partner benefits are post-tax in compliance with IRS regulations. This illustration does not apply to Domestic Partners.

# Flexible Benefit Plan

The benefits described in the example on page 5 that are available on a pre-tax basis are provided through Sharp HealthCare's Flexible Benefit Plan established under Section 125 of the Internal Revenue Code. This includes the Medical/Vision and Dental Plans, the Health and Dependent Day Care Spending Accounts, and the Personal Accident Insurance Plan.

The Flexible Benefit Plan requires that you make your selections in advance and that you agree to have your pay reduced by the amount needed to purchase the benefits you have chosen. The Flexible Benefit Plan deductions are not considered part of your wages and are therefore not subject to income or Social Security taxes, under current law.

# Eligibility

## ELIGIBLE EMPLOYEES

Regular full-time employees assigned and working 60 hours or more per pay period and regular part-time employees assigned and working 40 to 59 hours per pay period are eligible to participate in the benefit plans under ***SharpChoice*** the first of the month following 30 days of continuous employment.

**Following is a schedule of effective dates for 2024:**

| HIRE DATE | EFFECTIVE DATE |
|---|---|
| ▪ January 1 to January 3 | February 1 |
| ▪ January 4 to February 1 | March 1 |
| ▪ February 2 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 dependents are eligible to be enrolled under ***SharpChoice***.

***Spouse –*** Your legal spouse. Employees who are legally separated but not yet divorced may continue to cover their spouse under ***SharpChoice***. If you are a Sharp HealthCare employee who is married to a Sharp HealthCare employee, please see the section entitled "Two Sharp HealthCare Employees on our Plans" on page 7.

An employee who is subject to a court order to provide health coverage for a former spouse is not eligible to enroll that person as an eligible dependent. The order is for the employee to provide coverage, not Sharp HealthCare. The former spouse may be eligible for coverage through an independent insurer or for continuation of coverage through COBRA for a limited period of time. See the section "Continuation of Coverage (COBRA)" beginning on page 42 for additional information.

***Domestic Partner –*** The definition of a domestic partner for purposes of determining eligibility for coverage under the Sharp HealthCare medical/vision, dental, dependent life insurance and personal accident insurance benefit plans will be the definition recognized under the California State Law, as follows:

A domestic partnership shall be established in California when all of the following requirements are met:

- Both persons share a common residence[1]
- Neither person is married to someone else or a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
- The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
- Both persons are at least 18 years of age or if one or both are under 18, a certified copy of the court order(s) granting permission to the underage person(s) to establish a domestic partnership must be submitted.
- Both persons are members of the same or opposite sex; or

1 "Share a common residence" means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences.

- Both persons are capable of consenting to the domestic partnership.
- Both persons consent to the jurisdiction of the Superior Courts of California for the purpose of a proceeding to obtain a judgment of dissolution or nullity of the domestic partnership or for legal separation of partners in the domestic partnership, or for any other proceeding related to the partners' rights and obligations, even if one or both partners ceases to be a resident of, or maintain a domicile in, this state.
- Both persons file a Declaration of Domestic Partnership with the Secretary of State of California pursuant to this division.

Individuals must continue to meet the state requirements for domestic partnership in order to continue coverage as a domestic partner under the Plan.

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.

A child covered by a "Qualified Medical Child Support Order" or a "National Medical Support Notice" who is otherwise eligible for dependent coverage may be enrolled as described on page 9.

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 beginning on page 10 and the "Continuation of Coverage (COBRA)" section beginning on page 42.

***Dependent Verification Program –*** Sharp has a dependent verification program to ensure that all employee dependents who are receiving benefit coverage are eligible. This program 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. Upon your employment with Sharp, or a status change to a benefit eligible position, you will be required to provide verification documents for the dependents you enroll in Sharp medical and/or dental coverage. You should carefully review the definition of eligible dependents on pages 6 and 7. If you enroll dependents that do not meet the definition, your dependents will not be enrolled in the Plan.

## TWO SHARP HEALTHCARE EMPLOYEES ON OUR PLAN(S)

Special rules apply to two individuals[1] who both work for Sharp HealthCare and are enrolled (or have dependents enrolled) in the same medical/vision and dental coverages.

- One of you may enroll as an employee and the other as a dependent, or
- You may both enroll as employees and cover eligible dependents under either person's plan (not both).
- You can save more in premiums if you both enroll as employees.

1 You and your spouse, domestic partner, legally separated spouse, or eligible dependent children.

Note that both employees cannot enroll in the same coverage (twice) and/or enroll the same dependents (twice). The plan provisions do not allow the same dependents to be covered by more than one employee; nor do they allow dependents to be covered as both employee and dependent. Only one benefit would be paid for each subscriber (it would not be paid twice).

Refer to page 79 for special rules regarding Life/AD&D coverage and page 89 for Personal Accident Insurance.

### IN-AREA COVERAGE FOR NON-RESIDENT EMPLOYEES AND ELIGIBLE DEPENDENTS - MEDICAL PLAN ONLY

Employees who live or work outside Sharp Health Plan's service area (San Diego and southern Riverside counties) can be enrolled in medical coverage. Eligible dependents 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 ***SharpChoice***, you will make choices regarding your coverage. The ***SharpChoice*** benefit plan allows pre-tax deductions for employee premiums for medical/vision, dental, and personal accident insurance (except in cases of a domestic partnership where the deduction is post-tax), and pre-tax contributions for the flexible spending accounts. Benefit plans with pre-tax deductions are required to comply with the provisions of Section 125 of the Internal Revenue Service (IRS) Code. As a result, 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 or as required to add a dependent as a result of a qualified medical child support order. See the examples of "IRS Qualified Status Changes" beginning on page 10 or "Qualified Medical Child Support Orders" on page 9.

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 ***SharpChoice*** medical/vision and dental elections become effective on the first day of the month following 30 days of continuous employment provided you complete the enrollment process. If you are not in an "active at work"[1] status on that day due to an illness, injury or disability, your medical/vision and dental 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.

Your ***SharpChoice*** life, long term disability, group accident hospital indemnity, and personal accident insurance elections become effective the first day of the month following 30 days of continuous employment. If you are not in an "active at work" status on that day, your coverage will not be effective until the day you return to work.

### COVERAGE EFFECTIVE DATE FOR YOUR DEPENDENTS

**Coverage for your enrolled dependents 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 your spouse/domestic partner (if you are already married/certified) 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, also; however, their coverage will be effective the first of the following month.
- Coverage for a new spouse/domestic partner is effective on the first day of the month following the date of marriage/declaration provided you properly apply for coverage for your spouse/domestic partner within 31 days from the date of marriage/declaration. At this time, you may also enroll yourself and/or any new dependent child(ren) that meet the definition of eligible "child" acquired as a result of the marriage/declaration.

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

- You cannot enroll dependents in a plan in which you have not enrolled yourself.

A qualified medical child support order may require modification to these requirements.

## QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) / NATIONAL MEDICAL SUPPORT NOTICE (NMSN)

If your separated or divorced spouse, a state child support or Medicaid agency has obtained a "Qualified Medical Child Support Order" (QMCSO) or a "National Medical Support Notice" (NMSN), you will be required to provide health coverage for any child(ren) named in the QMCSO/NMSN. If a QMCSO/NMSN requires that you provide health coverage for your child and you do not enroll the child, Sharp HealthCare must enroll the child and withhold from your pay your share of the cost of coverage. If the child lives outside of Sharp Health Plan's service area, the plan will provide emergency and urgent care services only. Please contact Sharp Health Plan's Customer Service Department at (858) 499-8300 or 1-(800) 359-2002 for additional information. You may not drop health coverage for the child unless you prove that the QMCSO/NMSN is no longer in effect. Any reimbursements payable for a child covered by a QMCSO/NMSN will be made directly to the person who made the payment, normally to the custodial parent or legal guardian of the child, unless the individual authorizes payment to be made directly to the provider of services or supplies.

## YOUR ENROLLMENT RIGHTS

If you decline benefit coverage for yourself, your spouse, or your dependents due to other health insurance coverage, you may in the future be able to enroll in the ***SharpChoice*** benefit plans, provided you request enrollment within 31 days after other coverage ends. Also, if you have a dependent as a result of marriage/domestic partner certification, birth, adoption or placement for adoption, you may be able to enroll yourself, your spouse/domestic partner and your dependents, 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 dependents for health plan coverage if all of the following requirements are met:

- You or your dependent were covered under another health plan as an individual or dependent, including coverage under COBRA;
- You or your dependent lost coverage under the other health plan or COBRA continuation coverage for you or your dependent 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, provided Sharp HealthCare has received a completed enrollment form within 31 days of the date coverage was lost (60 days for CHIP).**

## WAIVER OF MEDICAL & DENTAL COVERAGE

If you are a full-time employee assigned and working 60 hours or more per pay period and you are covered by an-other plan (such as one provided by your spouse's employer) you may choose to waive ***SharpChoice*** coverage by making the appropriate selection when enrolling. Full-time employees who waive medical coverage receive $20 in waive dollars as additional compensation every pay period. To receive waive dollars you must elect waive coverage. Part-time employees are not eligible for waive dollars.

Once you waive medical and dental coverage, you may only re-enroll in the following circumstances:

- Within 31 days of the involuntary loss of your other medical coverage (e.g., through your spouse's termination of employment, exhaustion of COBRA continuation coverage, etc.);

- During a future annual open enrollment period;
- Within 31 days of the birth, adoption or placement for adoption of a child or your marriage as provided above;
- Within 31 days of a qualified status change.

## IF YOU FAIL TO ENROLL

You are encouraged to complete the ***SharpChoice*** enrollment process within 31 days of your initial eligibility date. However, if you are an eligible full-time or part-time employee assigned and working 40 or more hours per pay period and you fail to complete the ***SharpChoice*** enrollment process when you are first eligible for benefits, you will be automatically defaulted into no coverage for medical/vision and dental, and only the basic coverage for life and AD&D equal to 1x your annual base earnings, and basic long term disability insurance equal to 60% of your base salary, up to the policy maximum of $7,500 per month. Managers and above are automatically provided with 70% up to their respective policy maximum. See footnotes on page 80 of the Group Life and AD&D Insurance section for additional policy maximums. There is no coverage for your dependents.

## ENROLLMENT DEADLINE

To enroll when you are first eligible, you must enroll yourself and if you choose, your eligible dependents 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 dependents (as applicable) within 31 days of the date you acquire a new dependent, 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. Changes in your ***SharpChoice*** elections (other than for medical and dental coverage) may be subject to satisfactory evidence of good health and/or pre-existing condition limitations, depending on the plan. Also, the effective date of any increases in coverage for life, dependent life, LTD and personal accident insurance will be delayed until you return to work in a benefit eligible status.

## REHIRE/REINSTATEMENT

If you recently have been rehired as a Sharp HealthCare employee, it is important that you verify your benefit status and complete the process to enroll or re-enroll for benefits. If you have been rehired within 1 year of your termination date, you are eligible to enroll in benefits 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, the IRS requires that your previous pre-tax benefit elections are reinstated. IRS regulations do not allow changes in your pre-tax benefit elections if your re-hire date is within 30 days or less of your termination date.

You must complete your enrollment indicating the benefit coverage 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, whichever occurs first. Your ***SharpChoice*** life, dependent life, long term disability, group accident insurance, hospital indemnity insurance, and personal accident insurance will not become effective if you are not in an "active at work" benefits eligible status on that day. Your coverage will not be effective until the day you return to work.

# 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 complete the online enrollment process within 31 days of the change (60 days if eligible for the Children's Health Insurance Program).
The chart on pages 20-21 summarizes the benefit election changes you may be permitted to make based on the particular qualified status changes you experience.

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

Examples of IRS qualified status changes are:

- Marriage, divorce, legal separation or annulment1;
- 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.
- Eligibility or ineligibility and enrollment in the state Children's Health Insurance Program (CHIP). Sixty-day special enrollment/drop period applies.

In addition, for the Dependent Day Care Flexible Spending Account **only**, a qualified status change occurs if you experience any of the following:

- A change in the number of dependents needing dependent care (e.g., child reaches age 13, child starts school);
- A change in the dependent care provider (e.g., changed from a family member at no cost to a non-family member or change to a new facility);
- A change in the number of day care hours utilized; and,
- An increase in the pay of the dependent care provider (provided the dependent care provider is not a relative).

Day care expenses incurred by a child of a domestic partner, that does not meet the definition of dependent under Section 152 of the IRS Code, are not reimbursable under the Dependent Day Care Flexible Spending Account.

If you experience a qualified status change, you may be permitted to make changes to your **SharpChoice** coverage as shown under the section "Allowable SharpChoice Changes" beginning below. **You must access Workday Self-service within 31 days of the change to make the allowable change in coverage for you and your dependents.** However, life, dependent life, long term disability, group accident insurance, hospital indemnity insurance, and personal accident insurance, if you are not in an "active at work" benefits eligible status on the day your coverage is to become effective, your change will not become effective until the day you return to work.

**It is your responsibility to notify Sharp HealthCare within 31 days when an enrolled dependent no longer meets the dependent eligibility criteria or when you wish to add new dependents.**

## ALLOWABLE SHARPCHOICE CHANGES

The following pages describe benefit election changes you will be permitted to make during the plan year (outside of the annual open enrollment) based on the qualified status changes stipulated in Section 125 of the IRS Code and/or plan provisions, provided you have proof of the status change:

## MARRIAGE

If you become married, the following changes are permitted:

***Medical/Vision or Dental Coverages*** – You may be permitted to add coverage for your spouse; however, you may not change your plan option (e.g., Basic to Premium). You may be permitted to add or delete coverage for you and your eligible dependents, in a manner consistent with the qualified status change, if coverage for the individual becomes effective or is increased under the other employer's plan.

***Flexible Spending Accounts*** – You may be permitted to increase or decrease your contributions to the Health Care Spending Account, in a manner consistent with the qualified status change; however, you cannot add or drop the Health Care Spending Account. You may decrease your contribution to the minimum allowed contribution amount ($10 per pay period). You may be permitted to increase or decrease your contributions to the Dependent Day Care

Account if the change increases or decreases the need for childcare. You may add your Dependent Day Care coverage if the change creates or increases the need for childcare. You may drop your Dependent Day Care coverage if your spouse is not employed or participates in the Dependent Day Care Account under his or her employer's Plan.

***Life/AD&D Insurance*** **–** You may be permitted to add, delete or change coverage consistent with the qualified status change; however for life insurance, the insurance carrier requires you to complete the evidence of insurability application form if you elect to increase coverage by more than one level (e.g., 1x to 3x), or if you have previously been denied coverage.

***Long Term Disability (LTD) Insurance*** **–** You may be permitted to add, delete or change coverage consistent with the qualified status change, without evidence of insurability (EOI); however, a pre-existing condition provision applies.

***Group Accident Insurance*** **–** You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply**.**

***Hospital Indemnity Insurance*** **–** You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply**.**

***Critical Illness Insurance*** **–** You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Group Legal Plan*** **–** You may be permitted to add, delete, or change coverage consistent with the qualified status change.

***Personal Accident Insurance*** **–** You may be permitted to change your volume or amount in a manner consistent with the qualified status change. You may be allowed to change your selected plan option (e.g., individual to family) for the year.

## DIVORCE, LEGAL SEPARATION, ANNULMENT OR DEATH OF A SPOUSE OR DEPENDENT

If you, your spouse, or dependent(s) experience a change in marital status or death of your spouse or dependent, the following changes are permitted:

***Medical/Vision or Dental Coverages*** **–** You may be permitted to add coverage for you and/or your eligible dependents, or drop coverage for your spouse or affected dependent only, in a manner consistent with the qualified status change, if eligibility is lost under your spouse's plan as a result of the divorce, legal separation, annulment or death; however, you may not change your plan option (e.g., Basic to Premium) at this time. If you are currently waiving coverage, you may be permitted to enroll at this time.

***Flexible Spending Accounts*** **–** You may be permitted to decrease your contributions to the Health Care Spending Account to take into account the expenses of the affected spouse or dependent; however, you may not be permitted to drop the Health Care Spending Account entirely. You may decrease your contributions to the minimum allowed contribution amount ($10 per pay period). You may be permitted to add or drop coverage, or increase or decrease your contributions to the Dependent Day Care Spending Account in a manner consistent with the qualified status change if the change negates, increases or decreases the need for childcare.

***Life/AD&D Insurance*** **–** You may be permitted to add, delete or change coverage consistent with the qualified status change; however for life insurance, the insurance carrier requires you to complete the evidence of insurability application form if you elect to increase coverage by more than one level (e.g., 1x to 3x), or if you have previously been denied coverage.

***Long Term Disability (LTD) Insurance*** **–** You may be permitted to add, delete or change coverage consistent with the qualified status change, without evidence of insurability (EOI); however, a pre-existing condition provision applies.

***Group Accident Insurance*** **–** You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply**.**

***Hospital Indemnity Insurance*** **–** You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply**.**

***Critical Illness Insurance*** **–** You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Group Legal Plan*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change.

***Personal Accident Insurance*** – You may be permitted to add or delete coverage or you may change your volume or amount in a manner consistent with the qualified status change. You may be allowed to change your selected plan option (e.g., individual to family) for the year.

## BIRTH, PLACEMENT FOR ADOPTION, ADOPTION OF A NEW DEPENDENT

If you experience a change in the number of your dependents, the following changes are permitted:

***Medical/Vision or Dental Coverages*** – You may be permitted to add or delete the coverage for the child in a manner consistent with the qualified status change; however, you may not change your plan option (e.g., Basic to Premium) at this time. In the case of a child's birth, adoption, or placement for adoption with you or your spouse, the child will be covered automatically for the first 31 days only. If you do not enroll the child in group health coverage as a covered dependent within the first 31 days, group health coverage will stop. You may also add coverage for yourself and/or your spouse at this time. Coverage for you, your spouse and the child is retroactive to the date of the birth, adoption or placement. Dependents previously eligible may be added at this time, also; however, their coverage will be effective the first day of the following month.

***Flexible Spending Accounts*** – You may be permitted to enroll in, and increase or decrease your contributions to the Dependent Day Care Spending Account upon your return from your leave of absence. You may add or increase your contributions to the Health Care Spending Account in a manner consistent with the qualified status change when adding a new qualified dependent due to the birth of a child. Changes made will be effective the first of the following month.

***Life/AD&D Insurance*** – You may be permitted to add, delete or change coverage consistent with the qualified status change; however for life insurance, the insurance carrier requires you to complete the evidence of insurability application form if you elect to increase coverage by more than one level (e.g., 1x to 3x), or if you have previously been denied coverage.

***Long Term Disability (LTD) Insurance*** – You may be permitted to add, delete or change coverage consistent with the qualified status change, without evidence of insurability (EOI); however, a pre-existing condition provision applies.

***Group Accident Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Hospital Indemnity Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Critical Illness Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Group Legal Plan*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change.

***Personal Accident Insurance*** – You may be permitted to add or delete dependent coverage or change your volume or amount in a manner consistent with the qualified status change. You may be allowed to change your selected plan option (e.g., individual to family) at this time. Changes will be effective the first of the following month.

## LEGAL GUARDIANSHIP, CHILD CUSTODY CHANGE OR QUALIFIED MEDICAL CHILD SUPPORT ORDER/NATIONAL MEDICAL SUPPORT NOTICE

If a change in legal guardianship or physical legal custody occurs for a child, or a new paternity order for an employee's natural child (other than a newborn), or a Qualified Medical Child Support Order (QMSCO) or a National Medical Support Notice (NMSN) is issued, and the child meets the eligible dependent definition, the child may be enrolled within 31 days of the change of physical legal custody (or the court order) and the following changes are permitted:

***Medical/Vision or Dental Coverage*** – You may be permitted to add coverage for your dependent in a manner consistent with the qualified status change; however, you may not change your plan option (e.g., Basic to Premium) at this time. In the event of a QMSCO/NMSN, Sharp will be required to enroll you in Employee and Child(ren) coverage (with coverage for yourself) in order to enroll the child(ren) properly.

***Flexible Spending Accounts*** – You may be permitted to enroll in, and increase your contributions to the Health Care Spending Account and/or Dependent Day Care Spending Account consistent with the qualified status change. Changes will be effective the first of the following month.

***Life/AD&D Insurance*** – You may be permitted to add, delete or change coverage consistent with the qualified status change; however for life insurance, the insurance carrier requires you to complete the evidence of insurability application form if you elect to increase coverage by more than one level (e.g., 1x to 3x), or if you have previously been denied coverage.

***Long Term Disability (LTD) Insurance*** – You may be permitted to add, delete or change coverage consistent with the qualified status change, without evidence of insurability (EOI); however, a pre-existing condition provision applies.

***Group Accident Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply**.**

***Hospital Indemnity Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply**.**

***Critical Illness Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Group Legal Plan*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change.

***Personal Accident Insurance*** – You may be permitted to increase or decrease your coverage amount in a manner consistent with the qualified status change. You may be allowed to change your selected plan option (e.g., individual to family) at this time. Changes will be effective the first of the following month.

## CHANGE IN EMPLOYMENT STATUS BY YOU, YOUR SPOUSE OR DEPENDENTS

If you, your spouse, or dependents experience a change in employment status that affects your/their benefits coverage, the following changes are permitted:

***Medical/Vision or Dental Coverage*** – You may be permitted to add or delete coverage for you, your spouse, and/or your eligible dependents in a manner consistent with the qualified status change, if eligibility is gained or lost under the other employer's plan; however, you may not change your plan option (e.g., Basic to Premium) at this time.

***Flexible Spending Accounts*** – You will not be permitted to make changes to your contributions to the Health Care Spending Account and/or Dependent Day Care Spending Account at this time.

***Life/AD&D Insurance*** – You may be permitted to add, delete or change coverage consistent with the qualified status change; however for life insurance, the insurance carrier requires you to complete the evidence of insurability application form if you elect to increase coverage by more than one level (e.g., 1x to 3x), or if you have previously been denied coverage.

***Long Term Disability (LTD) Insurance*** – You may be permitted to add, delete or change coverage consistent with the qualified status change, without evidence of insurability (EOI); however, a pre-existing condition provision applies.

***Group Accident Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply**.**

***Hospital Indemnity Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply**.**

***Critical Illness Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Group Legal Plan*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change.

***Personal Accident Insurance*** – You may be permitted to add or delete coverage in a manner consistent with the qualified status change. You are not permitted to change your selected plan option (e.g., individual to family) at this time; however, you may change your volume or amount. You may change your plan option during the next annual open enrollment.

## CHANGE IN STATUS AFFECTING YOUR ELIGIBILITY FOR BENEFITS

If you have a change in status that affects your eligibility for benefits (i.e., per diem status to a full-time or part-time position), the following changes are permitted:

***Medical/Vision or Dental Coverage*** – You may be permitted to add or delete coverage in a manner consistent with the qualified status change, if eligibility is lost or gained; however, you may not change your plan option (i.e., Basic to Premium) at this time.

***Flexible Spending Accounts*** – You may be permitted to enroll in the Health Care Spending Account and/or Dependent Day Care Spending Account.

***Life/AD&D Insurance*** – You may be permitted to add, delete or change coverage consistent with the qualified status change; however for life insurance, the insurance carrier requires you to complete the evidence of insurability application form if you elect to increase coverage by more than one level (e.g., 1x to 3x), or if you have previously been denied coverage.

***Long Term Disability (LTD) Insurance*** – You may be permitted to add, delete or change coverage consistent with the qualified status change, without evidence of insurability (EOI); however, a pre-existing condition provision applies.

***Group Accident Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Hospital Indemnity Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Critical Illness Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Group Legal Plan*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change.

***Personal Accident Insurance*** – You may be allowed to add, delete or change coverage consistent with the qualified status change.

## DEPENDENT NO LONGER ELIGIBLE

If your dependent becomes ineligible for coverage as a result of reaching the plan's age limit or a family change that results in the dependent no longer meeting the definition of an eligible dependent under the plan, the following changes are permitted:

***Medical/Vision or Dental Coverage*** – You may delete dependent coverage consistent with the qualified status change.

***Flexible Spending Accounts*** – You may decrease your contributions to the Health Care and/or the Dependent Day Care Spending Accounts consistent with the qualified status change.

***Life/AD&D Insurance*** – You may drop coverage for the dependent consistent with the change.

***Long Term Disability (LTD) Insurance*** – You will not be permitted to make changes at this time.

***Group Accident Insurance*** – You may drop coverage for the dependent consistent with the change.

***Hospital Indemnity Insurance*** – You may drop coverage for the dependent consistent with the change.

***Critical Illness Insurance*** – You may drop coverage for the dependent consistent with the change.

***Group Legal Plan*** – You may not make changes at this time.

***Personal Accident Insurance*** – You may drop coverage for the dependent.

## INVOLUNTARY LOSS OF OTHER COVERAGE FOR YOU, YOUR SPOUSE OR DEPENDENTS

If you, your spouse, or your dependent experience an involuntary loss of coverage, the following changes are permitted:

***Medical/Vision or Dental Coverage*** – You may be permitted to add coverage for you, your spouse and/or your eligible dependents in a manner consistent with the qualified status change, if you, your spouse or dependent have received a corresponding decrease in coverage or lost coverage under another employer's plan; however, you may not change your plan option (e.g., Basic to Premium) at this time.

***Flexible Spending Accounts*** – No changes in contributions to the Health Care Spending Account/and or the Dependent Day Care Spending Account are permitted at this time.

***Life/AD&D Insurance*** – You may be permitted to add, delete or change coverage consistent with the qualified status change; however for life insurance, the insurance carrier requires you to complete the evidence of insurability application form if you elect to increase coverage by more than one level (e.g., 1x to 3x), or if you have previously been denied coverage.

***Long Term Disability (LTD) Insurance*** – You may be permitted to add, delete or change coverage consistent with the qualified status change, without evidence of insurability (EOI); however, a pre-existing condition provision applies.

***Group Accident Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply**.**

***Hospital Indemnity Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply**.**

***Critical Illness Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Group Legal Plan*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change.

***Personal Accident Insurance*** – You may not be permitted to change your selected plan option (e.g., individual to family) at this time; however, you may change your volume or amount. You may change your plan option during the next annual open enrollment.

## COMMENCEMENT OF A LEAVE OF ABSENCE

If you, your spouse or dependents begin a leave of absence, the following changes are permitted:

***Medical/Vision or Dental Coverage*** – You may be permitted to add or delete coverage in a manner consistent with the qualified status change; however, you may not change your plan option (e.g., Basic to Premium) at this time.

***Flexible Spending Accounts*** – You may be permitted to increase or decrease your contributions to the Health Care Spending Account at this time only if the leave of absence results in an increase or decrease, respectively, in dependents. You may be permitted to add coverage to the Dependent Day Care Spending Account, however, while you are on a leave of absence you may not contribute. Expenses reimbursed through the Dependent Day Care Spending Account must be incurred in order to enable you to remain gainfully employed, seek gainful employment, and/or go to school.

***Life/AD&D Insurance*** – You may be permitted to delete or change coverage consistent with the qualified status change; however for life insurance, the insurance carrier requires you to complete the evidence of insurability application form if you elect to increase coverage by more than one level (e.g., 1x to 3x), or if you have previously been denied coverage. Also, the effective date for any increases in coverage will be delayed until you return to active work in a benefit eligible status.

***Long Term Disability (LTD) Insurance*** – You may be permitted to add, delete or change coverage consistent with the qualified status change, without evidence of insurability (EOI); however, a pre-existing condition provision applies. Also, the effective date of any increase in coverage will be delayed until you return to active work in a benefit eligible status.

***Group Accident Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply. Also, the effective date of any increase in coverage will be delayed until you return to active work in a benefit eligible status.

***Hospital Indemnity Insurance*** **–** You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply. Also, the effective date of any increase in coverage will be delayed until you return to active work in a benefit eligible status.

***Critical Illness Insurance*** **–** You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply. Also, the effective date of any increase in coverage will be delayed until you return to active work in a benefit eligible status.

***Group Legal Plan*** **–** You may not make changes at this time.

***Personal Accident Insurance*** **–** You may be permitted to add or delete coverage in a manner consistent with the qualified status change. You will not be permitted to change your selected plan option (e.g., individual to family) at this time; however, you may change your volume or amount. You may change your plan option during the next annual open enrollment. However, any increases in coverage will not be effective until you return to work on an active at work status.

## RETURN FROM A LEAVE OF ABSENCE

If you, your spouse or dependents return from a leave of absence, the following changes are permitted:

***Medical/Vision or Dental Coverage*** **–** You may be permitted to add or delete coverage in a manner consistent with the qualified status change; however, you may not change your plan option (e.g., Basic to Premium) at this time.

***Flexible Spending Accounts*** **–** You may be permitted to add (if you add dependents as a result of the leave of absence), increase or decrease your contributions to the HealthCare Spending Account at this time only if the leave of absence results in an increase or decrease, respectively, in dependents. You may be permitted to add coverage or increase contributions to the Dependent Day Care Spending Account only if you added dependents as a result of the leave of absence.

***Life/AD&D Insurance*** **–** You may be permitted to add or change coverage consistent with the qualified status change; however for life insurance, the insurance carrier requires you to complete the evidence of insurability application form if you elect to increase coverage by more than one level (e.g., 1x to 3x), or if you have previously been denied coverage. Also, the effective date for any increases in coverage will be delayed until you return to active work in a benefit eligible status.

***Long Term Disability (LTD) Insurance*** **–** You may be permitted to add or change coverage consistent with the qualified status change, without evidence of insurability (EOI); however, a pre-existing condition provision applies. Also, the effective date of any increase in coverage will be delayed until you return to active work in a benefit eligible status.

***Group Accident Insurance*** **–** You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply. Also, the effective date of any increase in coverage will be delayed until you return to active work in a benefit eligible status.

***Hospital Indemnity Insurance*** **–** You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply. Also, the effective date of any increase in coverage will be delayed until you return to active work in a benefit eligible status.

***Critical Illness Insurance*** **–** You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Group Legal Plan*** **–** You may be permitted to add, delete, or change coverage consistent with the qualified status change.

***Personal Accident Insurance*** **–** You may be permitted to add coverage in a manner consistent with the qualified status change. You will not be permitted to change your selected plan option (e.g., individual to family) at this time; however, you may change your volume or amount. You may change your plan option during the next annual open enrollment.

## CHANGE IN BENEFIT COVERAGE FOR YOU, YOUR SPOUSE OR DEPENDENTS

If you, your spouse or dependents experience a change in benefits, such as a significant reduction in benefits coverage, an increase or decrease in premium, or an addition or deletion of a benefit option, the following changes are permitted:

***Medical/Vision or Dental Coverage*** – You may be permitted to add or delete coverage in a manner consistent with the qualified status change; however, you may not change your plan option (e.g., Basic to Premium) at this time.

***Flexible Spending Accounts*** – You are not permitted to change your Health Care Spending Account or your Dependent Day Care Spending Account contributions at this time. Changes may be made during the annual open enrollment to be effective January 1st of the next calendar year.

***Life/AD&D Insurance*** – You may be permitted to add, delete or change coverage consistent with the qualified status change; however for life insurance, the insurance carrier requires you to complete the evidence of insurability application form if you elect to increase coverage by more than one level (e.g., 1x to 3x), or if you have previously been denied coverage.

***Long Term Disability (LTD) Insurance*** – You may be permitted to add, delete or change coverage consistent with the qualified status change, without evidence of insurability (EOI); however, a pre-existing condition provision applies.

***Group Accident Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Hospital Indemnity Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Critical Illness Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Group Legal Plan*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change.

***Personal Accident Insurance*** – You may be permitted to add or delete coverage in a manner consistent with the qualified status change. You will not be permitted to change your selected plan option (e.g., individual to family) at this time; however, you may change your volume or amount. You may change your plan option during the next annual open enrollment.

## CHANGE IN BENEFIT ELECTIONS FOR YOU, YOUR SPOUSE OR DEPENDENTS DUE TO AN OPEN ENROLLMENT UNDER ANOTHER EMPLOYER'S BENEFIT PLAN

If your spouse or dependents experience an open enrollment and change in benefit elections under another employer's benefit plan, the following changes are permitted:

***Medical/Vision or Dental Coverage*** – You may be permitted to add coverage in a manner consistent with the qualified status change, if the spouse or dependent have received a corresponding decrease in coverage or dropped coverage under the other employer's plan; however, you may not change your plan option (e.g., Basic to Premium) at this time.

***Flexible Spending Accounts*** – You will not be permitted to change your Health Care Spending Account or your Dependent Day Care Spending Account contributions at this time. Changes may be made during the annual open enrollment to be effective January 1st of the next calendar year.

***Life/AD&D Insurance*** – You may be permitted to add, delete or change coverage consistent with the qualified status change; however for life insurance, the insurance carrier requires you to complete the evidence of insurability application form if you elect to increase coverage by more than one level (e.g., 1x to 3x), or if you have previously been denied coverage.

***Long Term Disability (LTD) Insurance*** – You may be permitted to add, delete or change coverage consistent with the qualified status change, without evidence of insurability (EOI); however, a pre-existing condition provision applies.

***Group Accident Insurance –*** You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Hospital Indemnity Insurance –*** You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Critical Illness Insurance –*** You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Group Legal Plan –*** You may be permitted to add, delete, or change coverage consistent with the qualified status change.

***Personal Accident Insurance –*** You may be permitted to enroll in, or increase the amount of coverage in a manner consistent with the qualified status change. You will not be permitted to change your selected plan option (e.g., individual to family) at this time. You may change your plan option during the next annual open enrollment.

## ELIGIBILITY/INELIGIBILITY FOR AND ENROLLMENT IN MEDICARE OR MEDI-CAL BY YOU, YOUR SPOUSE, OR DEPENDENT

If you, your spouse or dependents become eligible for and enroll in MediCare or MediCal, the following changes are permitted:

***Medical/Vision or Dental Coverage –*** You may be permitted to delete medical/vision coverage in a manner consistent with the qualified status change; however, you may not change your plan option (e.g., Basic to Premium) at this time. You will not be permitted to change dental coverage at this time.

***Flexible Spending Accounts –*** You will not be permitted to change your Health Care Spending Account or your Dependent Day Care Spending Account contributions at this time. Changes may be made during the annual open enrollment to be effective January 1st of the next calendar year.

***Life/AD&D Insurance –*** You will not be permitted to change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Long Term Disability (LTD) Insurance –*** You will not be permitted to change coverage at this time. You may do so during the next annual open enrollment or qualified family status change.

***Group Accident Insurance –*** You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Hospital Indemnity Insurance –*** You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Critical Illness Insurance –*** You will not be permitted to add, delete or change coverage at this time. You may do so bu ring the next annual open enrollment or qualified status change.

***Group Legal Insurance –*** You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Personal Accident Insurance –*** You will not be permitted to change the amount of coverage or selected plan option (e.g., individual to family) at this time. You may do so during the next annual open enrollment.

**The chart below summarizes the benefit election changes permitted as a result of an IRS qualified status change.**

| QUALIFIED STATUS CHANGE | GROUP HEALTH (MEDICAL/VISION & DENTAL) | LIFE/AD&D, DEPENDENT LIFE, LONG TERM DISABILITY (LTD), GROUP ACCIDENT, HOSPITAL INDEMNITY, CRITICAL ILLNESS, GROUP LEGAL PLAN AND PERSONAL ACCIDENT INSURANCE | HEALTH CARE FLEXIBLE SPENDING ACCOUNT | DEPENDENT DAY CARE FLEXIBLE SPENDING ACCOUNT |
|---|---|---|---|---|
| Birth, Adoption, Addition of New Dependent | May add, delete, or waive coverage for child or spouse consistent with the change. | May add, delete or change coverage consistent with the change. | May increase contributions. May add coverage consistent with the change. | May increase or decrease contributions or add coverage consistent with the change upon your return from leave to active status. |
| Marriage | May add coverage for your spouse. May add or delete coverage for you and your dependents consistent with the change. | May add, delete or change coverage consistent with the change. | May increase or decrease contributions; not allowed to add or stop contributions entirely. | May increase or decrease contributions. May add or delete coverage. |
| Divorce, Legal Separation, Annulment, Death of Spouse or Dependent | May add coverage for you, your spouse and dependents consistent with the change. May delete coverage for your spouse or affected dependent only. | May add, delete or change coverage consistent with the change. | May decrease contributions; not allowed to stop contributing entirely. | May increase or decrease contributions. May add or delete coverage. |
| Declaration or Dissolution of Domestic Partnership | May add or delete coverage for domestic partner consistent with the change. | No changes are permitted at this time. However, for Personal Accident Insurance, you may change from family to individual coverage. | No changes are permitted at this time. | No changes are permitted at this time. |
| Change in Legal Guardianship or Legal Custody of Dependent, QMCSO/NMSN | May add coverage for your dependent consistent with the change. | May add, delete or change coverage consistent with the change. | May increase contributions. May add coverage consistent with the change. | May increase contributions. May add coverage consistent with the change. |
| Employment Begins for Spouse or Dependent | May delete coverage for you, your spouse and/or dependents consistent with the change. | May add, delete or change coverage consistent with the change. | No changes are permitted at this time. | No changes are permitted at this time. |
| Employment Ends for Spouse or Dependent | May add coverage for you, your spouse and/or dependents consistent with the change. | May add, delete or change coverage consistent with the change. | No changes are permitted at this time. | No changes are permitted at this time. |
| Change in Status Affecting Your Eligibility for Benefits (i.e., Per Diem status to Full-Time/Part-Time status) | May add or delete coverage consistent with the change. | May add, delete or change coverage consistent with the change. | May add coverage. | May add coverage.. |
| Dependent No Longer Eligible | May delete dependent coverage consistent with the change. | May drop coverage for the dependent. | May decrease contributions. | May decrease contributions. |
| Involuntary Loss of Other Coverage by You, Spouse, or Dependent | May add coverage for you, your spouse and/or dependent consistent with the change. | May add, delete or change coverage consistent with the change. | No changes are permitted at this time. | No changes are permitted at this time. |
| Commencement or Return from a Leave of Absence by You, Spouse, or Dependent | May add or delete coverage consistent with the change. | May add, delete or change coverage consistent with the change; however, effective date of increases will be delayed until return to active work. | May add, increase or decrease contributions only if the LOA results in an increase or decrease, respectively, in dependents | May add coverage; however, when on an LOA, you may not contribute. May increase contributions upon return from leave only if you added dependents as a result of the leave. |
| Change in Benefit Elections for You, Your Spouse or Dependent | May add or delete coverage consistent with the change. | May add, delete or change coverage consistent with the change. | No changes are permitted at this time. | No changes are permitted at this time. |

| | | | | |
|---|---|---|---|---|
| Change in Benefit Elections for You, Your Spouse or Dependent due to an Open Enrollment under Another Employer's Plan | May add or delete coverage consistent with the change. | May add, delete or change coverage consistent with the change. | No changes are permitted at this time. | No changes are permitted at this time. |
| Eligibility/Ineligibility for and Enrollment in Medicare, Medi-Cal, or the Children's Health Insurance Program by You, Spouse, or Dependent | May add or delete coverage consistent with the changes. | No changes permitted at this time. | No changes are permitted at this time. | No changes are permitted at this time. |
| Change in Number of Dependents Needing Day Care (e.g., reaches age 13, starts school) | No changes are permitted at this time. | No changes are permitted at this time. | No changes are permitted at this time. | May add, increase, decrease or stop contributions consistent with the change. |
| Change in Dependent Day Care Provider | No changes are permitted at this time. | No changes are permitted at this time. | No changes are permitted at this time. | May add, increase, decrease or stop contributions consistent with the change. |
| Reduction in the Number of Hours of the Dependent Day Care Provider | No changes are permitted at this time. | No changes are permitted at this time. | No changes are permitted at this time. | May increase or decrease contributions consistent with the change. May add coverage consistent with the change. |
| Increase in Pay for the Dependent Day Care Provider (Not a Relative) | No changes are permitted at this time. | No changes are permitted at this time. | No changes are permitted at this time. | May increase contributions consistent with the change. |

## ELIGIBILITY FOR AND ENROLLMENT IN THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) BY YOUR ELIGIBLE DEPENDENTS

If your dependents become eligible for and enroll in the Children's Health Insurance Program (CHIP), you will have a 60-day special drop coverage period for medical/vision and dental coverage only. The following changes are permitted:

***Medical/Vision or Dental Coverage*** – You may be permitted to delete medical/vision coverage in a manner consistent with the qualified status change; however, you may not change your plan option (e.g., Basic to Premium) at this time.

***Flexible Spending Accounts*** – You will not be permitted to change your Health Care Spending Account or your Dependent Day Care Spending Account contributions at this time. Changes may be made during the annual open enrollment to be effective January 1st of the next calendar year.

***Life/AD&D Insurance*** – You will not be permitted to change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Long Term Disability (LTD) Insurance*** – You will not be permitted to change coverage at this time. You may do so during the next annual open enrollment or qualified family status change.

***Group Accident Insurance*** – You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Hospital Indemnity Insurance*** – You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Critical Illness Insurance*** – You will not be permitted to add, delete or change coverage at this time. You may do so bu ring the next annual open enrollment or qualified status change.

***Group Legal Insurance*** – You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Personal Accident Insurance*** – You will not be permitted to change the amount of coverage or selected plan option (e.g., individual to family) at this time. You may do so during the next annual open enrollment.

## CHANGE IN DEPENDENT DAY CARE PROVIDER OR NUMBER OF DEPENDENTS NEEDING CARE

If you experience a change in the number of dependents needing dependent day care (e.g., child reaches 13 years of age, child starts school, etc.); a change in the dependent day care provider; a change in the number of day care hours utilized; and/or, an increase in the pay of the dependent day care provider (provided the dependent care provider is not a relative), a change from a relative providing care at no cost to a day care provider (who is not a relative), you will be permitted to make the following changes:

***Medical/Vision or Dental Coverage*** – You will not be permitted to make changes at this time.
***Flexible Spending Accounts*** – You will not be permitted to change your Health Care Spending Account contributions at this time. You may be permitted to add, increase, decrease, or stop your Dependent Day Care Spending Account contributions if you experience a change in your day care provider. You may decrease your contributions if you have a reduction of hours of the day care provider. You may increase your contributions if there is an increase in pay to your day care provider.

***Life/AD&D Insurance*** – You will not be permitted to make changes at this time.

***Long Term Disability (LTD) Insurance*** – You will not be permitted to change coverage at this time. You may do so during the next annual open enrollment or qualified family status change.

***Group Accident Insurance*** – You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Hospital Indemnity Insurance*** – You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Critical Illness Insurance*** – You will not be permitted to add, delete or change coverage at this time. You may do so bu ring the next annual open enrollment or qualified status change.

***Group Legal Insurance*** – You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Personal Accident Insurance*** – You will not be permitted to make changes at this time.

## INCREASE IN ASSIGNED HOURS TO 40 OR MORE HOURS PER PAY PERIOD

If you are a per diem employee and take a full-time or part-time position (with assigned hours of 40 or more hours per pay period), you are eligible to enroll in the following benefit coverage (provided you have met the eligibility requirement of 30 days continuous employment). You have 31 days from the date of the qualified status change to complete the enrollment process.

***Medical/Vision or Dental Coverage*** – You may be eligible to enroll in medical/vision and dental coverage. Your coverage will be effective the first day of the month following completion of the enrollment process. If you fail to complete the enrollment process, you will be automatically defaulted to no coverage for medical/vision and dental plans.

***Flexible Spending Accounts*** – You may be eligible to enroll in and make contributions to the Health Care and/or Dependent Day Care Spending Accounts.

***Life/AD&D Insurance*** – You will be automatically enrolled in the Basic Life and AD&D insurance the first of the month following the date of your status change. You will be permitted to enroll in supplemental and dependent life insurance without evidence of good health provided this is your initial enrollment.

***Long Term Disability (LTD) Insurance*** – You will be automatically enrolled in the Basic LTD insurance the first of the month following the date of your status change. You will be permitted to enroll in supplemental LTD insurance without evidence of good health provided this is your initial enrollment, however, a pre-existing condition provision applies.

***Group Accident Insurance*** – You may be permitted to enroll in Group Accident Insurance at this time. No pre-existing condition limitations apply.

***Hospital Indemnity Insurance*** – You may be permitted to enroll in Hospital Indemnity Insurance at this time. No pre-existing condition limitations apply.

***Critical Illness Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Group Legal Plan*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change.

***Personal Accident Insurance*** – You may be permitted to enroll in Personal Accident Insurance at this time.

## DECREASE IN ASSIGNED HOURS TO LESS THAN 40 HOURS PER PAY PERIOD

If you are a full-time or part-time employee and you decrease your assigned hours to less than 40 hours per pay period, you are no longer eligible to participate in the ***SharpChoice*** benefit coverage. The status of your benefit coverage is as follows:

***Medical/Vision or Dental Coverage*** – Your medical/vision and dental coverage will continue through the last day of the month of your status change date. You will be eligible for COBRA continuation coverage the first of the month following your status change date. You will be notified of COBRA coverage by mail.

***Flexible Spending Accounts*** – Your contributions to the Health Care and Dependent Day Care Flexible Spending Accounts will stop effective on your status change date. You may continue to submit requests for Health Care reimbursement for eligible expenses incurred on or before your status change date. You may submit Dependent Day Care claims incurred through the end of the plan year (and 2½ month extension period if you have a balance on 12/31). In addition, for the Health Care Flexible Spending Account, you are eligible for COBRA continuation coverage through the end of the calendar year, (and 2½ month extension period if you have a balance on 12/31), at your own expense plus a 2% administrative charge. If you wish to submit claims up to your pre-selected goal after your termination date, you must enroll in COBRA-FSA, on a post-tax basis.

***Life/AD&D Insurance*** – Your life & AD&D and dependent life insurance will terminate as of the date you are no longer eligible. If you wish, you may convert your life insurance into an individual policy at this time.

***Long Term Disability (LTD) Insurance*** – Your long term disability insurance will terminate as of the date you are no longer eligible. You may be able to convert to an individual policy.

***Group Accident Insurance*** – Your Group Accident Insurance will terminate as of the last day of the month in which you are no longer eligible. You may convert your benefit into an individual policy at this time.

***Hospital Indemnity Insurance*** – Your Hospital Indemnity Insurance will terminate as of the last day of the month in which you are no longer eligible. You may convert your benefit into an individual policy at this time.

***Critical Illness Insurance*** – Your Critical Illness Insurance will terminate as of the last day of the month in which you are no longer eligible. If you wish, you may convert your benefit into an individual policy at this time.

***Group Legal Plan*** – Your Group Legal Plan will terminate as of your employment termination date. Any covered services that were open or still pending during your enrollment will be covered. This coverage is 100% portable for a 12-month period. If you choose to port your coverage, you must contact the MetLife Legal Plan at 1-800-821-6400 within 30 days of your last payroll deduction.

***Personal Accident Insurance*** – Your personal accident insurance will terminate as of the last day of the month in which you are no longer eligible. If you wish, you may convert your benefit into an individual policy at this time.

## CHANGE IN STATUS OF DOMESTIC PARTNERSHIPS (I.E., DECLARATION OR DISSOLUTION OF RELATIONSHIP)

The declaration or dissolution of a domestic partnership is not considered an IRS-qualified status change. Sharp HealthCare's policy will allow you to add or remove a domestic partner from medical/vision and/or dental coverage with proper documentation (i.e., declaration or termination notice) within 31 days of a related status change. However, any changes in elections for benefit plans with pre-tax deductions cannot be made without an IRS-qualified status change. As a result, when a status change related to a domestic partnership occurs that is not an IRS-qualified status change (such as the domestic partner changes employment or becomes eligible for other benefits) the employee's pretax deductions cannot be changed – only the post tax domestic partner deduction can be changed (added or stopped). The coverage change will be effective the first day of the month following completion of the paperwork or the status change date, whichever is later.

Following is an outline of how your individual benefit coverage is affected in cases of a declaration or dissolution of a domestic partnership:

***Medical/Vision or Dental Coverage*** – You may be permitted to add or remove a domestic partner with proper documentation. You may not change coverage for yourself at this time.

***Flexible Spending Accounts*** – You will not be permitted to make changes at this time. The IRS does not recognize domestic partners as eligible tax dependents. Children of domestic partners must meet the definition of a dependent under Section 152 of the IRS Code. If children meeting this definition are added as eligible dependents of the employee, there is a legal parent-child relationship with the employee, changes to flexible spending account contributions may be permitted.

***Life/AD&D Insurance*** – You will not be permitted to make changes at this time.

***Long Term Disability (LTD) Insurance*** – You will not be permitted to make changes at this time.

***Group Accident Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change.

***Hospital Indemnity Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations will apply.

***Critical Illness Insurance*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change. No pre-existing condition limitations apply.

***Group Legal Plan*** – You may be permitted to add, delete, or change coverage consistent with the qualified status change.

***Personal Accident Insurance*** – You will not be permitted to make changes at this time.

## INCREASE FROM PART-TIME (40-59 ASSIGNED HOURS PER PAY PERIOD) TO FULL-TIME (60-80 ASSIGNED HOURS PER PAY PERIOD)

If you are a benefit-eligible part-time employee (40-59 assigned hours per pay period) and increase your assigned hours to full-time (60-80 assigned hours per pay period) you are eligible to make changes in the following benefit coverage. You have 31 days from the date of the status change to complete the change in benefit elections.

***Medical/Vision or Dental Coverage*** – At this time, you may be permitted to change your medical and dental coverage category (e.g., Employee Only to Employee & Spouse, etc.) consistent with the status change; however, you may not change plan options, (e.g., Basic to Premium). You will be permitted to add or drop coverage at this time.

***Flexible Spending Accounts*** – You will not be permitted to enroll in or change your contributions to the Health Care and/or Dependent Day Care Spending Accounts.

***Life/AD&D Insurance*** – If you are currently enrolled in Supplemental Life insurance, you will experience a change in your premiums (based on salary). You will be permitted to change coverage at this time; however, the insurance carrier requires you to complete the evidence of insurability application form if you elect to increase coverage by more than one level (e.g., 1x to 3x) or if you have previously been denied coverage. You will be permitted to add or drop coverage at this time.

***Long Term Disability (LTD) Insurance*** – If you are currently enrolled in Supplemental Long Term Disability insurance you will experience a change in your premiums (based on salary). You will be permitted to add or drop coverage at this time.

***Group Accident Insurance*** – You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Hospital Indemnity Insurance*** – You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Critical Illness Insurance*** - You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Group Legal Insurance*** - You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Personal Accident Insurance*** – You will not be permitted to enroll in or change coverage at this time.

### DECREASE FROM FULL-TIME (60-80 ASSIGNED HOURS PER PAY PERIOD) TO PART-TIME (40-59 ASSIGNED HOURS PER PAY PERIOD)

If you are a full-time employee (60-80 assigned hours per pay period) and decrease your assigned hours to part-time (40-59 assigned hours per pay period) you are eligible to make changes in the following benefit coverage. You have 31 days from the date of the status change to complete the change in benefit elections.

***Medical/Vision or Dental Coverage*** – At this time, you may be permitted to change your medical and dental coverage category (e.g., Employee & Spouse to Employee Only, etc.) consistent with the status change; however, you may not change plan options (e.g., Basic to Premium). You will be permitted to add or drop coverage at this time.

***Flexible Spending Accounts*** – You will not be permitted to enroll in or change your contributions to the Health Care and/or Dependent Day Care Spending Accounts.

***Life/AD&D Insurance*** – If you are currently enrolled in Supplemental Life insurance, you will experience a change in your premiums (based on salary). You will be permitted to change coverage at this time; however, the insurance carrier requires you to complete the evidence of insurability application form if you elect to increase coverage by more than one level (e.g., 1x to 3x) or if you have previously been denied coverage. You will be permitted to add or drop coverage at this time.

***Long Term Disability (LTD) Insurance*** – If you are currently enrolled in Supplemental Long Term Disability insurance you will experience a change in your premiums (based on salary). You will be permitted to add or drop coverage at this time.

***Group Accident Insurance*** – You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Hospital Indemnity Insurance*** – You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Critical Illness Insurance*** - You will not be permitted to add, delete or change coverage at this time. You may do so bu ring the next annual open enrollment or qualified status change.

***Group Legal Insurance*** - You will not be permitted to add, delete or change coverage at this time. You may do so during the next annual open enrollment or qualified status change.

***Personal Accident Insurance*** — You will not be permitted to enroll in or change coverage at this time.

## Termination of Coverage

Except as required under COBRA, ERISA, the IRS Code or other applicable law, health care coverage for you and/or your dependents 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 dependents (as applicable) change to an ineligible status;
- The last day of the month for which you have not made any required contributions or paid the required premiums;
- The date of your death (your enrolled dependents will continue to have medical and dental coverage through the end of the month following 60 days from your death);
- The last day of the plan year following an open enrollment period during which you waive coverage;
- The date the ***SharpChoice*** plan, or with respect to any particular health and welfare benefit plan provided through the ***SharpChoice*** plan, is amended to terminate the eligibility of any class of eligible employees of which you are a member; or
- The day the ***SharpChoice*** plan ends.

Life insurance, group accident insurance, hospital indemnity insurance, personal accident insurance, and long term disability insurance terminate on the date you are no longer eligible (e.g., last day of the month of your termination date, last day of the month of your ineligible status, date on which you fail to make required contributions or pay the required premiums, etc.).

A specific benefit is no longer provided under your coverage on the date that benefit is no longer provided under the plan. Eligible expenses incurred prior to the coverage termination date will be payable through ***SharpChoice***. Expenses incurred after the coverage termination date will not be eligible for reimbursement from ***SharpChoice***. You may be able to continue certain coverages for a period of time. Each section of this booklet includes information on what happens when coverage 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. As an employee of Sharp HealthCare, you may be eligible for additional medical or family leave time as provided by Sharp HealthCare's in force LOA Policy. Please refer to the policy for more information. Such 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 ***SharpChoice*** benefits during an approved leave on the same terms and conditions in effect immediately prior to you taking such leave. If you exercise this option, benefits may be continued for a specific period of time as provided by Sharp HealthCare's in force LOA policy and other applicable law.

The amount you pay for ***SharpChoice*** benefits will be the same as if you were actively employed.

**The employee-paid portion for benefit premiums will accrue in arrears on a bi-weekly basis until you return from leave or reach the maximum of 24 weeks of benefits in a rolling 12-month period, whichever comes first. When you request your leave via the Workday Self-Service portal, you will be sent the arrears authorization form. for your completion. Once you return to work, 30% of the arrears bi-weekly premium amount will be deducted from each regular paycheck until the total accrued sum has been paid. On your return, the deductions for the arrears benefit premiums owed are in addition to the regular deduction to cover your benefit premium payment for your health and welfare benefits. It is important to note that if you are enro11ed in a Flexible Spending Account (FSA) deductions cannot accrue in arrears. If you wish to access your health FSA for services that occurred while out on leave of absence, please contact the Benefits Department at (858) 499-4336 upon your return from leave to make up any missed FSA deductions.**

**If arrears authorization is not provided by the time you return from leave, or your employment with Sharp terminates for any reason prior to the repayment of benefits premiums accrued during leave of absence, the entire unpaid balance must be paid in full. For unpaid balances, Sharp may pursue repayment utilizing collections resources and services as necessary.**

## QUALIFIED STATUS CHANGES

You may be able to change some of your ***SharpChoice*** benefit elections 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 some of 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). However, if you elect increased or additional coverage for life, dependent life, long term disability (LTD), group accident insurance, hospital indemnity insurance, or personal accident insurance (PAI), the increased coverage will not go into effect until you return to an "active at work" benefits eligible status and benefits may be subject to evidence of good health and pre-existing condition limitations.

## 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 and dental benefit elections during the annual open enrollment period. Your changes to medical/vision and dental 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 42.

Any increase or additional coverage amounts to the life, dependent life, LTD, group accident insurance, hospital indemnity insurance, or PAI elected during open enrollment will be delayed for employees who are not in active employment because of injury, illness, or disability. The initial, increased or additional insurance coverage will begin the date the employee returns to active employment, in a benefits eligible status (i.e., assigned and working at least 20 hours per week/40 hours per pay period). If you elect to add a newborn to dependent life insurance while on a leave of absence and were not enrolled in dependent life before the leave, you can not enroll in dependent life or add the newborn until you return to work in an active, benefits eligible status. During the annual open enrollment, and mid-year in the event of a qualified status change, employees on leave of absence may make elections for additional life, dependent life, LTD, group accident insurance, hospital indemnity insurance, or PAI coverage; however, any increased or additional insurance coverage will not go into effect until the employee returns to active status, is determined to be benefits eligible, and meets applicable evidence of insurability requirements and pre-existing condition limitations.

SHARP

# Group HEALTH BENEFITS


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SHARP

# 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 family 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 two Health Maintenance Organization (HMO) options provided through Sharp Health Plan: Basic HMO or Premium HMO option.

## Highlights of Basic and Premium HMO Options

Both 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 pages 31 through 33.

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 two options.

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.

## 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<br>$3,000 per family | $1,500 per individual<br>$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.

| BENEFIT FEATURE | BASIC HMO OPTION | PREMIUM HMO OPTION |
|---|---|---|
| **FAMILY PLANNING SERVICES** | | |
| Injectable contraceptives (including but not limited to Depo Provera) | $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) | 50% coinsurance of contracted rates. | 50% coinsurance of contracted rates |
| For a full description of the Assisted Reproductive Technologies (ART) benefit, contact Sharp Health Plan at (858) 499-8300 or 1-800-359-2002. | 50% coinsurance of contracted rates. Artificial reproductive technologies are not covered. | 50% coinsurance of contracted rates. Includes specified reproductive technologies:<br>▪ Artificial insemination up to a maximum of 3 inseminations<br>▪ GIFT and IVF up to a maximum of 3 cycles for any combination of procedures |
| **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** | | |
| Diagnosis and treatment of Severe Mental Illnesses for all members, Serious Emotional Disturbances for children, and other mental health conditions are covered with the copayments listed below.[3] | | |
| Inpatient | $250/admission | $150/admission |
| Office visits | $20/visit | $10/visit |
| Group Therapy | $7/visit | $7/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 |
| **CHEMICAL DEPENDENCY SERVICES** | | |
| 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 yr) | $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 57 | |
| Urgent care services | $30/visit | $15/visit |

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.

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

# 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 on the following page.

## 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 pay no deductible 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 either HMO plan option, you and your family 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 a dependent 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 covered member of your family. 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 member 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 29.

## 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 1-844-483-9033 or visit www.sharphealthplan.com. All calls are confidential..

# Sharp Best Health™ Wellness Program

Sharp Best Health™ is a comprehensive wellness program specifically designed for Sharp employees. Recognizing that all employees have a different goal and journey, Sharp Best Health™ offers a wide variety of resources to help employees meet their health and wellness goals. These resources are offered through a variety of formats and times in order to ensure it's easy for employees to receive the support they need at low or no cost to you.

Specific resources which make up the Sharp Best Health™ Wellness Program include:

- Free access to Sharp's New Weigh Weight Management program
- 50-66% coverage for a Weight Watchers (aka: WW) membership for all Full-time, Part-time, and Per Diem employees
- Steeply discounted membership to a digital fitness program
- Free membership to RethinkCare, a digital mindfulness and yoga platform
- Discounts on health and wellness resources, including Fitbit and local gyms
- Virtual, free mindfulness classes led by trained facilitators
- System Challenges and Competitions
- Quarterly, incentivized challenges focused on being active while supporting the San Diego community
- A social network designed to connect employees with those who have similar hobbies, goals and interests
- A Peer Supporter program designed to provide confidential, "just in time" support to employees in moments of stress or when things don't go as planned

You can access Sharp Best Health™ resources by visiting Sharp Best Health™ on SharpNET. For questions, please contact HYPERLINK "mailto: sharpbesthealth@sharp.com" sharpbesthealth@sharp.com.

## 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. However, Medicare requires that you apply for Medicare Part A (inpatient) when you become eligible. 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 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 and/or dental 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 and/or dental services or supplies, the ***SharpChoice*** Medical, Vision and Dental Plans, like most other plans, contain 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 and/or Dental Plan are 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 your spouse, be sure to file under his or her plan first. After you have received payment from that plan, then you can submit the claim to the appropriate ***SharpChoice*** Medical, Vision and/or Dental Plan for payment. 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, Sharp HealthCare may continue your medical coverage during a medical leave of absence. 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; See page 26 under Family Medical and other qualified leaves of absence for further details;
- 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 because 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 on the following page:

1. For Qualifying Events 1 or 2, Sharp HealthCare will notify the employee and his or her dependents, asapplicable, 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 and 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 no 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-Like Benefits for Certified Domestic Partners

COBRA-like benefits may be provided to certified domestic partners if medical/vision and/or dental coverage is lost due to the employee's termination of employment (for any reason other than gross misconduct); or, any reduction in the employee's work hours to the point where coverage would be lost; or, the death of the employee; or, the employee's entitlement to Medicare. Dissolution of the relationship is not a qualifying event. In addition, there is no secondary qualifying event for domestic partners. To be eligible, the domestic partnership must be a "registered domestic partnership" certified through the filing of a Declaration of Domestic Partnership with the State of California. This definition covers same sex partners and opposite sex partners. See full definition on pages 6 and 7.

# COBRA Benefits for Participants Residing Out-of-Area

For the medical plan only, if you or your dependents are COBRA-eligible[1] 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.

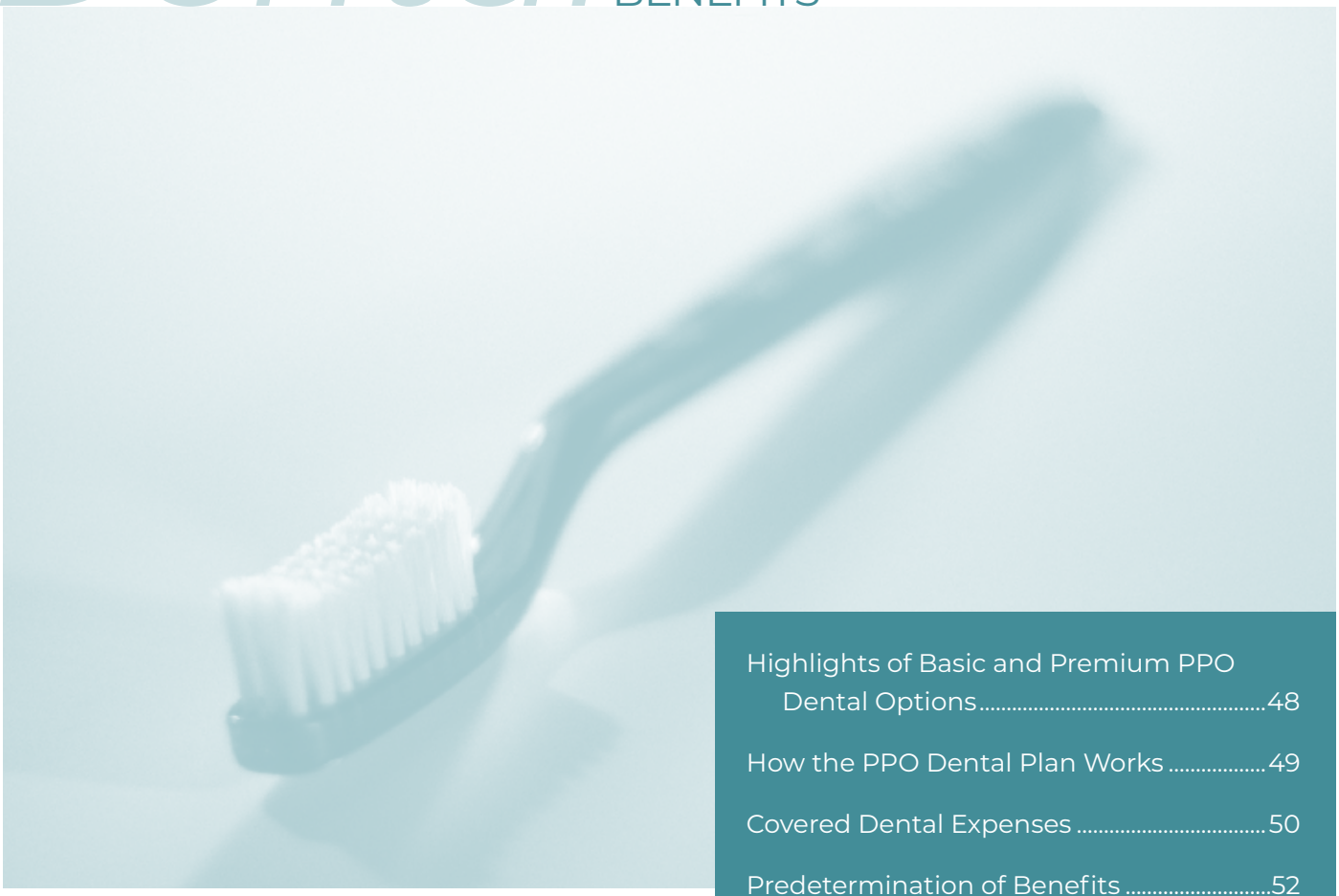
In addition, prescription benefit coverage is available; however, you must have your prescriptions filled at a plan pharmacy (e.g., Albertsons®/ Sav-On®, Costco®, CVS Pharmacy® locations including those at Target®, Ralphs®, Rite-Aid®, Vons®, Pavilions®, Walgreens®, Sharp Rees-Stealy Pharmacy, and independently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

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

1 This benefit applies to COBRA participants only; it does not apply to active employees with dependents residing out of Sharp Health Plan's service area.

SHARP

# Dental BENEFITS

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SHARP

# Dental BENEFITS

Good dental care is an important part of your overall good health. One of the most important things you can do is to receive regular dental treatment. ***SharpChoice*** offers you and your family two dental plan options that help pay for a broad range of dental services.

*Receive an annual maximum increase of $100 per year (for up to two years) if you complete your preventative care (two exams and two cleanings).*

With ***SharpChoice*** you can choose between two Preferred Provider Organization (PPO) dental options. Both options offer providers through a dental network of preferred providers and cover preventive dental care, basic services and major services as described below. The differences between the two options are the yearly benefit maximum and orthodontia coverage.

## Highlights of Basic and Premium PPO Dental Options

Both PPO dental options use the MetLife Preferred Dentist Program (PDP) Network of preferred providers and operate in the same way. The principle provisions of each plan option and the percentage covered by the plan are highlighted in the chart on the following page.

The Plan is insured by Sharp HealthCare and MetLife is the claims payor.

This section describes the benefits available through the ***SharpChoice*** Dental Plan. You should review this section thoroughly so that you understand your options and how the plan will or will not reimburse you. To minimize your costs and obtain the best possible care, it is important that you have all major dental services approved in advance by having your dentist submit a pretreatment estimate form.

## BASIC AND PREMIUM PPO DENTAL OPTIONS

| BENEFIT FEATURE | BASIC PPO DENTAL OPTION | | PREMIUM PPO DENTAL OPTION | |
|---|---|---|---|---|
| | IN-NETWORK | OUT-OF-NETWORK | IN-NETWORK | OUT-OF-NETWORK |
| Yearly deductible | $50 individual / $150 family | | $50 individual / $150 family | |
| Covered Copayment Percent of: | Negotiated PDP Network Dentist Fee | Reasonable and Customary Charges | Negotiated PDP Network Dentist Fee | Reasonable and Customary Charges |
| Preventive Services | 100% | 100% * | 100% | 100% * |
| Basic Services | 90% | 60% * | 90% | 60% * |
| Major Services | 60% | 40% * | 60% | 40% * |
| Orthodontia | Not covered | | 50% | 40% * |
| Orthodontia Lifetime Maximum | Not applicable | | $2,000/individual | |
| Yearly Benefit Maximum | $1,500/individual | | $2,000/individual | |

HIGHLIGHTS

* Percentage paid is based on reasonable and customary charges.

# How the PPO Dental Plan Works

The ***SharpChoice*** PPO Dental Plan gives you a choice. You may obtain dental care from any dental provider, or you may choose to obtain dental care from the MetLife Preferred Dentist Program (PDP) Network. There are no service area residency requirements for the Dental Plan. When you receive dental care from a MetLife PDP Network dentist, most benefits will be paid at a higher rate. Other advantages of using preferred network dentists include:

- Participating dentists have agreed to provide service at negotiated rates which are usually lower than standard rates.
- Network dentists will file your insurance claims for you.
- When you see a network dentist, you pay only your deductibles and coinsurance at the time of service.
- All claims are reviewed for dental necessity, so you do not have to pay for unnecessary services without your informed consent.

To obtain a directory of MetLife participating dentists in your area, call 1-(800) 942-0854 or access MetLife's website at www.metlife.com/dental.

### DENTAL PLAN DEDUCTIBLE

The deductible is the amount of covered dental expenses you must pay each plan year before the plan pays benefits.

The deductible you pay is the first $50 of covered expenses for basic and major dental care you receive in a plan year. You do not have to pay a deductible for covered expenses for diagnostic and preventive dental care.
The deductible applies separately to each covered person, up to $150 per family per plan year. For example, if three covered members of a family each have $50 of basic or major dental services, no additional deductible will be required for any other family member.

### HOW THE PPO DENTAL PLAN PAYS BENEFITS

The plan pays a percentage of covered expenses remaining after you pay the deductible, if any. The amount you pay for covered services is your coinsurance. The benefit percentage the plan pays depends on the type of dental treatment you receive and whether your care is provided by a network or non-network provider.

When expenses are covered under this dental plan and under any medical plan of any group policy, the plan pays benefits in the following order:

- Any medical benefits;
- Any covered dental benefits.

If covered expenses paid under any medical plan are more than the total amount of covered expenses payable under this plan, no benefits will be paid under this plan.

### PAYMENTS TO PREFERRED DENTIST PROGRAM NETWORK PROVIDERS

PDP Network providers have contracts with negotiated fees that specify how much they can charge for dental services. A negotiated fee refers to the PDP fee schedule which participating dentists agree to accept as payment in full. The fee is typically 10-30% below the average fees of dentists in your area. This gives you better control of how much you will pay and how much the plan will pay.

### PAYMENTS TO NON-NETWORK PROVIDERS

Non-network providers will be paid according to reasonable and customary charges. Reasonable and customary charges are those that fall within the usual range of dental charges for the same service. The Dental Plan will only pay for dental costs that meet reasonable and customary guidelines. You are responsible for paying the amount that exceeds reasonable and customary charges when you use a non-network dentist.

This means that non-network provider charges will probably be more than the network contracted rates. Therefore, you will probably have to pay more of the total cost of services. It is important that you are aware of this when you choose your dental provider.

### SCHEDULE OF BENEFITS

The PPO Dental Plan pays benefits according to the Schedule of Benefits in effect on the day the treatment or service was received. Benefits will be paid as a percentage of the amount allowed by the plan which is shown in the chart on page 51. **The percentages paid to non-network providers are based on reasonable and customary charges.**

### MAXIMUM BENEFITS

The most the plan will pay for any covered person in any one plan year is the yearly benefit maximum shown in the chart on page 49. This yearly maximum applies to preventive, basic and major dental care combined. The plan has an annual maximum incentive provision which provides a $100 increase per year (for up to two years) if you complete your preventative care (two exams and two cleanings). The Premium PPO Dental Option has a higher yearly maximum than the Basic PPO Dental Option.

If you have chosen coverage under the Premium PPO Dental Option, there is a separate lifetime maximum benefit for orthodontia services. The lifetime maximum benefit is the total amount the plan will pay for all orthodontia services received by a covered person during the entire time that person is covered by this plan.

## Covered Dental Expenses

Covered dental expenses are the amounts allowed by the plan you or your covered family members incur for the following services and supplies. Covered services and supplies must be performed or prescribed by a licensed dentist according to generally accepted dental practice.

### DIAGNOSTIC AND PREVENTIVE SERVICES

***Exams:*** Oral examinations, limited to two (2) times per plan year (only one per six month period) including routine bitewing x-rays and diagnostic laboratory procedures. One emergency oral examination per year (in addition to the two described above). A third cleaning for at risk members with one of the following conditions: Heart disease, Stroke, Diabetes, Maternity, Chronic Kidney disease, Organ Transplants, Head and Neck Cancer radiation, Hypertension, Thyroid disease, Sjogren's Syndrome.

***Fluoride Applications:*** Fluoride applications, limited to two (2) times per plan year, no age limit.

***Palliatives:*** Treatment for the temporary and/or immediate relief of dental pain.

***Prophylaxis:*** Cleaning and polishing of the teeth, limited to two (2) times per plan year.

***Sealants:*** Application of sealants to the permanent molars of your covered dependent child who is under the age of 19, limited to one (1) application every three years.

***Space Maintainers***

***X-rays:*** Full mouth x-rays limited to one (1) set every three years.

### BASIC SERVICES

***Anesthesia:*** General anesthesia for oral surgery, except when due to pre-orthodontic treatment.

***Consultations:*** Consultations but not more than twice in a dental expense period.

***Endodontia:*** Endodontic services, including root canal therapy (except for final restoration).

***Extractions:*** Pulling of teeth, including removal by surgery of impacted wisdom teeth, except when due to pre-orthodontic treatment.

***Fillings:*** Amalgam, silicate, acrylic and composite or resin fillings.

***Medicine or Prescribed Drugs***

***Oral Surgery:*** Oral surgery, including simple and surgical extractions (such as wisdom teeth).

***Periodontal Maintenance:*** Periodontal maintenance where periodontal treatment (including scaling, root planing, and periodontal surgery, such as gingivectomy, gingivoplasty, gingival curettage and osseous surgery) has been performed. Periodontal maintenance is limited to four times in any year less the number of teeth cleanings received during such 12 month period.

***Prosthetic Repairs:*** Repairs or recementing of crowns, inlays, bridgework or dentures. Relining or rebasing of dentures, but only after a period of six (6) months from date of initial placement and only if the plan covered such placement.

The plan covers only one relining or rebasing of dentures during one three-year period.

## MAJOR SERVICES

***Crowns:*** Gold and porcelain to metal crowns when the tooth cannot be restored with a filling or when needed as a support for a bridge.

***Fixed or Removable Appliances:*** For tooth guidance or to control harmful habits.

***Inlays and Onlays:*** Gold foil, metallic, porcelain, and labial veneers (front teeth only) when replaced after five (5) years.

***Prosthetics - Initial Placement:*** Full and partial dentures, fixed and removable bridgework, implants, and the addition of teeth to partial dentures or fixed bridgework.

***Prosthetics - Replacement:*** Replacement of a denture, bridgework or implant, but only when replaced after five (5) years from the original installation, unless the denture is a stayplate or is needed as the result of an injury.

Replacement of a crown, but only when replaced after five (5) years from original installation.

*NOTE: Any benefits paid for temporary crowns, bridges or dentures are subtracted from benefits paid for permanent crowns, bridges or dentures. The total benefit paid for temporary dentures will not be over the maximum benefit for permanent dentures.*

## ORTHODONTIA SERVICES - PREMIUM PPO DENTAL OPTION ONLY

If you are enrolled in the Premium PPO Dental Option, orthodontic services are payable at the percentage shown in the chart on page 45, up to a $2,000 lifetime maximum per person. You must remain enrolled in the Premium PPO Dental Option until all services are completed for orthodontia services to be covered. Covered orthodontic services include:

- Preliminary examinations, including x-rays and any proposed treatment plan;
- Diagnostic procedures;
- Formal retention including full-banded treatment.

Your payments for orthodontic services will be made in equal installments. Charges for courses of treatment started prior to effective date of coverage will be prorated from date of coverage. Please contact the Sharp HealthCare Employee Benefits Department for specific information.

# Predetermination of Benefits

Whenever the charges of a dentist for a proposed course of treatment include services in excess of $250, a pretreatment estimate form should be submitted. By using this procedure, you will have an advance estimate of what portion of the cost will be covered.

The dentist's pretreatment estimate form should be filed for review before beginning the course of treatment. This form details the condition of the patient's mouth, the dentist's proposed services and the charge for those services. The Claims Administrator will then determine whether the treatment and the related expenses are appropriate and will notify you and your dentist of the estimated benefits payable based on the planned course of treatment. If a description of the procedures to be performed and an estimate of the dentist's charges are not submitted in advance, benefits will be payable in accordance with the standard features of the plan and may be less than you expect.

A pretreatment estimate is not intended to interfere with your relationship with your dentist. Rather, it is intended to provide useful information to you and your dentist. **You are both informed in advance of the treatment of the estimated benefits payable for the proposed course of treatment and of the expenses that will remain your full responsibility.**

# Dental Plan Exclusions and Limitations

The following list is a general description of expenses for services and supplies not covered by the PPO Dental Plan. Expenses which are not covered include (but are not limited to):

***Appliances:*** Items intended for sport or orthodontia use. (Orthodontia exclusion does not apply to Premium PPO Dental Option).

***Claim Form Completion:*** Any charges made by your dentist for completion of a claim form.

***Cosmetic Dentistry:*** Services performed for cosmetic purposes, and any related services or supplies, that alter appearance but do not restore or improve impaired physical function, unless necessary due to an accident which occurred while employee (or dependent) was covered under the plan.
***Decorative:*** Decoration or inscription of any tooth, device, appliance, crown or other dental work.

***Duplicate Prosthetic Devices or Appliances***

***Excess Care/Excess Charges/Experimental Procedures:*** Any service that is not necessary or is not normally perform-ed for proper dental care of the condition, or any service that is not approved by the attending dentist. Charges in excess of the customary and reasonable charge for dental services or supplies. Services considered experimental or not approved by the American/Canadian Dental Association.

***Hospital Expenses***

***Lost or Stolen Prosthetics***

***Medical Plan Coverages:*** Any dental services to the extent to which coverage is provided under the terms of the medical plan or those dental procedure codes deemed as medical in nature.

***Missed Appointment:*** Any charges by a dentist or doctor for a broken appointment.

***Non-Professional Care:*** Services rendered by other than a dentist, or a dental hygienist or x-ray technician under the supervision of a dentist.

***Oral Hygiene Counseling, etc:*** Education or training in and supplies used for dietary or nutritional counseling, personal oral hygiene instruction, or plaque control. Charges for supplies normally used at home, including but not limited to, toothpaste, toothbrushes, waterpiks and mouthwashes.

***Orthodontia:*** Orthodontia or procedures, appliances or restorations used to increase vertical dimension or to restore occlusion. (Orthodontia exclusion does not apply to Premium PPO Dental Option).

***Poor Prognosis:*** Services for which the submitted documentation indicates a poor prognosis.

***Prior to Effective Date:*** Charges for courses of treatment that were begun prior to the covered person's effective date, including crowns, bridges, dentures, or appliances ordered prior to the effective date.

***Prosthetics:*** Replacement of dentures within five (5) years of original installation, unless the denture is a stayplate or is needed as the result of an injury.

- Replacement of functional bridge or denture.
- Replacement of a crown within five (5) years of original installation if the plan covered that installation.
- Adjustments, repairs or relines to prostheses within six (6) months of placement.

***Vertical Dimension:*** Procedures for change of vertical dimension, restoration of occlusion, bite registration or bite analysis.

***War:*** Services or supplies received as a result of dental disease, defect or injury because of an act of war, whether declared or undeclared.

***Work-related Illness or Injury:*** Any illness or injury covered by Workers' Compensation or the Occupational Disease Law.

# How to File a Claim for Dental Benefits

If you receive dental services from a participating network provider, you do not have to file a claim. This will be done for you by the provider. For all other services treated by a non-network provider, you must file a claim. Claim forms are available from your Human Resources office, the Employee Benefits Department, or MetLife's website at www.metlife.com/dental.

Your claim is a request for payment or reimbursement. When you file a claim you are, in effect, asking the plan to make payment based on the information on the claim form. For this reason it is very important to fill out the claim form properly and accurately.

Everyone benefits when claims are filled out correctly the first time. You save on unnecessary paperwork and the Plan saves on administrative costs. When you are filing a claim, remember to:

- Use a separate claim form for each family member;
- Use a separate claim form for each course of treatment;
- Provide your Social Security number;
- Submit copies of completely itemized bills showing the type of dental services provided;
- Avoid submitting the same claim twice;
- File your spouse's claim under his or her plan first (if he/she has dual coverage).

Claims should be submitted promptly. Return completed forms, correspondence and all bills according to the instructions provided on the forms.

All claims found to be fraudulent will be prosecuted to the full extent allowed by law.

**All claims must be submitted for payment no later than one year following the occurrence. Claims should be mailed, faxed, or submitted by phone to:**

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282
By Fax: 1-859-389-6505
By Phone: 1-877-638-3379

## PAYMENT OF CLAIMS

When your claim has been verified and approved, benefits will be paid to you or directly to your dental care providers if you have assigned benefits to them. Approved claims are processed and paid approximately 10 days from the date of receipt.

## CLAIM QUESTIONS

If any portion of a claim is not paid, or if you do not understand or do not agree with the handling of a claim, contact MetLife's Customer Service Department at 1-(800) 942-0854. If you still have questions, contact the Employee Benefits Department.

# Appeal Policy and Procedure

Sharp HealthCare has established an appeal process for receiving and resolving plan participant complaints or grievances with the ***SharpChoice*** Dental Plan and its providers. If you have a complaint regarding your eligibility, coverage, or a denial of benefits or any other matter, you should contact the Employee Benefits Department for assistance.

If your claim has been denied, in whole or in part, you may appeal the decision and request additional review of your claim. Your request for review should be sent to the following address within 180 days after the date you receive notice of the denial or adverse decision:

MetLife
Group Claims Review
P.O. Box 14589
Lexington, KY 40512

When requesting a review, please state the reason you believe the claim was improperly denied, and whether you are requesting a first or second review. You may submit any comments, questions, documents or information you or your dental provider deem appropriate. Your claim will receive a full and fair review involving a dental professional other than the one who initially made the denial or adverse decision. If there are medical considerations involved in the claim, MetLife will consult appropriately trained and qualified professionals to make those decisions. MetLife will review your claim within 30 days of receipt for pre- and post-service claims. Appeal decisions will be made no later than:

- 72 hours for urgent care claims (or sooner if medical exigencies require it)
- 30 days for pre-service claims (15 days each, if two appeals required)
- 60 days for post-service claims (30 days each, if two appeals required)

MetLife will also provide you with a written or electronic version of the decision in a manner you can understand. You have the right to request copies of all documents, records, and other information MetLife used in evaluating your claim at no cost to you.

If MetLife denies your first appeal in whole or in part, you may request a second level appeal and MetLife will respond to that request within 30 days. At the end of the second level appeal, if you are not satisfied with the decision, you have the right to resolve your grievance through binding arbitration which is the final step for resolving grievances.

## ARBITRATION

Any grievance, including a professional liability claim, which may arise between you or a covered dependent and the plan or a plan provider, must be resolved through binding arbitration rather than a lawsuit. Binding arbitration means that your dispute is resolved by an administrative judge instead of a civil or criminal judge. After the second level appeal process has failed to resolve your grievance to your satisfaction, you may begin the arbitration process by submitting a demand for arbitration to the plan. Arbitration will be conducted in accordance with the rules and regulations of the American Arbitration Association as amended from time to time.

The PPO Dental Plan options are administered by Sharp HealthCare. Sharp HealthCare, confers the maximum discretionary authority permitted by law to the Plan Administrator to interpret, construe and administer the provisions of the plan.

## 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 dental plan. For an explanation of Coordination of Benefits (COB), refer to page 40.

## Continuation of Coverage (COBRA)

Federal law requires the plan to offer covered employees and dependents the opportunity to continue group health coverage when it ends for certain reasons. For an explanation of how to continue your dental coverage under the plan, see the section “Continuation of Coverage (COBRA)” beginning on page 42.

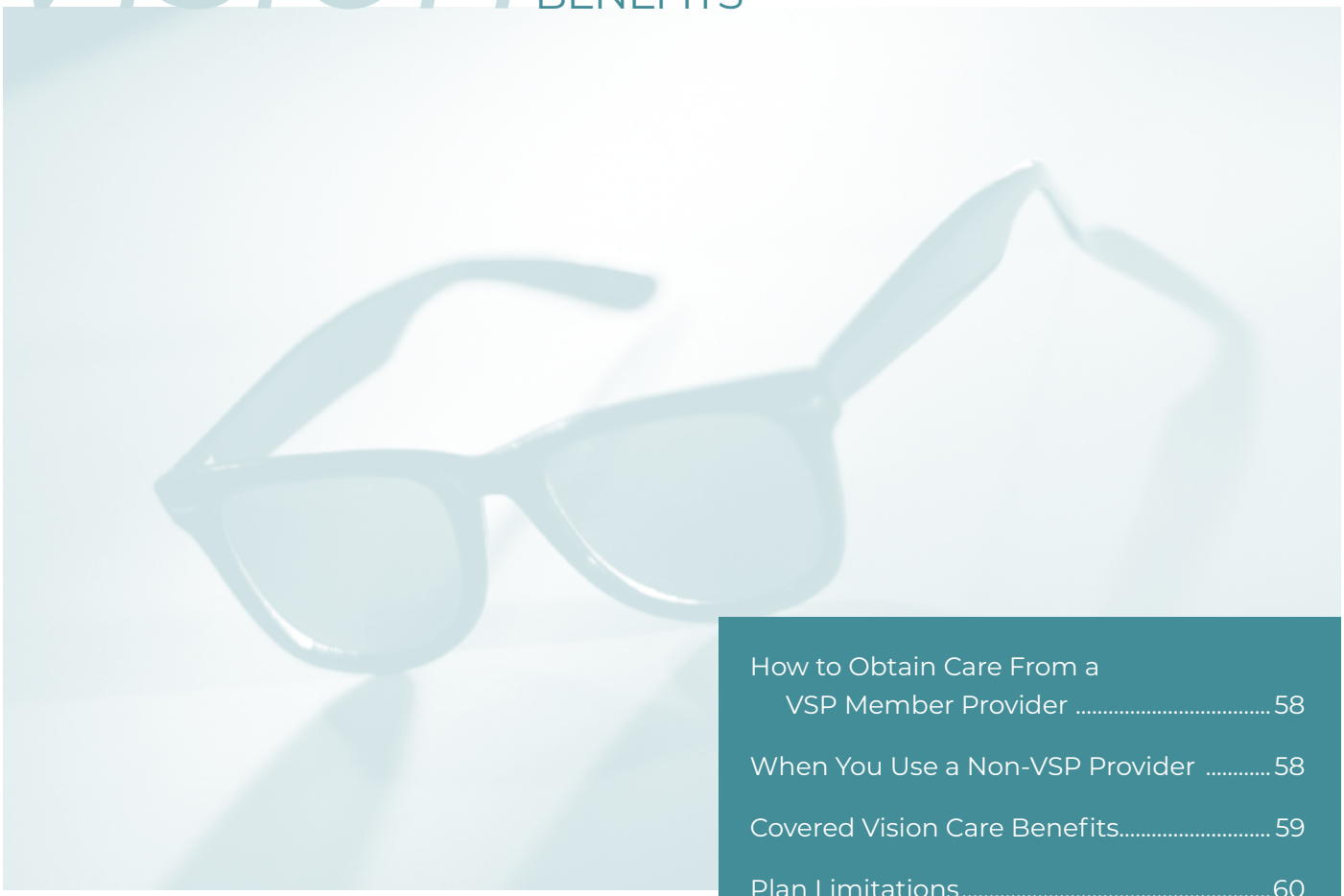
## COBRA-Like Benefits for Certified Domestic Partners

COBRA-like benefits may be provided to certified domestic partners if dental coverage is lost due to the employee’s termination of employment (for any reason other than gross misconduct); or, any reduction in the employee’s work hours to the point where coverage would be lost; or, the death of the employee; or, the employee’s entitlement to Medicare. Dissolution of the relationship is not a qualifying event. In addition, there is no secondary qualifying event for domestic partners.

To be eligible, the domestic partnership must be a “registered domestic partnership” certified through the filing of a Declaration of Domestic Partnership with the State of California. This definition covers same sex partners and opposite sex partners. See full definition on pages 6 and 7.

SHARP

# Vision BENEFITS

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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 | PREMIUM VISION PLAN | |
|---|---|---|---|
| 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 | |
| Frame[2] | $150 Allowance | Up to $70.00 | |
| Necessary Contact Lenses[3] | Up to $210.00 | Up to $210.00 | |
| Elective Contact Lenses[3] | Up to $150.00 | Up to $105.00 | |
| Pediatric Eye Exam (Ages 0-18) | Basic Plan – $25/Visit<br>Premium Plan – $20/Visit | Basic Plan – $100/Visit<br>Premium Plan – $100/Visit | |
| Pediatric Glasses (Ages 0-18) | Basic Plan – $25 Copayment<br>Premium Plan – $20 Copayment | Basic Plan – $100 Copayment<br>Premium Plan – $100 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 40.

## 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 42.

## COBRA-Like Benefits for Certified Domestic Partners

COBRA-like benefits may be provided to certified domestic partners if medical/vision coverage is lost due to the employee's termination of employment (for any reason other than gross misconduct); or, any reduction in the employee's work hours to the point where coverage would be lost; or, the death of the employee; or, the employee's entitlement to Medicare. Dissolution of the relationship is not a qualifying event. In addition, there is no secondary qualifying event for domestic partners.

To be eligible, the domestic partnership must be a "registered domestic partnership" certified through the filing of a Declaration of Domestic Partnership with the State of California. This definition covers same sex partners and opposite sex partners. See full definition on pages 6 and 7.

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# Employee ASSISTANCE PROGRAM


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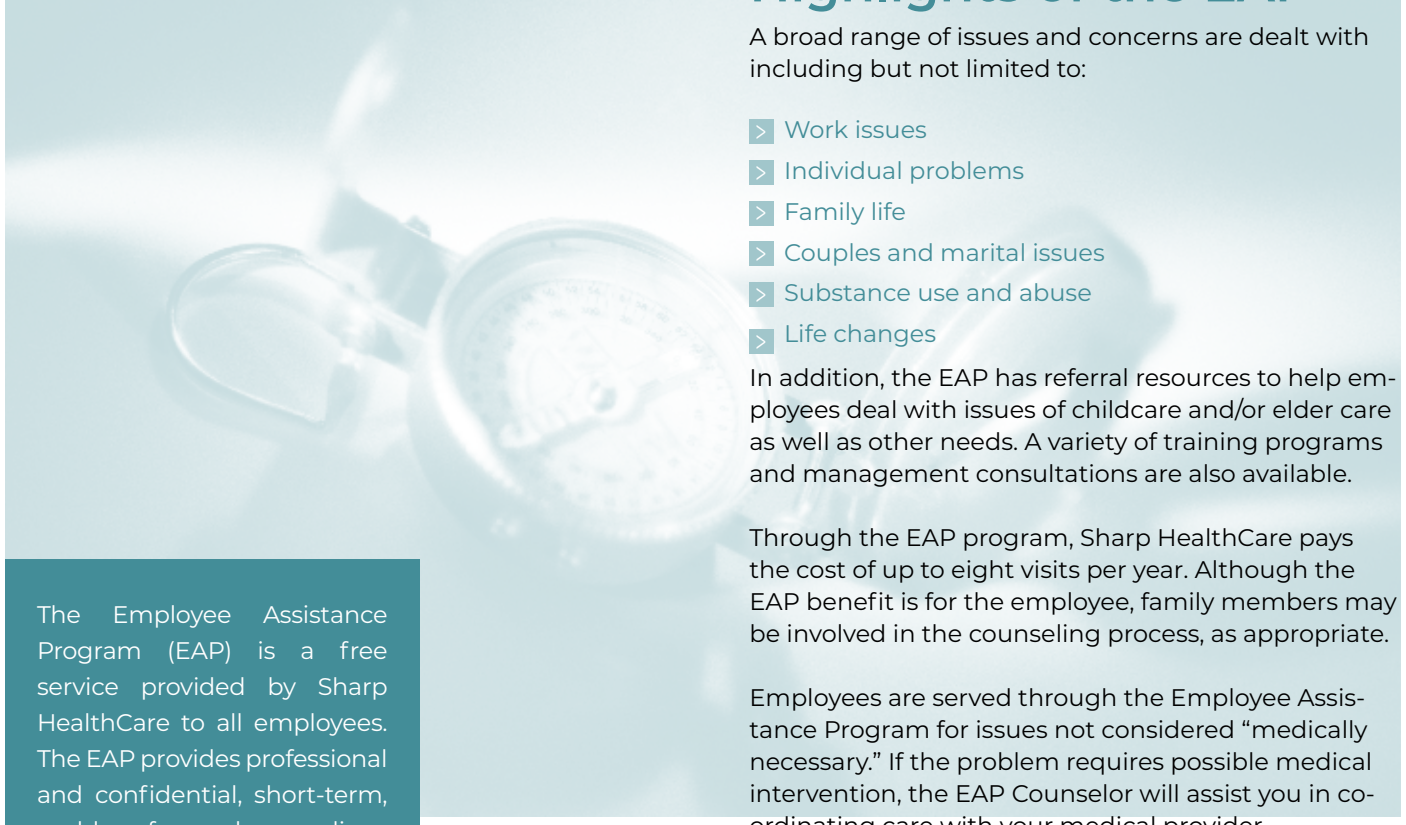
SHARP

# Employee ASSISTANCE PROGRAM



The Employee Assistance Program (EAP) is a free service provided by Sharp HealthCare to all employees. The EAP provides professional and 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 issues
- 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 visits per year. Although the EAP benefit is for the employee, family members may be involved in the counseling process, 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 Monday through Friday from 8:30 a.m. to 5:30 p.m.

Employee Assistance Program:
(619) 681-0022

***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 42. See page 45 for information regarding COBRA-like benefits for certified domestic partners.

Employees who have terminated employment with Sharp and who move out of the Employee Assistance Program's coverage area (San Diego county) are eligible to enroll in COBRA EAP coverage for authorized services rendered by contracted providers within the service area only.

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# *Flexible* SPENDING ACCOUNTS


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SHARP

# Flexible SPENDING ACCOUNTS

Sharp HealthCare is pleased to provide you with the opportunity to participate in two Flexible Spending Accounts (FSAs), one for health care expenses and one for dependent day care expenses. These accounts do not provide you with any additional medical, dental or vision coverage, they simply provide you with a means of paying for certain health and dependent day care expenses with pre-tax dollars. The advantage of paying expenses on a pre-tax basis is that you will have more spendable income and you pay less in taxes, so you save money.

The tax savings available through the two Flexible Spending Accounts are provided through the ***SharpChoice*** Flexible Benefit Plan established under Section 125 of the Internal Revenue Code. As explained earlier in this booklet (on page 6), the Section 125 plan allows you to pay your share of the cost for Medical/Vision, Dental, and Personal Accident Insurance coverage, as well as your contributions (by pre-tax payroll deduction) to Health Care and Dependent Day Care Spending Accounts.

Because the money you contribute to these accounts is free from federal and state income and Social Security taxes, you gain a significant tax advantage. Keep in mind, however, if you receive reimbursement for an expense under this plan, you cannot claim a Federal Income Tax Credit or deduction for that same expense.

There are two types of Flexible Spending Accounts:

- Health Care Spending Account
- Dependent Day Care Spending Account

Health care or dependent care expenses incurred by a dependent who does not meet the definition of "qualified dependent" under Section 152 of the IRS Code, are not reimbursable under the Flexible Spending Accounts.

The definition of "qualified dependent" covers two categories, "Qualifying Child" and "Qualifying Relative."

To be a "Qualifying Child," the child must meet all of the following requirements:

- Be the employee's child or child of the employee's domestic partner and not be the tax code dependent of another person;
- Be under age 19 if not a full-time student, or under age 24 if a full-time student; however, for dependent day care, child must be under age 13;

- Be unmarried and younger than the taxpayer claiming the individual on his/her tax return;
- Have the taxpayer's household as his/her primary residence (lives there more than one-half of the calendar year); and,
- Not provide more than half of his/her own support.

To be a "Qualifying Relative," (other than spouse) the dependent must meet all of the following requirements:

- Be the taxpayer's child or descendent of child, sibling, parent, niece/nephew, in-law, or member of the taxpayer's household;
- Earn less than the income limit set forth by the IRS;
- Receive at least half of the taxpayer's support during the tax year; and,
- Not be a qualified child of another taxpayer.

# Eligibility and Enrollment

You are eligible to participate in either or both of the Flexible Spending Accounts if you are a regular full-time or part-time employee, assigned and working 40 hours or more per pay period. Part-time employees assigned and working less than 40 hours per pay period, per diem, temporary and casual employees are not eligible.

As a new employee, you can participate in the FSA program on the first day of the month following or coinciding with 30 days of continuous employment provided you complete an enrollment form. Each year you must re-enroll and make any desired changes to your FSA deductions during the annual open enrollment period.

To enroll in the Flexible Spending Accounts, indicate the amount you wish to contribute to a Health Care and/or a Dependent Day Care Spending Account when you complete your ***SharpChoice*** enrollment process. If you choose to open a Flexible Spending Account, you need to be aware that it is an annual election and you will continue to be an active participant in the program until the end of the year.

In addition, if you choose not to enroll in the Flexible Spending Accounts during the annual open enrollment, you may not enroll during the year. The only exception to this is if you experience a qualified status change affecting your eligibility to enroll in the HealthCare and/or Dependent Day Care Spending Account.

You may enroll or re-enroll each year in the Flexible Spending Accounts during the annual open enrollment period for ***SharpChoice*** benefits. The account(s) will be effective at the beginning of the next calendar year.

**Please note that you must re-enroll each year during the annual enrollment period to continue either or both of your accounts for the upcoming year.**

# Qualified Status Changes

IRS regulations allow you to make changes to your FSA contributions during the year only if you experience a qualified status change. However, there is a $20.00 minimum for any increase/decrease. Please refer to the chart on page 20 summarizing the allowed FSA contribution changes in the event you experience one of the qualified status changes listed.

# How Much You May Contribute

You can elect to have pre-tax amounts deducted from your paycheck up to the annual amounts for each account as shown below. IRS regulations require that you must use the money in your account or it must be forfeited. Therefore, it's very important that you estimate your anticipated costs carefully.

Money cannot be transferred between the Health Care and Dependent Day Care Accounts. By law, these accounts must remain separate.

## HEALTH CARE SPENDING ACCOUNT

You may contribute a minimum of $260 per year (or $10 per pay period) up to the annual statutory limit to the Health Care Spending Account.

### DEPENDENT DAY CARE SPENDING ACCOUNT

You may contribute a minimum of $260 per year (or $10 per pay period) up to a maximum of $5,000 per year to the Dependent Day Care Spending Account. If you are single or married and file a joint return, you may deduct up to a total of $5,000. If you are married but file separate income tax returns, the maximum contribution you can make to a Dependent Day Care Spending Account is $2,500. In addition, the IRS does not allow contributions larger than the earned income of the lower-paid spouse. So, if you or your spouse earns less than $5,000 a year, your maximum contribution would be lower.

If your spouse is a full-time student or is disabled, he or she is treated as having $200 earned income for the month if you have one qualifying dependent, and $400 for the month if you have two or more qualifying dependents.

## How the FSA Plan Works

There are actually two separate accounts, one for health care expenses and one for dependent day care expenses. You may enroll in one or both accounts. When you enroll, you designate how much of the total amount of money you set aside will be for eligible health care and/or how much will be for eligible day care. The money deducted for your health care account can be used **ONLY** for eligible health care expenses; likewise the amount set aside for day care can be used **ONLY** for day care. **You cannot decide later that you want to use money from your health care account for eligible day care expenses, or vice versa.**

The total amount you set aside for eligible health and dependent day care will be deducted automatically from your paychecks in equal amounts throughout the year. **The money in your FSA is not taxed, even when you receive reimbursements from your account.** It comes out of your paycheck before Social Security, federal, or state income, and State Disability Insurance (SDI) taxes are withheld. As you incur eligible health care/day care expenses during the year, you pay the expenses out of your pocket, then submit a claim for reimbursement from your account.

### TAX CONSIDERATIONS

When you use your Health Care or Dependent Day Care Spending Account to pay for an eligible expense, you cannot claim the same expense as a deduction on your income tax return.

You will be required to pay income taxes on any reimbursement paid for an ineligible expense. If you are not sure whether an expense qualifies for reimbursement from your FSA Account, please contact the FSA administrator.

### 2½ MONTH EXTENSION

If you are a participant in the Flexible Spending Accounts at the end of the calendar year (as of December 31st) and you have a balance in your account, you may be reimbursed for eligible FSA expenses incurred through March 15th of the next calendar year. Expenses incurred during the 2½ month extension period and submitted for reimbursement by March 31st will be applied to your previous year's balance first. Once that balance is exhausted, all remaining reimbursement requests (for expenses incurred within the 2½ month extension period) will be applied to the current balance.

For this reason it is essential that you plan ahead before deciding how much to contribute, and only put in those dollars you are confident you will use. You have until March 31st of each year to file all claims against your accounts for the previous calendar year.

# Continuing Participation if Employment Ends or You Become Ineligible

## CONTINUATION OF COVERAGE UNDER COBRA

Sharp HealthCare permits you to continue contributing to your Health Care Spending Account after participation would end due to termination of your employment with Sharp HealthCare or due to a qualified status change where you are no longer eligible to participate (such as a change in hours worked or a change to per diem status) through the COBRA-FSA, as discussed under the section "Continuation of Coverage (COBRA)" beginning on page 40, but only through the end of the plan year in which the qualified status change occurs. There is no COBRA continuation coverage for the Dependent Day Care FSA. Your contributions will stop as of your termination date; however, you may continue to submit Dependent Day Care claims incurred through the end of the calendar year (and 2½ month extension period if you have a balance on 12/31). You have until March 31st of the following year to submit claims for reimbursement.

If you decide to continue contributing to your Health Care Spending Account, all the provisions of the account will be the same, except for the way you deposit money in the account. Instead of putting money into the account before taxes are withheld, you make after-tax contributions to continue participating. Because of this change, you would lose the advantage of paying the eligible expenses with pre-tax dollars. To continue contributing to the account, you will be required to continue contributing at the previously elected level, plus 2% of that amount for administrative expenses.

If you continue contributing to the Health Care Spending Account through COBRA, you can file claims for expenses incurred up through the date in which you have made COBRA payments (and through the 2½ month extension period if you have a balance on 12/31). You have until March 31st of the following year to submit claims for reimbursement. If you do not elect COBRA-FSA for the Health Care Spending Account, you may only submit claims incurred through your termination date.

If you are a participant in the FSA's at the end of the plan year (12/31) and have a balance in your account at that time, and you subsequently terminate your employment with Sharp, you may be reimbursed for eligible FSA expenses incurred up through March 15th of the next calendar year from the previous year's balance.

## CONTINUING COVERAGE WHILE ON A LEAVE OF ABSENCE

### *Health Care Spending Account*

If you take a leave of absence and wish to be reimbursed from your health care FSA for eligible expenses incurred during your leave of absence, you **must** continue making after-tax contributions to your health care FSA (by mailing your contribution to the Employee Benefits Department) up to the amount of your annual contribution, by electing one of the following options. IRS regulations do not allow reimbursement of expenses incurred during any period you are no longer making contributions to your health care flexible spending account.

- Before you start your leave, you may prepay the amount of the pay period contributions you estimate you will miss while you are on leave;
- During your leave, you may make your contributions each pay period with your other benefit premium payments in a timely manner; or,
- After you return from leave, you may make catch-up contributions equal to the amount of the pay period contributions you missed while you were on leave. All catch-up contributions must be made before any expenses will be reimbursed and no later than March 15 of the next calendar year.

## DEPENDENT DAY CARE SPENDING ACCOUNT

IRS regulations stipulate that expenses to be reimbursed through the Dependent Day Care Spending Account must be incurred in order to enable you to remain gainfully employed, seek gainful employment, and/or go to school. As a result, in most cases, IRS regulations do not allow you to continue your contributions to the Dependent Day Care Spending Account while you are on a leave of absence. Contact the Employee Benefits Department for more information.

# The Health Care Spending Account

The Health Care Spending Account can be used to pay for expenses which are not covered by any medical, dental, or vision plan for you and your eligible dependents. Eligible dependents are those you claim as dependents on your federal tax return. You or your dependents do not have to be enrolled in a ***Sharp-Choice*** health care plan to participate in the Health Care Spending Account. However, you must be eligible for benefits as defined by Sharp HealthCare.

## ELIGIBLE HEALTH CARE EXPENSES

Any health care expenses recognized by the Internal Revenue Service as an eligible and deductible item on your income tax return can be reimbursed through the Health Care Spending Account for you or anyone who qualifies as a dependent under IRS regulations. If you claim health care expenses for reimbursement under the Health Care Spending Account, you cannot claim them as itemized deductions on your federal tax return.

Expenses incurred for a medicine or a drug are eligible for reimbursement only if it is a prescribed medicine or drug or is insulin. Purchase of over-the-counter (OTC) medications (e.g. Advil, ibuprofen, cough syrup) are eligible for reimbursement without a prescription. Other OTC items that are not considered a drug or a medicine (e.g. feminine hygiene products, bandages and reading glasses) are also reimbursable.

## ELIGIBLE EXPENSES

Examples of eligible health care expenses according to IRS definitions (which are not covered by a medical, dental, or vision plan) include:

## ELIGIBLE HEALTH CARE EXPENSES EXAMPLES

| TYPE OF HEALTH CARE | SERVICE OR PRODUCT |
|---|---|
| Physician and Hospital Visits | ▪ Ambulance Fees<br>▪ Co-payments<br>▪ Deductibles<br>▪ Diagnostic fees<br>▪ Lab fees<br>▪ Surgical fees |
| Dental | ▪ Cavity repair and filings<br>▪ Cleanings<br>▪ Crowns<br>▪ Orthodontia expenses incurred during the plan year<br>▪ Oral surgery |
| Vision | ▪ Contact lenses<br>▪ Eye examination fees<br>▪ Eye glasses<br>▪ Eye surgery (Lasik, cataracts) |
| Therapies | ▪ Acupuncture<br>▪ Chiropractors<br>▪ Psychiatric care<br>▪ Psychologist fees with letter of medical necessity<br>▪ Smoking cessation<br>▪ Weight loss programs with letter of medical necessity; does not cover cost of food |
| Over-the-Counter Items | ▪ Bandages<br>▪ Contact lenses solution<br>▪ Crutches<br>▪ First aid kits<br>▪ Hearing devices<br>▪ Vitamins with letter of medical necessity<br>▪ Walkers and wheelchairs |
| Over-the Counter Medications | ▪ Acne medications<br>▪ Allergy medications<br>▪ Cold and flu medications<br>▪ Pain relievers<br>▪ Feminine hygiene products |
| Prescriptions | ▪ Any medication purchased with a prescription with the exception of prescriptions for cosmetic purposes |

Specifically EXCLUDED from reimbursement are the over-the-counter items and drugs for maintaining general good health and well-being including toiletries (e.g. electric toothbrushes, sundry items, cosmetics, vitamins and dietary supplements).

## INELIGIBLE EXPENSES

Some examples of items that are NOT considered eligible health care account expenses include:

- Any expense incurred in connection with an illegal operation
- Automobile insurance premiums
- Babysitting, child care, or day care, even if care allows parent to get medical care
- Bottled water
- Breast augmentation such as implants or injections
- Cosmetic procedures and surgery to improve patient's appearance (face lifts, hair transplants, hair removal, teeth whitening and liposuction)
- Dietary supplements (herbal homeopathic, and all non-FDA approved remedies)
- Exercise/fitness programs or equipment
- Funeral and burial expenses
- Health club dues
- Herbal medicines
- Household and domestic help – even if recommended by a qualified physician
- Insurance premiums
- Missed appointment fees
- Uniforms
- Vacation or travel taken for general health purposes

# The Dependent Day Care Spending Account

The Dependent Day Care Spending Account is a program whereby, through pre-tax payroll deduction, you can pay for day care expenses (or expenses for the care of an elderly parent or disabled family member) in order for you and your spouse (if married) to work outside your home. This account cannot be used for medically-related expenses.

## DEPENDENT DAY CARE ELIGIBILITY REQUIREMENTS

Reimbursements for dependent day care are subject to the following eligibility requirements:

- The care must be necessary in order for you to work, to look for work, or to attend school full-time (for at least five months during the year). If you are married, the care must be necessary for you and your spouse both to work, or you must work and your spouse must be a full-time student or disabled.
- Expenses must be for dependent day care, not education.

**If the dependent is a child:**

- He or she must be under age 13 and live in the same residence for more than one-half of the (calendar) year.
- Care may be provided inside or outside your home, but it may not be provided by anyone considered your dependent for income tax purposes, such as one of your older children.
- If the care is provided by a facility that cares for more than six children, the facility must be licensed.

**If the dependent is an adult:**

- He or she must be physically or mentally incapable of caring for himself or herself.
- He or she cannot have income that exceeds the income limitation set forth by the IRS.
- Care may be provided either inside or outside your home; however, expenses outside your home are eligible only if the dependent regularly spends at least eight hours each day in your household.

## ELIGIBLE DEPENDENT DAY CARE EXPENSES

Expenses eligible for reimbursement must relate to the care of the qualifying dependent. These include:

- Wages paid for the services of a baby-sitter or companion, including FICA/FUTA taxes paid on those wages. Expenses are not eligible if the person providing care is your child under 19 years old or someone you claim as a dependent.
- Costs for a private school that provides care beyond educational requirements.
- Costs for "away from home" facilities, as long as your dependent spends at least eight hours a day at home.

- Services of a qualified day care center, that is, a day care center that:
  - Meets the requirements of state and local law;
  - Provides care for more than six individuals; and
  - Receives payment for services.
- Any other day care expenses considered tax deductible by the IRS.

**You may also obtain more information from the Employee Benefits Department, FSA Plan Administrator or your local IRS office. Publication 503 lists and describes eligible day care expenses.**

### WHAT CANNOT BE REIMBURSED FROM A DEPENDENT DAY CARE SPENDING ACCOUNT

- Day care for dependents who are age 13 or older;
- Dependents being cared for by your spouse, by your other children under age 19, or by another of your dependents;
- Dependents who could be cared for by your employed spouse whose work hours do not coincide with yours;
- Services paid for by another organization or provided without cost;
- Transportation to or from the day care location;
- Care provided in full-time residential institutions, such as nursing homes and homes for the mentally disabled;
- Child support payments;
- Clothing, entertainment or food;
- Overnight camp expenses.

### DEPENDENT DAY CARE TAX CREDIT

If you use your account to pay for dependent day care expenses, you cannot claim the Federal Dependent Care Tax Credit for the same expenses. In addition, deposits made to a Dependent Day Care Spending Account reduce dollar-for-dollar the eligible expenses you can claim as a tax credit. You should carefully consider which alternative is best for you based on your tax bracket and personal circumstances. You should consult with your tax advisor to determine which alternative is best for you.

In general, some advisors have determined that if your adjusted gross income (your total family income less qualifying deductions) is more than $28,000, you should consider using the Dependent Day Care Spending Account for the first $5,000 of child care expenses. If your adjusted gross income is less than $20,000, you probably are better off using the Federal Dependent Care Tax Credit first. If your income falls between $20,000 and $28,000, you should consult with your tax advisor to find out which alternative is best for you.

## Initial Request Processing for Flexible Spending Account Benefits

Sharp HealthCare's Third Party Administrator rules on every reimbursement request that is submitted. If any request for reimbursement is wholly or partially denied, Sharp's 3rd Party Administrator will notify you of its decision in writing. Such notification will contain (1) specific reasons for the denial, (2) specific reference to pertinent Plan provisions (3) a description of any additional material or information necessary for you to perfect such request and an explanation of why such material or information is necessary and (4) information as to the steps to be taken if you wish to submit a request for review. Notification will be given within sixty (60) days after the request is received or within one hundred twenty (120) days, if special circumstances require an extension of time for processing the request, and if written notice of such extension and circumstances is given by Sharp's 3rd Party Administrator to you within the initial sixty (60) day period).

If such notification is not given within such period, the request will be considered denied as of the last day of such applicable 60 or 120 day period and you may request a review of said denied request. After your review you may choose to appeal the denied request.

# How to File a Claim for Reimbursement from Your FSA Account

To receive reimbursement for an eligible expense, you must submit:

- A completed claim form, available from the FSA Plan Administrator at www.WageWorks.com or the Sharp HealthCare Employee Benefits Department or visit the Employee Benefits website via the Sharp intranet at:
  http://sharpnet.sharp.com/hr/benefits
- Proof that the expense was incurred during the period in which you were enrolled. Once your claim is approved, you will be reimbursed from the appropriate account.
- If your are participating in the Health Care FSA, a debit card will be mailed to your home.

Please note that claims for health care services must first be submitted to your health plan carrier.

It is important to remember that claims for a given calendar year must be for services actually performed during that year and up through the 2½ month extension period to March 15th (but not necessarily billed). For example, you cannot use the current year's deposits to pay for services performed in the previous year.

The minimum claim amount is $25. This $25 minimum is waived after December 1 of each plan year.

In addition, with the Health Care FSA, you are eligible to receive the full amount of your annual election at any time during the year provided you have an eligible claim equal to your annual election amount – even if you don't yet have that full amount in your account. For example, assume you elect to contribute $1,000 to your account for the year. You submit a claim for $400 when your account only has $250. You will be reimbursed for the full $400 and your future contributions would be credited against the $150 account debit. The amount paid on a claim will never be more than the unclaimed balance of your annual election amount.

With the Dependent Day Care FSA, you will only be reimbursed for your expenses up to the amount you have in your account. For example, if you submit a reimbursement request for $250, but you only have $175 in your account, you will receive a check for $175 initially, and the balance will be paid as you make additional contributions.

You may file a claim at any time during the plan year for eligible expenses incurred during that year. An expense is incurred when the service is provided, not when you are billed or when you pay for it.

Health care and dependent day care expenses from a given year up through the 2½ month extension period to March 15th can only be paid with money deposited in your FSA that same year. You have until March 31st of the following year to submit claims for expenses incurred during the plan year that just ended. **After March 31st, your FSA is closed and any money remaining in it is FORFEITED.**

Submit a claim with proof of your expenses – either an itemized bill from your medical provider (reflecting patient's name, date of service, type of service, type of treatment, expenses incurred, prescription number, etc.), an Explanation of Benefits (EOB) from your health plan carrier, or a Statement of Service from your day care provider. The IRS does not consider canceled checks to be valid proof of services rendered.

Expenses must be incurred during the plan year (and/or through the 2½ month extension period).

Any benefits provided by Sharp HealthCare based on salary will not be affected by your FSA contribution.

## HEALTH CARE REIMBURSEMENT REQUESTS

Submit Reimbursement Requests for eligible medical, dental and vision care expenses that will not be reimbursed by any other employer-sponsored benefit plan and which would qualify as a deduction on your income tax form.

## DEPENDENT DAY CARE REIMBURSEMENT REQUESTS

Submit Reimbursement Requests for eligible dependent day care expenses that will not be reimbursed by any other employer-sponsored benefit plan and which would qualify as a credit on your income tax form.

You must include the name, address and taxpayer identification number of the person(s) to whom you paid reimbursed day care expenses on your income tax return.

### CLAIM DEADLINE

**The deadline for filing your claims for eligible expenses incurred during the calendar year and up through March 15th of the following year is March 31st of the following calendar year.** You may submit claims via WageWorks website, mobile application, or by mail, fax;

Health Equity Claims Administrator
P.O. Box 14053
Lexington, KY 40512
Phone: 1-(877) 924-3967
Fax: 1-(877) 353-9236
Website: https://www.WageWorks.com
Mobile App: https://WageWorks4m.com/aboutmobile

# Appeal Policy and Procedure

If you have any questions about a reimbursement request, you should contact the Sharp HealthCare Employee Benefits Department at (858) 499-5292.

Within sixty (60) days after the date you receive written notice of a denied request you may (1) file a written request with Sharp HealthCare for a review of the denied request and of pertinent documents and (2) submit written issues and comments to Sharp. Sharp will notify you of its decision in writing. Such notification will contain specific reasons for the decision as well as specific references to pertinent Plan provisions. The decision on review will be made within sixty (60) days after the request for review is received by Sharp (or within one hundred twenty (120) days, if special circumstances require an extension of time for processing the request, and if written notice of the extension and circumstances is given to you within the initial sixty (60) day period).

SHARP

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SHARP

# Group LIFE AND (AD&D) INSURANCE

Although we do not like to think about it, should death occur, the survivors left behind could face serious financial hardship. You or your family might need an alternative source of income to pay off bills and meet ongoing financial requirements. Should you or a member of your family die – your legal spouse/certified domestic partner or child, for example – the loss can cause unexpected expenses. This is the purpose of life insurance, to provide funds for those left behind.

Sharp HealthCare provides Basic Life and AD&D (Accidental Death and Dismemberment) Insurance coverage at no cost to you and offers additional Optional Life Insurance coverage and Dependent Life Insurance at group rates. Employee Life Insurance provides a benefit to your named beneficiaries in the event of your death. Accidental Death and Dismemberment Insurance provides an additional benefit to your named beneficiaries in the event of your accidental death or a benefit to you if you suffer an eligible loss (sight, speech, hearing, or loss of a limb) as a result of a covered accident.

## Eligibility and Effective Date of Coverage

You are automatically enrolled for Basic Life and AD&D insurance (equal to 1x annual base earnings)1 if you are a regular full-time or part-time employee assigned and working 40 hours or more per pay period. Basic life and AD&D insurance is provided at no cost to you. Your insurance will start the first day of the month following or coinciding with 30 days of continuous employment. If you are not in an "active at work" status on that day, your coverage will be effective on the day you return to active work.

You may enroll for Optional Life insurance when you are first eligible and during your initial enrollment period, up to 4x[2] your annual base earnings up to the plan maximum of $1,000,000 (Basic and Optional Life combined), without providing evidence of insurability (EOI). If you do not elect the Optional buy-up option during your initial enrollment period, you can elect the coverage at a subsequent open enrollment or if you experience an IRS qualified family status change; however, you will be required to submit a health statement as evidence of insurability (EOI)[3] if you enroll for, or increase by, more than a one level increase

1 Your "annual base earnings" means your gross base wages (base hourly rate X your assigned hours) received from Sharp HealthCare in effect just prior to the date of loss. It includes eligible wages before taxes and any deductions made for pre-tax contributions to a qualified retirement or deferred compensation plan, a Section 125 plan, or a flexible spending account. It does not include income received from commissions, bonuses, incentive pay, on-call pay, shift differential, charge pay, and any other compensation received from Sharp or income received from sources other than Sharp HealthCare. The employer-paid Basic Life and AD&D insurance amounts for eligible Managers/Directors is 1.5x base annual earnings not to exceed $1,000,000; Vice Presidents is 2x base annual earnings not to exceed $1,000,000; and SVPs is 3x base annual earnings not to exceed $2,000,000.

2 Up to 3.5x for Managers/Directors; up to 3x for VPs not to exceed $1,000,000 (Basic and Optional combined). Up to 4x for SVPs not to exceed $2,000,000 (Basic and Optional combined).

3 If you have submitted EOI and coverage is denied, any subsequent election will require EOI.

(e.g., 1x to 2x – no EOI required, but 1x to 3x – EOI is required). Please note that if you are required to submit evidence of insurability, coverage in excess of a one level increase is not automatic or guaranteed. Coverage is effective the date of approval by the insurance company. Evidence of insurability is not required for the Basic Life and AD&D Insurance coverage.

Your life insurance benefit is calculated by multiplying your annual base earnings by the amount of life insurance you have elected (e.g., 1x, 2x, 3x) rounded up to the next $1,000 increment. Your annual base earnings are calculated by multiplying your gross base hourly rate x your assigned hours x 26 pay periods.

**EXAMPLE:**
Assume your gross base hourly rate is $20.39/hour, you are full-time (assigned 80 hours per pay period) and the multiple of life insurance you have elected is 3x salary.

1. Multiply your gross base hourly rate x your assigned hours x 26 pay periods to obtain your annual base earnings ($20.39 x 80 x 26 = $42,111).
2. Multiply your annual base earnings by the multiple of life insurance you have elected ($42,111 x 3 = $127,233).
3. Round that total up to the next $1,000 increment ($127,233 rounded = $128,000).
4. Your life insurance benefit is $128,000.

## OPTIONAL LIFE AND DEPENDENT LIFE INSURANCE EVIDENCE OF INSURABILITY REQUIREMENTS (A Health Statement is required)

| | IF YOU ENROLL AT INITIAL NEW HIRE ENROLLMENT OR DUE TO CHANGE TO A BENEFIT ELIGIBLE STATUS (Assigned & working 40 or more hours a pay period) | IF YOU ENROLL AT ANNUAL OPEN ENROLLMENT | IF YOU ENROLL AT ANYTIME DUE TO AN IRS QUALIFYING EVENT/FAMILY STATUS CHANGE | IF YOU ENROLL AT ANTIME (Not initial New Hire, Annual Open Enrollment or Family Status Change) |
|---|---|---|---|---|
| OPTIONAL LIFE INSURANCE | Health statement not required | Health statement is required if applying for more than a 1-level increase (e.g., 1x to 3x) or if previously denied due to poor health. | Health statement is required if applying for more than a 1-level increase (e.g., 1x to 3x) or if previously denied due to poor health. | Not Applicable – You cannot enroll at anytime. You may enroll as a new hire, during the annual open enrollment and within 31 days of a qualified status change. |
| DEPENDENT LIFE INSURANCE | Health statement is required for $100,000 coverage level only | Health statement is required if applying for more than a 1-level increase (e.g., $5,000 to $25,000) or if previously denied due to poor health, or if applying for the $100,000 coverage level. Health statement is NOT required for depend-ent children for any level. | Health statement is required if applying for more than a 1-level increase (e.g., $5,000 to $25,000) or if previously denied due to poor health, or if applying for the $100,000 coverage level. Health statement is NOT required for dependent children for any level. | Not Applicable – You cannot enroll at anytime. You may enroll as a new hire, during the annual open enrollment and within 31 days of a qualified status change. |

dent Life Insurance. Your eligible dependents are:

- Your legal spouse/certified domestic partner;
- Your dependent children who are less than age 26

# Two Married Sharp Employees

Special rules apply to married individuals who both work for Sharp HealthCare, as shown below.

for Life and AD&D coverage under ***SharpChoice***, the following applies:

- You may not cover your spouse/domestic partner as a dependent if your spouse/domestic partner is enrolled for coverage as an employee. Neither of you may enroll in the spouse Life Insurance option.
- No dependent child may be covered by more than one employee in the plan.
- No dependent child may be covered as both an employee and a dependent.

In the event that you, your spouse/domestic partner or dependents receive a benefit under this plan, only one benefit would be paid for each participant (it would not be paid twice).

# Naming a Beneficiary

A beneficiary is who you designate to receive the proceeds of your Group Life and AD&D insurance in the event of your death.

It is important that you name a beneficiary at the time of your enrollment, and keep your designation current. If more than one beneficiary is named and you do not designate their order or share of payments, the beneficiaries will share equally. The share of a beneficiary who dies before you, or the share of a beneficiary who is disqualified, will pass to any surviving beneficiaries in the order you designated.

If you do not name a beneficiary, or if all named beneficiaries do not survive you, your death benefit will be paid to your estate. Minor children can not receive life and AD&D insurance payments directly. You may name a trust or legal guardian for the child(ren) as the beneficiary. If you name a minor child, benefits may be held by the insurance company until the child is of legal age. You are always the beneficiary under the Dependent Life Insurance Plan.

## TO DESIGNATE OR CHANGE YOUR BENEFICIARIES FOR LIFE AND AD&D INSURANCE AND PERSONAL ACCIDENT INSURANCE

Beneficiary Designation for Life and AD&D and Personal Accident Insurance is in Workday. Once you have logged in to Workday, utilize the steps in the Job Aid available in the Managing your Benefits Article. You may add or edit existing beneficiaries in Workday at any time throughout the year by selecting Benefits on your Employee Profile, My Beneficiaries and Edit. A beneficiary can be an individual or a trust. Additionally, if you would like to add contingent (alternate) beneficiaries in the event that your primary beneficiaries are deceased or are unable to be located, you may do so by completing the same process as above. Contingent beneficiaries must also equal 100%, separate from primary beneficiary elections.

## TRAVEL ASSISTANCE SERVICES

You and any of your eligible dependents who are traveling with you are eligible for Travel Assistance services provided by Sharp's Life Insurance carrier through an arrangement with United Healthcare Global. Travel assistance is provided 24 hours a day, seven days a week, every day of the year. This service provides access to pre-travel, personal, and emergency assistance with travel-related problems and circumstances while you are traveling at least 100 miles from home and for fewer than 90 consecutive days.

For more information and to obtain your Travel Assistance identification card please visit the Employee Benefits website at

**http://sharpnet.sharp.com/hr/benefits/Life-Accident-Disability-Insurance-Documents.cfm.**

# Employee Life and AD&D Insurance

## AMOUNT OF LIFE INSURANCE

***Basic Life and AD&D Insurance:*** Sharp HealthCare pays the full cost of your Basic Life and AD&D Insurance.

Your Basic Life and AD&D Insurance amount is equal to one times your annual base earnings[1] (based on assigned hours) up to a total amount of $1,000,000, Basic and Optional combined, for each coverage.[2]

***Optional Life Insurance:*** You pay the cost of your Optional Life Insurance with post-tax payroll deductions.

You may purchase Optional Life Insurance in an amount equal to one, two, three or four times your annual base earnings. However, the total amount of your Basic and Optional Life amounts combined can not exceed $1,000,000.[3]

1 Your "annual base earnings" means your gross base wages (base hourly rate X your assigned hours X 26 pay periods) received from Sharp HealthCare in effect just prior to the date of loss. It includes eligible wages before taxes and any deductions made for pre-tax contributions to a qualified retirement or deferred compensation plan, a Section 125 plan, or a flexible spending account. It does not include income received from commissions, bonuses, incentive pay, on-call pay, shift differential, charge pay, and any other compensation received from Sharp or income received from sources other than Sharp HealthCare.

2 The employer-paid Basic Life and AD&D insurance amounts for eligible: Managers/Directors is 1.5x base annual earnings not to exceed $1,000,000; Vice Presidents is 2x base annual earnings not to exceed $1,000,000; and, Senior Vice Presidents is 3x base annual earnings not to exceed $2,000,000.

Coverage amounts are rounded up to the nearest $1,000, if not already an exact multiple of $1,000. When your annual base earnings increase, your benefit amount also will increase up to the maximum benefit. If you are away from work due to disability on the date a change in benefit amount would occur because of a change in pay rate, the change will not take effect until you return to active work. A decrease in the amount of your insurance will take effect on the date of the decrease.

### COVERAGE AMOUNT AT AGE 65 AND BEYOND

If you are enrolled in Optional Life insurance, beginning on and after your 65th birthday, the insurance company decreases the amount of your insurance coverage. In the event of death the insurance company pays a percentage of the amount otherwise payable as follows:

| AT AGE | MAXIMUM AMOUNT PAYABLE |
|---|---|
| 65 but less than 70 | Insurance company pays 65% of pre-age 65 coverage amount |
| 70 and over | Insurance company pays 50% of pre-age 65 coverage amount |

### TAX INFORMATION (IMPUTED LIFE)

Under federal tax laws, if the total of the Basic Life Insurance Sharp HealthCare provides for you is more than $50,000, the value of the premiums for coverage above $50,000 (based on IRS tables) will be added to your W-2 earnings. This is called “imputed income”. Imputed income is shown on your paycheck stub. You will pay federal, state and Social Security taxes on this amount. AD&D is not considered life insurance for purposes of the imputed income calculation.

### EXAMPLE OF IMPUTED LIFE

Assume you earn $60,000 so your Basic Life Insurance equals $60,000 which is $10,000 over the $50,000 limit. You will be taxed on the premium cost of the excess $10,000 of coverage – not the coverage itself. Imputed income usually is a relatively small amount.

If you have questions about how this will affect your taxes, discuss the available options with your tax advisor.

# Dependent Life Insurance

Dependent Life Insurance can help you meet expenses if one of your covered dependents1 dies. You pay the full cost of your Dependent Life Insurance with post-tax payroll deductions. You may enroll for dependent life insurance at your initial enrollment period, if you experience a family status change, or during the annual open enrollment. A Health Statement will be required when enrolling in the Spouse Life $100,000 coverage level, or if increasing coverage greater than 1 level, or if previously denied an increase in coverage. Some other restrictions may apply.

### AMOUNT OF DEPENDENT LIFE INSURANCE

You may elect $5,000, $10,000, $25,000, $50,000, $75,000 or $100,000 for your spouse/domestic partner and $5,000 or $10,000 for your children, respectively, of Dependent Life insurance in the combinations stated in the following chart:

| LEGAL SPOUSE/DOMESTIC PARTNER | CHILD)REN) |
|---|---|
| $5,000 | $5,000 |
| $10,000 | $10,000 |
| $25,000 | N/A |
| $50,000 | N/A |
| $75,000 | N/A |
| $100,000 | N/A |

Each dependent child who is under age 26 is eligible for this benefit.

The amount of insurance for your spouse cannot be more than 100% of your life insurance amount (Basic and Optional combined).

3 The employee-paid Optional Life insurance amounts that may be purchased for eligible: Managers/Directors are 1.5, 2.5, or 3.5x base annual earnings; Vice Presidents are 1, 2 or 3x base annual earnings; and Senior Vice Presidents are 1, 2, 3, or 4x base annual earnings. The total amount of Basic and Optional insurance combined cannot exceed $1,000,000 for Managers/Directors and Vice Presidents; and $2,000,000 for Senior Vice Presidents.

## Option to Accelerate Payment of Life Benefits (Accelerated Benefits Rider)

If you or your eligible dependent(s) are diagnosed with a terminal illness, you may elect to receive a portion of your life insurance proceeds while you are still living. You must be diagnosed as terminally ill with a life expectancy of less than 12 months. The maximum benefit you may choose is 75% of your life insurance amount in effect on the date of certification of terminal illness (subject to a total maximum benefit of $500,000).

The funds are paid directly to you in a single lump sum or installment payments and are payable only once. The remaining benefit is then paid to your beneficiary after your death. Premium payments must continue to be paid on the full amount of life insurance.

You must complete a claim form to choose this option and provide proof, including certification from a physician, that your life expectancy is less than 12 months. If you are married, the insurance company will request signed written consent from your spouse prior to payment of your benefit. When you elect this option, the total amount of your insurance otherwise payable on your death, will be reduced by the accelerated/living benefit paid to you. This benefit may be taxable to you. Contact your tax advisor if you have questions.

The living benefit option also applies to Optional Life Insurance benefits (subject to a total maximum benefit – Basic and Optional combined – of $500,000).

### ACCELERATED DEATH BENEFITS EXCLUSIONS

- No benefits are payable for a terminal condition if a required premium is due and unpaid.

## Limitation & Exclusions

Optional Life benefits or Dependent Life benefits will not be paid for deaths caused by suicide in the first 24 months after your effective date of coverage.

No increased or additional Optional Life benefits or Dependent Life benefits will be payable for deaths caused by suicide occurring within 24 months after the day such increased or additional insurance is effective.

## Accidental Death & Dismemberment (AD&D) Exclusions

A benefit will not be paid for any loss that is contributed to or caused by:

1. War, declared or undeclared, or any act of war, or
2. Intentionally self-inflicted injuries, while sane or insane, or
3. Suicide, or suicide attempt, while sane or insane, or
4. Active participation in a riot, or
5. Committing or attempting to commit a felony or misdemeanor, or
6. Disease, bodily or mental illness (or medical or surgical treatment thereof), or
7. Infections, except septic infections of, and through a visible wound, or
8. Controlled substances (as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments) that are voluntarily taken, ingested or injected, unless as prescribed or administered by a Physician, or
9. Serving full-time active duty in the Armed forces of any country or international authority, or

10. Boarding, leaving or being in or on any kind of aircraft. However, this exclusion will not apply if the Covered Person is a fare paying passenger on a commercial aircraft or traveling as a passenger in any aircraft that is owned or leased by or on behalf of the Sponsor, or
11. Loss suffered as a result of Accidental Injury during any period of incarceration.

# When Life & AD&D Insurance Coverage Ends

Life and AD&D Insurance coverage for you and Life Insurance coverage for your dependents ends on the earliest of the following dates:

- The date you are no longer actively at work for Sharp HealthCare;
- The date you no longer are in an eligible group;
- The date your eligible group is no longer covered;
- The date any required contributions or premiums were due and not paid;
- The date this plan ends;
- The Accelerated Death Benefit ends on the date your insurance stops, the date you receive payment of the benefit for your terminal illness, or at the beginning of the period in which you are eligible to convert your life insurance.

Coverage for your dependents will end when yours does, or earlier if they become ineligible (for instance, because of age limit or divorce).

# Continuation of Life Insurance Coverage While on a Leave of Absence

## FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA) AND OTHER QUALIFIED LEAVES OF ABSENCE

If you have a medical, family or other qualified leave from active work certified by Sharp HealthCare under the Family Medical Leave Act (FMLA) or other applicable legislation, for purposes of eligibility and termination of coverage you will be considered to be actively at work during the FMLA leave. Your coverage will remain in force during the leave up to 24 weeks or your term date, whichever occurs first, provided you pay the premiums and continue to meet the requirements as set forth in the FMLA or other applicable legislation. See page 26 under Family Medical and other qualified leaves of absence for further details. Please refer to Sharp HealthCare's LOA policy for more information. If you are on a leave of absence during the annual open enrollment, or if you experience a mid-year IRS qualified status change (see IRS Qualified Status Changes beginning on page 10), any increase in Group Life & AD&D, and Dependent Life Insurance coverage will not be effective until the date you return to active work in a benefits eligible status (assigned and working 20 hours per week/40 hours per pay period).

## CONTINUATION OF LIFE INSURANCE DURING TOTAL DISABILITY

***Continuation of Coverage Benefit***

The Group Life Insurance Plan has a continuation of coverage benefit for the Basic benefit only (1x annual-base earnings up to a policy maximum of $1,000,000) that begins six months (180 days) after your date of total disability and ends after five years or attainment of age 65 (whichever occurs first). The continuation of coverage benefit applies only if:

- You become totally disabled while you are a plan participant before you reach the age of 60; and
- Your disability is approved by the insurance carrier to receive Long Term Disability benefits.

The continuation of coverage benefit allows you to continue your Basic Life insurance coverage and Sharp pays the premium for a period of time. The continuation of coverage begins after six months (180 days) of total disability and ends after five years or when you reach age 65, whichever occurs first. After five years or the attainment of age 65 (whichever occurs first) if you wish to continue your Basic Life insurance coverage, you will be required to convert to an individual policy as explained below. Reductions in the amount of benefit apply when you attain age 65 and again later at age 70. The continuation of coverage benefit applies to only Basic Life insurance

coverage. If you wish to continue your Optional Life insurance coverage, you will be required to convert to an individual insurance policy as explained in the following section(s).

# Converting to Individual Coverage

## PORTABILITY

In the event your life insurance coverage ends and you are no longer in an eligible class for any reason except retirement and you have been insured for at least twelve (12) months, you can take your coverage with you according to the terms outlined in the contract until you are covered by another group term life insurance policy; or the date you reach age 70, whichever comes first. If you had an enrolled spouse/certified domestic partner, or eligible dependent children, they also may be eligible for the life insurance portability only (no AD&D). The maximum coverage equals the amount of your life insurance in effect at the time coverage ends or the policy maximum of $750,000 (life and AD&D combined), whichever is less. The minimum amount you may convert is $10,000. You must apply for portable coverage within 60 days after the date your coverage ends or you begin working less than the minimum number of hours required for eligibility. The cost for this individual coverage will be based on the insurance company's regular premium rates at your then attained age.

## CONVERSION

In the event your life insurance coverage ends and you are no longer in an eligible class for any reason, you may convert your life coverage to an individual life policy, without evidence of insurability. If you had an enrolled spouse/certified domestic partner, or eligible dependent child, they also may be eligible. The maximum amounts that you can convert are the amounts you are insured for under the plan. You may convert a lower amount of life insurance.

You must apply for individual life insurance under this life conversion privilege and pay the first premium within 60 days after the date your employment terminates or you are no longer eligible to participate in the coverage of the plan.

If you die within the 60-day conversion application period, a benefit will be paid to the appropriate beneficiary as though the benefit had been converted to an individual policy. The benefit is payable whether or not you have applied for the individual policy.

If you wish to continue coverage, you should contact the Sharp HealthCare Employee Benefits Department for details.

# Initial Claim Processing for Life Benefits

The Plan Administrator, through the insurance company, rules on every claim that is filed. Within 90 days from when the initial claim is received, it will be approved, or you or your beneficiary will receive written notice that the claim was denied. In some instances there may be cause for an extension for review of the claim. The Group Life Insurance Policy provides for a 90 day extension period. If it is determined that an extension is necessary, you or your designated beneficiary will be communicated with appropriately at the end of the initial 90 day claim review period.

If the claim is denied, in whole or in part, the notice of the claim denial will be communicated to you or your beneficiary and will include the specific reason for the denial (reference to the initial decision), specific reference to the Plan provision(s) on which the denial is based, a description of any additional material or information that you or your beneficiary could present in order to receive the claimed benefits, and explanation of the reason you or your beneficiary must submit this information, and an explanation of the procedure that must be followed to appeal the denial of the claim.

If you or your beneficiary do not receive communication from the Plan Administrator within 90 days after filing the initial Claim, the denied claim may be appealed.

# How to File a Life and AD&D Insurance Claim

You or your designated beneficiary must file a claim before benefits can be considered for payment by the Life and AD&D Insurance Plan.

To file a claim for benefits under the Life and AD&D Insurance Plan, you or your beneficiary should contact the Employee Benefits Department. The Employee Benefits Department will help you prepare the appropriate claim forms and file the claim. To ensure that you or your beneficiary receives benefits promptly, the notification to the Benefits Department should occur within 90 days after the loss. If it is not possible to give proof within this time limit, it must be given no later than 1 year after the proof is required. These time limits will not apply during any period you or your authorized representative lacks the legal capacity to give proof of claim.

# Appeal Policy and Procedure

### LIFE CLAIMS (EXCLUDING ACCELERATED DEATH BENEFITS):

If you or your beneficiary have any questions about a claim payment, contact the Sharp HealthCare Employee Benefits Department at (858) 499-5292. If you or your beneficiary disagree, in whole or in part, with the reason the claim was denied, write within 180 days of receipt of the written denial to the Plan Administrator. Be sure to state why the claim should not have been denied and submit any data, questions, or comments you think are appropriate.

The appeal will be reviewed by the Plan Administrator and you or your beneficiary will be notified of the final decision within 60 days of the date the appeal is received. If it is determined that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 60 days (120 days in total). To the fullest extent permitted by law, the Plan Administrator has the discretion to determine all matters relating to coverage, eligibility and benefits. Any determination by the Plan Administrator is final and binding.

Please refer to page 102 for the Accelerated Death Benefit Appeal Policy and Procedure.

SHARP

# Personal ACCIDENT INSURANCE




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SHARP

# Personal ACCIDENT INSURANCE

You can cover yourself and your eligible family members through the Personal Accident Insurance (PAI) Plan. The Personal Accident Insurance Plan is an additional accidental death and dismemberment (AD&D) plan which protects you and your family in the event you die or suffer an eligible loss (as outlined below) due to a covered accident.

PAI insurance pays a benefit if you lose your sight, speech, hearing or a limb or die as the result of a covered accident on or off the job. PAI death benefits are paid to your beneficiary; benefits for other losses are payable to you. PAI death benefits are paid in addition to any life and other AD&D insurance benefits.

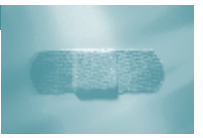
Your insurance will start the first of the month following or coinciding with 30 days of continuous employment. If you are not in an "active at work" status on that day, your coverage will be effective on the day you return to active work. If you are on a leave of absence during open enrollment, any increase in Personal Accident Insurance will be effective the date you return to work in a benefits-eligible status (assigned and working 20 hours per week or 40 hours per pay period).

## Naming a Beneficiary

You need to name a beneficiary for death benefits provided under the PAI Plan. See information beginning on page 80 on naming a beneficiary.

## Your PAI Coverage Options

Personal Accident Insurance is available up to a $500,000 maximum. However, if you choose an amount above $300,000, the amount cannot exceed 10 times your annual base earnings. *(Basic annual earnings are defined in the Life Insurance section of this booklet on page 80).*



### TWO MARRIED SHARP EMPLOYEES

If you and your spouse/domestic partner are both eligible for PAI Insurance coverage, one, but not both, may purchase family coverage. The other spouse/domestic partner may elect single coverage only.

### COVERAGE FOR YOUR FAMILY

You can choose PAI coverage for yourself only, or for yourself and your family. If you choose family coverage, the amount of coverage for each dependent is a percentage of the amount of insurance you select. In the event that you are covered under the policy as an insured or as an insured dependent, the combined principal sum may not exceed $500,000.

| IF YOU COVER | YOUR FAMILY PAI BENEFIT EQUALS: |
|---|---|
| Your spouse/domestic partner and no dependent child(ren) | 60% of your coverage amount for your spouse/domestic partner |
| Your spouse/domestic partner and dependent child(ren) | 50% of your coverage amount for your spouse/domestic partner; 10% of your coverage amount for each child (up to a maximum benefit of $25,000 per child) |
| Dependent child(ren) and no spouse/domestic partner | 20% of your coverage amount (up to a maximum benefit of$25,000 per child) |

### REDUCTION IN COVERAGE AMOUNTS AFTER AGE 70

Your PAI coverage amount will be limited to a percentage of the total coverage after you reach age 70. These limits are:

Age 70 - 74 . . . . . .65% of total
Age 75 - 79 . . . . . 45% of total
Age 80 - 84. . . . . 30% of total
Age 85 and above . . . . . 15% of total

Your covered dependents' insurance also will reduce proportionately (regardless of their ages) when you reach the age levels shown above.

## Accidental Loss

The PAI Plan pays a benefit if you lose your life, sight, hearing, a limb, or suffer a permanent paralysis as the result of a covered accident. The loss benefit will range from 25% to 100% of your full benefit, depending on the extent of your loss.

If you suffer any of the losses listed below as the direct result of a covered accidental injury, and the loss is incurred within 365 days of the accident, you will receive the following benefits:

| FOR LOSS OF | PERCENTAGE OF BENEFIT PAYABLE |
|---|---|
| Life | 100% |
| Both hands; both feet; sight of both eyes: one hand and one foot; speech and hearing of both ears; either hand or foot and sight of one eye; or quadriplegia (total paralysis of all upper and lower limbs) | 100% |
| Paraplegia (total paralysis of both lower limbs) | 75% |
| Either hand or foot; sight of one eye; speech or hearing of both ears; or hemiplegia (total paralysis of upper and lower limbs on one side of the body) | 50% |
| Hearing of one ear; or thumb and index finger of the same hand; uniplegia | 25% |

NOTE: Loss of hand or foot means that it is completely severed at or above the wrist or ankle joint. Loss of thumb and index finger means they are completely severed at or above the metacarpophalangeal joint. Loss of eyesight, speech or hearing means entire and permanent loss which cannot be recovered.

If more than one loss is sustained as a result of a covered accident, payment will be made for only the one loss for which the largest amount is payable under the Plan. No loss sustained prior to such accident shall be included in determining the amount payable.

Injury means bodily injury: 1) which is sustained as a direct result of an unintended, unanticipated accident that is external to the body and that occurs while the injured person's coverage under this policy is in force; 2) which directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a covered loss.

## Bereavement and Trauma Counseling

If you or a covered dependent suffers an accidental death or an accidental dismemberment or paralysis for which an accidental death or accidental dismemberment and paralysis benefit is payable under the Plan, or if he or she goes into a coma for which a coma benefit (as described on this page) is payable under the Plan, the PAI Plan will pay covered bereavement and trauma counseling expenses that are due to his or her death or dismemberment or paralysis or coma. The covered bereavement and trauma counseling expenses must be incurred within one year after the date of the accident causing such loss(es), up to a maximum of $100 per session for up to 10 sessions for the insured person and all of his or her immediate family members combined with respect to all such losses caused by the same accident.

## Seat Belt Benefit

If you or a covered dependent dies as the result of a covered automobile accident while properly using a seat belt, the beneficiary will receive an additional benefit equal to 10% of the base benefit. The maximum benefit is $10,000.

## In-Hospital Indemnity Benefit

If you or a covered dependent suffers an injury that requires you, him, or her to be confined in a hospital as an inpatient, within 90 days of the date of the accident that caused the injury, the PAI Plan will pay a benefit after 7 day(s) of confinement due to that injury, retroactive to the first day of confinement. The amount of the benefit is the lesser of $5,000 or 5% of the insured person's principal sum per month of inpatient confinement due to that injury. It is payable monthly for a maximum of six months during any one period of confinement. The plan will pay benefits calculated at a rate of 1/30th of the monthly benefit for each day of confinement for which the company is liable when the insured person is confined for less than a full month. Only one benefit is provided for any one day of confinement, regardless of the number of injuries for which the confinement is required.

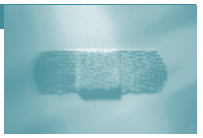
## Exposure and Disappearance

If you or a covered dependent is unavoidably exposed to the elements as the result of a covered accident and suffer any loss otherwise covered, normal PAI Plan benefits will be paid.

A covered person's maximum PAI benefit will be paid if that person is not found within one year of the disappearance, forced landing, stranding, sinking, or wrecking of a conveyance in which the covered person was an occupant.

## Coma Benefit

If you or a covered dependent is injured in a covered accident which results in being in a coma, a monthly coma benefit may be paid. The benefit is payable monthly as long as the insured person remains comatose due to that injury but ceases on the earliest of: 1) the date the insured person ceases to be comatose due to that injury; 2) the date the injured person dies, or 3) the date the total amount of monthly coma benefits paid for all injuries caused by the same accident equals 100% of the principal sum. A coma is a profound state of unconsciousness from which the individual cannot be aroused, even by powerful stimulation as determined by a licensed physician. To qualify, the comatose condition must occur within 365 days of the covered accident, must have continued for at least 30 consecutive days, and be total, continuous and permanent at the end of this period. The coma benefit will be 1% of the covered person's PAI benefit amount per month up to a maximum of 100 months. The PAI benefit amount for a comatose condition will be adjusted for any benefits paid or payable under the policy for other losses as a result of the same accident. The total benefits paid will not exceed the amount of the covered person's PAI death benefit.



# Common Carrier Benefit

If you die as a result of a covered accident while a passenger (but not while as a pilot, operator or member of the crew) in any common carrier, your accidental death benefit will be doubled (subject to a maximum of $250,000). Common carrier is any land, sea, or air conveyance operated under a license for the transportation of passengers for hire.

# Limited Air Travel Benefit

Insurance under the PAI Plan includes riding as a passenger in (including boarding or alighting from) any aircraft being used for transportation of passengers, but not as a pilot or crew member.

Flying in any aircraft owned or operated by Sharp HealthCare (or by the employer of an insured person if other than Sharp HealthCare) is not covered, unless previously consented to in writing by the insurance company.

# Waiver of Premium Benefit

If you become totally disabled while covered by this Plan, your PAI coverage will be extended up to one full year without payment of premiums. You must provide proof of total disability to the insurance company. This benefit is subject to any age reductions and terminations stated in the policy.

# Special Benefits

If you cover your family through the PAI Plan, special benefits may be available to them in the event of your covered accidental death, as outlined on the following pages. These benefits are only available to insured dependents who are enrolled in the family coverage.

### TUITION BENEFIT

This benefit pays an annual benefit equal to the actual annual tuition (exclusive of room and board), 10% of your PAI benefit amount, or $10,000, whichever is less, for each covered dependent child enrolled as a full-time student in a university, college or vocational school above the 12th grade level on the date of your accidental death. Benefits are paid each year the child continues his or her education as a full-time student for up to four consecutive years or until your child reaches age 26, whichever occurs first. If your child is in the 12th grade at the time of your death, the benefit will still be payable provided he or she enrolls in an institution for higher learning within 365 days following your accidental death. Eligible dependent child means your unmarried child, including natural, step, foster or adopted children (from the moment of placement in your home), under the age of 26 (if attending an accredited institution of higher learning on a full time basis) and is primarily dependent on you for support and maintenance.

### SPOUSE TRAINING BENEFIT

This benefit is designed to assist a non-working spouse in entering the work force. The Plan will pay a special benefit equal to the actual cost of the training program, 5% of your PAI benefit amount, or $5,000, whichever is less. To be eligible for this benefit, your spouse must enroll in any professional or trades training program and the costs for the training program must be incurred within 30 months of the date of your accidental death.

### ADDITIONAL INDEMNITY FOR CHILDREN'S DISMEMBERMENT AND PARALYSIS

The PAI Plan will pay a benefit under this rider when an insured has family coverage in effect under the policy and an insured dependent child suffers an accidental dismemberment or an accidental paralysis for which an accidental dismemberment benefit or a paralysis benefit is payable under the policy. This benefit is payable to or on behalf of an insured dependent child. It is payable with respect to the benefit specified on page 84 which provides the larger benefit for all injuries suffered by the insured dependent child in the same accident. The amount payable under this rider is an amount equal to the amount payable under the accidental dismemberment benefit or paralysis benefit, subject to a maximum of $25,000.

### DAY CARE BENEFIT

A special benefit will be paid for each covered child under age 13 who is enrolled in an accredited day care center on the date of your accidental death, or enrolls within 365 days following the date of the accident. The maximum benefit payable for each qualifying child is the actual cost per year charged by the day care center, 5% of your PAI benefit amount or $5,000, whichever is less. This benefit is payable annually for a maximum of four consecutive years, or until the child reaches age 13, whichever comes first, but only if the child remains enrolled in a licensed day care center.

### COMMON DISASTER BENEFIT

If you are involved in a covered common accident with your spouse which results in the loss of both of your lives within 90 days of the covered accident, your spouse's PAI benefit amount will be increased to equal your PAI benefit amount, up to a maximum benefit of $250,000. (Common accident means the same accident or separate accidents occurring within the same 24-hour period.)

### FAMILY EXTENSION BENEFIT

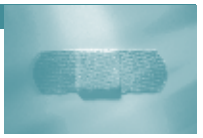
In the event of your death in a covered accident, your covered dependent's coverage under the PAI policy will be continued without premium payment. Coverage will be continued until the earliest of:

1) the date following 12 months from the date of the Insured's death;
2) the date the Insured Spouse remarries (in which case coverage ends for all Insured Dependents);
3) the date the Insured Dependent otherwise ceases to be a member of an eligible class of persons as described in the Classification of Eligible Persons section of the Master Application; or
4) the date the Policy ends.

## Exclusions

There are certain exclusions under the PAI Plan. No benefits are payable if loss or death results from:

- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury or auto-eroticism.
- Sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these.
- Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if the Insured Person is:
  - a. riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
  - b. performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft; or
  - c. riding as a passenger in an aircraft owned, leased or operated by the Policyholder or the Insured Person's employer.
- Declared or undeclared war or any act of declared or undeclared war.
- Infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes.
- Full time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which the Insured Person is not covered due to his or her active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.).
- The Insured Person being under the influence of intoxicants while operating any vehicle or means of transportation or conveyance.
- The Insured Person being under the influence of drugs unless taken under the advice of and as specified by a Physician.
- The Insured Person's commission of or attempt to commit a crime.
- The medical or surgical treatment of sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from the treatment.



- Stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm.

Also, no benefits are payable for any injury that occurred before the effective date of your coverage.

## When PAI Coverage Ends

Your PAI coverage will end on the earliest of the following dates:

- The date you are no longer eligible to participate in the plan;
- The date you fail to make a required contribution when due;
- The date the PAI Plan ends.

Your dependents' coverage will end when yours does or earlier if they become ineligible because they no longer qualify as a dependent.

## Continuation of Coverage While on a Leave of Absence

If you have a medical, family or other qualified leave from active work certified by Sharp HealthCare under the FMLA or other applicable legislation, for purposes of eligibility and termination of coverage you will be considered to be actively at work during the FMLA leave. Your coverage will remain in force during the leave up to 24 weeks or your term date, whichever occurs first, provided you pay the premiums and continue to meet the requirements as set forth in the FMLA or other applicable legislation. See page 26 under Family Medical and other qualified leaves of absence for further details. Please refer to Sharp HealthCare's LOA policy for more information. If you are on a leave of absence during the annual open enrollment, any increase in life & AD&D and dependent life insurance coverage will be effective the date you return to active work in a benefits eligible status (assigned and working 20 hours per week/40 hours per pay period).

## Converting PAI Coverage to an Individual Policy

If your coverage ends because you are no longer an employee of Sharp HealthCare or you are no longer eligible for coverage prior to age 70, you may convert your PAI coverage to an individual policy. You must apply and pay the first premium within 31 days from the date coverage ends. No physical exam is required.

You may convert to a policy which is equal to or less than the amount of insurance for which you were insured under the group policy, but not to an individual policy that is more than $500,000 or less than $20,000.

The individual policy will become effective the date the application is received by the insurance company or the date coverage under the group policy terminates, whichever occurs later.

## Initial Claim Processing for PAI Benefits

The Plan Administrator, through the insurance company, rules on every claim that is filed. Within 30 days from when your initial claim is received, your claim will be approved, or you will receive written notice that your claim is denied.

If your claim is denied, in whole or in part, the notice of the claim denial will be communicated to you and will include the specific reason for the denial (reference to the initial decision), specific reference to the Plan provision(s) on which the denial is based, a description of any additional material or information that you could present in order to receive the claimed benefits, an explanation of the reason you must submit this information, and an explanation of the procedure you must follow if you want to appeal the denial of your claim.

If you do not receive communication from the Plan Administrator within 30 days after filing your initial Claim, you may appeal the denied claim.

# How to File a Claim for PAI Benefits

A claim must be filed within 20 days or as soon as reasonably possible after a covered person dies or suffers a loss due to an accident. You or your designated beneficiary must file a claim before benefits can be considered for payment by the Personal Accident Insurance Plan. To file a claim for benefits under the Personal Accident Insurance Plan, you or your beneficiary should contact the Employee Benefits Department. The Employee Benefits Department will tell you what information is needed and help you prepare the appropriate claim forms.

# Appeal Policy and Procedure

## PERSONAL ACCIDENT INSURANCE CLAIMS:

If you have any questions about a claim payment, you should contact the Sharp HealthCare Employee Benefits Department at (858) 499-5292. If you disagree, in whole or in part, with the reason your claim was denied, you should write within 60 days of receipt of the written denial to the Plan Administrator. Be sure to state why you believe the request should not have been denied and submit any data, questions, or comments you think are appropriate.

Your appeal will be reviewed by the Plan Administrator and you will be notified of the final decision within 60 days of the date your appeal is received. If it is determined that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 60 days (120 days in total). To the fullest extent permitted by law, the Plan Administrator has the discretion to determine all matters relating to coverage, eligibility and benefits. Any determination by the Plan Administrator is final and binding.

SHARP

# Long TERM DISABILITY INSURANCE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SHARP

# Long TERM DISABILITY INSURANCE

For most people, financial security depends on regular income from your job. The loss of a paycheck can create a financial hardship for you and your family. If you cannot work because of an illness, injury or other qualified disability, Sharp HealthCare's Long Term Disability (LTD) program provides you with some protection of your earnings.

The purpose of Long Term Disability (LTD) benefits is to provide income replacement when you are unable to work due to disability caused by a covered illness or injury that extends beyond six months. Sharp HealthCare automatically provides full-time and part-time active employees assigned and working 40 or more hours per pay period with basic LTD coverage equal to 60% of your covered base earnings up to the monthly policy maximum.[1]

Your covered "base earnings" means your gross base wages (base hourly rate X your assigned hours) received from Sharp HealthCare in effect just prior to your date of disability. It includes eligible wages before taxes and any deductions made for pre-tax contributions to a qualified retirement or deferred compensation plan, a Section 125 plan, or a flexible spending account. It does not include income received from commissions, bonuses, incentive pay, on-call pay, shift differential, charge pay, and any other compensation received from Sharp or income received from sources other than Sharp HealthCare.

Your basic monthly LTD benefit is calculated by multiplying your gross base hourly rate X your assigned hours X 26 pay periods, divided by 12 months less offsets from other sources of income X 60% not to exceed $7,500 per month for staff and $8,750 for managers and directors.[1]

You may purchase supplemental coverage equal to an additional 6⅔% (staff, leads, supervisors) which will bring your total LTD coverage equal to 66⅔% of your covered base earnings up to the monthly policy maximum. Managers and above are not eligible for this benefit.

1 For Managers/Directors, the LTD benefit is 70% of covered base earnings up to the monthly policy maximum of $8,750. For Vice Presidents and Senior Vice Presidents, the benefit is 70% up to $20,000 of covered base earnings.

# Eligibility and Enrollment

You are automatically enrolled for basic LTD coverage if you are a regular full-time or part-time employee assigned and working at least 40 hours per pay period. Basic LTD coverage equal to 60%[2] of covered base earnings is provided at no cost to you. Coverage for new employees is effective the first day of the month following or coinciding with 30 days of continuous employment. If you are not in an "active at work" status on that day, your coverage will be effective on the day you return to active work.

You may enroll for supplemental LTD coverage (staff, leads, supervisors only) when (1) you are first eligible and during your initial enrollment period or (2) within 31 days of a qualified family status change or (3) at a subsequent annual open enrollment without providing evidence of insurability (EOI). However, pre-existing condition limitations will apply.

# Taxes on Your LTD Benefits

Sharp HealthCare pays the full cost of basic LTD coverage. You may purchase supplemental coverage (additional 6⅔ employee paid contribution) (staff, leads, supervisors only) through post-tax payroll deduction. If you receive LTD benefit payments, they will be taxable up to the percentage of the premium Sharp HealthCare pays of the total cost of coverage. Conversely, LTD benefit payments will be non-taxable up to the percentage of the premium that you pay for the total cost of coverage.

# How the LTD Plan Works

The LTD Plan is designed to continue a portion of your earnings during an eligible disability that extends beyond six months. You must apply for long-term disability benefits through the Sharp HealthCare Employee Benefits Department. A claim packet will be mailed to your home when you have been on an approved leave of absence for at least 4 consecutive months.

## WHEN BENEFITS ARE PAID

Your benefits under the LTD Plan begin for an approved disability after an elimination period of six months. You must also be under a physician's continuing care during the time you are disabled. All benefits are paid on a monthly basis. Your first long-term disability payment will occur at end of the month after your elimination period. Additional payments will be paid at the end of each month (in arrears) while you continue to be totally disabled.

## WHAT DISABILITY OR DISABLED MEANS

You are disabled when the insurance company determines that:

- You are unable to perform the material duties of your regular occupation due to sickness or injury; and
- After benefits have been paid for 24 months, you are disabled when the insurance company determines that you are unable to perform the material duties of any other occupation for which you are reasonably suited based upon your education, training or experience[1].

## THE AMOUNT OF PAY REPLACED

The LTD Plan provides for a monthly gross income – from all sources – equal to either 60%[2] or 66⅔% of your covered base earnings (depending on your LTD plan coverage) based on your base hourly rate as of your last day of work prior to the date you become disabled. This means that the LTD benefit paid is reduced by any other source of income so that total earnings (from all sources) equals 60%[2] or 66⅔% of your salary up to the policy maximum as described below.

## MINIMUM AND MAXIMUM BENEFITS

Under this Plan, the minimum monthly benefit is the greater of:

- $100; or
- 10% of your covered monthly earnings multiplied by the monthly benefit percentage (60% or 66⅔%)[2].

The maximum monthly benefit payable is $7,500 for Staff employees, $8,750 for Managers and Directors, and $20,000 for Vice Presidents and Senior Vice Presidents.

2 Basic LTD for Managers and above is 70% of covered base earnings at no cost. There is no Supplemental LTD benefit.

## COORDINATION WITH OTHER DISABILITY BENEFITS

The amount you are eligible to receive under the LTD Plan is coordinated with other benefits you are eligible to receive. You must apply for other sources of disability benefits when you become eligible.

The insurance company calculates the percentage of your benefits, subtracts other disability income you are eligible to receive, and pays you the resulting difference.

## OTHER SOURCES OF DISABILITY INCOME

Your benefits from this Plan will be reduced by any benefits that you are eligible to receive from other sources (including lump sum payments). The insurance company will subtract from your gross disability payment the following deductible sources of income:

Other income benefits:

1. Disability income benefits you are eligible to receive because of your total disability under any group insurance plan(s);
2. Disability income benefits you are eligible to receive because of your total disability under any governmental retirement system, except benefits payable under a federal government employee pension benefit;
3. All benefits (except medical or death benefits) including any settlement made in place of such benefits you are eligible to receive because of total disability under:
   a. Workers' Compensation Laws;
   b. Occupational disease law;
   c. Any other laws of like intent as (a) or (b above; and
   d. Any compulsory benefit law.
4. Any of the following that you are eligible to receive:
   a. Any formal salary continuance plan;
   b. Wages, salary or other compensation, excluding the amount allowable when engaged in Rehabilitative Employment; and
   c. Commissions or monies, including vested renewal commissions, but, excluding commissions or monies that you earned prior to total disability which are paid after total disability has begun;
5. That part of disability benefits paid for by you that you are eligible to receive because of your total disability under a group retirement plan; and
6. That part of Retirement Benefits (excluding Retirement Benefits as defined in the contract) paid for by you that you are eligible to receive under a group retirement plan; and
7. Disability or Retirement Benefits under the United States Social Security Act, the Canadian pension plans, or any other government plan for which:
   a. You are eligible to receive because of your total disability or eligibility for Retirement Benefits; and
   b. Your dependents are eligible to receive due to (a) above.
8. Disability and early Retirement Benefits will be offset only if such benefits are elected by you or do not reduce the amount of your normal Retirement Benefits then funded.

If the combined benefits payable from the sources listed above exceed 66⅔% (70% for managers and above) of your base pay, only the minimum monthly benefit will be paid from the LTD Plan.

Once payments under this Plan have started, your benefit will not be reduced by any cost of living increases in Social Security benefits.

If benefits from any of these plans are paid retroactively, the amount of the retroactive payment also will offset the benefits you have already received or will

receive from the Plan for the same period of time. The insurance company will contact you regarding methods of reimbursement for retroactive benefits.

Keep in mind that your benefits will be reduced if you are eligible for other benefits, like Social Security, whether or not you actually apply for benefits. That is why it is important that you apply for benefits as soon as possible. Of course, if you supply proof that you have applied for those benefits and were denied payment, this offset will not apply.

### HOW LONG BENEFITS CONTINUE

There is a maximum benefit period determined by the age at which you become disabled.

Once LTD benefit payments begin, they may continue for the lengths of time shown below (following the six month elimination period) as long as you meet Plan requirements:

| AGE ON DATE WHEN DISABILITY BEGINS | MAXIMUM BENEFIT PERIOD* |
|---|---|
| Age 61 or less | To age 65, but not less than 5 years |
| 62 | 42 months |
| 63 | 36 months |
| 64 | 30 months |
| 65 | 24 months |
| 66 | 21 months |
| 67 | 18 months |
| 68 | 15 months |
| 69 or older | 12 months |

* Maximum Benefit Period is the duration listed above or Social Security normal retirement age (whichever is longer).

### WAIVER OF PREMIUM

During any period you are receiving LTD benefits under this Plan, you will not be required to make premium payments for your LTD insurance coverage.

# Benefit Limitations

### MENTAL ILLNESS, SUBSTANCE ABUSE AND NON-VERIFIABLE SYMPTOMS LIMITATIONS

Disabilities due to Mental Illness, Substance Abuse or Non-Verifiable Symptoms will not exceed a combined monthly benefit payment period of 24 months. However, benefit payments would continue beyond the 24 month period if you were to be hospitalized or institutionalized due to Mental Illness and/or Substance Abuse. Payments would continue during the period of confinement.

If you were not confined in a hospital or institution for Mental Illness and/or Substance Abuse, and were fully participating in an extended treatment plan for the condition that caused the disability, the monthly benefit will be payable to you for up to a period of 24 months from the date of disability.

Benefits will not be paid beyond the limited benefit payment period as indicated above, or the maximum benefit period of payment as described in the chart on this page, whichever occurs first.

### PRE-EXISTING CONDITION LIMITATION FOR BASIC AND SUPPLEMENTAL COVERAGE

If you are disabled due to a pre-existing condition, your LTD benefit payments will be delayed and may be denied.

A pre-existing condition means any sickness or injury for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescription drugs or medicines in the three months just prior to the effective date of coverage; or have symptoms for which you would have consulted a health care provider in the three months just prior to the effective date of coverage; and the disability begins in the first twelve months after the employee's effective date of coverage.

## Recurring Disabilities

If, after receiving a benefit under this Plan, you return to work your regular assigned hours and in less than six months become disabled again for the same reason, LTD benefits begin again immediately. However, if you return to work your regular assigned hours for six months or more and again become disabled, you will have to wait the full 180 days before benefits begin again.

## When Benefits End

LTD benefits end when you are no longer disabled, when you do not meet specific requirements, or at the end of the benefit period.

Your LTD benefits will stop at the earliest of the following:

- The date you are no longer disabled under the terms of the Plan;
- The date you fail to submit proof of continuing disability;
- The date you die;
- The end of the maximum benefit period;
- The date you refuse to accept or continue rehabilitative employment when it has been properly approved.

## Survivor Benefit

If you have been receiving benefits under the LTD Plan and you die, your eligible survivor may receive a lump sum benefit equal to 3 months of your last disability payment.

Your eligible survivor means your spouse or certified domestic partner, if living, otherwise your children under age 26. If there are no eligible survivors, payment will be made to your estate.

## Some Disabilities Are Not Covered

You will not receive LTD benefits if your disability is a result of certain conditions or situations. The plan does not cover any disabilities caused by, contributed to by, or resulting from:

- Intentional self-inflicted injury;
- Committing a felony;
- Pre-existing condition;
- War or any act of war, declared or undeclared; or
- An injury or sickness that occurs while you are confined in any penal or correctional institution.

## When Coverage Ends

Your participation in the LTD Plan will end on the earliest of:

- The date Sharp HealthCare discontinues this Plan;
- The date you no longer are in an eligible group;
- The date your eligible group is no longer covered;
- The last day for which you made any required employee contribution;
- The date your employment terminates.

## Continuation of Long Term Disability Coverage While on a Leave of Absence

### CONTINUATION OF COVERAGE DURING CERTAIN ABSENCES

If you are disabled, your LTD coverage will continue during the six month elimination period and during the period during which your premium is being waived.

### FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA) AND OTHER QUALIFIED LEAVES OF ABSENCE

If you have a medical, family or other qualified leave from active work certified by Sharp HealthCare under the FMLA or other applicable legislation, for purposes of eligibility and termination of coverage you will be considered to be actively at work during the FMLA leave. Your coverage will remain in force during the leave up to 24 weeks or your term date, whichever occurs first, provided you pay the premiums and continue to meet the requirements as set forth in the FMLA or other applicable legislation. See page 26 under Family Medical and other qualified leaves of absence for further details. Please refer to Sharp HealthCare's LOA policy for more information. If you are on a leave of absence during the annual open enrollment, or if you experience a mid-year IRS qualified status change (see IRS Qualified Status Changes beginning on page 10), any increase in long-term disability insurance will not be effective until the date you return to active work in a benefits eligible status (assigned and working 20 hours per week/40 hours per pay period).

### CONVERSION

If your employment with Sharp HealthCare ends, you are eligible to convert your basic LTD coverage to an individual policy with the insurance company for up to a maximum of 12 months, provided you have been covered under the plan for at least 12 consecutive prior months. The maximum amount eligible for conversion is the amount you were eligible for at the time of conversion or $4,000 per month (whichever is less). If your benefit amount is equal to $4,000 the insurance company will require you to complete an evidence of insurability form for approval. You must apply for a conversion policy and pay the first quarterly premium to the insurance company within 60 days of your coverage end date.

Conversion is not available if you have a status change from a full-time or part-time position to a per diem or non-benefit eligible position.

## Initial Claim Processing for LTD Benefits

The Plan Administrator, through the insurance company, rules on every claim that is filed. Within 45 days from when your initial claim is received, it will be approved, or you will receive written notice that your claim is denied. In some instances there may be cause for an extension for review of your claim. The LTD Insurance policy provides for a 30 day extension, and in extreme circumstances an additional 30 days (60 days in total). If it is determined that an extension is necessary, you will be notified in writing at the end of the initial 45 day claim review.

If your claim is denied, in whole or in part, the notice of the claim denial will be communicated to you and will include the specific reason for the denial (reference to the initial decision), specific reference to the Plan provision(s) on which the denial is based, a description of any additional material or information that you could present in order to receive the claimed benefits, an explanation of the reason you must submit this information that you could present in order to receive the claimed benefits, an explanation of the reason you must submit this information, and an explanation of the procedure you must follow if you want to appeal the denial of your claim.

If you do not receive communication from the Plan Administrator within 45 days after filing your initial Claim, you may appeal the denied claim.

# How to File a Claim for LTD Benefits

You must file a claim before LTD benefits can begin. You must also provide proof of disability. Please contact the Benefits Department for a claim form and assistance.

To receive LTD benefits, you will be required to provide:

- A completed claim form;
- Proof of claim to include:
  - that you are under regular care of a doctor;
  - the appropriate documentation of your monthly earnings;
  - the date your disability began;
  - the cause of your disability;
  - the extent of your disability, including restrictions and limitations preventing you from performing your regular occupation; and,
  - the name and address of any hospital or institution where you received treatment, including all attending doctors.
- Your attending physician's statement which verifies your disability and that it is continuous;
- A list of all other disability income benefits available to you and proof that you have applied for them.

Your initial claim should be filed within 90 days of the date your disability starts or as soon as reasonably possible. If it is not possible to give proof within 90 days, or as soon as reasonably possible, it must be given no later than one year after the disability occurs except in the absence of legal capacity. Payment of Plan benefits will normally be made monthly during the duration of your covered disability.

In addition to your LTD benefits through this Plan, you may be eligible for Social Security Disability Benefits after six months of your continued disability. You must also apply for benefits through your local Social Security office if your disability continues for six months.

# Appeal Policy and Procedure

## LONG TERM DISABILITY CLAIMS AND ACCELERATED DEATH BENEFITS:

If you have any questions about a claim payment, you should contact the Sharp HealthCare Employee Benefits Department at (858) 499-5292. If you disagree, in whole or in part, with the reason your claim was denied, you should write within 180 days of receipt of the written denial to the Plan Administrator. Be sure to state why you believe the claim should not have been denied and submit any data, questions, or comments you think are appropriate.

Your appeal will be reviewed by the Plan Administrator and you will be notified of the final decision within 45 days of the date your appeal is received. If it is determined that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). To the fullest extent permitted by law, the Plan Administrator has the discretion to determine all matters relating to coverage, eligibility and benefits. Any determination by the Plan Administrator is final and binding.

SHARP

# *Critical* ILLNESS INSURANCE


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SHARP

# Critical ILLNESS INSURANCE

Many employees have had a family member, friend or acquaintance impacted by the physical, emotional and financial effects of a critical illness such as a colleague diagnosed with cancer, a parent who has suffered a stroke, or a loved one who had a heart attack. Living with a critical illness may affect your financial security and that of your family. Despite having good medical insurance, there are still expenses associated with a critical illness that many medical plans do not cover such as medical copays and deductibles, out-of-net-work treatments, prescription drug co-pays, childcare bills, mortgage and rent payments, car payments, utility payments and other household bills. Critical illness Insurance can help give you the peace of mind needed to concentrate on recovery instead of finances.

## Eligibility

Eligible dependents include:

- Your legal spouse
- Domestic partners (to the extent permissible by state insurance regulations)
- Dependent child/children under age 26

## Benefit Eligibility Criteria

You are eligible to purchase Critical Illness Insurance if you are a regular full-time or part-time employee in a benefit eligible status, assigned and working 40 or more hours per pay period, and are actively at work. New hires are eligible the first of the month following 30 days from date of hire. You may also be eligible to enroll during the annual open enrollment period, or within 31 days of any qualified status changes such as marriage, birth or adoption or if you reclassify to a benefit eligible status. The plan provides coverage for you, your spouse/domestic partner, and eligible children under age 26. You, your spouse/domestic partner and your dependent child(ren) can apply for a Selected Benefit Amount of $10,000, $20,000 or $30,000 (guaranteed issue). Critical illness insurance does not replace your current medical insurance. In fact, you need to acknowledge that you have medical insurance in place to be approved for this coverage.

# Covered Services

Critical illness insurance provides a lump-sum benefit in the event you or your covered dependent are diagnosed with one of the following medical conditions (as they are defined by the group certificate):

- Invasive Cancer[1]
- Non-invasive Cancer[1, 2]
- Heart Attack
- Stroke[2]
- Coronary Artery Bypass Graft
- Kidney Failure
- Alzheimer's Disease[4]
- Covid-19
- Occupational HIV and Hepatitis
- Childhood, Infectious and Progressive Diseases[5]
- Major Organ Transplant

If you are diagnosed with one of the covered conditions and meet all the group certificate requirements, you will receive an Initial Benefit equal to 100% or 25% of the Selected Benefit Amount for the covered condition.

- Under this plan, you can also receive a Recurrence Benefit[4-5] equal to 100% of the Initial Benefit if you are diagnosed with another occurrence of certain covered conditions and MetLife has already paid the Initial Benefit for that covered condition.
- Initial Benefits and Recurrence Benefits will be paid until the Total Benefit Amount has been reached.
- There is no waiting period required for this coverage.

The following example illustrates that during the life of the Critical Illness Insurance certificate, (where the employee has selected a $10,000 Benefit Amount), it is possible to receive both Initial Benefits and Recurrence Benefits for certain covered conditions. The Total Benefit Amount for this example is $30,000.

| PAYMENT EXAMPLE | |
|---|---|
| A covered employee has a Heart Attack | MetLife would pay an Initial Benefit equal to 100% of the benefit amount the employee selected = $10,000. The employee would still have $20,000 of the Total Benefit Amount available if he or she is diagnosed with another Covered Condition. |
| One year later, the employee has another Heart Attack | MetLife would pay a Recurrence Benefit equal to 100% of the Initial Benefit = $10,000. |
| At a later date, the employee is diagnosed with full benefit Cancer. | MetLife would pay a Benefit equal to 100% of the benefit amount the employee selected = $10,000. The employee would still have $5,000 of the Total Benefit Amount available if he or she is diagnosed with another covered condition. |
| At a later date, the employee is diagnosed with Alzheimer's. | MetLife would pay the balance of the employee's coverage of $5,000. |

**Employee:** Benefit of $10,000, $20,000 or $30,000 (Your enrollment will be guaranteed issue provided you are actively at work).

**Spouse/Domestic Partner:** 100% of employee's benefit amount (enrollment is guaranteed, provided employee is actively at work).

**Dependent Child(ren):** 100% of employee's benefit amount (enrollment is guaranteed, provided employee is actively at work).

1 Please review the Disclosure Statement for specific information about Cancer benefits.
2 In certain states, the covered condition is severe stroke.
3 Please review the Disclosure Statement for specific information about Alzheimer's disease.
4 Refer to the Certificate for which diseases are covered.
5 Please review the Disclosure Document or Outline of Coverage/Disclosure Document for information on which Covered Condition may be eligible for a Recurrence Benefit. There may be a Benefit Suspension Period between recurrences of the same Covered Condition, as well as occurrences of different Covered Cond1t1ons. There may be a limitation on the number of Recurrence Benefits payable per Covered Condition. We will not pay a benefit for a Covered Condition that is subject to a Benefit Suspension Period. If a Recurrence Benefit is payable for a Cancer Covered Condition, we will not pay such benefit unless the Covered Person has not had symptoms of or been treated for the same cancer for which we paid a benefit during the Treatment Free Period.

### HEALTH SCREENING/WELLNESS BENEFIT

Critical Illness Insurance provides an annual health screening/wellness benefit for you or your covered spouse/domestic partner and each covered dependent. This benefit pays $75 per calendar year for you and each covered dependent. Check your certificate, or contact MetLife directly at (800) 438-6388 for a list of covered tests.

### MAMMOGRAM BENEFIT

Critical Illness Insurance provides an annual mammogram benefit of up to $200 for you or your spouse/domestic partner. The plan pays for one mammogram benefit per calendar year per individual. Proof of the mammogram must be sent directly to MetLife Insurance Company for review and approval in order for you to receive this benefit. Contact MetLife directly at (800) 438-6388 to obtain further information.

## Premiums and Contributions

Premiums are unisex and based on attained age as of the premium due date.  For dependent children, premiums are determined on rate per employee with dependent child coverage.

Contributions to the cost of the Critical Illness Insurance are through after tax payroll deductions for employee and any enrolled dependents. The total premium rate for Critical Illness Insurance provided under the Plan is set by MetLife.

## Limitations & Exclusions

For Limitations and Exlusions, please refer to your Certificate of Coverage. You may obtain a Certificate of Coverage by contacting the Employee Benefits Department at Sharp HealthCare.

## Continuation of Coverage

Employees leaving Sharp HealthCare or who reclassify to an ineligible benefit status may continue coverage and pay premiums by direct bill provided by the insurance carrier at no additional cost. Coverage for eligible dependents may continue as well.

### WHILE ON A LEAVE OF ABSENCE

If you have a medical, family or other qualified leave from active work certified by Sharp HealthCare under the FMLA or other applicable legislation, for purposes of eligibility and termination of coverage you will be considered to be actively at work during the FMLA leave. You may continue your Critical Illness Insurance coverage and pay premiums by direct bill provided by the insurance carrier at no additional cost. Coverage for eligible dependents can continue as well. As long as premiums are paid, coverage cannot be cancelled.

## Plan Termination or Changes

The group policy set forth those situations in which Sharp HealthCare and/or MetLife have the right to change or end the policy.

Sharp HealthCare reserves the right to change or terminate the Plan at any time. Any such action will be taken only after careful consideration. In the event your Critical Illness Insurance ends, you may be eligible to continue your coverage. The circumstances under which you may continue your coverage are described in your MetLife certificate.

Your consent is not required to terminate, modify, amend, or change the Plan. Sharp HealthCare shall be empowered to amend the Plan or any benefit under the Plan at any time by a signed written instrument. Sharp HealthCare reserves the right to terminate the Plan or any benefit under the Plan at any time.

# How to File a Claim for Critical Illness Insurance Benefits

Claim forms needed to file for Critical Illness Insurance benefits must be obtained by contacting MetLife directly within 30 days of the date of the Covered condition. You may contact them by email at CII@metlife.com, or by calling their toll free number at 1-(800) 438-6388. MetLife will be ready to answer questions about your Critical Illness Insurance and to assist you in filing your claim.

The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully and any required medical statements and bills are submitted with the claim form. The completed claim form should be returned to MetLife at the address on the form.

Please refer to the eligibility for benefits provisions of your MetLife certificate for procedures for requesting a determination as to eligibility for benefits and the claims provisions of your MetLife certificate for claim procedures that apply to the Critical Illness Insurance coverage provided under the Plan.

In carrying out their respective responsibilities under the Plan, the Plan Administrator and other Plan fiduciaries, including MetLife as claim fiduciary, shall have discretionary authority to interpret the terms of the Plan and to determine eligibility for, and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

# Appeal Policy and Procedure

### GROUP CRITICAL ILLNESS INSURANCE CLAIMS:

If you disagree with MetLife's claim determination regarding benefits for group critical illness insurance, you or your duly authorized representative may contact MetLife to have the claim reviewed on appeal. The request for a review on appeal must be made in writing within 60 days of the date of MetLife's initial denial. It should be submitted to:

Metropolitan Insurance Company
Group Critical Illness Insurance
501 U.S. Highway 22
Bridgewater, New Jersey 08807

Your request for an appeal should include any and all information you believe should be considered. MetLife will provide notification of its decision on appeal within 60 days of the date it receives the request for an appeal. If MetLife requires additional time to make a decision on appeal, it will provide written notice setting forth the reasons for the extension. MetLife's final decision will be made not later than 120 days after it receives the request for appeal.

Please refer to the appeals provisions of your MetLife certificate for appeal procedures that apply to the critical illness insurance provided under the Plan.

SHARP

# *Group* ACCIDENT INSURANCE


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SHARP

# Group ACCIDENT INSURANCE

You can cover yourself and your eligible dependents through the Group Accident Insurance Plan in the event you sustain an injury related to an accident. This plan offers an extensive menu of covered accident related occurences that pay you or your covered dependent a lump sum benefit. Some of the covered accidents are fractures, dislocations, burns and lacerations, plus many more.

## Eligibility

Eligible dependents include:

- Your legal spouse/Domestic partner
- Eligible dependent child/children under age 26

## Benefit Eligibility Criteria

You are eligible to purchase Group Accident Insurance if you are a regular full-time or part-time employee in a benefit eligible status, assigned and working 40 or more hours per pay period, and are actively at work. New hires are eligible the first of the month following 30 days from date of hire. You may also be eligible to enroll during the annual open enrollment period, or within 31 days of any qualified status changes such as, marriage, birth, adoption or if you reclassify to a benefit eligible status. The plan provides coverage for you, your spouse/domestic partner, and eligible children under age 26. You, your spouse/domestic partner and your dependent child(ren) will have a choice to enroll in either the Low option or High option on a guaranteed issues basis. Benefits are based on a flat schedule amount which varies depending on the plan option you select. Group Accident Insurance does not replace your current medical insurance. For further details on this plan including how to file a claim, contact MetLife's customer service department at (800) 438-6388.

# Covered Services

Group Accident Insurance provides a lump-sum benefit for you or your eligible covered dependents for a wide variety of accidental occurrences including but not limited to fractures, dislocations, burns, lacerations, even a broken tooth. There are several more occurrences that are covered such as coma, concussion, acupuncture and chiropractic therapy. It is important to know that any occurrence must relate to injuries sustained in an accident.

You will have a choice to enroll in either a high plan or low plan option. The lump sum benefit will be paid based on a flat schedule and there is no coordination with other insurance coverage. The payment schedule is pre-determined by MetLife, the insurance company. For a full schedule of covered services please refer to your Certificate of Coverage. You may obtain a certificate by contacting the Employee Benefits Department at Sharp HealthCare. If you are not certain if an accident is covered you may reach out to MetLife by calling 1-(800) 438-6388.

### REDUCTION IN COVERAGE AMOUNTS AFTER AGE 65

Group Accident Insurance coverage will be limited to a percentage of the total coverage amount after you reach age 65. These limits are shown below:

| | |
|---|---|
| Age 65 -69 | 25% of the amount listed in the schedule above |
| Age 70 and over | 50% of the amount listed in the schedule |

Reductions will also apply to your covered dependents.

### TWO MARRIED SHARP EMPLOYEES

If you and your spouse/domestic partner are both eligible for Group Accident Insurance, one, but not both, may purchase family coverage. The other spouse/domestic partner may elect single coverage only.

# Premiums and Contributions

Premiums are 100% employee paid and are based on the employee's enrollment category, i.e. employee only, employee and spouse/domestic partner, employee and child, or employee and family. Premiums paid for the cost of Group Accident Insurance are made through after-tax payroll deductions for employee and any enrolled dependents. The total premium rate for Group Accident Insurance provided under the Plan is set by MetLife.

# Limitations & Exclusions

For Limitations and Exclusions, please refer to your Certificate of Coverage. You may contact the Employee Benefits Department at Sharp HealthCare to have the certificate sent to you.

# Continuation of Coverage - Portability

If you are no longer eligible for coverage under the Group Accident Insurance Plan due to your employment ending, or if you reclassifying to a non-benefit eligible position, you may continue your coverage on a direct-billed basis by contacting MetLife directly at their toll free number at 1-(800) 438-6388. Coverage for eligible dependents may also be continued.

### WHILE ON A LEAVE OF ABSENCE

If you have a medical, family or other qualified leave from active work certified by Sharp Healthcare under the FMLA or other applicable legislation, for purposes of eligibility and termination of coverage you will be considered to be actively at work during the FMLA leave. At the time of your leave of absence you will be required to complete the appropriate premium arrears form. Missed premiums will be collected via your paycheck upon return from your leave. See page 26 under Family Medical and other qualified leaves of absence for further details.

# How to File a Claim for Group Accident Insurance

Claim forms needed to file for Group Accident Insurance benefits must be obtained by contacting MetLife directly by calling their toll-free number at 1-(800) 438-6388. MetLife will be ready to answer your questions and assist you in filing your claim.

# Plan Termination or Changes

The group policy set forth those situations in which Sharp HealthCare and/or MetLife have the right to change or end the policy.

Sharp HealthCare reserves the right to change or terminate the Plan at any time. Any such action will be taken only after careful consideration. In the event your Group Accident Insurance ends, you may be eligible to continue your coverage. The circumstances under which you may continue your coverage are described in your MetLife Certificate. To obtain a copy of your certificate please contact the Employee Benefits Department.

Your consent is not required to terminate, modify, amend, or change the Plan. Sharp HealthCare shall be empowered to amend the Plan or any benefit under the Plan at any time by a signed written instrument. Sharp HealthCare reserves the right to terminate the Plan or any benefit under the Plan at any time.

# Appeal Policy and Procedure

## GROUP ACCIDENT INSURANCE CLAIMS:

If you disagree with MetLife's claim determination regarding benefits for Group Accident Insurance, you or your duly authorized representative may contact MetLife to have the claim reviewed on appeal. The request for review on appeal must be made in writing within 60 days of the date of MetLife's initial denial. It should be submitted to:

Metropolitan Insurance Company
Group Accident Insurance
501 U.S. Highway 22
Bridgewater, New Jersey 08807

Your request for an appeal should include any and all information you believe should be considered. MetLife will provide notification of its decision on appeal within 60 days of the date it receives the request for an appeal. If MetLife requires additional time to make a decision on appeal, it will provide written notice setting forth the reasons for the extension MetLife's final decision will be made not later than 120 days after it receives the request for appeal.

Please refer to the appeals provisions of your MetLife certificate for appeal procedures that apply to the Group Accident Insurance provided under the Plan.

SHARP

# *Hospital* INDEMNITY INSURANCE


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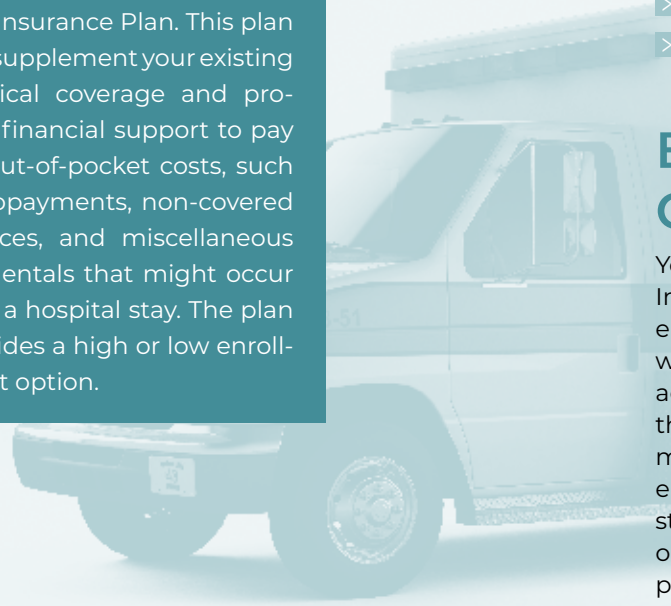
SHARP

# Hospital INDEMNITY INSURANCE

You can cover yourself and your eligible dependents through the Hospital Indemnity Insurance Plan. This plan can supplement your existing medical coverage and provide financial support to pay for out-of-pocket costs, such as copayments, non-covered services, and miscellaneous incidentals that might occur with a hospital stay. The plan provides a high or low enrollment option.



## Eligibility

Eligible dependents include:

- Your legal spouse/Domestic partner
- Eligible dependent child/children under age 26

## Benefit Eligibility Criteria

You are eligible to purchase Hospital Indemnity Insurance if you are a regular full-time or part-time employee in a benefit eligible status, assigned and working 40 or more hours per pay period, and are actively at work. New hires are eligible the first of the month following 30 days from date of hire. You may also be eligible to enroll during the annual open enrollment period, or within 31 days of any qualified status changes such as, marriage, birth, adoption or if you reclassify to a benefit eligible status. The plan provides coverage for you, your spouse/domestic partner, and eligible children under age 26. You, your spouse/domestic partner and your dependent child(ren) will have a choice to enroll in either the Low option or High option on a guaranteed issues basis. Benefits are based on a flat schedule amount which varies depending on the option you select. Hospital Indemnity Insurance does not replace your current medical insurance. In fact, you need to be enrolled in a medical plan to enroll in this coverage. For further details on this plan including how to file a claim, contact MetLife's customer service department at (800) 438-6388.

# Covered Services

Hospital Indemnity Insurance provides a lump-sum benefit for you or your covered dependent according to the schedule as shown below. For a full schedule of services please refer to your Certificate of Coverage.

You may obtain a certificate by contacting the Employee Benefits Department at Sharp.

| SUBCATEGORY | BENEFIT LIMITS (Applies to Subcategory) | BENEFITS | | |
|---|---|---|---|---|
| **HOSPITAL BENEFITS** | | | **LOW PLAN** | **HIGH PLAN** |
| Admission Benefit | 4 time(s) per calendar year[1] | Admission | $500 | $1,000 |
| | | ICU Supplemental Admission (Benefit paid concurrently with the Admission benefit when a Covered Person is admitted to ICU) | $500 | $1,000 |
| Confinement Benefit | 15 days per calendar year ICU Supplemental Confinement will pay an additional benefit for 15 of those days | Confinement[4] | $100 | $200 |
| | | ICU Supplemental Confinement (Benefit paid concurrently with the Confinement benefit when a Covered Person is admitted to ICU) | $100 | $200 |
| Confinement Benefit for Newborn Nursery Care | 2 day(s) per confinement | Confinement Benefit for Newborn Nursery Care[5] | $25 | $50 |
| Inpatient Rehabilitation Benefit | 15 days per calendar year | Inpatient Rehabilitation (For Injury or Sickness) | $100 | $200 |
| **OTHER BENEFITS** | | | **LOW PLAN** | **HIGH PLAN** |
| Health Screening Benefit | 1 time(s) per calendar year per covered person | Health Screening | $75 | $75 |

* Any benefit(s) marked with an asterisk requires a prior Hospital Admission or Confinement.

1 If a covered person is readmitted within 90 days for the same or related sickness/injury for which we paid an Admission Benefit, an additional Admission Benefit is not payable.

4 If the Admission Benefit is payable for a Confinement, the Confinement Benefit will begin to be payable the day after Admission.

5 Payable for the period of newborn confinement for a newborn child who is not sick or injured.

## HEALTH SCREENING/WELLNESS BENEFIT

Hospital Indemnity Insurance provides a $75 health screening/wellness benefit to you or your covered dependents once per calendar year. For specifics as to which screenings are covered under this benefit, please refer to your Certificate of Coverage or, contact MetLife directly at 1-800-438-6388. Your certificate may be provided to you by contacting the Sharp Employee Benefits Department.

## REDUCTION IN COVERAGE AMOUNTS AFTER AGE 65

Your Hospital Indemnity Insurance coverage will be limited to a percentage of the total coverage amount after you reach age 65. These limits are shown below:

Age 65 -69 . . . . . 25% of the amount listed in the schedule above

Age 70 and over . . . . . 50% of the amount listed in the schedule

Reductions will also apply to your covered dependents. Reductions do not apply to the Health Screening/Wellness benefit.

### TWO MARRIED SHARP EMPLOYEES

If you and your spouse/domestic partner are both eligible for Hospital Indemnity Insurance, one, but not both, may purchase family coverage. The other spouse/domestic partner may elect single coverage only.

## Premiums and Contributions

Premiums are 100% employee paid and are based on the employee's enrollment category, i.e. employee only, employee and spouse/domestic partner, employee and child, or employee and family. Premiums paid for the cost of Hospital Indemnity Insurance are made through after-tax payroll deductions for employee and any enrolled dependents. The total premium rate for Hospital Indemnity Insurance provided under the Plan is set by MetLife.

## Pre-Existing Condition Limitation

The Hospital Indemnity plan does not have any pre-existing condition limitations.

## Limitations & Exclusions

For Limitations and Exclusions, please refer to your Certificate of Coverage. You may contact the Employee Benefits Department at Sharp to have the certificate sent to you.

## Continuation of Coverage – Portability

If you are no longer eligible for coverage under the Hospital Indemnity Plan due to your employment ending, or if you reclassifying to a non-benefit eligible position, or you become eligible for similar coverage (if the group policy ends) you may continue your coverage on a direct-billed basis by contacting MetLife directly at their toll free number at 1-(800) 438-6388. Coverage for eligible dependents may also be continued.

### WHILE ON A LEAVE OF ABSENCE

If you have a medical, family or other qualified leave from active work certified by Sharp Healthcare under the FMLA or other applicable legislation, for purposes of eligibility and termination of coverage you will be considered to be actively at work during the FMLA leave. At the time of your leave of absence you will be required to complete the appropriate premium arrears form. Missed premiums will be collected via your paycheck upon return from your leave. See page 26 under Family Medical and other qualified leaves of absence for further details.

# How to File a Claim for Hospital Indemnity Insurance

Claim forms needed to file for Hospital Indemnity Insurance benefits must be obtained by contacting MetLife directly by calling their toll-free number at 1-(800) 438-6388. MetLife will be ready to answer your questions and assist you in filing your claim.

# Plan Termination or Changes

The group policy set forth those situations in which Sharp HealthCare and/or MetLife have the right to change or end the policy.

Sharp HealthCare reserves the right to change or terminate the Plan at any time. Any such action will be taken only after careful consideration. In the event your Hospital Indemnity Insurance ends, you may be eligible to continue your coverage. The circumstances under which you may continue your coverage are described in your MetLife Certificate. To obtain a copy of your certificate please contact the Employee Benefits Department.

Your consent is not required to terminate, modify, amend, or change the Plan. Sharp HealthCare shall be empowered to amend the Plan or any benefit under the Plan at any time by a signed written instrument. Sharp HealthCare reserves the right to terminate the Plan or any benefit under the Plan at any time.

# Appeal Policy and Procedure

## HOSPITAL INDEMNITY INSURANCE CLAIMS:

If you disagree with MetLife's claim determination regarding benefits for Group Hospital Indemnity Insurance, you or your duly authorized representative may contact MetLife to have the claim reviewed on appeal. The request for review on appeal must be made in writing within 60 days of the date of MetLife's initial denial. It should be submitted to:

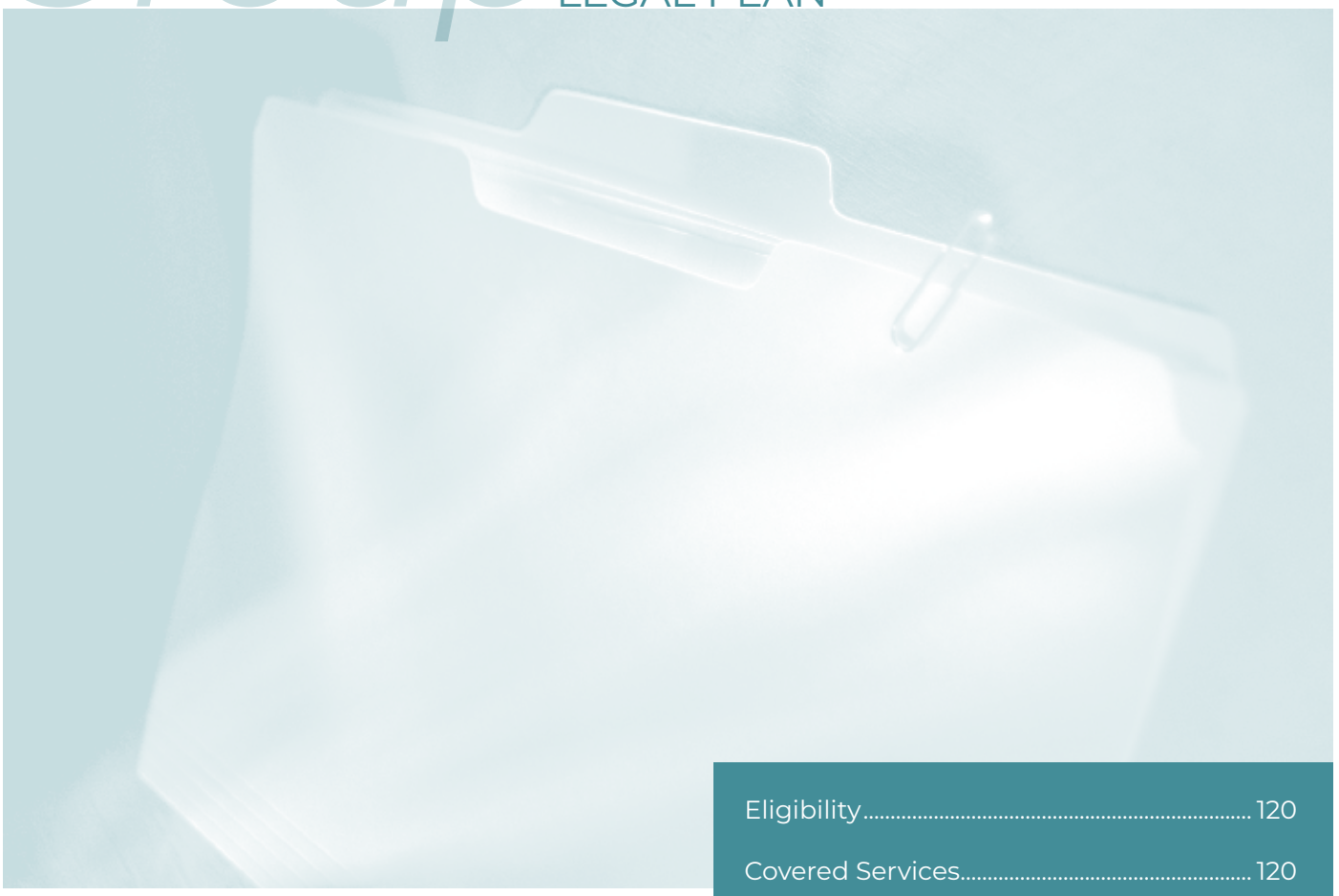
Metropolitan Insurance Company
Group Hospital Indemnity Insurance
501 U.S. Highway 22
Bridgewater, New Jersey 08807

Your request for an appeal should include any and all information you believe should be considered. MetLife will provide notification of its decision on appeal within 60 days of the date it receives the request for an appeal. If MetLife requires additional time to make a decision on appeal, it will provide written notice setting forth the reasons for the extension MetLife's final decision will be made not later than 120 days after it receives the request for appeal.

Please refer to the appeals provisions of your MetLife certificate for appeal procedures that apply to the Group Hospital Indemnity Insurance provided under the Plan.

SHARP

# Group LEGAL PLAN

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SHARP

# Group LEGAL PLAN

You are eligible to enroll in the Group Legal Plan if you are a regular full-time or part-time employee, assigned and working 40 or more hours per pay period. The Group Legal Plan provides you, your legal spouse/certified domestic partner, and your eligible children under age 26, a full menu of legal services, access to a network of qualified attorneys, and representation of covered services. Cover your parents for certain services by enrolling in the PlusParents option.

## Eligibility

You are eligible to enroll in coverage the first of the month following or coinciding with 30 days of continuous employment. If later you decide to cancel coverage, you must wait until the next annual open enrollment period. At that time you will need to contact Metlife Customer Service Department at 1-800-438-6388.

## Covered Services

### TELEPHONE AND OFFICE CONSULTATION

The plan provides unlimited telephone and office consultation. This service provides the opportunity to discuss with an attorney any personal legal matters that are not specifically excluded covered services. The Plan Attorney will explain your rights, point out your options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if you so request. If representation is covered by the Plan, you will not be charged for the Plan Attorney's services. If representation is recommended, but is not covered by the plan, the Plan Attorney will provide a written fee statement in advance. You may choose whether to retain the Plan Attorney at your own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year you may use this service; however, for a non-covered matter, this service is not intended to provide you with continuing access to a Plan Attorney in order to seek advice that would allow you to undertake your own representation.

The Plan also provides for representation of the following covered services as described below for you, your legal spouse/certified domestic partner or eligible dependents as a plan "participant."

## CONSUMER PROTECTION

**Consumer Protection Matters –** This service covers the participant as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction. The controversy must be evidenced by a written document such as a sales slip, contract, note or warranty. This service does not include disputes over real estate, construction, insurance or collection activities after a judgment.

**Personal Property Protection –** This service covers counseling the participant on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters.

**Small Claims Assistance –** This service covers counseling the participant on prosecuting a small claims action; helping the participant prepare documents; advising the participant on evidence, documentation and witnesses; and preparing the participant for trial. The service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment, or any services relating to post-judgment actions.

## DEBT MATTERS

**Debt Collection Defense –** This service provides participants with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, foreclosure, repossession or garnishment, up to and including trial, if necessary. It includes a motion to vacate a default judgement. It does not include counter claim, cross or third party claims; bankruptcy; any action arising out of family law matters, including support or post-decree issues; or any matter where the creditor is affiliated with Sharp HealthCare.

**Identity Theft Defense –** This service provides the participant consultation with an attorney regarding potential creditor actions resulting form identity theft, and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts as set forth in the Debt Collection Defense coverage. In addition it provides participants with on-line help and information about identity theft and prevention.

**Identity Theft Resolution –** This service provides covered participants with access to Identity Restoration Services provided by Identity Force, a Transunion brand. These services include assisting you in recovering from identity theft by helping with paperwork, making calls and doing all the heavy lifting to make sure your identity is restored. For further information and to discuss your situation with an identity theft specialist, please visit:

http://www.legalplans-idtheft.com.

**Personal Bankruptcy or Wage Earner Plan –** This service covers the employee and spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or Wage Earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with Sharp HealthCare, even if the employee or spouse chooses to reaffirm that specific debt.

**Tax Audits –** This service covers reviewing tax returns and answering questions the IRS or a state or local taxing authority has concerning the participant's tax return; negotiating with the agency; advising the participant on necessary documentation; and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes, costs of hiring an accountant or the preparation of any tax returns.

## DEFENSE OF CIVIL LAWSUITS

**Administrative Hearing Representation –** This service covers participants in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. It does not apply where services are available or are being provided by virtue of a homeowner or vehicle insurance policy. It does not include family law matters, post judgement matters, or litigation of a job-related incident.

**Civil Litigation Defense –** This service covers the participant in defense of an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgement matters, matters with criminal penalties, or litigation of a job-related incident. Services do not include bringing counter, third party or cross claims, even when this may be part of the defense.

**Incompetence Defense –** This service covers the participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the participant incompetent.

## DOCUMENT PREPARATION

**Affidavits –** This service covers preparation of any affidavit in which the participant is the person making the statement.

**Deeds –** This service covers the preparation of any deed for which the participant is either the grantor or grantee.

**Demand Letters –** This service covers the preparation of letters that demand money, property or some other property interest of the participant, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the participant. Negotiations and representation in litigation are not included.

**Document Review –** This service covers the review of any personal legal document of the participant, such as letters, leases or purchase agreements.

**Elder Law Matters –** This service covers counseling the participant on any personal issues relating to the participant's parents as they affect the participant. This includes reviewing documents of the parents to advise the participant on the effect on the participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills. The service also incudes preparing deeds for the parents when the participant is either the grantor or grantee; and preparing promissory notes for the parents when the participant is the payor or payee.

**Immigration Assistance –** This service covers advice and consultation, preparation of affidavits and powers of attorney, review of immigration documents, and helping the participant with preparations for hearings.

**Mortgages –** This service covers the preparation of any mortgage or deed of trust for which the participant is the mortgagor. This service does not include documents pertaining to business, commercial or rental property.

**Promissory Notes –** This service covers the preparation of any promissory note for which the participant is the payor or payee.

## FAMILY LAW

**Adoption and Legitimization (Contested and Uncontested) –** This service covers all legal services and court work in a state or federal court for and adoption for the employee and spouse/certified domestic partner. Legitimization of a child for the employee and spouse/certified domestic partner, including reformation of a birth certificate, is also covered.

**Name Change –** This service covers the participant for all necessary pleadings and court hearings for a legal name change.

**Prenuptial Agreement –** This service covers the preparation of an agreement by an employee and his or her fiancé/partner prior to their marriage/certified domestic partner relationship, outlining how property is to be divided in the event of separation, divorce or death of a spouse/certified domestic partner. Representation is provided only to the employee. The fiancé/partner will be required to have separate counsel or waive representation.

**Contested Guardianship/Conservatorship –** This service provides covered participants in establishing a guardianship or conservatorship over a person and his or her estate when you or your spouse is appointed guardian or conservator. It includes obtaining a guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings after the initial accounting.

**Uncontested Guardianship/Conservatorship –** This service covers establishing an uncontested guardianship or conservatorship over a person and his or her estate when the employee or spouse/certified domestic partner is appointed guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork and attending the hearing. If the proceeding becomes contested, the employee or spouse will be required to pay all additional legal fees. This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings once guardianship or conservatorship has been established.

**Protection from Domestic Violence –** This service covers the employee as the victim of domestic violence. It provides the employee with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. It does not include suits for damages, defense of any action, or representation for the offender.

**Reproductive Assistance –** This service provides the participant up to twenty hours of reviewing and preparing any necessary agreements or documents, the preparation and filing of any pleadings or other documentation to obtain any necessary orders or decrees, and representation at any hearing or other proceeding related to the matter as may be required by law. This service does not include representation of any party other than you and/or your spouse, even if you and/or your spouse may be required to pay that party's legal fees or expenses. It is your's and/or your spouse's responsibility to pay fees beyond the first twenty hours.

## PERSONAL INJURY

**Personal Injury (25% of Network Maximum) –** Subject to applicable law and court rules, plan attorneys will handle personal injury matters (where the participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the participant's responsibility to pay this fee and all costs.

## REAL ESTATE MATTERS

**Boundary or Title Disputes (Primary Residence) –** This service covers negotiation and litigation arising from boundary or title disputes involving a participant's primary residence, where coverage is not available under the participant's homeowner's or title insurance policies. This service includes filing to remove a mechanic's lien.

**Eviction and Tenant Problems (Primary Residence Tenant Only) –** This service covers the participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.

**Sale or Purchase of Home (Primary Residence) –** This service covers the review or preparation, by an attorney representing the participant, of all relevant documents (including the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation) which are involved in the purchase or sale of a Participant's primary residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, unimproved land, new construction, rental property, property held for business or investment or leases with an option to buy. Home equity and construction loans are not included under this service.

**Home Equity Loans (Primary Residence) –** This service covers the review or preparation of a home equity loan on the participant's primary residence.

**Property Tax Assessment (Primary Residence) –** This service covers the participant for review and advice on a property tax assessment on the participant's primary residence. It also includes filing the paperwork; gathering the evidence; negotiating a settlement; and attending the hearing necessary to seek a reduction of the assessment.

**Refinancing of Home (Primary Residence) –** This service covers the review or preparation, by an attorney representing the participant, of all relevant documents (including the mortgage and deed, and documents pertaining to title, insurance, recordation and taxation) which are involved in the refinancing of a Participant's primary residence. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. This benefit does not include the refinancing of a second home, vacation property, unimproved land, rental property or property held for business or investment. Home equity loans are not included under this service.

**Security Deposit Assistance (Primary Residence – Tenant only) –** This service covers counseling the participant as a tenant in recovering a security deposit from the participant's residential landlord for the participant's primary residence; reviewing the lease and other relevant document; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing the participant for the small claims trial. This service does not include the Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgement actions.

**Zoning Applications –** This service provides the participant with the services of a lawyer to help get a zoning change or variance for the participant's primary residence. Services include reviewing the law, reviewing surveys, advising the participant, preparing applications, and preparing for and attending the hearing to change zoning.

## TRAFFIC AND CRIMINAL MATTERS

**Juvenile Court Defense –** This service covers the defense of an employee's dependent child in any juvenile court matter, provided there is no conflict of interest with the employee, in which case this service provides an attorney for the employee only.

**Traffic Ticket Defense (no DUI) –** This service covers representation of the participant in defense of any traffic ticket except driving under the influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

**Restoration of Driving Privileges –** This service covers representation in proceedings to restore the participant's driver's license.

## WILLS AND ESTATE PLANNING

**Trusts –** This service covers the preparation of reversible and irrevocable trusts for the participant. It does not include tax planning or services associated with funding the trust after it is created.

**Living Wills –** This service covers the preparation of a living will for the participant.

**Powers of Attorney –** This service covers the preparation of any power of attorney when the participant is granting the power.

**Probate (10% of Network Discount) –** Subject to applicable law and court rules, plan attorneys will handle probate matters at a fee 10% less than the plan attorney's normal fee. It is the participant's responsibility to pay this reduced fee and all costs.

**Wills and Codicils –** This service covers the preparation of a simple or complex will for the participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

# Network of Attorneys and How to Access Plan Benefits

Legal services are provided through a panel of carefully selected Participating Law Firms. Lawyers in this network are called Plan Attorneys. All legal services, as described on the previous pages, are covered at 100%, provided an in-network attorney is selected.

To access benefits, you may call MetLife Legal Plans' Client Service Center at 1-800-438-6388. Once eligibility is verified and the extent of the case determined, you are assigned a case number (a case number is assigned for each case) and given the phone number(s) of Plan Attorney(s) that is most convenient for you. You then call the Plan Attorney to schedule an appointment. Evening and Saturday appointments are available.

**Service for Non-covered Matters (4 hours) –** For non-covered matters that are not otherwise excluded, this benefit provides four hours of attorney time and services per calendar year. It is your responsibility to pay fees beyond that usage. No more than a combined maximum of four hours of attorney time and service are provided for you, your spouse, and your eligible dependents per calendar year.

### OUT-OF-NETWORK BENEFITS

You have the freedom to choose an out-of-network attorney and are reimbursed according to an established fee schedule. Also, if there are no Participating Law Firms in the area, you will be asked to select your own attorney. In both of these circumstances, the plan will reimburse you for the non-Plan attorney fees in accordance with an established fee schedule. For services to be covered, you or your eligible dependents must have obtained a case number, retained an attorney and the attorney must begin work on the covered legal matter while you are an eligible participant of the plan. An out-of-network fee schedule can be obtained by contacting MetLife Legal Plans at 1-800-438-6388.

# Exclusions

Certain matters are excluded from coverage under the plan. No services, not even a consultation, can be provided for the following matters:

- Payment made to a third party such as costs, witness fees, filing fees, transcripts or fines;
- Appeals or class actions or tax return preparation;
- Business, farm, patent, trademark or copyright matters;
- Rental property when you are the landlord;
- Matters for which an attorney client relationship exists prior to the participant becoming eligible for plan benefits;
- Matters or disputes involving Sharp HealthCare, MetLife Legal Plans, MetLife or a Plan Attorney;
- Matters concerning employment including Company and statutory benefits, unemployment and workers' compensation;
- Frivolous or unethical matters;
- Matters in which there is a conflict of interest between the employee and spouse or dependents in which case services are excluded for spouse or dependents.

# Plan Provisions

### WHEN COVERAGE BEGINS

You may enroll in the plan effective the first of the month following 30 days of continuous employment or during the annual open enrollment period. You must be in an active at work, benefits eligible status fot this benefit to begin. You can change or drop coverage at this time. If you become eligible after the annual open enrollment, you may elect to participate by completing the enrollment process within 30 days of the date you become eligible.

### MINIMUM PARTICIPATION PERIOD

The Plan has a minimum participation period of one year and you must maintain the coverage for the entire (calendar) year. If you are a mid-year new hire or newly-eligible employee, you will be required to continue in the plan for the remainder of the calendar plan year.

## WHEN COVERAGE ENDS

If you cease to be eligible to participate in the plan or your employment with Sharp HealthCare ends, the Plan will cover the legal fees for those covered services that were opened and pending during the period you were enrolled in the plan. No new matters may be started after you become ineligible.

## PORTABILITY

If you terminate your employment with Sharp HealthCare or reclassify to an ineligible benefit status, you may continue coverage for a period of 12 months. Premiums must be prepaid in a lump sum within 30 days of your benefit termination date. Contact MetLife Legal Plans at 1-(800) 821-6400.

## AMENDMENT OR TERMINATION

Sharp HealthCare expects to continue to offer participation in the Group Legal Plan. It reserves the right to amend, or terminate the Plan at any time. If the Plan is terminated, all covered services then in process will be handled to their conclusion under the Plan.

## ADMINISTRATION AND FUNDING

The Group Legal Plan is provided for and administered through a contract with MetLife Legal Plans. MetLife Legal Plans makes all determinations regarding attorneys' fees and what constitutes covered services. All contributions collected from employees electing this coverage are paid to MetLife Legal Plans.

## COST OF THE PLAN

You pay the cost of the Plan through after-tax payroll deductions.

## PLAN CONFIDENTIALITY, ETHICS, AND INDEPENDENT JUDGMENT

Your use of the Plan and the legal services are confidential. The Plan Attorneys will maintain strict confidentiality of the traditional lawyer-client relationship. Sharp HealthCare will know nothing about your legal matters or the services you use under the Plan. Plan administrators will have access only to limited statistical information needed for orderly administration of the Plan.

No one will interfere with the Plan Attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the Plan are subject to ethical rules established by the courts for lawyers. The attorney will adhere to the rules of the Plan and he or she will not receive any further instructions, direction or interference from anyone else connected with the Plan. The attorney's obligations are exclusively to you. The attorney's relationship is exclusively with you. MetLife Legal Plans, Inc., or the law firm providing services under the Plan is responsible for all services provided by their attorneys.

The Plan has no liability for the conduct of any Plan Attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Plan. You have the right to retain at your own expense any attorney authorized to practice law in that state.

Plan attorneys will refuse to provide services if the matter is clearly without merit, frivolous or for the purpose of harassing another person. If you have a complaint about the legal services you have received or the conduct of an attorney, call MetLife Legal Plans at 1-800-438-6388. Your complaint will be reviewed and you will receive a response within two business days of your call.

## OTHER SPECIAL RULES

In addition to the coverages and exclusions listed, there are certain rules for special situations. Please read this section carefully.

## IF OTHER COVERAGE IS AVAILABLE TO YOU

If you are entitled to receive legal representation provided by any other organization such as a government agency, or if you are entitled to legal services under any other legal plan, coverage will not be provided under this Plan. However, if you are eligible for legal aid or Public Defender services, you will still be eligible for benefits under this Plan, so long as you meet the eligibility requirements.

## IF YOU ARE INVOLVED IN A LEGAL DISPUTE WITH YOUR DEPENDENTS

You may need legal help with a problem involving your spouse or your eligible dependents. In some cases, both you and your eligible dependent may need an attorney. If it would be improper for one attorney to represent both you and your dependent, only you will be entitled to representation by the plan attorney. Your dependent will not be covered under the Plan.

### IF YOU ARE INVOLVED IN A LEGAL DISPUTE WITH ANOTHER EMPLOYEE

If you or your dependents are involved in a dispute with another eligible employee or that employee's dependents, MetLife Legal Plans will arrange for legal representation with independent and separate counsel for both parties.

### IF YOU ARE AWARDED ATTORNEYS' FEES AS PART OF A SETTLEMENT

If you are awarded attorneys' fees as a part of a court settlement, the Plan must be repaid from this award to the extent that it paid the fee for your attorney.

## Continuation of Coverage While on a Leave of Absence

If you have a medical, family or other qualified leave from active work certified by Sharp HealthCare under the FMLA or other applicable legislation, for purposes of eligibility and termination of coverage you will be considered to be actively at work during the FMLA leave. You may continue your group legal benefit and pay premiums in arrears upon your return from your leave of absence. See page 26 under Family Medical and other qualified leaves of absence for further details regarding premium payments.

## Denials of Benefits and Appeal Procedures

### DENIALS OF ELIGIBILITY

MetLife Legal Plans verifies eligibility using information provided by Sharp HealthCare. When you call for services, you will be advised if you are ineligible and MetLife Legal Plans will contact Sharp HealthCare for assistance. If you are not satisfied with the final determination of eligibility, you have the right to a formal review and appeal. Send a letter within 60 days explaining why you are eligible to:

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

Within 30 days, you will be provided with a written explanation.

### DENIALS OF COVERAGE

If you are denied coverage by MetLife Legal Plans or by any Plan Attorneys, you may appeal by sending a letter to:

MetLife Legal Plans
Director of Administration
Eaton Center
111 Superior Avenue, Suite 800
Cleveland, Ohio 44114-2507

The Director will issue MetLife Legal Plans' final determination within 30 days of receiving your letter. This determination will include the reasons for the denial with reference to the specific Plan provisions on which the denial is based and a description of any additional information that might cause MetLife Legal Plans to reconsider the decision, and an explanation of the review procedure.

SHARP

# Definitions

SHARP

# Definitions

The following definitions will provide explanations for some of the key terms used throughout this book. Other key terms not listed in this section are identified or defined in specific sections of this book.

**Accidental injury** means any accidental injury caused by external forces under unexpected circumstances and which does not arise out of or in the course of work for pay or profit by the covered person. All injuries received in one accident are considered one accidental injury.

**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.

**Beneficiary** means the person(s) you have designated to receive benefits if you die.

**Benefit percentage** means the percentage of covered expenses the plan pays. The various schedules of benefits throughout this book show the benefit percentage for each covered expense.

**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, 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 of covered dental expenses you or your covered dependents must pay before the plan pays any benefits. The schedule of benefits shows the deductible amounts for the dental plan.

**Dentist** means an individual, other than a relative, licensed to practice dentistry.

**Dependent** means an enrolled employee's legal spouse or certified domestic partner or your biological child, stepchild, legally adopted child, or a child for whom you are currently the legal guardian pursuant to a court order that is currently in force, under the age of 26. Dependent 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.

**Domestic Partnership** for the purposes of determining eligibility for coverage under the Sharp HealthCare benefit plans will be the definition recognized under the State of California statutes.

**Eligible Employee** means any employee of Sharp HealthCare and/or its affiliated entities who has met the eligibility requirements of the plan(s).

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

**Evidence of Insurability** means a statement of your or your dependent's medical history which the insurance company will use to determine if you or your dependent is approved for life insurance coverage. Evidence of insurability will be provided at your expense if you apply for coverage after you or your dependent's initial eligibility date.

**Fee Schedule** means the schedule of fees outlining the maximum charge for any service or supply that will be covered by network providers under the dental plan. The prevailing charge level for dental services is identified using information on the fees actually charged in the area. Only that part of a charge for a service or supply that is within the fee schedule is covered.

**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.

**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, dentists, 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).

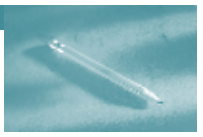
**Primary Care Physician or PCP** means a Plan physician, possibly affiliated with a PMG, who is chosen by you or your dependents and who is primarily responsible for supervising, coordinating, and providing initial care, for maintaining the continuity of care, and providing or initiating referrals for 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, dentists, hospitals and other plan providers, as updated from time to time.

**Spouse** means your legally married husband or wife.



SHARP

# Administrative INFORMATION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SHARP

# Administrative INFORMATION

This section provides some general information about the plans and programs 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

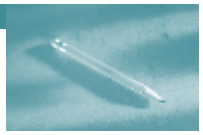
Sharp HealthCare
8695 Spectrum Center Boulevard
San Diego, CA 92123

### PLAN YEAR

| | |
|---|---|
| Medical/Dental/Vision | January 1 - December 31 |
| Flexible Spending Accounts | January 1 - December 31 |
| Flexible Benefits | January 1 - December 31 |
| Group Life Insurance | January 1 - December 31 |
| Personal Accident Insurance | January 1 - December 31 |
| Long Term Disability Insurance | January 1 - December 31 |
| Group Critical Illness Insurance | January 1 - December 31 |
| Group Legal Plan | January 1 - December 31 |
| Group Accident Insurance | January 1 - December 31 |
| Hospital Indemnity Insurance | 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 | 510 | 1003 | Vision – benefits are fully insured under an insurance contract with Sharp Health Plan and Vision Service Plan. |
| ▪ Dental | | 300303 | Dental – benefits are self-insured by Sharp HealthCare and payments for benefits are made under Sharp HealthCare's general assets. Claims are paid through a third party arrangement with Metropolitan Life Insurance Company. |
| Sharp HealthCare Flexible Benefit Plan | 508 | NONE | Each benefit covered by the Sharp HealthCare Flexible Benefits Plan is funded as described in this chart. |
| Sharp HealthCare Flexible Spending Accounts | 505, 509 | NONE | The Sharp HealthCare Flexible Spending Accounts are funded through employee salary reduction elections. |
| Sharp HealthCare Group Life and AD&D Insurance Plan | 502 | 327739-002 | For claims incurred prior to 7/01/03: Benefits are fully insured under an insurance contract with UNUM Provident Corporation. |
| | | SA3-860-039555-01 | For claims incurred 7/01/03 through 12/31/14: Benefits are fully insured under an insurance contract with The Lincoln Life Insurance Company. |
| | | 668970 | For claims incurred 1/01/15 through 12/31/16: Benefits are fully insured under an insurance contract with Reliance Standard Life Insurance Company. |
| | | SA3-860-066938-01 | For claims incurred 1/01/17 and after: Benefits are fully insured under an insurance contract with The Lincoln National Life Insurance Company. |
| Sharp HealthCare Personal Accident Insurance Plan | 504 | PAI 0009116259 | Benefits are fully insured under an insurance contract with National Union Fire Insurance Company of Pittsburgh. |
| Sharp HealthCare Long Term Disability Income Protection Plan | 503 | 327739-01 | For dates of disability prior to 7/01/03: Benefits are fully insured under an insurance contract with UNUM Provident Corporation. |
| | | GF3-860-039555-01 | For dates of disability claims 7/01/03 through 12/31/14: Benefits are fully insured under an insurance contract with The Lincoln National Life Insurance Company. |
| | | 669924 | For dates of disability claims 1/01/15 through 12/31/16: Benefits are fully insured under an insurance contract with Reliance Standard Life Insurance Company. |
| | | GF3-860-066938-01 | For dates of disability claims 1/01/17 and after: Benefits are fully insured under an insurance contract with The Lincoln National Life Insurance Company |
| Sharp HealthCare Group Critical Illness Insurance Plan | 517 | 0139213 | Plan effective January 1, 2009. Fully underwritten. Benefits are fully insured through a contract with Metropolitan Life Insurance Company. |
| | | 0138633 | Plan effective January 1, 2009. Simplified Issue. Benefits are fully insured through a contract with Metropolitan Life Insurance Company. |
| | | 0151010 | Plan effective January 1, 2013. Guaranteed Issue. Benefits are fully insured through a contract with Metropolitan Life Insurance Company. |
| | | 0300303 | Plan effective January 1, 2023. Guaranteed Issue. Benefits are fully insured through a contract with Metropolitan Life Insurance Company. |
| Sharp HealthCare Group Accident Insurance Plan | | 0300303 | Plan effective January 1, 2023. Guaranteed Issue. Benefits are fully insured through a contract with Metropolitan Life Insurance Company. |
| Sharp HealthCare Hospital Indemnity Insurance Plan | | 0300303 | Plan effective January 1, 2023. Guaranteed Issue. Benefits are fully insured through a contract with Metropolitan Life Insurance Company. |
| Sharp HealthCare Group Legal Plan | 516 | 010/1180 | Plan effective March 1, 2004. Benefits are fully insured through a contract with MetLife Legal PLans. |

# Claims Administrators

You can send different types of claims to the appropriate administrators for processing. Here are the claims administrators for each plan:

## HMO Medical Plan

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

## PPO Dental Plan

Metropolitan Life Insurance Company
P.O. Box 981282
El Paso, TX 79998-1282
1-(800) 942-0854 Customer Service & Claims
1-(800) 474-7371 Provider Directory & Information

## 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

## Flexible Spending Accounts (FSA)

Health Equity
P.O. Box 14053
Lexington, KY 40512
1-(877) 924-3967 (phone)
1-(877) 353-9236 (fax)

## Group Life Insurance Plan

**For Claims Incurred Prior to 7/01/03:**
UNUM Provident Corp.
Group Life Benefits
PO. Box 9061
Portland, MN 04104-5046
1-(800) 445-0402

**For Claims Incurred 7/01/03 through 12/31/14, or 1/01/17 and after:**
The Lincoln National Life Insurance Company
Group Benefits Life Claims
P.O. Box 7212
London, KY 40742-9952
1-(888) 787-212

**For Claims incurred 1/01/15 through 12/31/16:**
Reliance Standard Life Insurance Company
2001 Market Street, Suite 1500
Philadelphia, PA 19103
1-(800) 351-7500 Customer Service & Claims

## Personal Accident Insurance Plan

National Union Fire Insurance of Pittsburgh
AIG Benefits Solutions
A&H Claim Department
P.O. Box 25987
Shawnee Mission, KS 66225-5987
1-(800) 551-0824 / (302) 661-4176

## Long Term Disability Income Protection Plan

**For Dates of Disability Prior to 7/01/03:**
UNUM Provident Corp.
Glendale Customer Care Center
655 North Central Avenue, Suite 800
Glendale, CA 91203
1-(800) 424-2008

**For Dates of Disability Claims Incurred 7/01/03 through 12/31/14, or 1/01/17 and after:**
The Lincoln National Life Insurance Company
Group Benefits Disability Claims
P.O. Box 7209
London, KY 40742-7209
1-(800) 320-7585

**For Dates of Disability Claims Incurred 1/01/15 through 12/31/16:**
Reliance Standard Life Insurance Company
2001 Market Street, Suite 1500
Philadelphia, PA 19103
1-(800) 351-7500 Customer Service & Claims

## Group Critical Illness Insurance

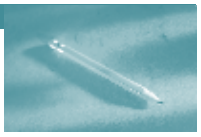
Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10116-0188
1-(800) 438-6388

## Group Legal Plan

MetLife Legal Plans
Eaton Center
1111 Superior Avenue, Suite 800
Cleveland, OH 44114-2507
1-(800) 821-6400

## Group Accident Insurance

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10116-0188
1-(800) 438-6388



- Hospital Indemnity Insurance

  Metropolitan Life Insurance Company
  200 Park Avenue
  New York, NY 10116-0188
  1-(800) 438-6388

## 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, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents 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 and welfare benefit or exercising your rights under ERISA.

## ENFORCE YOUR RIGHTS

If your claim for a health and welfare benefit 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 plans described in this book are not to be construed as conditions of employment. Sharp HealthCare reserves the right to modify, revoke, suspend, terminate, or change any or all such plans 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.*

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# HealthCare BENEFIT PLAN NOTICES


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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 147 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 lymph edema.

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/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm
- 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, 2023.

# 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 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).

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***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).*

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|---|---|
| Date: | October 1, 2023 |
| 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

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|---|---|
| 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). |

SHARP