Scripps | Scripps Health Plan

Combined Evidence of Coverage and Disclosure Form

Effective January 1, 2026

We have included a **Summary Benefit Description** for Scripps Health Plan, which briefly describes your coverage, followed by comprehensive benefit descriptions. We highly recommend that you familiarize yourself with this booklet to help you gain access to the care you need. The Summary Benefit Description can be found beginning on **Page 7**. Take time to review this booklet as you will find this information useful throughout the year.

NOTICE

This Evidence of Coverage and Disclosure Form booklet describes the terms and conditions of coverage of your Scripps Health Plan.

Scripps Health Plan
10790 Rancho Bernardo Road, 4S-300
San Diego, California 92127
www.ScrippsHealthPlan.com

Please read this Evidence of Coverage and Disclosure Form carefully and completely so that you understand which services are covered health care services, and the limitations and exclusions that apply to your plan. If you or your dependents have special health care needs, you should carefully read those sections of the booklet that apply to those needs.

If you have questions about the Covered Benefits of your plan, or if you would like additional information, please contact Customer Service at the address above or by telephone at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065.**

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the Covered Benefits offered by Scripps Health Plan. The Group Agreement must be consulted to determine the exact terms and conditions of coverage. The Group Agreement will be furnished upon request at the Plan contact information above. However, the Summary Benefits Description, exclusions, and limitations is complete and is incorporated by reference into the contract.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. Call your prospective doctor, medical group, independent practice association, or clinic or call Scripps Health Plan at the Customer Service telephone number listed at the back of this booklet to ensure that you can obtain the health care services that you need.

Your Introduction to Scripps Health Plan

Welcome to Scripps Health Plan, by Scripps Health Plan Services, Inc. (referred to as "Scripps Health Plan" or "Plan" going forward), which offers a wide choice of physicians, hospitals and non-physician health care services.

You will be able to select your own Primary Care Physician (PCP) from the Scripps Health Plan (HMO) Directory of general practitioners, family practitioners, internists, obstetricians/ gynecologists, and pediatricians. Each of your eligible family members must also select a PCP. All Covered Benefits must be provided by or arranged through your PCP, except for the following: obstetrical/gynecological (OB/GYN) services provided by an obstetrician/ gynecologist or a family practice physician within the same medical group as your PCP, urgent care provided in your PCP service area by an urgent care clinic when instructed by your assigned medical group, Emergency Services and Care, or Mental Health or Substance Use Disorder services. See the "How to Use the Plan" section for information.

Note: A decision will be rendered on all requests for prior authorization of services as follows: for urgent services and in-area urgent care, within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than 72 hours from receipt of the request and, where applicable, information reasonably necessary in order to make a prior authorization decision; for other services, within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than five (5) business days from receipt of the request and, where applicable, information reasonably necessary in order to make a prior authorization decision. The treating provider will be notified of the decision within 24 hours followed by written notice, and Members will be notified within two (2) business days of the decision.

You will have the opportunity to be an active participant in your own health care. Please review this booklet, which summarizes the coverage and general provisions of Scripps Health Plan.

If you have any questions regarding the information, you may contact us by calling our Customer Service Department at **1-844-337-3700**. The hearing and speech impaired may contact Scripps Health Plan Customer Service Department through toll-free text telephone (TTY): **1-888-515-4065**.

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SUMMARY BENEFIT DESCRIPTION

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Covered Services	Member Cost-Sharing (when using network providers)
Calendar Year Medical Deductible	$0 per person / $0 per family
Calendar Year Out-of-Pocket Maximum (includes all copays)	$1,500 per person /$3,000 per family
Lifetime Maximum	Unlimited
Physician Services	
Primary Care Physician (PCP) Office Visit (in-person or telehealth) A woman may self-refer to an OB/GYN or family practice physician in her personal physician's medical group for OB/GYN services. This benefit also includes medically necessary home visits by a Plan physician.	$25 copay / visit
Specialist Office Visit	$40 copay / visit
Allergy Testing & Treatment	
Testing	$15 copay / visit
Injections / Serum	$10 copay / visit
Hospital Services	
Outpatient Surgery Prior authorization required.	$200 copay / visit
Inpatient Prior authorization required for non-emergent admissions, member copay applies to all covered Inpatient services, see **Benefit Descriptions** for more information.	$300 copay /admission
Transplant Services Prior authorization required.	Physician Services and Hospital Services copays apply.
Bariatric Surgery Prior authorization required.	Physician Services and Hospital Services copays apply.
Emergency Services	
Urgent Care Services	$45 copay / visit
Emergency Room Services	Covered 100% after $175 copay per visit (waived if admitted).

Covered Services	Member Cost-Sharing (when using network providers)
Copay waived if you are admitted to inpatient as a result of your Emergency Room visit, includes Physician Services.	
Ambulance Services Prior authorization required for non-emergent transport.	$150 copay
Preventive Services (age & frequency schedules apply)	
Routine Well Child Exams & Immunizations	$0 copay
Colorectal Cancer Screening, including colonoscopy following positive test/procedure result	$0 copay
Routine Gynecological Exams, to include cervical cancer screening	$0 copay
Routine Mammograms	$0 copay
Routine Adult Physical Exams, Immunizations, and Preventive Care	$0 copay
Outpatient Diagnostic Procedures	
Diagnostic Lab	$0 copay
Diagnostic X-Ray	$0 copay
Advanced Diagnostic Imaging (CT, MRI, PET) Prior Authorization required.	$150 copay / visit / test
Genetic Testing Prior authorization required.	$250 copay / lab visit
Biomarker Testing Prior authorization is NOT required for members with advanced or metastatic stage 3 or 4 cancer. Medically necessary biomarker testing is covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a member's disease or condition to guide treatment decisions.	$0 copay
Mental Health & Substance Use Disorders (Provided by Magellan Health) (See **Benefit Descriptions**, some services require prior authorization)	
Inpatient Mental Health and Substance Use Disorder Services Prior authorization required for non-emergent admissions, member copay applies to all covered Inpatient services, see **Benefit Descriptions** for more information.	Covered 100% after $300 copay / admission
Residential Care for Mental Health or Substance Use Disorder Condition	Covered 100% after $300 copay / admission

Covered Services	Member Cost-Sharing (when using network providers)
Prior authorization required for non-emergent admissions, member copay applies to all covered Inpatient services, see **Benefit Descriptions** for more information.	
Outpatient Office Visit (in-person or telehealth) With a psychiatrist, psychologist, or other non-physician mental health provider.	$25 copay / visit
Individual or Group Counseling, Evaluation & Treatment	$25 copay / visit
Outpatient Therapy for Gender Dysphoria	$25 copay / visit
In-Office Behavioral Health Treatment for Autism Spectrum Disorder Prior authorization is required.State law recommends the adoption of an Individual Treatment Plan, see **Benefit Descriptions** for more information.	$25 copay / visit
Outpatient Monitoring for Drug Therapy	$25 copay / visit
Outpatient Monitoring for Detox	$25 copay / visit
Partial Hospitalization (Day Programs) Prior Authorization is required.	$0 copay / visit
Intensive Outpatient Treatment Prior Authorization is required.	$0 copay / visit
Outpatient Psychiatric Observation Prior Authorization is required.	$0 copay / visit
Transcranial Magnetic Stimulation (TMS) Prior Authorization is required.	$0 copay / visit
Electroconvulsive Therapy (ECT) Prior Authorization is required.	$0 copay / visit
Psychological Testing Prior Authorization is required.	$0 copay / visit
Non-Emergency Psychiatric Transportation For emergency transport and medically necessary transport, prior authorization required for non-emergent transport.	$150 copay
Community Assistance, Recovery, and Empowerment (CARE) Court Program Services Includes evaluation and provision of health care services when required/recommended pursuant to a CARE agreement/plan approved by a court by an in-network or out-of-network provider. (Prior authorization and cost-sharing	$0 copay / visit

Covered Services	Member Cost-Sharing (when using network providers)
may be required for prescription drugs. See Prescription Drugs section.)	
Family Planning Services Copayments listed in this section are for outpatient Physician services only. If services are performed at a facility (Hospital, Ambulatory Surgery Center, etc.), the facility Copayment listed under the applicable facility benefit in the **Summary of Benefits** will also apply.	
Clinical Services for Contraception Includes consultations, examinations, procedures, device insertion/removal, ultrasound, anesthesia, patient education, referrals, counseling, and management of side effects.	Copay of administering provider (PCP or Specialist) / visit / provider.
Contraceptives Includes all FDA approved contraceptive drugs, devices, and other products, including over the counter at in-network pharmacies.	$0 copay
Tubal Ligation/Similar Sterilization Procedures	$0 copay
Vasectomy	$0 copay
Infertility Treatment Prior authorization is required.	Physician Services and Hospital Services copay.
Prescription Infertility Drugs	See **Prescription Drugs** section**.**
Abortion Services	$0 copay
Maternity & Newborn Care	
Prenatal and Postnatal Physician Office Visits	$0 copay
Medically Necessary Ultrasound	$0 copay
Inpatient Delivery of Newborn	Covered 100% after $300 copay / admission
California Pre-Natal Testing	$0 copay
Breast Pump Rental or Purchase	$0 copay
Newborn & Well-Baby Assessments	$0 copay
Doula Program Prior Authorization is required.	$0 copay
Other Services	
Outpatient Rehabilitation Therapy Includes Speech, Physical, and Occupational Therapy, prior authorization required.	$30 copay / visit
Cardiac & Pulmonary Rehabilitation	$30 copay / visit
Durable Medical Equipment Prosthetics, Orthotics, and other Supportive Devices.	Covered 100% after $250 deductible.
Hearing Aids	$150 copay

Covered Services	Member Cost-Sharing (when using network providers)
Limit one set for 36 months.	
Skilled Nursing Facility (SNF) Services 100 day maximum per member, per calendar year, prior authorization required.	$0 copay / admission
Home Health Care – Including home visits by a nurse, home health aide, medical social worker, physical therapist, speech therapist or occupational therapist 120 days maximum per member, prior authorization required.	$0 copay / visit
Home Infusion Therapy	$0 copay
Inpatient/Outpatient Hospice	$0 copay
Office/Facility-Based Infusion Therapy	Physician Services and Hospital Services copay.
Acupuncture & Chiropractic Services (provided by ASH Plans of California)	
Acupuncture Services Limited to 20 visits per calendar year, combined with Chiropractic Services.	$15 copay / visit
Chiropractic Services Limited to 20 visits per calendar year, combined with Acupuncture Services.	$15 copay / visit
Telehealth Services (Provided by Doctor on Demand)	
Provider Video Visits Includes medical or mental health consultations.	$25 copay / video visit
Prescription Drugs (Provided by MedImpact)	
Deductible	$0
Prescription Drug Out-of-Pocket Maximum	$3,000 Individual /$5,500 Family
Retail Pharmacy Contraceptives (up to 12 mos.) Generic – Tier 1 High-Cost Generic/Brand (formulary) – Tier 2 Brand (non-formulary) – Tier 3	Up to a 30-day supply $0 copay $20 copay* $50 copay* $90 copay*
Retail **Choice90** Pharmacy or **Mail Order** Contraceptives (up to 12 mos.) Generic – Tier 1 High-Cost Generic/Brand (formulary) – Tier 2 Brand (non-formulary) – Tier 3	Up to a 90-day supply $0 copay $40 copay* $125 copay* $270 copay*
Brand Name Drugs. If you or your physician requests a brand name drug when a lower-cost generic drug is available, you will be required to pay the difference in price, plus the applicable copay. These additional amounts will not apply to your annual out-of-pocket maximum. If no therapeutic equivalent generic substitute is available for an original, brand name contraceptive, there is a $0 copay.	

Covered Services	Member Cost-Sharing (when using network providers)
Specialty Medications – Tier 4	30% coinsurance per prescription. $125 minimum copay per prescription. $250 maximum copay per prescription. * $250 maximum copay per 30-day prescription for oral anticancer medication. * You can receive up to a 30-day supply of medication through the specialty mail service provider.

**Not to exceed 50% of the plan cost.*

1. ELIGIBILITY AND ENROLLMENT

To participate as a member in the Plan, you must meet the eligibility criteria in this "Eligibility and Enrollment" section, as well as eligibility criteria established by your employer. If you have questions about becoming eligible for coverage through your employer or qualifying a dependent, contact your Human Resources Benefits Manager.

Who is Covered?

The following individuals may be claimed as dependents under your Scripps Health Plan:

- Your legal Spouse or Domestic Partner,
- Your dependent children or children for whom you have legal custody (up to age 26),
- Dependent adult children over 26 (with a qualifying disability or handicap),
- Newborns, adopted children and individuals to be covered through guardianship.

Dependent children will not lose coverage due to enrolling or dis-enrolling in secondary or post-secondary education.

Dependents can be added to the plan during the Open Enrollment period or following a Qualifying Event. Qualifying Events include:

- Marriage or establishment of a Domestic Partnership,
- The birth of a child,
- The adoption of a child,
- Appointment as one's Guardian.

You will need to report any new dependents by completing a change form, which is available from your employer. The form must be completed and returned to Scripps Health Plan within thirty (30)

days of the change. If you do not return the form within thirty (30) days of the change, you will need to make the changes during the next annual enrollment period.

Newborns are automatically covered for the first 30 days of life. During that period, you will be required to complete an Enrollment Form to enroll your newborn for health coverage beyond the initial 30 days after the date of birth.

A young adult reaching 26 years of age may be eligible to continue coverage due to a permanent/long-term disability. Qualifying individuals must have a physically or mentally disabling injury, illness or condition and be chiefly dependent upon the primary beneficiary for support and maintenance. Notice will be provided to you at least ninety (90) days before a dependent child reaches 26 years of age – included with a request that if you care for dependents qualifying under this provision, you respond within 60 days with proof of dependency or incapacity of the individual. You will be asked to provide verification of incapacity/dependency annually.

If you have questions about Eligibility and Enrollment, contact your Human Resources Benefits Manager. You can also contact our Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065.**

Effective Date of Coverage

Your Plan and coverage become effective the first day that you qualify as an Eligible Employee, as defined by your employer. Your employer may require a waiting period prior to becoming eligible to receive health benefits and is responsible for notifying Scripps Health Plan when employees become eligible. To determine if your employer includes a waiting period before becoming benefit-eligible, contact your Human Resources Benefits Manager.

2. HOW TO USE THE PLAN

Choice of Physicians and Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

A close physician-to-patient relationship helps to ensure the best medical care. To support effective management of your care, each Member is required to select a Primary Care Physician (PCP) at the time of enrollment. A directory of In-Network providers is available online at **www.ScrippsHealthPlan.com**. If you need assistance in selecting your PCP, contact our Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**. You may also request a printed version of the Provider Directory by contacting Customer Service or downloading the Provider Directory from our web site **www.ScrippsHealthPlan.com**.

It is your responsibility to access the website or contact Customer Service to verify if the provider is accepting new patients, prior to selecting a PCP. If you do not select a PCP at the time of enrollment, the Plan will designate a PCP for you, and you will be notified of the name of the

designated PCP. This designation will remain in effect until you notify the Plan of your selection of a different PCP.

A PCP must also be selected for a newborn or an adopted child within 30 days from the date of birth or placement for adoption. You may designate a pediatrician as the PCP for your child. You cannot preselect the newborn's medical group. The PCP selected for the month of birth must be in the same medical group as the mother's PCP when the newborn is the natural child of the mother. If the mother of the newborn is not enrolled as a Member or if the child has been placed with the Subscriber for adoption, the PCP selected must be a physician in the same medical group as the Subscriber. If you do not select a PCP within thirty (30) days following the birth or adoption, the Plan will designate a PCP from the same medical group as the natural mother of the Subscriber. You can change the child's PCP and medical group. The effective date of your child's new medical group will be the first of the month following discharge from the hospital. If you want to change the PCP for the child after the month of birth or placement for adoption, see the section below on "Changing PCP or Designated Medical Group." If your child is ill during the first month of coverage, be sure to read the information about changing PCPs during a course of treatment or hospitalization, under the "Changing PCPs or Designated Medical Group" sections.

Remember, coverage will cease on the 30th day at 11:59pm Pacific Time following the dependent's date of birth or placement for adoption, unless an application for the addition of the dependent is submitted and received by Scripps Health Plan prior to the 30th day. If you have any questions, please contact your Employer.

Role of the Medical Group

Most Scripps Health Plan PCPs contract with medical groups to share administrative and authorization responsibilities with them. Your PCP coordinates with your designated medical group to direct all your medical care needs and refer you to specialists or hospitals within your designated medical group unless, because of your health condition, care is unavailable within the medical group.

Your designated medical group and Scripps Health Plan ensures that a full panel of specialists is available to provide for your health care needs and help your PCP manage the utilization of your health plan benefits by ensuring that referrals are directed to providers who are contracted with them. Medical groups also have admitting arrangements with hospitals contracted with Scripps Health Plan in their area and some have special arrangements that designate a specific hospital as "in-network." Your designated medical group works with your PCP to authorize services and ensure that services are performed by their in-network provider. In some cases, a non-Scripps Health Plan provider may provide Covered Benefits at an in-network facility where we have authorized you to receive care. You are not responsible for any amounts beyond your in-network cost share for the Covered Benefits you receive at an in-network facility where we have authorized you to receive care.

Scripps Health Plan shall arrange for the provision of Covered Benefits from providers outside its network if unavailable within the network if Medically Necessary for a Member's condition. For Medically Necessary referrals to non-network providers, your cost share will not exceed applicable in-network copayments, coinsurance, and deductibles.

The name of your PCP and your designated medical group is listed on your Scripps Health Plan member identification card. The Scripps Health Plan Customer Service Department can answer any questions you may have about changing the medical group designated for your PCP and whether the change would affect your ability to receive services from a particular specialist or hospital. You may call our Customer Care Service Department toll-free at **1-844-337-3700** with any questions, or for the hearing and speech impaired TTY: **1-888-515-4065**.

Changing PCPs or Designated Medical Group

You or your dependent may change PCPs or designated medical group at any time by calling our Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**. You may choose a different PCP and/or medical group for each family member. PCP changes are effective the first of the month following your requested change. You can also find a PCP by visiting **www.ScrippsHealthPlan.com** and selecting the *Find a Doctor* link at the top of the Web page.

If you change to a medical group with no affiliation to your PCP, you must select a new PCP affiliated with the new medical group and transition any specialty care you are receiving to specialists affiliated with the new medical group. The change will be effective the first day of the month following notice of approval by Scripps Health Plan. Once your PCP change is effective, all care must be provided or arranged by the new PCP with the exception of OB/GYN services that are not provided by your PCP. You are not required to obtain a referral or prior authorization for sexual and reproductive health care services, or for OB/GYN services. OB/GYN services must be provided by an obstetrician/gynecologist or a family practice physician within the same medical group as your PCP. Once your medical group change is effective, all previous authorizations for specialty care or procedures are no longer valid and must be transitioned to specialists affiliated with the new medical group, even if you remain with the same PCP.

Voluntary medical group changes are not permitted during the third trimester of pregnancy or while confined to a hospital. The effective date of your new medical group will be the first of the month following discharge from the hospital or when pregnant, following the completion of post-partum care.

Additionally, changing your PCP or designated medical group during a course of treatment may interrupt the quality and continuity of your health care. For this reason, the effective date of your new PCP or designated medical group, when requested during a course of treatment, will be the first of the month following the date it is medically appropriate to transfer your care to your new PCP or designated medical group, as determined by the Plan.

Request for an exception to this policy may be reviewed and approved by the Medical Director. For information about approval for an exception to the above provisions, please contact Customer Service.

If your PCP discontinues participation in the Plan, Scripps Health Plan will notify you in writing and designate a new PCP for you to ensure immediate access to medical care. You can select a different PCP at any time by contacting Customer Service. Your selection must be approved by Scripps Health Plan prior to receiving any services under the Plan. In the event that your selection has not been approved and an emergency arises, refer to the "**Emergency Services and Care"** section within the "Benefit Descriptions" for information.

NOTE: IT IS IMPORTANT TO KNOW THAT WHEN YOU ENROLL IN SCRIPPS HEALTH PLAN, SERVICES ARE PROVIDED THROUGH THE PLAN'S DELIVERY SYSTEM, BUT THE CONTINUED PARTICIPATION OF ANY ONE DOCTOR, HOSPITAL, OR OTHER PROVIDER CANNOT BE GUARANTEED.

Continuity of Care by a Terminated or Non-Participating Provider

Completion of Covered Benefits by a terminated or non-participating provider may be provided under certain conditions. If you are a new Member to the Plan, or if your provider's contract with the Plan ends, you may request to continue treatment with your current provider for the following Covered Benefits:

- **An Acute Condition** – Completion of Covered Benefits shall be provided for the duration of the acute condition,
- **A Serious Chronic Condition** (example: medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration) – Completion of Covered Benefits for a serious chronic condition shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage for a newly enrolled member,
- **A Serious and Complex Medical Condition** (example: acute illness, a condition serious enough to require specialized medical care to avoid reasonable possibility of death or permanent harm or a chronic illness or condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged time) – Completion of Covered Benefits shall be provided for the time period necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the Plan in consultation with the Member and the terminated/non-participating provider and consistent with good professional practice. Completion of Covered Benefits shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage with the Plan,
- **A Pregnancy** – Completion of Covered Benefits shall be provided for the duration of the pregnancy,
- **A Maternal Mental Health Condition** – Completion of Covered Benefits shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later,

- **Care of a Newborn Child Between Birth and Age 36 Months** - Completion of Covered Benefits shall not exceed 12 months from the contract termination date or 12 months from the effective date of coverage with the Plan,
- **Performance of a Surgery or Other Procedure (Including Postoperative Care)** – Authorized by the Plan as part of a documented course of treatment and has been recommended and documented by the non-contracting provider to occur within 180 days of the contract's termination date or within 180 days of the effective date of coverage with the Plan,
- **Inpatient or Institutional Treatment -** Completion of Covered Benefits shall last the earlier of 90 days from the date the notice of the right to elect continuing care is provided to the Member or the date on which the Member is no longer undergoing continuing care by that provider or facility,
- **A Terminal Illness** – Completion of Covered Benefits shall be provided for the duration of a terminal illness, which may exceed 12 months from the contract termination date or 12 months from the effective date of coverage with the Plan.

If a condition falls within a qualifying condition under state and federal law, the more generous time frames would be followed.

Member cost-sharing during the period of completion of Covered Benefits will be the same as if the Member was receiving care from an in-network provider.

If the non-contracting provider does not agree to comply with the Plan's contractual terms and conditions that are imposed upon current contracted providers, or if the provider has been terminated for reasons related to a medical disciplinary cause, we will not approve the request for continuity of care services. Further, new Members who were offered an out-of-network option or who had the option to continue with their previous health plan or provider and instead voluntarily chose to change health plans, are not eligible for continuity of care with their provider.

Contact Customer Service at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065** to receive information regarding eligibility criteria and the policy and procedure for requesting continuity of care from a terminated or non-participating provider. You may also access a Continuity of Care (CoC) form on our website at **www.ScrippsHealthPlan.com**.

Relationship with Your PCP and Other Physicians

If you or your dependents are not able to establish a satisfactory relationship with your PCP or other treating physician, Scripps Health Plan will provide access to other available providers. If you would like to file a Grievance about a provider, see the "Grievance Process" section of this Evidence of Coverage for information on filing a grievance.

How to Receive Care

At the time of enrollment, you will choose a PCP who will coordinate all Covered Benefits. You must contact your PCP for all health care needs including preventive services, routine health problems, consultations with Plan specialists (except as provided under Obstetrical/ Gynecological (OB/GYN) Physician Services, reproductive and sexual health care, and Mental Health or Substance Use

Disorder Services), admission into a hospice program through a participating hospice agency, Emergency Services and Care, urgent services and for hospitalization. Your PCP is responsible for providing primary care and coordinating or arranging for referral to other necessary health care services and requesting any needed prior authorization.

You should cancel any scheduled appointments at least 24 hours in advance. This policy applies to appointments with or arranged by your PCP or any other provider. Because your physician has set aside time for your appointments in a busy schedule, you need to notify the office within 24 hours if you are unable to keep the appointment. This allows the office staff to offer that time slot to another patient who needs to see the physician. If you have not selected a PCP for any reason, please contact the Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**. Monday through Friday, between 8:00a.m. and 5:00p.m. Pacific Standard Time to select a PCP.

Obstetrical/Gynecological (OB/GYN) Physician Services

A Member may arrange for obstetrical and/or gynecological (OB/GYN) services by an OB/GYN or a family practice physician who is not their designated PCP. A referral from a PCP or from the affiliated medical group is not needed. However, the OB/GYN or family practice physician must be in the same medical group as their PCP. A member may also designate an OB/GYN to serve as their Primary Care Physician when the OB/GYN agrees to function as a Primary Care Physician.

OB/GYN are defined as:

- Physician services related to prenatal, perinatal and postnatal (pregnancy) care,
- Physician services provided to diagnose and treat disorders of the female reproductive system and genitalia,
- Physician services for treatment of disorders of the breast,
- Routine annual gynecological examinations/annual well-woman examinations.

It is important to note that services by an OB/GYN or a family practice physician outside of the PCP's medical group without authorization will not be covered under this Plan. Before making the appointment, the Member should call the Customer Service Department at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065** to confirm that the OB/GYN or family practice physician is in the same medical group as their PCP. Members are not required to obtain a referral or prior authorization to access reproductive and sexual health care.

Doula Program

Our doula services are part of our efforts to improve access to pregnancy care. Our goal is a healthy outcome for parent and baby.

With a referral, you are eligible for the following doula services:

- One (1) initial visit with your doula.

- Up to eight (8) additional visits; these can be a combination of prenatal and postpartum visits.
- Support during labor and delivery (including labor and delivery resulting in a stillbirth, abortion or miscarriage).
- Up to two (2) three-hour postpartum visits.

Members can get doula services up to 12 months after the end of pregnancy.

Referral to Specialty Services and Prior Authorization

You can receive specialty services through a referral from your PCP. Your PCP is responsible for coordinating all your health care needs and can best direct you for required specialty services. Your PCP will generally refer you to a Plan specialist or Plan non-physician health care practitioner in the same medical group as your PCP. If the type of specialist or non-physician health care practitioner you need is not available within your PCP's medical group, you may be referred outside of your medical group for care. Your PCP will request any necessary prior authorization from your medical group or the Plan. The Plan specialist or Plan non-physician health care practitioner will provide a complete report to your PCP so that your medical record is complete.

Prior Authorization

Some services require approval or prior authorization before you can receive services. Prior authorization requirements for certain services help to assure that you are getting the services you need when you need them. You, your primary care physician, or specialist may need to submit a prior authorization request for additional services. You should always work with your treatment team to make sure that when authorization is required, the provider has received that authorization prior to rendering services. You will be notified in writing of the determination status of all prior authorization requests. An authorization approval letter will include the name of the provider and the effective dates for the authorization. A denial letter will include the reason for the denial and your rights to appeal the decision.

For Mental Health or Substance Use Disorder services, Scripps Health Plan has partnered with Magellan[1] to provide our members access to Magellan's network of mental health practitioners and facilities. Magellan requires prior authorization for non-emergent inpatient admissions and certain Outpatient Services. For more information about prior authorization requirements for Mental Health or Substance Use Disorder Services, refer to the "Inpatient and Outpatient Mental Health or Substance Use Disorder Services" sections in the Benefit Descriptions. You can also obtain a copy of nonprofit professional associations' Mental Health or Substance Use Disorder clinical review criteria, education programs, and training materials by contacting Magellan's Customer Service at **1-866-272-4084** (or TTY: **711**)**.**

[1] In California, Magellan is doing business as Human Affairs International of California, Inc.

Typically, your physician will contact Scripps Health Plan to obtain prior authorization; but you are ultimately responsible for ensuring that the prior authorization process is followed.

Prior authorization is NOT required for:

- Emergency Services and Care,
- Family planning services, including abortion services and FDA-approved contraceptive drugs, devices, and other products,
- Vasectomy services and procedures,
- Preventive care, such as immunizations and annual physicals,
- Basic prenatal care,
- Sexually transmitted disease (STD) services,
- Human immunodeficiency virus (HIV) testing,
- FDA-approved biomarker testing indicated for Members with advanced or metastatic stage 3 or 4 cancer.

Turnaround time once a prior authorization has been submitted:

- **Routine requests and concurrent reviews**: Within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than 5 business days from the receipt of the request and, where applicable, information reasonably necessary in order to make a prior authorization decision,

- **Expedited**: Within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than 72-hours from the receipt of the request and, where applicable, information reasonably necessary in order to make a prior authorization decision (because your provider believes that your condition is life-threatening). If the request is not deemed to be urgent to the Scripps Health Plan clinical reviewers based on the information submitted, we will make a decision in no more than 5 business days,

- **Extension**: An extension may be needed for Scripps Health Plan to obtain additional clinical information or consultation by an expert reviewer necessary to make a determination. For expedited requests, providers and members are given 48 hours to submit additional clinical information. For routine requests, providers and members are given 45 calendar days to submit additional clinical information,

- **Routine Requests for Pharmacy Prior Authorization**: Within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than within 72-hours from receipt of the request and, where applicable, information reasonably necessary in order to make a prior authorization decision,

- **Expedited Pharmacy or drug requests**: Within the shortest applicable timeframe that is appropriate for the Member's condition, but no longer than 24-hours from the receipt of the request and, where applicable, information reasonably necessary in order to make a prior authorization decision (if your provider believes that your condition is life-threatening).

Scripps Health Plan maintains a list of services that require prior authorization. Contracted providers have a list of what services require prior authorization. Providers can also contact Scripps Health Plan's utilization management department if they have any questions or need more information on criteria. You can get the criteria that decisions are based upon by contacting Scripps Health Plan Customer Service. You have the right to review the list of services that require authorization and to know how we make decisions.

The materials provided to you are the guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual needs and the Covered Benefits under your contract.

Services that require prior authorization include:

- Inpatient and outpatient surgery,
- Provider administered Injectable medications,
- Durable Medical Equipment (DME), this includes power wheelchairs, nebulizers, etc.

When Services are not Approved as Requested

If Scripps Health Plan does not fully approve a requested service or denies the service, you will receive a notification that your request was denied in whole or in part. Reasons why we might make this decision include:

- The requested service was not a Covered Benefit,
- The requested service was not Medically Necessary,
- The requested service is approved in an amount that is less than what was requested,
- The requested service is for a continuation of a service that you are currently receiving, and the continuation is either fully denied or approved in an amount less than what was asked.

Inside the notification, you will be informed of the following:

- What action was taken and the reason for the decision,
- Your right to file an appeal and our appeals process,
- Your right to request a review by a different Scripps Health Plan qualified health professional,
- Your right to ask for an expedited resolution, and how to make an expedited request,
- Your right to continue to receive health services if you decide to appeal,
- How to request that your Covered Benefits continue,
- Your right to ask for an extension for you to provide additional information that may help in an appeal decision.

Obtaining a Standing Referral

You may obtain a standing referral to a specialist if your PCP and the Specialist determine that continuing care is necessary from a specialist. The referral will be part of a treatment plan and the referral may be limited to a certain number of visits, may be limited to a certain period of time. If you have a condition or disease requiring specialized medical care for a prolonged period and that is a life-threatening, degenerative, or disabling condition, including mental health or substance use

disorder conditions, you may receive a referral to a specialist or specialty care center with expertise to treat the disease or condition, for the purpose of coordinating care, if the primary care physician and specialist or specialty care center, if any, and plan medical director, determine it is Medically Necessary. The referral will be part of a treatment plan if Medically Necessary. A referral will be made to a health plan's participating provider unless you receive prior authorization to see a specialist outside of a health plan's network. If there is no qualified specialist within the health plan network to provide appropriate treatment you may be referred to a non-contracted provider; in this case, you would be liable for in-network copays.

NOTE: You will receive a decision within three (3) business days of the date of the request if all appropriate medical records and other necessary information to make the decision are provided.

Prior Authorization for Acupuncture and Chiropractic Benefits

Scripps Health Plan is working with American Specialty Health Plans of California, Inc. (ASH Plans) to allow members access to their network of over 700 licensed practitioners in San Diego County. Members can self-refer to practitioners that are part of the ASH Plans network. Should a member's treatment plan require any authorization, the practitioner will contact ASH Plans to initiate and obtain authorization for services. To learn more about Prior Authorization requirements for Acupuncture and Chiropractic Benefits, contact ASH Plans by phone at **1-800-678-9133.**

Second Opinions

You have the right to request a Second Medical Opinion if you have questions or concerns about your care or treatment plan. A Second Opinion may be requested for either medical, or Mental Health or Substance Use Disorder services. You may request a Second Opinion if:

- If you question the reasonableness or necessity of recommended surgical procedures,
- If you question a diagnosis or treatment plan for a condition that threatens loss of life, limb or bodily function or for a serious chronic condition,
- If you don't understand why certain care is being recommended or prescribed to you,
- If a diagnosis is unclear due to conflicting test results,
- Your treatment plan does not appear to be improving your overall health condition.

The second opinion will be provided on an expedited basis, where appropriate. If you are requesting a second opinion, the second opinion will be provided by a physician within the same medical group as your PCP. If you are requesting a second opinion about care received from a specialist, the second opinion shall be provided by any Plan specialist of the same or equivalent specialty. All second opinion consultations must be pre-authorized. A second opinion will only be approved to an out-of-network provider, only if the services are not available in network. Your PCP may also decide to offer such a referral even if you do not request it. State law requires that health plans disclose to members, upon request, the timelines for responding to a request for a second opinion. To request a copy of these timelines, you may call the Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**.

After Hours

Your primary care physician or a designated covering physician (including mental health providers) will be available to you by telephone 24 hours a day, 7 days a week. When you need care after hours, on weekends or on holidays, always try to call your doctor first. He or she will be able to direct you to the most appropriate place for treatment.

Mental Health or Substance Use Disorder Services

Your plan covers the Medically Necessary treatment of Mental Health or Substance Use Disorders, which includes those mental health conditions or substance use disorders identified in the most recent editions of the International Classification of Diseases or the Diagnostic and Statistical Manual of Mental Disorders. Your Covered Benefits include basic health care services, as defined in Definitions section of this document; intermediate services, including the full range of levels of care, including, but not limited to, residential treatment, partial hospitalization, and intensive outpatient treatment; and prescription drugs. Your Covered Benefits for Mental Health or Substance Use Disorder services are not limited to short-term or acute treatment. Scripps Health Plan has contracted with Magellan, a Mental Health Service Administrator (MHSA), to underwrite and deliver all mental health, including maternal mental health, and substance use disorder services through a unique network of mental health Participating Providers. All non-emergency Mental Health or Substance Use Disorder services must be arranged through Magellan. You do not need a referral from your PCP to access Mental Health or Substance Use Disorder services.

All mental health, including maternal mental health, and substance use disorder services, except for emergency or urgent services, must be provided by a Magellan Participating Provider. A list of Magellan Participating Providers is available in the online Scripps Health Plan Provider Directory. Additionally, some services require prior authorization from Magellan (see the "Inpatient Mental Health or Substance Use Disorder Services" and "Outpatient Mental Health or Substance Use Disorder Services" sections for more information). A link to a list of Magellan Participating Providers is available on our website at **www.ScrippsHealthPlan.com** – click on *Find a Doctor* and follow the link under **Behavioral Health Providers**. Members may also contact Magellan directly for information and to select a Magellan Participating Provider by calling **1-866-272-4084** or for the hearing and speech impaired TTY: **711**. Your PCP may also contact Magellan to obtain information regarding Magellan Participating Providers for you. Nonprofit professional associations' Mental Health or Substance Use Disorder clinical review criteria, education programs, and training materials are available to you by contacting Magellan's Customer Service.

Non-emergency Mental Health or Substance Use Disorder services received from a provider who does not participate in the Magellan Participating Provider network will not be covered, except for urgent or Emergency Services and Care, or services provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services. If you do not use a Magellan Participating Provider, you will be responsible for all charges. This limitation does not apply to urgent or Emergency Services and Care, or services provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services.

Behavioral health and wellness screenings for children and adolescents ages 8 to 18 are available to help identify mental health concerns early, for problems such as depression, anxiety, suicide risk, and drug and alcohol abuse. Examples of these screenings include GAD-7 (for anxiety), Columbia Depression Scale (depression), Suicide Behavior Questionnaire, and many others. The United States Preventive Services Task Force (USPSTF) recommends screening for anxiety beginning at age 8 and depression beginning at age 12. The American Academy of Pediatrics (AAP) also recommends depression and suicide risk screening during all well-child checks beginning at age 12. Early identification of concerns and early intervention can help prevent progression of mental health issues, improve long term outcomes, and reduce the negative impact on a child's development, helping to maintain overall well-being and quality of life.

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

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

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

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

In some cases, a non-Magellan provider may provide Covered Benefits at an in-network facility where Magellan has authorized you to receive care. You are not responsible for any amounts beyond your in-network cost share for the Covered Benefits you receive at an in-network facility where Magellan has authorized you to receive care. For complete information regarding Covered Benefits for Mental Health or Substance Use Disorder services, please refer to the "Inpatient Mental Health or Substance Use Disorder Services" and "Outpatient Mental Health or Substance Use Disorder Services" sections within the Benefit Descriptions.

Prior Authorization for Mental Health Admissions:

Prior authorization is required for all non-emergency Mental Health Hospital inpatient admissions including acute inpatient care and Residential Care. The provider should call Magellan at **1-866-272-4084** at least five (5) business days prior to the admission.

See the "Inpatient and Outpatient Mental Health or Substance Use Disorder Services" sections for a full list of services requiring prior authorization. Magellan will render a decision on all requests for prior authorization of services as follows:

- For urgent services, as soon as possible to accommodate the Member's condition not to exceed 72 hours from receipt of the request,
- For other services, within five (5) business days from receipt of the request. The treating provider will be notified of the decision within 24 hours followed by written notice to the provider and Member within two (2) business days of the decision.
- For all delayed, denied, or modified prior authorization requests for mental health/substance use disorder services, the Plan shall provide all utilization review determination criteria and any education program materials relied upon in rendering the adverse determination upon your request and at no cost to you.

Prior authorization is not required for an emergency admission.

24-Hour Psychosocial Support:

Notwithstanding the Covered Benefits provided under Outpatient Mental Health or Substance Use Disorder Services, the Member also may call **1-866-272-4084** on a 24-hour basis for confidential psychosocial support services. Professional counselors will provide support through assessment, referrals, and counseling.

Emergency Services and Care

What is an Emergency:

An emergency means a medical and/or psychiatric screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate licensed persons 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, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility.

What to do in case of Emergency: Members who reasonably believe that they have an emergency medical or mental health condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system or go to the nearest hospital emergency room.

Life Threatening: Obtain care immediately. Contact your PCP no later than 24 hours after the onset of the emergency, or as soon as it is medically possible for the Member to provide notice.

Non-Life Threatening: Consult your PCP, anytime day or night, regardless of where you are prior to receiving medical care.

Post-Stabilization: Once your Emergency Medical Condition or Psychiatric Emergency Medical Condition has stabilized, your treating health care provider may believe that you require additional Medically Necessary hospital services prior to your being safely discharged. Contracted and non-contracted hospitals are required to timely notify the plan once you are clinically stable for prior-authorization to provide post-stabilization care or to arrange for a post-stabilization transfer. If the plan determines that you may be safely transferred to a plan contracted hospital, and you refuse to consent to the transfer, the hospital must provide you written notice that you will be financially responsible for 100% of the cost for services provided to you once your emergency condition is stable. Also, if the hospital is unable to determine your name and contact information of the plan in order to request prior authorization for services once you are stable, it may bill you for such services.

Follow-Up Care: Follow-up care, which is any care provided after the initial emergency room visit, must be provided or authorized by your PCP. For a complete description of the Emergency Services and Care benefit and applicable copayments, see the "Emergency Services and Care" section within Benefit Descriptions.

Follow-Up Healthcare Treatment: Medical or surgical services for the diagnosis, prevention or treatment of medical conditions arising from an instance of rape or sexual assault. For a complete description of the Emergency Services benefit and applicable copayments, see the "Emergency Services" section within Benefit Descriptions.

If you have an Emergency Medical Condition and get Emergency Services and Care from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these Emergency Services and Care. We may attempt to negotiate with the provider or pay an additional amount to resolve the claim. If we pay more, your cost share will not increase. You should ensure the out-of-network provider or facility has a copy of your insurance card prior to discharge.

NOTE: IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR SERVICES THAT YOU RECEIVED FROM A NON-CONTRACTED PROVIDER, PLEASE CONTACT SCRIPPS HEALTH PLAN TOLL FREE AT 1-844-337-3700 OR FOR THE HEARING AND SPEECH IMPAIRED TTY: 1-888-515-4065.

Urgent Care Services

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

Contact your PCP or your assigned medical group to be directed to the appropriate urgent care that is within your PCP's medical group. An urgent condition is not an emergency but may require

prompt medical attention. If you require urgent care for a condition that could reasonably be treated in your PCP's office or in an urgent care clinic (i.e., care for a condition that is not such that the absence of immediate medical attention could reasonably be expected to result in placing your health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part), contact your PCP or your assigned medical group to be directed to the appropriate urgent care that is within your PCP's assigned medical group.

Prior Authorization for Inpatient Medical-Surgical, Home Health Care, and Other Services

Your PCP is responsible for obtaining prior authorization before you can be admitted to the hospital or a skilled nursing facility, including sub-acute care admissions, except for Mental Health or Substance Use Disorder services which are described in the previous "Mental Health or Substance Use Disorder Services" section. Your PCP is responsible for obtaining prior authorization before you can receive home health care and certain other services or before you can be admitted into a hospice program through a participating hospice agency. If your PCP determines that you should receive any of these services, he or she will request authorization. Your PCP will arrange for your admission to the hospital, skilled nursing facility, or a hospice program through a participating hospice agency, as well as for the provision of home health care and other services. For hospital admissions for mastectomies or lymph node dissections, the length of hospital stays will be determined solely by the Member's physician in consultation with the Member. For information regarding length of stay for maternity or maternity-related services, please refer to the "Pregnancy and Maternity Care" section.

Liability of Member for Payment

You are responsible for obtaining required referrals or prior authorization for Covered Benefits. You are not required to obtain prior authorization for PCP services, outpatient mental health or substance use disorder office visits, Emergency Services and Care, and OB/GYN services.

You will be responsible for all applicable copayments or coinsurance for receiving Covered Benefits. You are responsible for all care that is rendered without the appropriate referral or prior authorization.

You may be responsible for paying a minimum charge, or copayment, to the physician or provider of services at the time you receive services. The specific copayments, as applicable, are listed in the Summary Benefit Description. In some cases, a non-Scripps Health Plan provider may provide Covered Benefits at an in-network facility where we have authorized you to receive care. You are not responsible for any amounts beyond your in-network cost share for the Covered Benefits you receive at an in-network facility where we have authorized you to receive care.

Other Charges

While obtaining coverage under this plan, you may incur charges and out-of-pocket costs such as copayments and coinsurance charges. Please refer to Summary of Benefits and Coverage or the

Summary Benefit Description for further information about copayments, coinsurance, deductibles, and out-of-pocket maximums. If you have any questions, please contact our Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**.

Member Calendar Year Out-of-Pocket Maximum

The Out-of-Pocket Maximum is the maximum total amount of copayments and deductibles you pay each calendar year for Covered Benefits, with certain exceptions. Once you reach your Out-of-Pocket Maximum, you will not be responsible for any copayments or deductibles for Covered Benefits. You must continue to pay your monthly contribution to your employer for your health plan premiums.

Once a Member's Out-Of-Pocket Maximum has been met, the Plan will pay 100% of the allowed charges for that Member's Covered Benefits for the remainder of that benefit year, except as described below. Once the family Out-Of-Pocket Maximum has been met, the Plan will pay 100% of the allowed charges for the Subscriber's and all covered dependents' Covered Benefits for the remainder of that calendar year, except as described below.

If an individual meets their Out-Of-Pocket Maximum before the family Out-Of-Pocket Maximum is reached, the Plan will pay 100% of the allowed charges for that individual; other family members shall continue to be responsible for copays until either (a) their individual Out-Of-Pocket Maximum for the year is met or (b) the family out-of-pocket maximum is met.

Once the benefit year Out-Of-Pocket Maximum requirement has been reached, the Member will receive a notification letter and no longer be assessed a deductible, copayment, or coinsurance. The Member must bring a copy of the letter to visits with participating providers for the remainder of the benefit year to ensure that copayments are not assessed. It is your responsibility to maintain accurate records of your copayments to determine when your benefit year out-of-pocket maximum responsibility has been reached.

You must notify Scripps Health Plan Customer Service in writing if you feel that your Member benefit year out-of-pocket maximum responsibility has been reached prior to receiving the notification letter. At that time, you must submit complete and accurate records to Scripps Health Plan substantiating your copayment expenditures for the period in question.

Scripps Health Plan
Attn: Customer Service
10790 Rancho Bernardo Road, 4S-300
San Diego, California 92127
Phone: 1-844-337-3700
TTY: 1-888-415-4065

Copayments for benefits not administered by the Plan, such as vision and dental care, do not apply towards the Calendar Year Out-of-Pocket Maximum.

Charges for services that are not covered or not authorized do not apply to the Out-of-Pocket Maximum. Please visit our website at **www.ScrippsHealthPlan.com** for a list of services requiring authorization.

Copayments and charges for services not accruing to the Member calendar year Out-Of-Pocket Maximum continue to be the Member's responsibility after the calendar year out-of-pocket maximum is reached.

Calendar Year Medical Deductibles

There are no benefit year medical deductibles to be met within your plan.

Limitation of Liability

Members shall not be responsible to Plan providers for payment for services if the services are a benefit of the Plan and when the member has received the required prior authorization for Covered Benefits. When Covered Benefits are rendered by a Plan provider, the Member is responsible only for the applicable copayments, except as set forth in the "Third Party Recovery Process and the Member's Responsibility" section. A Plan provider may not balance bill you for charges over the applicable Member responsibility. Members are responsible for the full charges for any non-Covered Benefits they obtain.

A member will be responsible for all charges for care that is not authorized or is not a Covered Benefit.

Member Identification Card

You will receive your Scripps Health Plan identification card after enrollment. If you do not receive your identification card or if you need to obtain medical or prescription services before your card arrives, contact the Scripps Health Plan Customer Service Department at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065** so that they can coordinate your care and direct you to a PCP or pharmacy.

Right of Recovery

Whenever payment on a claim has been made in error, Scripps Health Plan will have the right to recover such payment from the Subscriber or Member or, if applicable, the provider or another health benefit plan, in accordance with applicable laws and regulations. Scripps Health Plan reserves the right to deduct or offset any amounts paid in error from any pending or future claim to the extent permitted by law. Circumstances that might result in payment of a claim in error include, but are not limited to, payment of benefits in excess of the benefits provided by the health plan, payment of amounts that are the responsibility of the Subscriber or Member (deductibles, copayments, coinsurance or similar charges), payment of amounts that are the responsibility of another payer, payments made after termination of the Subscriber or Member's eligibility, or payments on fraudulent claims.

Customer Service Department

If you have a question about services, providers, Covered Benefits, how to use this plan, or concerns regarding the quality of care or access to care that you have experienced, you should call the Scripps Health Plan Customer Service Department at **1-844-337-3700**. The hearing impaired may contact Scripps Health Plan's Customer Service Department through our toll-free TTY number,

1-888-515-4065. Customer Service can answer many questions over the telephone.

If you have questions about your Pharmacy Benefits, you may contact Scripps Health Plan's Pharmacy Benefits Manager, MedImpact, by phone at **1-844-282-5343** or by fax at **1-858-549-1569**.

If you have questions about your Acupuncture/Chiropractic Benefits, you may contact American Specialty Health Plans of California, Inc. by phone at **1-800-678-9133**.

If you have questions about your Mental Health Benefits, you may contact Magellan, the Mental Health Service Administrator, by phone at **1-866-272-4084** (or TTY: **711**).

Expedited Decisions

Scripps Health Plan has established a procedure for our Members to request an expedited decision including those regarding appeals. A Member, physician, or representative of a Member may request an expedited decision when the routine decision-making process might seriously jeopardize the life or health of a Member, or when the Member is experiencing severe pain, or it is believed that a Member enrollment has been or will be improperly canceled, rescinded, or not renewed. Scripps Health Plan shall make a decision and notify the Member as soon as possible to accommodate the Member's condition not to exceed 72 hours following the receipt of the request. Physicians will be notified by Scripps Health Plan within 24-hours of making an expedited decision. An expedited decision may involve admissions, continued stay or other health care services. Concurrent care will not be discontinued until the provider has been notified and agrees with a plan of your care.

If we are unable to provide a decision or complete our review of an expedited decision request in the timeframe above, you and your provider will be notified in writing that we were unable to make the determination with the information provided or we need to consult other resources. You will be notified of the information that is incomplete, if action on your part is required and when we expect to make a determination.

If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact Scripps Health Plan Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**.

For All Mental Health or Substance Use Disorder Services

For all Mental Health or Substance Use Disorder services Scripps Health Plan has contracted with Magellan. Magellan should be contacted for questions about Mental Health or Substance Use Disorder services, Magellan's network of contracting providers, or Mental Health or Substance Use Disorder benefits. Nonprofit professional associations' Mental Health or Substance Use Disorder clinical review criteria, education programs, and training materials are available to you by contacting Magellan at **1-866-272-4084** (or TTY: **711**).

Magellan can answer many questions over the telephone. Magellan has established a procedure for our members to request an expedited decision. A member, physician, or representative of a member may request an expedited decision when the routine decision-making process might seriously jeopardize the life or health of a member, or when the member is experiencing severe pain, or it is believed that a member enrollment has been or will be improperly canceled, rescinded, or not renewed. Magellan shall make a decision and notify the Member and physician as soon as possible to accommodate the Member's condition, not to exceed 72 hours following the receipt of the request. An expedited decision may involve admissions, continued stay or other health care services. If you would like additional information regarding the expedited decision process, or if you believe your particular situation qualifies for an expedited decision, please contact Magellan at the number listed above. For information on additional rights, see the "Grievance Process" section.

Payment of Providers

Scripps Health Plan generally contracts with groups of physicians to provide services to Members. A fixed, monthly fee is paid to these groups of physicians for each Member whose PCP is in the group. This payment system, capitation, includes incentives to the groups of physicians to manage all services provided to Members in an appropriate manner consistent with the Agreement. If you want to know more about this payment system, contact Customer Service at **1-844-337-3700,** TTY: **1-888-515-4065** or talk to your Plan provider. By law, every contract between the Plan and a provider shall provide that in the event the health plan fails to pay the provider, the Member shall not be liable to the provider for any sums owed by the health plan.

3. PREMIUMS

Premiums are collected by your employer and paid directly to Scripps Health Plan. You are not responsible for paying monthly premiums, unless you are receiving benefits under an extension of coverage (e.g. COBRA or CAL-COBRA). Premium rates are subject to change during the term of the Group's Policyholder Agreement and you will be notified of any change thirty (30) days before such a change takes place.

You should contact your Human Resources Benefits Manager for questions about periodic payment of premiums, including premiums that are withheld from your salary or amounts paid directly to your employer for health coverage.

4. BENEFIT DESCRIPTIONS

The copayments for these services, if applicable, can be found in the Summary Benefit Description. The following are the basic health care services covered by Scripps Health Plan without charge to the Member, except for copayments where noted, and as set forth in the "Third Party Recovery Process and the Member's Responsibility" section. These services are covered when Medically Necessary and when provided by the Member's PCP or other Plan provider or authorized as described in this section. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the Benefit Descriptions Section and the "Exclusions and Limitations" section of this handbook.

Except as specifically provided below, services are covered only when rendered by an individual or entity that is licensed or certified by the state to provide health care services and is operating within the scope of that license or certification.

Hospital Services

The following hospital services customarily furnished by a hospital will be covered when Medically Necessary and authorized.

Inpatient Hospital Services Include:

1. Semi-private room and board, unless a private room is Medically Necessary,
2. General nursing care, and special duty nursing when Medically Necessary,
3. Meals and special diets when Medically Necessary,
4. Intensive care services and units,
5. Operating room, special treatment rooms, delivery room, newborn nursery and related facilities,
6. Hospital ancillary services including diagnostic laboratory, X-Ray services and therapy services,
7. Drugs, medications, biologicals, and oxygen administered in the hospital, and up to three (3) days' supply of drugs supplied upon discharge by the Plan physician for the purpose of transition from the hospital to home,
8. Surgical and anesthetic supplies, dressings and cast materials, surgically implanted devices and prostheses, other medical supplies and medical appliances and equipment administered in hospital,
9. Processing, storage and administration of blood, and blood products (plasma), in inpatient and outpatient settings. Includes the storage and collection of autologous blood,
10. Radiation therapy, chemotherapy, and renal dialysis,

11. Respiratory therapy and other diagnostic, therapeutic and rehabilitation services as appropriate,

12. Coordinated discharge planning, including the planning of such continuing care as may be necessary,

13. Inpatient services, including general anesthesia and associated facility charges, in connection with dental procedures when hospitalization is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. This includes members under the age of seven (7) and the developmentally disabled who meet these criteria. Excludes services of dentist or oral surgeon,

14. Sub-acute care,

15. Medically Necessary inpatient substance use disorder detoxification services required to treat potentially life-threatening symptoms of acute toxicity or acute withdrawal are covered when a covered Member is admitted through the emergency room or when Medically Necessary inpatient substance use disorder detoxification is prior authorized,

16. Rehabilitation when furnished by the hospital and authorized.

Please refer to the "Hospice Program Services" section for inpatient hospital services provided under the hospice program benefit.

Outpatient Hospital Services Include:

- Services and supplies for treatment or surgery in an outpatient setting or ambulatory surgery center;
- Outpatient services, including general anesthesia and associated facility charges, in connection with dental procedures when the use of a hospital or outpatient facility is required because of an underlying medical condition and clinical status or because of the severity of the dental procedure. Includes members under the age of seven (7) and the developmentally disabled who meet these criteria. Excludes services of dentist or oral surgeon.

Transgender Benefits:

Scripps Health Plan provides coverage for the following benefits for a diagnosis of gender dysphoria:

- All services are covered for transgender members that are covered for non-transgender members. These include services that are Medically Necessary or meet the definition of reconstructive surgery. No categorical exclusions or limitations apply. Each request for authorization of services or surgery related to a diagnosis of gender dysphoria (GID) must be considered on a case-by-case basis and analyzed by referring to the gender with which the member identifies.

- Member cost sharing is based on the type of service performed and the place of service where it is rendered. Please refer to your Summary Benefit Description for the applicable copayments for the services provided.

Physician Services (Other than for Mental Health or Substance Use Disorder Services)

Physician Office Visits (in-person or telehealth):

Office visits for examination, diagnosis and treatment of a medical condition, disease or injury, including specialist office visits, second opinion or other consultations, diabetic counseling, and OB/GYN services from an OB/GYN or a family practice physician who is within the same medical group as the PCP are covered. Covered Benefits are provided for Diabetes self-management training and education to enable a member to effectively manage diet and blood sugar and avoid complications caused by the disease. Covered Benefits are also provided for asthma self-management training and education to enable a Member to properly use asthma-related medication and equipment such as inhalers, spacers, nebulizers and peak flow monitors. Covered Benefits are also provided for routine newborn circumcision.

No additional charge for surgery or anesthesia; radiation or renal dialysis treatments; medications administered in the physician's office, including chemotherapy.

Allergy Testing and Treatment:

Office visits for the purpose of allergy testing and treatment, including injectables and serum are covered. Please refer to the Summary Benefit Description for applicable Member cost sharing.

Inpatient Medical and Surgical Services:

This Covered Benefit includes coverage for physicians' services in a hospital or skilled nursing facility for examination, diagnosis, treatment, and consultation, including the services of a surgeon, assistant surgeon, anesthesiologist, pathologist, and radiologist. Inpatient physician services are covered when hospital and skilled nursing facility services are also covered.

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

This benefit includes coverage for prophylaxis, diagnosis, and treatment that is prescribed or ordered by the treating physician and surgeon and is medically necessary, as defined by current nationally recognized clinical practice guidelines by expert treating physicians published in peer-reviewed medical literature. Covered treatment includes antibiotics, medication, and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy. Coverage for immunomodulating therapies for PANDAS/PANS will not be limited in a manner that is inconsistent with the treatment recommendations pursuant to California Code, Health and Safety Code Section 1367.38(d) nor require a trial of therapies that treat only neuropsychiatric symptoms before authorizing coverage

of immunomodulating therapies. Please refer to the Summary Benefit Description for applicable Member cost sharing.

Medically Necessary Home Visits by Plan Physician:

Please refer to the Summary Benefit Description for applicable cost sharing for this benefit.

Treatment of Physical Complications of a Mastectomy, Physical Complications of a Failed Breast Prosthesis and Lymphedemas:

Please refer to the Summary Benefit Description for applicable cost sharing for this benefit.

Preventive Health Services

Preventive Health Services, as defined, when rendered by a physician are covered in accordance with current recommendations from the United States Preventative Services Task Force (USPSTF), Centers for Disease Control and Prevention, and the Advisory Committee on Immunization Practices. Preventative Health Services listed by the USPSTF as a Grade "A" or "B" recommendation or items or services integral to the provision of an item or service that is set forth in California Code, Health and Safety Code Section 1367.002(a)(1)-(4) are not subject to Member cost share.

Preventive health services include but are not limited to:

- Well Child Care
- Immunizations
- Well-Woman Exams
- Fall Prevention
- Mammograms
- Cancer Testing/Screenings
  - Cervical cancer
  - Colorectal cancer
- Required colonoscopy for a positive result on a test or procedure other than a colonoscopy
- Routine Preventive Care
- Smoking Cessation Program
- Alcohol Misuse Screening and Counseling
- STI and HIV Screening and Counseling
  - HIV testing, regardless of whether the testing is related to a primary diagnosis
- Diabetic Eye Exam
- Obesity Screening and Management
- Screenings
  - Maternal Mental Health
  - Chlamydia
  - Gonorrhea
  - Syphilis
  - HIV
  - Hepatitis B and C
  - Bacteriuria
  - Osteoporosis
  - Depression
  - Diabetes
  - Blood Pressure
  - Lipid disorder
  - Abnormal aortic aneurysm
  - Adverse childhood experiences (ACEs)

Adolescent, Children, Newborn Preventive Health Services

Preventive health services include but are not limited to:

- Developmental screenings and surveillance
- Psychosocial behavioral assessment
- Anemia screening, supplements
- Gonorrhea prophylaxis treatment
- History and physical exam
- Oral health risk assessment
- Vision and hearing screenings/assessment
- Tobacco counseling and cessation interventions
- Dental prevention
  - Fluoride varnish
  - Fluoride supplements
- Measurements
  - Length/height and weight
  - Head circumference, weight for length
  - Body mass index (BMI)
  - Blood pressure
- Screenings
  - Adverse childhood experiences (ACEs)
  - Anxiety
  - Blood screening
  - Critical congenital health defect
  - Depression
  - Lead screening
  - Metabolic/hemoglobin, phenylketonuria, sickle cell, congenital hypothyroidism
  - Tuberculin

The purpose of a preventive visit is to review the Member's overall health, identify risks and find out how to stay healthy. The plan covers 100% of a preventive visit when seen by the assigned PCP.

The purpose of an office visit (in-person or telehealth) is to discuss or get treated for a specific health concern or condition. The Member cost sharing will apply for the visit based on the services provided. Please refer to the Summary Benefit Description for applicable cost sharing**.**

If the Member schedules a preventive care visit and discusses a specific health concern or condition with their PCP, the provider's office may code and bill the appointment as an office visit.

Diagnostic X-Ray/Lab Services

X-Ray, Laboratory, Major Diagnostic Services:

All outpatient diagnostic X-Ray and clinical laboratory tests are covered. These services include diagnostic imaging, electrocardiograms, diagnostic clinical isotope services, bone mass measurements, and periodic blood lipid screening.

Sexually transmitted disease (STD) tests are covered, including the cost of at-home test kits and laboratory costs for processing those kits, when ordered by an in-network provider and are deemed Medically Necessary or appropriate.

Advanced Imaging Services:

The plan covers charges made on an outpatient basis by a physician, hospital or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including but not limited to:

- C.A.T. scans,
- Magnetic Resonance Imaging (MRI),
- Nuclear medicine imaging including positron emission tomography (PET) Scans,
- Complex Imaging Expenses for preoperative testing will be payable under this Covered Benefit.

Genetic Testing and Diagnostic Procedures:

Member genetic testing is covered for certain conditions when the Member has risk factors such as family history or specific symptoms. The testing must be expected to lead to increased or altered monitoring for early detection of disease, a treatment plan or other therapeutic intervention and determined to be Medically Necessary and appropriate in accordance with Scripps Health Plan medical policy.

Scripps Health Plan covers Medically Necessary biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a Member's disease or condition to guide treatment decisions.

Acupuncture Services

Acupuncture Services are Medically Necessary services rendered or made available to a Member by an appropriately licensed practitioner of acupuncture services for treatment or diagnosis of musculoskeletal and related disorders, nausea and pain. Acupuncture means the stimulation of certain points on or near the surface of the body by the insertion and removal of single-use, sterilized, disposable needles and/or electrical stimulation (electro-Acupuncture) to normalize physiological functions, to prevent or modify the perception of pain or to treat musculoskeletal and related disorders, nausea or conditions which include pain as a primary symptom. In addition, it may include such services as adjunctive physiotherapy modalities and procedures provided during the same course of treatment and in support of Acupuncture Services.

Covered Benefits:

- New patient examination,
- Established patient examination,
- Acupuncture needle insertion and removal with or without electrical stimulation,
- Adjunctive physiotherapy modalities and procedures,
- Urgent Services,
- Emergency Services and Care.

NOTE: Limited to 20 visits per calendar year combined with Chiropractic Services.

Durable Medical Equipment, Prostheses and Orthoses and Other Services

Medically Necessary durable medical equipment, prostheses, and orthoses for activities of daily living, and supplies needed to operate durable medical equipment are Covered Benefits. Coverage is limited to the standard item of equipment that will adequately meet the medical needs of the member. Examples of covered durable medical equipment include oxygen and oxygen equipment and its administration; blood glucose monitors as medically appropriate for insulin dependent, non-insulin dependent and gestational diabetes; apnea monitors; and ostomy and medical supplies to support and maintain gastrointestinal, bladder or respiratory function are covered. When authorized as durable medical equipment, other covered items include peak flow monitor for self-management of asthma, glucose monitor for self-management of diabetes, apnea monitors for management of newborn apnea, breast pump and the home prothrombin monitor for specific conditions as determined by Scripps Health Plan. Covered Benefits are provided at the most cost-effective level of care that is consistent with professionally recognized standard of practice. If there are two or more professionally recognized items equally appropriate for a condition, Covered Benefits will be based on the most cost-effective item.

Durable Medical Equipment Also Covers:

1. Replacement of durable medical equipment is covered only when it no longer meets the clinical needs of the patient or has exceeded the expected lifetime of the item. This does not apply to the Medically Necessary replacement of nebulizers, facemasks and tubing, and peak flow monitors for the management and treatment of asthma. Please refer to the "Prescription Drugs" section of this handbook for Covered Benefits for asthma inhalers and inhaler spacers,

2. Medically Necessary repairs and maintenance of durable medical equipment, as authorized by Plan provider. Repair is covered unless necessitated by misuse or loss,

3. Breast pump rental or purchase is only covered if obtained from a designated Plan provider. For further information call Customer Service. There is no copay for breast pumps and related lactation supplies. Please refer to the "Pregnancy and Maternity Care" section of this handbook for description of coverage.

The following services/supplies are covered by the medical benefit:

- Blood glucose monitors and continuous glucose monitors,
- Insulin pumps and insulin pump supplies,
- Podiatric (foot) appliances for prevention of complications associated with diabetes (in accordance with Medicare guidelines).

The following diabetic supplies are covered by the Prescription Drug benefit:

- Test strips and solutions for blood glucose monitors,
- Visual reading and urine testing strips,
- Injection aids, syringes, lancets, automatic lancing devices, drawing up devices,
- Monitors for the visually impaired,

- Medications for treatment of diabetes.

Please refer to the "Diabetes Care" section of this handbook for more information about covered devices, equipment, and supplies for the management and treatment of diabetes.

If you are enrolled in a hospice program through a participating hospice agency, medical equipment and supplies that are reasonable and necessary for the palliation and management of terminal illness and related conditions are provided by the hospice agency. Please refer to the "Hospice Program Services" section of this handbook for further information.

The Durable Medical Equipment benefit does NOT cover:

Covered Benefits do not include environmental control equipment or generators. No Covered Benefits are provided for backup or alternate items unless mandated by State law.

Prostheses:

Scripps Health Plan will cover Medically Necessary prostheses for activities of daily living, including the following:

- Supplies necessary for the operation of prostheses,
- Initial fitting and replacement after the expected life of the item,
- Repairs, even if due to damage,
- Prostheses relating to a mastectomy (including prosthetic bras),
- Surgically implanted prostheses including, but not limited to, artificial larynx prostheses for speech following a laryngectomy,
- Prosthetic devices used to restore a method of speaking following laryngectomy, including initial and subsequent prosthetic devices and installation accessories. This does not include electronic voice producing machines,
- Cochlear implants,
- Cataract spectacles or intraocular lenses that replace the natural lens of the eye after cataract surgery are covered, in addition to, one pair of conventional eyeglasses or contact lenses if Medically Necessary,
- Wigs prescribed by a physician as a prosthetic for hair loss due to injury, disease, or treatment of a disease, up to $150 per member, per calendar year after paying applicable deductible,
- Artificial limbs and eyes.

Please refer to the "Reconstructive Surgery" section for Covered Benefits related to surgically implanted and other prosthetic devices (including prosthetic bras) provided to restore and achieve symmetry incident to a mastectomy. Surgically implanted prostheses including, but not limited to, Blom-Singer and artificial larynx prostheses for speech following a laryngectomy are covered as a surgical professional benefit.

Orthoses:

Medically Necessary orthoses for activities of daily living, including the following:

- Special footwear required for foot disfigurement which includes but is not limited to foot disfigurement from cerebral palsy, arthritis, polio, spina bifida, or by accident or developmental disability,
- Medically Necessary functional foot orthoses that are custom made rigid inserts for shoes, ordered by a physician or podiatrist, and used to treat mechanical problems of the foot, ankle or leg by preventing abnormal motion and positioning when improvement has not occurred with a trial of strapping or an over-the-counter stabilizing device,
- Medically Necessary knee braces for post-operative rehabilitation following ligament surgery, instability due to injury, and to reduce pain and instability for members with osteoarthritis.

Covered Benefits for Medically Necessary orthoses are provided at the most cost-effective level of care that is consistent with professionally recognized standards of practice. If there are two or more professionally recognized appliances equally appropriate for a condition, the Plan will provide Covered Benefits based on the most cost-effective appliance. Covered Benefits are provided for orthotic devices for maintaining normal activities of daily living only.

Please see the "Diabetes Care" section for devices, equipment and supplies for the management and treatment of diabetes.

Chiropractic Services

Chiropractic Services are the Medically Necessary services provided by an appropriately licensed Chiropractor for treatment or diagnosis of musculoskeletal and related disorders and pain syndromes primarily through manipulation of the spine, joints, and/or musculoskeletal soft tissue. Chiropractic Services include: 1) differential diagnostic examination and related diagnostic X-Rays, radiological consultations, and clinical laboratory studies when used to determine the appropriateness of Chiropractic Services; 2) chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue; 3) physiotherapy modalities and procedures (e.g. electrical muscle stimulation, therapeutic exercises, etc.) provided during the same Course of Treatment and in support of chiropractic manipulation; and 4) appropriate supports or appliances.

Covered Benefits:

- New patient examination,
- Established patient examination,
- Chiropractic Manipulation,
- Adjunctive physiotherapy modalities and procedures,
- Plain film X-Rays and clinical laboratory tests,
- Chiropractic supports and appliances,
- Urgent services,

- Emergency Services and Care.

NOTE: Limited to 20 visits per calendar year combined with Acupuncture Services.

Pregnancy and Maternity Care

Routine prenatal care will be covered as Preventive Care for services received by a pregnant female in a physician's, obstetrician's, or gynecologist's office but only to the extent described below:

1. Prenatal and Postnatal Physician Office Visits: Coverage for prenatal care under this Preventive Care Covered Benefit is limited to routine pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant member (maternal weight, blood pressure, fetal heart rate check, and fundal height).

2. Specialist Office Visits: A patient may be referred to a Maternal Fetal Medicine (MFM) Specialist or Perinatologist in addition to a regular OB/GYN physician for examination, diagnosis and/or treatment of a high-risk pregnancy. These Specialist visits are covered separately, same as any other specialist office visit. Pregnancies with a greater chance of complications are called "high-risk." Several factors can make a pregnancy high risk, including existing health conditions, the mother's age, lifestyle, and health issues that happen before or during pregnancy.

3. Inpatient Hospital and Professional Services: Hospital and Professional services for the purposes of a normal delivery, C-Section, complications or medical conditions arising from pregnancy or resulting childbirth, and routine newborn circumcision. In some cases, a non-Scripps Health Care Provider may provide Covered Benefits at an in-network facility where we have authorized you to receive care. You are not responsible for any amounts beyond your in-network cost share for the Covered Benefits you receive at an in-network facility where we have authorized you to receive care.

4. Doula Services: Includes one initial visit with a doula and up to eight additional visits that can be a combination of prenatal and postpartum visits. Postpartum visits may include up to two, three-hour sessions. Services also include support during labor and delivery including labor and delivery that results in stillbirth, abortion or miscarriage. Doula services are available with a referral from your PCP or OB/GYN and can be received up to twelve months after the end of pregnancy.

5. Maternal Mental Health Screenings: Includes providing at least one (1) maternal health screening to be conducted during pregnancy, at least one (1) additional screening to be conducted during the first six (6) weeks of the postpartum period, and additional postpartum screenings, if determined to be medically necessary and clinically appropriate in the judgment of the treatment provider.

6. Newborn Screenings: Includes providing coverage for all testing recommended by the California Newborn Screening Program and for participation in the statewide prenatal testing program,

administered by the State Department of Health Services, known as the Expanded Alpha Feto Protein Program.

7. Ultrasounds: Includes providing coverage for the following:

    - Medically Necessary fetal ultrasounds performed during pregnancy,
    - All initial and repeat and/or Level II pregnancy ultrasounds even when diagnosis is normal pregnancy, assuming they were done for Medically Necessary indications unless documentation to the contrary is submitted with the claim.

    Ultrasounds are not covered for the following:

    - Ultrasounds done solely to determine the fetal sex or to provide the parents with a view and photograph of the fetus,
    - 3D Ultrasounds as an imaging tool to view the fetus.

    Please refer to the "Diagnostic X-Ray/Lab Services" section for information on coverage of other genetic testing and diagnostic procedures.

8. Abortion Services: Termination of pregnancy services are covered.

9. Breast Feeding Support: Includes providing coverage as preventative for the following:

    - Counseling,
    - Consultations with a trained provider,
    - Equipment Rental.

10. Breast Feeding Durable Medical Equipment: Includes providing coverage as a preventative Covered Benefit.

    - A manual or standard electric breast pump is considered Medically Necessary for the initiation or continuation of breastfeeding. Coverage includes the rental or purchase of one (1) breast pump with each pregnancy. Coverage is limited to the specific breast pump models supplied by Scripps Health Plan's capitated DME vendor, and all other models are excluded from coverage.

    - Coverage for the purchase or rental of breast pump equipment is limited to one (1) item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

    - Rental of heavy-duty hospital grade breast pump is covered and considered Medically Necessary when:
        - A newborn infant is confined to a neonatal intensive care unit (NICU), or

- Direct breastfeeding is not possible because of a separation due to the prolonged or repeat hospitalization of either the infant or mother, or
- The infant has a medical condition or congenital anomaly that prevents effective breastfeeding, or
- The mother has a medical condition or anatomical anomaly that prevents effective breastfeeding

- Rental of a heavy duty electrical/hospital grade breast pump when requested solely for convenience is considered not Medically Necessary,

Scripps Health Plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of the Plan.

11. Human Milk: Coverage is provided for pasteurized donor human milk obtained from a contracted and licensed tissue bank when medically necessary and available with a referral from your PCP or OB/GYN.

The following are considered preventive prenatal services:

- Folic Acid supplements,
- Gestational Diabetes screenings,
- Iron deficiency anemia screenings,
- Preeclampsia preventive medicine,
- Low dose aspirin.

The Newborns' and Mothers' Health Protection Act requires group health plans to provide a minimum hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after a C-Section unless the attending physician, in consultation with the mother, determines a shorter hospital length of stay is adequate.

If the hospital stay is less than 48 hours after a normal, vaginal delivery or less than 96 hours after a C-Section, a follow-up visit for the mother and newborn within 48 hours of discharge is covered when prescribed by the treating physician. This visit shall be provided by a Health Care Provider whose scope of practice includes both postpartum and newborn care. The treating physician, in consultation with the mother, shall determine whether this visit shall occur at home, the contracted facility or the physician's office.

Family Planning Services

The following family planning services are considered preventive services and Covered Benefits:

- All FDA-approved contraceptive drugs, devices, and other products, including all FDA-approved contraceptive drugs, devices, and products available over the counter at in-

network pharmacies (for example: intrauterine device (IUD), injectable [i.e., Depo-Provera], implantable, and over the counter contraceptives),

- Tubal ligation, vasectomy, or other similar sterilization procedures,
- Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling,
- Follow up services related to the drugs, devices, products, and procedures, including, but not limited to, management of side effects, counseling for continued adherence, and device removal.

Oral contraceptives and medications administered by a pharmacist are covered under the Prescription Drug benefit. Members may receive a 12-month supply of contraceptives at one time. Please refer to the description of the "Prescription Drugs" section of this handbook for more information.

Infertility Services

The Plan will cover the diagnosis and treatment of infertility and medically necessary fertility services consistent with established medical practices and the most current professional guidelines for the diagnosis and treatment of infertility as published by the American Society for Reproductive Medicine (ASRM).

Infertility means a condition or status characterized by any of the following:

1. A licensed physician's findings, based on the patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors, consistent with generally accepted medical standards such as those of the ASRM and the Centers for Disease Control and Prevention (CDC). This definition shall not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility.
2. A person's inability to reproduce either as an individual or with their partner without medical intervention.
3. The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. "Regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

Prior Authorization is required for services related to infertility and assisted reproductive technologies, including services provided by or to a third party (e.g., oocyte, sperm, or embryo donor; gestational carrier; or surrogate) that enable an intended recipient to become a parent. Prior authorization requests will be reviewed in a timely manner consistent with medically necessary care, in accordance with applicable law. Authorization criteria are consistent with established medical practices and the most current professional guidelines as established by ASRM.

Professional guidelines are used to inform clinical decision-making and will not be applied to deny, delay, or limit coverage required under Health and Safety Code section 1374.55. Prior authorization criteria will not impose limitations, conditions, or requirements that are more restrictive than those applied to other medically necessary benefits and will not be used in a manner that discriminates or delays access to infertility or fertility services required under applicable law.

Coverage for the diagnosis and treatment of infertility is provided without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex or sexual orientation consistent with Section 1374.55.

If you meet the definition of infertility, Covered Benefits include:

- Services to diagnose infertility to include: physician services, including consultation and referral; physical examination; genetic evaluation; screening and diagnostic laboratory and imaging services; semen analysis; tubal evaluation and uterine evaluation; sperm DNA fragmentation analysis; hormone testing; ovulation testing; thyroid function testing; ovarian reserve testing; diagnostic surgery and biopsy; and any other services to diagnose infertility consistent with the established medical practices and the most current professional guidelines published by ASRM.
- Fertility services to treat infertility to include: a maximum of three (3) attempts to collect or retrieve sperm; a maximum of three (3) completed oocyte retrievals; procurement of donor semen, oocyte and embryo; physician services, including consultation and referral; surgery to treat infertility; medication to treat infertility; reproductive counseling; genetic counseling; genetic testing and screening; laboratory and imaging services; infectious disease screening and testing; medication to induce ovulation; intrauterine insemination; intracervical insemination; preimplantation genetic testing; in vitro maturation; in vitro fertilization; intracytoplasmic sperm injection; ovarian tissue reimplantation; Embryo biopsy; assisted hatching; thawing of previously cryopreserved gametes, embryos, and tissues; unlimited embryo transfers, using single embryo transfers in accordance with section 1374.55(a)(1); and any other fertility services to treat infertility consistent with the established medical practices and the most current professional guidelines published by ASRM.
- Donors, Donor Material, and Surrogate services to include: laboratory and imaging services; genetic testing and screening; infectious disease screening and testing; medication to induce ovulation; retrieval of donor gametes; gamete and embryo transfer; and any other medically necessary infertility and fertility services, as specified above, to enable the enrollee to become a parent using donor gametes, donor embryos, and surrogate services.
- Cryopreservation and storage of sperm, oocytes, and embryos for a period of five (5) years from the time the genetic material is first cryopreserved.
- Standard fertility preservation services when medically necessary to prevent iatrogenic infertility, in accordance with generally accepted standards of care.

You have a right to receive treatment for infertility and fertility services when you meet the requirements in Health and Safety Code section 1374.55.

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

Ambulance Services

The Plan will pay for ambulance services as follows:

Emergency Ambulance Services:

For transportation to the nearest hospital which can provide such emergency care only if the Member reasonably believed that the medical or psychiatric condition was an Emergency Medical Condition which required ambulance services, as described in the "Emergency Services and Care" section.

Non-Emergency Ambulance Services:

Medically Necessary ambulance services to transfer the Member from a non-Plan hospital to a Plan hospital, between Plan facilities, between a mental health facility and another facility, or from facility to home or another facility which an ambulance is Medically Necessary, while confined in a hospital or skilled nursing facility to receive Medically Necessary inpatient or outpatient treatment when an ambulance is required for safe and adequate transport and the use of the ambulance is pre-authorized.

Pursuant to Senate Bill 1180 and Health and Safety Code 1371.51, Members who receive covered services provided by a noncontracted community paramedicine program, a triage to alternate destination program, and a mobile integrated health program, will pay no more than the same cost-sharing amount as for the same covered services received from a contracted program.

Tele-Health Consultation

Doctor on Demand provides fast, easy, and cost-effective access to some of the best doctors, psychologists, and other healthcare providers in the country. Members can have "Video Visits" with providers on their smartphone or computers at any time of day. Download the Doctor on Demand App for free on the iTunes Store® or Google Play® Store.

Medical and Mental Health Consultation

Scripps Health Plan covers video visits on your smartphone, tablet or computer with board certified physicians, psychiatrists and licensed psychologists, through the Doctor on Demand network. It's fast and easy to register:

- Download the Doctor on Demand app on iTunes or Google Play, or visit **www.doctorondemand.com/Scripps**
- When prompted enter Scripps as your employer, and then enter your health plan member ID

Covered Benefits include (but are not limited to):

- Coughs, Colds and Sore Throats
- Pediatric Issues
- Nausea and Diarrhea
- Rashes and Skin Issues
- Sports Injuries
- Mental Health

Prescription copays will apply to any medications prescribed by a physician during a consultation. In addition to Doctor on Demand, your medical group may offer tele-health services. Scripps Health Plan will provide coverage, and reimburse the treating provider, for services appropriately delivered to a Member through telehealth on the same basis and to the same extent as in-person services. These services are also available to you in-person or via telehealth, where applicable, through your PCP, treating specialist or from another contracted individual or facility provider, such as urgent care centers. You have a right to access your telehealth medical records and records of any services provided through Doctor on Demand will be shared with your PCP unless you object.

Urgent Care Services

Urgent Care services are not emergencies; but may require prompt medical attention. An urgent condition may be treated in your PCP's office or in an urgent care clinic.

If you require Urgent Care services, contact your PCP or your assigned medical group to be directed to the appropriate Urgent Care that is within your PCP's assigned medical group. If you need help finding an Urgent Care provider, you may contact Scripps Health Plan at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**. If it is not feasible to contact your physician, assigned medical group, or the Plan, or if you are outside of your medical group's service area or San Diego County, you should go to the closest Urgent Care center to access care.

Coverage for Urgent Conditions:

Covered expenses include charges made by an urgent care provider to evaluate and treat an urgent condition. Your coverage includes:

- Use of urgent care facilities when you cannot reasonably wait to visit your physician,
- Physicians services,
- Nursing staff services,
- Laboratory and Radiology services.

Please contact your physician after receiving treatment of an urgent condition. Follow-up care is not considered an urgent condition and is not covered as part of an urgent care visit. Once you have been treated and discharged, you should contact your physician for any necessary follow-up care, which must be obtained by your physician through your assigned medical group.

Emergency Services and Care

An emergency means a medical and/or psychiatric screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate licensed persons 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, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility.

"Active labor" means a labor at a time at which either there is inadequate time to effect safe transfer to another hospital prior to delivery or a transfer may pose a threat to the health and safety of the patient or the unborn child.

A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating physician, or other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician, the Member's medical condition is such that, within reasonable medical probability, no material deterioration of the Member's condition is likely to result from, or occur during, the release or transfer of the Member.

Members who reasonably believe that they have an Emergency Medical or Psychiatric Emergency Medical Condition which requires an emergency response are encouraged to appropriately use the "911" emergency response system where available. The Member should notify the PCP or Magellan by phone within 24 hours of the commencement of the Emergency Services and Care, or as soon as it is medically possible for the Member to provide notice.

Whenever possible, go to the emergency room of your nearest Scripps Health Plan hospital for medical emergencies. A listing of Scripps Health Plan hospitals is available in the Provider Directory, which can be accessed at **www.ScrippsHealthPlan.com.** If it is not feasible to contact your physician or the Plan, access care at the closest emergency room.

Pursuant to Assembly Bill 2843, coverage is provided for emergency room medical care and follow-up health care treatment for a Member following a rape or sexual assault without cost-sharing for the first nine (9) months after the Member initiates treatment. Cost-sharing waiver is subject to the Member's treating provider submitting all requests for claims payments using accurate diagnosis codes specific to rape or sexual assault. Members are permitted to receive services from providers outside of Scripps Health Plan's network if the services are unavailable within the network to ensure timely access to covered health care services consistent with timely access requirements. Coverage provided under this section is coverage of sensitive services provided to a protected individual as those terms are defined in Section 56.05 and pursuant to Section 56.107 of the Civil Code. Scripps Health Plan is prohibited from requiring any of the following for coverage:

- Member to file a police report on the rape or sexual assault;
- Charges to be brought against an assailant; or,
- An assailant to be convicted.

Follow-up care is not considered an Emergency Medical Condition and is not covered as part of an emergency room visit. Once a Member has been treated and discharged, the Member should contact their PCP for any necessary follow-up care.

Emergency Services and Care copayment is waived if the Member is admitted directly to the same hospital as an inpatient from the emergency room and the inpatient copayment applies instead.

Continuing or Follow-up Treatment:

If you receive Emergency Services and Care from a non-Plan hospital, follow-up care must be authorized by Scripps Health Plan or it may not be covered. If, once your Emergency Medical Condition is stabilized, and your treating health care provider at the non-Plan hospital believes that you require additional Medically Necessary hospital services, the non-Plan hospital must contact Scripps Health Plan to obtain timely authorization. Scripps Health Plan may authorize continued Medically Necessary hospital services by the non-Plan hospital. If Scripps Health Plan determines that you may be safely transferred to a hospital that is contracted with the Plan and you refuse to consent to the transfer, the non-Plan hospital must provide you with written notice that you will be financially responsible for 100% of the cost for services provided to you once your emergency condition is stable.

If the non-Plan hospital is unable to determine the contact information at Scripps Health Plan in order to request prior authorization, the non-Plan hospital may bill you for such services. If you believe you are improperly billed for services you receive from a non-Plan hospital, you should contact Scripps Health Plan at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065.**

Reimbursement for Covered Expenses:

If you paid out-of-pocket for services that would normally be covered by the Plan, you must submit to the Plan a Member Claim Reimbursement Form as soon as possible but not more than 365 days from the initial date of service. The form may be accessed on the Scripps Health Plan website at **www.ScrippsHealthPlan.com/member-information** or you may contact Customer Service to obtain a claim form by calling **1-844-337-3700** or TTY: **1-888-515-4065**.

1. If Out-of-Area urgent or Emergency Services and Care were received, you must submit to the Plan a completed Member Claim Reimbursement Form with the urgent care or emergency room visit statement and proof of payment. The Plan will reimburse the paid amount less your copay. This must be received by the Plan within 365 days from the initial date of service. If the claim is not submitted within this period, the Plan may not pay for those services. The Plan will review the claim retrospectively for coverage. You will be

notified of our determination within 45 business days from receipt of the complete claim. In the event covered medical transportation services are obtained in such an emergency situation, Scripps Health Plan shall pay the medical transportation provider directly less your copay.

2. When traveling outside of the United States and you are in need of Emergency Services and Care please be sure to present your Scripps Health Plan member ID card. If the provider does not accept your insurance, you may have to pay out-of-pocket for your services. Scripps Health Plan requires that you submit the Member Claim Reimbursement Form, along with an itemized statement, and any documentation of medical records and any payments you have already made for us to consider the charges for reimbursement less your copay. Claims may be submitted by mail. For U.S. Mail, submit to the following address:

Scripps Health Plan
Attention: Direct Member Reimbursements
10790 Rancho Bernardo Road, 4S-300
San Diego, CA 9212
Fax: 858-964-3102

HIV Prophylaxis

Benefits are provided for antiretroviral drugs that are medically necessary for the prevention of AIDS/HIV, including preexposure prophylaxis or postexposure prophylaxis. If the FDA has approved one (1) or more therapeutic equivalents of a drug, device, or product for the prevention of AIDS/HIV, then Scripps Health Plan will cover at least one (1) therapeutically equivalent version without prior authorization or step therapy pursuant to Section 1342.74.

Scripps Health Plan shall not prohibit a pharmacy provider from dispensing preexposure prophylaxis or postexposure prophylaxis.

Scripps Health Plan shall cover preexposure prophylaxis and postexposure prophylaxis furnished by a pharmacist, as authorized in Sections 4052.02 and 4052.03 of the Business and Professions Code, including the pharmacist's services and related testing ordered by the pharmacist.

Preexposure prophylaxis or postexposure prophylaxis by a pharmacist at an out-of-network pharmacy are not covered.

Home Health Care Services, PKU-Related Formulas and Special Food Products, Home Infusion Therapy

Home Health Care Services:

Covered Benefits are provided for Home Health care services when the services are Medically Necessary, ordered by the PCP and authorized.

Home visits to provide skilled services. The following professional providers are covered:

- Registered Nurse,
- Licensed Vocational Nurse,
- Certified home health aide in conjunction with a skilled service (RN, LVN, PT, OT, SP),
- Medical Social Worker,
- Physical therapist, occupational therapist, or speech therapist.

In conjunction with the professional services rendered by a home health agency, medical supplies used during a covered visit by the Home Health agency necessary for the Home Health care treatment plan are covered, to the extent the Covered Benefit would have been provided had the Member remained in the hospital or skilled nursing facility.

This Covered Benefit does not include medications, drugs, or injectables covered under the "Prescription Drugs" section. This includes a Covered Benefit of up to 120 days maximum per member, per calendar year. Prior authorization for services is required.

Please refer to the "Hospice Program Services" section for information about when a Member is admitted into a hospice program and a specialized description of skilled nursing services for hospice care.

PKU-Related Formulas and Special Food Products:

Covered Benefits are provided for enteral formulas, related medical supplies and special food products that are Medically Necessary for the treatment of phenylketonuria (PKU) to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. These Covered Benefits must be prior authorized and must be prescribed or ordered by the appropriate health care professional. PKU-related formulas are covered under the "'Prescription Drugs" Section.

Home Infusion/Home Injectable Therapy Provided by a Home Infusion Agency:

Covered Benefits are provided for home infusion and intravenous (IV) injectable therapy when provided by a home infusion agency.

Services include home infusion agency skilled nursing services, parenteral nutrition services and associated supplements, medical supplies used during a covered visit, pharmaceuticals administered intravenously, related laboratory services and for Medically Necessary, FDA-approved injectable medications, when prescribed by the PCP and prior authorized, and when provided by a home infusion agency.

This Covered Benefit does not include medications, drugs, insulin, insulin syringes, specialty drugs covered under the "Prescription Drugs" section, and services related to hemophilia, which is covered as described below.

Hemophilia Home Infusion Products and Services:

Covered Benefits are provided for home infusion products for the treatment of hemophilia and other bleeding disorders. All services must be prior authorized by the Plan and must be provided by a participating Hemophilia Infusion Provider. Most participating home health care and home infusion agencies are not participating Hemophilia Infusion Providers. A list of Participating Hemophilia Infusion Providers is available online at **www.ScrippsHealthPlan.com**. You may also verify this information by calling Customer Service at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**.

Hemophilia Infusion Providers offer 24-hour service and provide prompt home delivery of hemophilia infusion products.

Following evaluation by your physician, a prescription for a blood factor product must be submitted to and approved by the Plan. Once prior authorized by the Plan, the blood factor product is covered on a regularly scheduled basis (routine prophylaxis) or when a non-emergency injury or bleeding episode occurs. Emergencies will be covered as described in the "Emergency Services and Care" section.

Included in this Covered Benefit is the blood factor product for in-home infusion use by the Member, necessary supplies such as ports and syringes and necessary nursing visits. Services for the treatment of hemophilia outside the home, except for services in infusion suites managed by a participating Hemophilia Infusion Provider and Medically Necessary services to treat complications of hemophilia replacement therapy are not covered under this Covered Benefit but may be covered under other medical Covered Benefits described elsewhere in this "Benefit Descriptions" section.

***Services and certain drugs may be covered under the "Physical and Occupational Therapy" section, the "Prescription Drugs" section or as described elsewhere in this "Benefit Descriptions" section.**

Skilled Nursing Facility Services

Subject to all the inpatient hospital services provisions under the "Hospital Services" section, Medically Necessary skilled nursing services, including subacute care, will be covered when provided in a skilled nursing facility and preauthorized. This Covered Benefit is limited to 100 days during any calendar year except when received through a hospice program provided by a participating hospice agency. The 100 preauthorized day maximum on skilled nursing services is a combined maximum between a skilled nursing facility in a hospital unit and skilled nursing facility.

Hospice Program Services

Hospice services are covered when provided through a participating hospice agency when an eligible Member requests admission to and is formally admitted to an approved hospice program. The Member must have a terminal illness as determined by the Plan provider's certification and the admission must receive prior approval from Scripps Health Plan. Members with a terminal illness who have not elected to enroll in a hospice program can receive a pre-hospice consultative visit

from a participating hospice agency. Covered Benefits are available on a 24-hour basis to the extent necessary to meet individual needs for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions. Members can continue to receive Covered Benefits that are not related to the palliation and management of the terminal illness from the appropriate Health Care Provider. Member copayments when applicable are paid to the participating hospice agency.

All the services listed below are covered and must be received through the participating hospice agency:

1. Pre-hospice consultative visit regarding pain and symptom management, hospice, and other care options including care planning. Members do not have to be enrolled in the hospice program to receive this Covered Benefit,

2. Interdisciplinary Team care with development and maintenance of an appropriate plan of care and management of terminal illness and related conditions,

3. Skilled nursing services, certified health aide services and homemaker services under the supervision of a qualified registered nurse,

4. Bereavement services,

5. Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed,

6. Medical direction with the medical director being also responsible for meeting the general medical needs for the terminal illness of the Members to the extent that these needs are not met by the PCP,

7. Volunteer services,

8. Short-term inpatient care arrangements,

9. Pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of terminal illness and related conditions,

10. Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the Member to maintain activities of daily living and basic functional skills,

11. Nursing care services are covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain a Member at home. Hospitalization is covered when the Interdisciplinary Team makes the determination that skilled nursing care is required at a level that cannot be provided in the home. Either homemaker services or home health aide services or both may be covered on a 24-hour continuous basis during

periods of crisis, but the care provided during these periods must be predominantly nursing care,

12. Respite care services are limited to an occasional basis and to no more than 5 consecutive days at a time.

Members can change their participating hospice agency only once during each period of care. Members can receive care for two 90-day periods followed by an unlimited number of 60-day periods. The care continues through another period of care if the Plan provider recertifies that the Member is terminally ill.

Physical and Occupational Therapy

Rehabilitation services include physical therapy, occupational therapy, and/or respiratory therapy pursuant to a written treatment plan and when rendered in the provider's office or outpatient department of a hospital. Covered Benefits for speech therapy are described in the "Speech Therapy" section. Medically Necessary services will be authorized for an initial treatment period and any additional subsequent Medically Necessary treatment periods if after conducting a review of the initial and each additional subsequent period of care, it is determined that continued treatment is Medically Necessary.

Please refer to the "Home Health Care Services" section for information on coverage for rehabilitation services rendered in the home.

Speech Therapy

Outpatient Covered Benefits for speech therapy services are covered when diagnosed and ordered by a physician and provided by an appropriately licensed speech therapist, pursuant to a written treatment plan for an appropriate time to: (1) correct or improve the speech abnormality, or (2) evaluate the effectiveness of treatment when rendered in the provider's office or outpatient department of a hospital.

Services are provided for the correction of, or clinically significant improvement of, speech abnormalities that are the likely result of a diagnosed and identifiable medical condition, illness, or injury to the nervous system or to the vocal, swallowing, or auditory organs, and to Members diagnosed with mental health conditions.

Additionally, coverage for speech therapy is available for the treatment of Autism Spectrum Disorder (as an exception to the above non-chronic condition coverage criteria).

Continued outpatient Covered Benefits will be provided for Medically Necessary services as long as continued treatment is Medically Necessary, pursuant to the treatment plan and likely to result in clinically significant progress as measured by objective and standardized tests. The provider's treatment plan and records will be reviewed periodically. When continued treatment is not Medically Necessary pursuant to the treatment plan, not likely to result in additional clinically significant improvement, or no longer requires skilled services of a licensed speech therapist, the

Member will be notified of this determination and Covered Benefits will not be provided for services rendered after the date of written notification.

Please refer to the "Home Health Care Services" section for information on coverage for speech therapy services rendered in the home. See the "Hospital Services" section for information on inpatient Covered Benefits and the "Hospice Program Services" section for hospice program services. Refer to the "Outpatient Mental Health" section for information on coverage for Autism Spectrum Disorder and related care.

Cardiac and Pulmonary Rehabilitation

Comprehensive programs of cardiac rehabilitation services that include exercise, education and counseling are covered for members who meet certain conditions. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.

Prescription Drugs

Pharmacy Benefits are administered by MedImpact, Scripps Health Plan's Pharmacy Benefits Manager (PBM). Scripps has chosen to partner with MedImpact to offer members both value and effective therapies to manage your health care needs.

Covered Benefits are provided for outpatient prescription drugs when all requirements specified in this section are met, when outpatient prescription drugs are prescribed by a physician or other licensed health care provider within the scope of his or her license, when the prescribing provider is a licensed provider and when outpatient prescription drugs are obtained from a participating, network pharmacy. Outpatient prescription drugs ordered for the management or treatment of a mental health or substance use disorder are covered under this Pharmacy benefit.

Scripps Health Plan's Drug Formulary is a list of preferred generic, high cost generic (high cost generics have relevant alternatives and cost more than $50 per 30 day supply) and brand medications that: (1) have been reviewed for safety and efficacy (2) have been approved by the Food and Drug Administration (FDA); and (3) are eligible for coverage under the Scripps Health Plan Outpatient Prescription Drug benefit.

Medically Necessary Non-Formulary drugs are covered and subject to higher copayments. Select drugs, drug dosages, and most specialty drugs require prior authorization for medical necessity, including appropriateness of therapy and efficacy of lower cost alternatives. Prescription smoking cessation drugs are covered for Members when ordered by a licensed provider.

Outpatient Prescription Drug Formulary:

Medications are selected for inclusion in Scripps Health Plan's Outpatient Drug Formulary based on safety, efficacy, FDA bio equivalency data, and cost. Scripps Health Plan's Outpatient Drug Formulary includes generic, brand-name, and specialty drugs.

New drugs and clinical data are reviewed regularly to update the Formulary. Drugs considered for

inclusion or exclusion from the Formulary are reviewed by MedImpact and Scripps Health Plan's Pharmacy and Therapeutics Committee.

The Formulary includes most generic drugs and is periodically reviewed consistent with professional practice guidelines. The fact that a Drug is listed on the Formulary does not guarantee that a Member's Physician will prescribe it for a particular medical condition.

Select contraceptives are covered with a $0 copayment. Members who are stable on their current FDA-approved, self-administered hormonal contraceptive, may receive up to a 12-month supply at one time. If no therapeutic equivalent generic substitute is available in the market for an original, brand name contraceptive, there is a $0 copayment. If a covered therapeutic equivalent of a drug, device, or product is deemed medically inadvisable by a provider, Scripps Health Plan shall defer to the determination and judgment of the provider and provide coverage for the alternative prescribed contraceptive drug, device, product, or service without imposing any cost-sharing requirements. Medical inadvisability may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives, and ability to adhere to the appropriate use of the drug or item, as determined by the provider. Note: If the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, it is not required to cover all the therapeutically equivalent versions if at least one is covered without cost sharing.

Members may access the Drug Formulary online at **www.ScrippsHealthPlan.com** or by calling the Customer Service Department toll free at **1-844-337-3700** or TTY at **1-888-515-4065** for the hearing and speech impaired. Members may also call to inquire if a specific drug is included in the Formulary or to obtain a printed copy of the Drug Formulary.

Members may also request eligibility for a prescription drug; cost sharing information for the prescription drug and other formulary alternatives, accurate at the time it is provided, including any variance in cost sharing based on the Member's preferred dispensing pharmacy, whether retail or mail order, or the provider; and applicable utilization management requirements for the prescription drug and other formulary alternatives.

Retail Participating Pharmacy (Outpatient Prescription Drugs):

To obtain drugs at a participating pharmacy, the Member must present his or her Scripps Health Plan identification card. Except for covered emergencies, claims for drugs obtained without using the identification card will be denied.

Covered Benefits are provided for specialty drugs only when obtained from a Network Specialty Pharmacy, except in the case of an emergency. In the event of an emergency, covered specialty drugs that are needed immediately (e.g., blood thinners or HIV medications after an exposure) may be obtained from any participating pharmacy or, if necessary, from a non-participating pharmacy. The Member is responsible for paying the applicable copayment for each covered prescription Drug at the time the Drug is obtained.

Over-the-counter FDA-approved contraceptive drugs, devices, and products can be obtained at participating pharmacies without a prescription, cost sharing, or utilization management

requirements.

For questions about participating pharmacies, you may contact Scripps Health Plan's Pharmacy Benefits Manager, MedImpact, by phone at 1-844-282-5343 or by fax at 1-858-549-1569.

Mail Order and Choice90 (Outpatient Prescription Drugs):

For long-term maintenance medications (up to a 90-day supply), members have the option to have medications delivered to their home through Scripps Outpatient Pharmacy. To use the mail order service, Members are required to register by accessing the prescription drug section of **www.ScrippsHealthPlan.com**.

Members may also choose a Choice90 retail pharmacy for certain long-term maintenance medications (up to a 90-day supply). Members may take their ID card to a participating Choice90 retail pharmacy. Go to **www.ScrippsHealthPlan.com** to find a Choice90 retail pharmacy.

The Member is responsible for paying the applicable copayment for each covered prescription drug at the time the drug is obtained.

If 50 percent (50%) of the cost of a drug is less than or equal to the Member's copayment, the Member will only be required to pay the participating pharmacy the lesser amount.

If the participating pharmacy contracted rate is less than or equal to the Member's copayment, the Member will only be required to pay the participating pharmacy contracted rate.

Select over the counter (OTC) drugs with a United States Preventive Services Task Force (USPSTF) rating of A or B may be covered at a quantity greater than a 30-day supply.

It is the Plan's intent to comply with federal law regarding preventive care benefits under the Patient Protection and Affordable Care Act. All prescriptions which qualify for the preventive care benefit, as defined by the appropriate federal regulatory agencies, and which are provided by a network-participating pharmacy, will be covered at 100% with no deductible, copay or coinsurance required.

The Plan formulary provides information about medications requiring prior authorization or that include a Step Therapy requirement. You can ask your pharmacist or physician if a certain drug is a brand name or generic drug, requires prior authorization, or requires Step Therapy to be completed. You can also visit the prescription drug coverage section of **www.ScrippsHealthPlan.com** to view the Plan Formulary and individual medication requirements.

If you or your physician requests a **brand-name drug** when a lower-cost **generic drug** is available, a lower-cost medication may be recommended to you and your provider. If a generic drug is proposed but you wish to receive the brand-name drug when it is not Medically Necessary, you will be responsible for the difference in cost plus the brand name copay. These additional amounts will not apply to your annual Out-Of-Pocket Maximum.

The Member or prescribing provider may provide information supporting the medical necessity for

using a brand name drug versus an available generic drug equivalent through the MedImpact prior authorization process. See the section below on Prior Authorization Process for Select Formulary, Non-Formulary, and Specialty Drugs for information on the approval process. If the request is approved, the Member is responsible for paying the applicable brand name drug co-payment. If the request is denied the member will be required to pay the difference in price, plus the applicable copay.

When drugs are obtained at a non-participating pharmacy for a covered Emergency Medical Condition, the Member must first pay 100% of all charges for the prescription, and then submit a completed Prescription Drug Claim form noting "Emergency" as the reason for manually filing the claim request.

MedImpact Healthcare Systems, Inc.
PO Box 509098
San Diego, CA 92150-9098
Fax: 858-549-1569
Email: **Claims@Medimpact.com**

For covered Emergency Medical Conditions, the Member will be reimbursed the purchase price of covered prescription drug(s) minus any applicable copayment(s). See definition of "Emergency Medical Condition" within the Definitions section of this document for information on scenarios considered a covered emergency. Prescription Drug Claim forms are available by contacting Customer Service **1-844-337-3700** or online at **www.ScrippsHealthPlan.com**. Claims must be received within 365 days (1 year) from the date of service to be considered for payment.

Obtaining Specialty Drugs through the Specialty Drug Program:

Specialty Drugs are Outpatient Prescription Drugs requiring coordination of care, close monitoring, or extensive patient training for self-administration that cannot be dispensed by a retail pharmacy and are available at a Network Specialty Pharmacy. Specialty Drugs may also require special handling or manufacturing processes (such as biotechnology), restriction to certain Physicians or pharmacies, or reporting of certain clinical events to the FDA. Because of these unique characteristics, specialty medications are much higher in cost.

Specialty Drugs are available exclusively from a Scripps Outpatient Pharmacy and MedImpact Direct Specialty. Most Specialty Drugs require prior authorization for Medical Necessity by Scripps Health Plan, as described in the Prior Authorization section below.

A Network Specialty Pharmacy offers 24-hour clinical services, coordination of care with Physicians, and reporting of certain clinical events associated with select Drugs to the FDA. To obtain a complete list of Specialty Drugs or select a Network Specialty Pharmacy, you may go to **www.ScrippsHealthPlan.com** or call Customer Service **1-844-337-3700**.

Prior Authorization for Select Formulary, Non-Formulary, Step Therapy, and Specialty Drugs:

Some Formulary drugs, and most specialty drugs require Prior Authorization for medical necessity. Select contraceptives may require prior authorization for medical necessity in order to be covered

without a copayment. Select Non-Formulary drugs may require prior authorization for medical necessity, and to determine if lower cost alternatives are available and just as effective. Compounded drugs are covered when the following conditions are met:

- The compounded Prescription Drug includes at least one active ingredient medication,
- There are no FDA-approved, commercially available Medically Necessary alternative(s),
- The Prescription Drug is self-administered and,
- It is being prescribed for an FDA- approved indication.

If a compounded Prescription Drug is approved for coverage, the Non-Formulary Brand Name Drug Copayment applies.

Select Formulary Drugs require Step Therapy where a member is required to demonstrate that a particular drug was not effective, or side effects outweigh the clinical benefits of continuing that particular drug. The Formulary indicates which drugs require either Step Therapy or Prior Authorization.

You or your physician may request prior authorization by submitting a Prior Authorization form with supporting medical documentation to MedImpact via fax at **1-858-790-7100**. Once all required supporting information is received, Medimpact will review your request for Prior Authorization or Step Therapy and make a decision to approve or deny your request. **Routine Requests for Prior Authorization:** Decisions for routine requests for prior authorization are issued within 72-hours from receipt of the information.

- **Expedited Prior Authorization requests** (for exigent circumstances) Decisions will be issued 24-hours from the receipt of the information (Your request will be reviewed as an exigent circumstance if your provider believes that your condition is life-threatening).

For the treatment of mental health and substance use disorders, coverage for at least one (1) medication approved by the FDA in each of the following categories is available without prior authorization, step therapy, or utilization review:

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

Opiate Quantity Thresholds:

Certain classes, categories, doses, or combinations of opiate drugs may require prior authorization when the quantity for the last 90 days is above a threshold considered unsafe in the professional clinical judgment of your pharmacist. If your pharmacy provider deems that an opiate quantity

above the threshold is Medically Necessary for you, your provider may need to submit a Prior Authorization request to support the medical necessity for coverage.

Appeals and Exceptions:

Members and their providers may request an Exception to any Prior Authorization or Step Therapy requirement by indicating the Request for Exception on the Pharmacy Prior Authorization form. Your notice of denial will include information on how to file an appeal if you disagree with our decision to deny an Exception Request for Step Therapy, or a request for a non-formulary medication. Standard appeals are resolved within 30 calendar days, and within 72 hours for expedited appeals (for exigent circumstances). The notice will also include information on how to request an External Appeal through the Department of Managed Health Care's Independent Medical Review process. More information is provided below in the Section "Grievance Process."

If your prior authorization or step therapy exception request for an outpatient drug has been denied, you, your designee or your provider may request that the original exception request and subsequent denial of such request be reviewed by an independent review organization (IRO). When a member requests an External Exception Review, all records related to the request are forwarded to an Independent Review Organization that is contracted but not part of Scripps Health Plan. Submitting an External Exception Review does not preclude you from submitting a complaint with the Department of Managed Health Care. You will be notified of the IRO's decision within 72 hours for standard requests or 24 hours for expedited requests. Please submit your external exception request to:

Scripps Health Plan
Attention: Appeals & Grievances, Pharmacy External Exception Review
10790 Rancho Bernardo Road, 4S-300
San Diego, California 92127
Phone: 858-927-5907 TTY: 1-888-515-4065
Fax: 858-964-3100

Call our Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065** for further information.

See the "Grievance Process" section of this Evidence of Coverage for information on filing a grievance, your right to seek assistance from the Department of Managed Health Care and your rights to independent medical review (IMR).

Inpatient Mental Health or Substance Use Disorder Services

Scripps Health Plan has partnered with Magellan to provide Members with access to the Magellan network of Mental Health or Substance Use Disorder providers. Magellan's network includes access to local health care providers, as well as facilities providing inpatient treatment, partial-hospitalization, and residential care. Mental Health or Substance Use Disorder providers include, but are not limited to, psychiatrists; registered psychologists, registered psychologist assistants, or psychology trainees; associate marriage and family therapists or marriage and family therapist

trainees; qualified autism service providers or qualified autism service professionals; associate clinical social workers; and associate professional clinical counselors or professional clinical counselor trainees; and persons who are licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

Inpatient Mental Health or Substance Use Disorder Services:

Your plan covers the Medically Necessary treatment of Mental Health or Substance Use Disorders. Magellan administers Mental Health or Substance Use Disorder services for Scripps Health Plan Members within California. These services are provided through a unique network of Magellan Participating Providers.

All non-emergency inpatient Mental Health or Substance Use Disorder services, including residential care, must be prior authorized by Magellan. For prior authorization for Mental Health or Substance Use Disorder services, Members should contact Magellan at **1-866-272-4084** (or TTY: **711**).

All non-emergency Mental Health or Substance Use Disorder services must be obtained from Magellan Participating Providers. Refer to the "Mental Health or Substance Use Disorder Services" paragraphs in the "How to Use the Plan" section for more information.

Covered Benefits are provided for Medically Necessary covered Mental Health or Substance Use Disorder, subject to applicable copayments and charges in excess of any benefit maximums. Coverage for these services is subject to all terms, conditions, limitations and exclusions of the agreement, to any conditions or limitations set forth in the benefit description.

Covered Benefits are provided for inpatient hospital and professional services, including Prescription Drugs, in connection with hospitalization for the treatment of mental health conditions and substance use disorder conditions, including inpatient psychiatric observation and inpatient monitoring of substance detox.

Inpatient Prescription Drugs for the management or treatment of mental health or substance use disorder are covered under your inpatient hospital benefit.

Covered Benefits are provided for inpatient and professional services in connection with residential care admission for the treatment of mental health conditions and substance use disorder conditions. All non-emergency inpatient Mental Health or Substance Use Disorder services must be prior authorized by Magellan and obtained from Magellan Participating Providers.

In some cases, a non-Magellan provider may provide Covered Benefits at an in-network facility where Magellan has authorized you to receive care. You are not responsible for any amounts beyond your in-network cost share for the Covered Benefits you receive at an in-network facility where Magellan has authorized you to receive care. When participating in an inpatient residential care program, prescription drugs ordered for you are covered under your pharmacy benefit, refer to the "Prescription Drugs" section.

Please refer to the "Hospital Services" section for information on Medically Necessary inpatient substance use disorder detoxification.

Outpatient Mental Health or Substance Use Disorder Services

Your plan covers the Medically Necessary treatment of Mental Health or Substance Use Disorders.

Outpatient Office Visits (in-person or telehealth):

Office visits for Mental Health or Substance Use Disorder conditions are covered under your plan. Covered Benefits are provided for outpatient office visits with Mental Health or Substance Use Disorder providers that include, but are not limited to: psychiatrists; registered psychologists, registered psychologist assistants, or psychology trainees; associate marriage and family therapists or marriage and family therapist trainees; qualified autism service providers or qualified autism service professionals; associate clinical social workers; and associate professional clinical counselors or professional clinical counselor trainees; and persons who are licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

You do not need to obtain prior authorization to access any of the services below; however, state law recommends adoption of an Individual Treatment Plan (ITP), which is reviewed every six (6) months by Magellan. An Individual Treatment Plan is required for Behavioral Health Treatment only. For more information, see *Behavioral Health Treatment* below:

1. Psychiatrist Office Visit (Specialist),
2. Psychologist Office Visit,
3. Individual or Group Chemical Dependency Counseling,
4. Individual or Group Evaluation or Treatment,
5. Intensive Outpatient Therapy for Gender Dysphoria,
6. Outpatient Monitoring for Drug Therapy,
7. Outpatient Monitoring for Detox,
8. Behavioral health crisis services provided by a 988 Center, Mobile Crisis Team, or Other Provider of Behavioral Health Crisis Services,
9. Community Assistance, Recovery, and Empowerment (CARE) Court Program Services, excluding Prescription Drugs.

Your plan covers all health care services when required or recommended for the Member pursuant to a CARE agreement or a CARE plan approved by a court, regardless of whether the service is provided by an in-network or out-of-network provider. You will not be charged any form of cost sharing for services provided pursuant to a CARE agreement or CARE plan, with the exception of any applicable prescription drug copayments.

Behavioral Health Treatment:

Behavioral Health Treatment (BHT) are professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, which develop or

restore, to the maximum extent practicable, the functioning of an individual with autism spectrum disorder.

Behavioral health treatment is covered when prescribed by a physician or licensed psychologist and provided under an individual treatment plan approved by Magellan. Treatment must be obtained from Magellan Participating Providers. The individual treatment plan is reviewed every six (6) months and is designed to:

- Describe the patient's behavioral health impairments, or developmental challenges to be treated,
- Design an intervention plan that includes the type(s) of service(s) recommended, the duration of those services and the parent participation needed to achieve the patient's goals and objectives,
- Provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Autism Spectrum Disorder,
- Discontinue intensive behavioral intervention services when treatment goals and objectives are achieved or are no longer appropriate.

Outpatient – Other Services:

Your plan covers other Mental Health or Substance Use Disorder Covered Benefits provided on an outpatient basis. Some of the Covered Benefits listed below require prior authorization by Magellan before members may access these services.

Outpatient prescription drugs for the management or treatment of a mental health or substance use disorder are covered under your pharmacy benefit. See the "Outpatient Prescription Drugs" section.

1. Partial Hospitalization (e.g. day program)
2. Intensive Outpatient Treatment
3. Outpatient Psychiatric Observation (for an acute psychiatric crisis)
4. Transcranial Magnetic Stimulation (TMS)
   TMS is a non-invasive method of delivering electrical stimulation to the brain for the treatment of severe depression.
5. Electroconvulsive Therapy (ECT)
6. Psychological Testing
7. Non-Emergency Psychiatric Transportation
8. Behavioral Health Treatment for Autism Spectrum Disorder (home appointment)

Additional services for Autism Spectrum Disorder, other than behavioral health treatment, must be coordinated by the Member's PCP and assigned medical group in order for services to be covered. The Member cost sharing will apply based on the service provided. Please refer to the Summary Benefit Description for applicable cost sharing and see the "Benefit Descriptions" section for further explanation of coverage.

Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones

Hospital, Ambulatory Surgery Center, and professional services provided for conditions of the teeth, gums or jaw joints and jaw bones, including adjacent tissues are a Covered Benefit only to the extent that they are provided for:

- The treatment of tumors of the gums,
- The treatment of damage to natural teeth caused solely by an accidental injury is limited to Medically Necessary services until the services result in initial, palliative stabilization of the Member as determined by the Plan; Dental services provided after initial medical stabilization, prosthodontics, orthodontia, and cosmetic services are not covered. This benefit does not include damage to the natural teeth that is not accidental (e.g., resulting from chewing or biting),
- Medically Necessary non-surgical treatment (e.g., splint and physical therapy) of Temporomandibular Joint Syndrome (TMJ),
- Surgical and arthroscopic treatment of TMJ if prior history shows conservative medical treatment has failed,
- Medically Necessary treatment of maxilla and mandible (jaw joints and jaw bones),
- Orthognathic surgery (surgery to reposition the upper and/or lower jaw) which is Medically Necessary to correct skeletal deformity,
- Dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate repair, or
- Teeth partly or completely impacted in the bone of the jaw.

The Plan covers deep sedation/general anesthesia and associated facility charges in conjunction with dental surgery or procedures performed by a dentist, oral surgeon, or oral maxillofacial surgeon at the following locations:

- a properly equipped and staffed office,
- a hospital or outpatient surgery center.

For any of the following:

- individuals age seven (7) years or younger who have a level of anxiety that prevents good coping skills, those who are very young and do not understand how to cope in a cooperative fashion, or those requiring extensive dental treatment,
- individuals who are severely psychologically impaired or developmentally disabled,
- individuals who have one or more significant medical comorbidities which:
    - preclude the use of either local anesthesia or conscious sedation, or
      for which careful monitoring is required during and immediately following the planned procedure.
    - individuals in whom conscious sedation would be inadequate or contraindicated for any of the following procedures:
        - removal of two or more impacted third molars,

- removal or surgical exposure of one impacted maxillary canine,
- surgical removal of two or more teeth involving more than one quadrant,
- routine removal of six or more teeth,
- full arch galvanoplasty,
- periodontal flap surgery involving more than one quadrant,
- apical excision of tooth-related lesion greater than 1.25 cm or ½ inch,
- tooth-related radical resection or ostectomy with or without grafting,
- placement or removal of two or more dental implants,
- tooth transplantation or removal from maxillary sinus,
- extraction with bulbous root and/or unusual difficulty or complications noted,
- removal of exostosis involving two areas,
- removal of torus mandibularis involving two areas.

See the "Exclusions and Limitations" section for additional services that are not covered.

Weight Management

Services for the treatment of morbid obesity or a mental health or substance use condition identified in the current International Classification of Diseases or the Diagnostic and Statistical Manual of Mental Disorders include bariatric surgical procedures, prescriptions, and related outpatient services, are covered and subject to medically necessity and prior authorization.

See the "Exclusions and Limitations" section for additional services that are not covered.

Special Transplant Benefits

Covered Benefits are provided for certain procedures listed below only if: (1) performed at a Transplant Network Facility approved by Scripps Health Plan to provide the procedure, (2) prior authorization is obtained, in writing, from the Plan Medical Director, and (3) the recipient of the transplant is a Member.

The Plan Medical Director shall review all requests for prior authorization and shall approve or deny benefits, based on the medical circumstances of the member, and in accordance with established Scripps Health Plan medical policy. Failure to obtain prior written authorization as described above and/or failure to have the procedure performed at a Scripps Health Plan approved Transplant Network Facility will result in denial of claims for this benefit.

Pre-transplant evaluation and diagnostic tests, transplantation and follow-ups will be allowed only at a Scripps Health Plan approved Transplant Network Facility. Non-acute/non-emergency evaluations, transplantations, and follow-ups at facilities other than a Scripps Health Plan Transplant Network Facility will not be approved. Evaluation of potential candidates at a Scripps Health Plan Transplant Network Facility is covered subject to prior authorization. In general, more than one evaluation (including tests) within a short time period and/or more than one Transplant Network Facility will not be authorized unless the medical necessity of repeating the service is

documented and approved. For information on Scripps Health Plan's approved Transplant Network, call our Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**.

The following procedures are eligible for coverage under this provision:

- Human heart transplants,
- Human lung transplants,
- Human heart and lung transplants in combination,
- Human liver transplants,
- Human kidney and pancreas transplants in combination (kidney only transplants are covered under the "Organ Transplant Benefits" section),
- Human bone marrow transplants, including autologous bone marrow transplantation or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and are not considered Experimental or Investigational Services,
- Pediatric human small bowel transplants,
- Pediatric and adult human small bowel and liver transplants in combination.

Reasonable charges for services incident to obtaining the transplanted material from a living donor or an organ transplant bank will be covered.

Organ Transplant Benefits

Hospital and professional services provided in connection with human organ transplants are a Covered Benefit to the extent that they are provided in connection with the transplant of a cornea, kidney, or skin, and the recipient of such transplant is a Member. Services related to obtaining the human organ transplant material from a living donor or an organ transplant bank will be covered.

Dialysis Benefits

Covered Benefits are provided for dialysis services, including renal dialysis, hemodialysis, peritoneal dialysis and other related procedures. Included in Covered Benefits are dialysis related laboratory tests, equipment, medications, supplies and dialysis self-management training for home dialysis.

For chronic hemodialysis, application for Medicare Part A and Part B coverage must be made.

Chronic dialysis (peritoneal or hemodialysis) must be authorized by the Member's medical group or Scripps Health Plan and provided within the Member's medical group. The fact that the Member is outside the geographic area served by the Participating Medical Group will not entitle the Member to coverage for maintenance of chronic dialysis to facilitate travel.

Diabetes Care

Diabetic Equipment:

Covered Benefits are provided for the following devices and equipment, including replacement after the expected life of the item and when Medically Necessary, for the management and treatment of diabetes when Medically Necessary and authorized:

- Blood glucose monitors, including those designed to assist the visually impaired,
- Insulin pumps and all related necessary supplies,
- Continuous glucose monitors and all related necessary supplies,
- Podiatric devices to prevent or treat diabetes-related complications, including extra-depth orthopedic shoes,
- Visual aids, excluding eyewear and/or video-assisted devices, designed to assist the visually impaired with proper dosing of insulin,
- Diabetic testing supplies including blood and urine testing strips and test tablets, lancets and lancet puncture devices and pen delivery systems for the administration of insulin are covered under the Outpatient Prescription Drugs benefit, please see the "Prescription Drugs" section for more information.

Diabetes Self-Management Training:

Diabetes outpatient self-management training, education and medical nutrition therapy that is Medically Necessary to enable a Member to properly use the diabetes-related devices and equipment is covered, as well as any additional treatment for these services if directed or prescribed by the Member's PCP and is authorized.

These Covered Benefits shall include, but not be limited to, instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications. Precertification is required after six (6) visits.

Reconstructive Surgery

Medically Necessary services in connection with reconstructive surgery when there is no other more appropriate covered surgical procedure, and with regards to appearance, when reconstructive surgery offers more than a minimal improvement in appearance (including congenital anomalies) are covered.

In accordance with the Women's Health and Cancer Rights Act, surgically implanted and other prosthetic devices (including prosthetic bras) and reconstructive surgery on either breast to restore and achieve symmetry related to a mastectomy, and treatment of physical complications of a mastectomy, including lymphedemas, are covered.

Surgery must be authorized as described above. Covered Benefits will be provided in accordance with guidelines established by the Plan and developed in conjunction with plastic and reconstructive surgeons.

Clinical Trials

Covered Benefits are provided for routine patient care for Members who have been accepted into an Approved Clinical Trial for the prevention, detection, or treatment of cancer or another Life-Threatening disease or condition when prior authorized through the Member's medical group, and:

- The clinical trial has a therapeutic intent and the Member's physician determines that the Member's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the participant or beneficiary, and
- The hospital and/or physician conducting the clinical trial is a Plan provider, unless the protocol for the trial is not available through a Plan provider.

Drugs, items, devices, and services for routine patient care will be paid on the same basis and at the same benefit levels as other Covered Benefits.

"Routine patient care" consists of those drugs, items, devices and services that would otherwise be covered by the Plan for a Member who is not enrolled in an Approved Clinical Trial. See "Definitions" section for information regarding an Approved Clinical Trial and Life-Threatening diseases or conditions.

See the "Exclusions and Limitations" section for additional services that are not covered.

Vision Services

The following services are Covered Benefits:

- Medically Necessary visits to diagnose and treat injuries or diseases of the eye,
- Refraction services necessary for the assessment or treatment of a medical condition,
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens,
- Special Contact Lenses:
    - Up to two Medically Necessary contact lenses per eye in any 12-month period for aniridia (missing iris),
    - Up to six Medically Necessary aphakic contact lenses per eye in any 12-month period for aphakia (absence of the crystalline lens of the eye).

Contact lenses, eyeglasses, and refractions for the purpose of correcting vision only are not Covered Benefits.

Hearing Services

The following services are Covered Benefits:

- Audiology exams,
- Hearing aids (limit one set for 36 months) – Must use contracted hearing aid provider.

5. EXCLUSIONS AND LIMITATIONS

The Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this Evidence of Coverage (EOC).

These exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary Treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by the Plan or required by law.

1. Acupuncture Services

This Plan does not cover acupuncture services, except as described in this EOC in SECTION 4 Benefit Descriptions, or as required by law.

2. Chiropractic Services

This Plan does not cover chiropractic services, except as described in this EOC in SECTION 4 Benefit Descriptions or as required by law.

3. Clinical Trials

This Plan does not cover clinical trials, except an Approved Clinical Trial as described in this EOC in SECTION 4 Benefit Descriptions, or as required by law.

Coverage of an Approved Clinical Trial does not include the following:

- The investigational drug, item, or service itself.
- Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member.
- Drugs, items, devices, and services specifically excluded from coverage in this EOC, except for drugs, items, devices, and services required to be covered pursuant to state and federal law.
- Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor.

This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental Services or Investigational Services independent review process as described in this EOC in SECTION 6 General Provisions, or to the Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in this EOC in SECTION 6 General Provisions.

4. Cosmetic Services, Supplies, or Surgeries

This Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function except as described in this EOC in SECTION 4 Benefit Descriptions, or as

required by law. The Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth except as described in this EOC in as described in this EOC in SECTION 4 Benefit Descriptions, or as required by law.

This exclusion does not apply to the following:

- Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages.
- Reconstructive surgery as described in this EOC in SECTION 4 Benefit Descriptions.
- For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this EOC in SECTION 4 Benefit Descriptions.

5. Custodial or Domiciliary Care

This Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as described in this EOC in SECTION 4 Benefit Descriptions, or as required by law.

This exclusion does not apply to the following:

- Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals.
- Assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, or inpatient hospital care.
- Custodial care provided in a healthcare facility.

6. Dental Services

This Plan does not cover dental services or supplies, except as described in this EOC in SECTION 4 Benefit Descriptions, as required by law.

7. Dietary or Nutritional Supplements

This Plan does not cover dietary or nutritional supplements, except as described in this EOC in SECTION 4 Benefit Descriptions, or as required by law.

8. Disposable Supplies for Home Use

This Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this EOC in SECTION 4 Benefit Descriptions, or as required by law.

9. Experimental Services or Investigational Services

This Plan does not cover Experimental Services or Investigational Services, except as described in this EOC in SECTION 4 Benefit Descriptions, or as required by law.

Experimental Services means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

(1) Testing is not complete; and
(2) The efficacy and safety of such services in human subjects are not yet established; and
(3) The service is not in wide usage.

The determination that a service is an Experimental Service or Investigational Service is based on:

(1) Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration);
(2) Consultation with provider organizations, academic and professional specialists pertinent to the specific service;
(3) Reference to current medical literature.

However, if the Plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the Plan must provide an external, independent review.

Qualifications

1. You must have a Life-Threatening or Seriously Debilitating condition.
2. Your Health Care Provider must certify to the Plan that you have a Life- Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the Plan.
3. Either (a) your Health Care Provider, who has a contract with or is employed by the Plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available

standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy.

4. You have been denied coverage by the Plan for the recommended or requested service.
5. If not for the Plan ’s determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered.

External, Independent Review Process

If the Plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the Plan will notify you within five business days of its decision and your opportunity to request external review of the Plan’s decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the Plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

DMHC’s Independent Medical Review (IMR)

This exclusion does not limit, prohibit, or modify a Member’s rights to an IMR from the DMHC as described in this EOC in SECTION 6 General Provisions. In certain circumstances, you do not have to participate in the Plan ’s grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial. See SECTION 6 General Provisions.

10. Vision Care

This Plan does not cover vision services, except as described in this EOC in SECTION 4 Benefit Descriptions as required by law.

11. Hearing Aids

This Plan does not cover hearing aids, except as described in this EOC in SECTION 4 Benefit Descriptions as required by law.

12. Immunizations

This Plan does not cover non-Medically Necessary or non-preventive immunizations solely for foreign travel or occupational purposes, except as required by law.

13. Non-licensed or Non-certified Providers

This Plan does not cover treatments or services rendered by a non- licensed or non-certified Health Care Provider, except as required by law. This exclusion does not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.

14. Prescription Drugs / Outpatient Prescription Drugs

The Plan does not cover the following Prescription Drugs, except as required by law:

- When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function.
- When prescribed solely for the treatment of hair loss, sexual dysfunction, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease.
- When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of Class III or severe obesity. Enrollment in a comprehensive weight loss program, if covered by the Plan, may be required for a reasonable period of time prior to or concurrent with receiving the Prescription Drug.
- When prescribed solely for the purpose of shortening the duration of the common cold.
- Prescription Drugs available over the counter or for which there is an over-the- counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to:
  - Insulin,
  - Over-the-counter drugs as covered under preventive services, e.g., over- the-counter FDA-approved contraceptive drugs),
  - Over-the-counter drugs for reversal of an opioid overdose, or
  - An entire class of Prescription Drugs when one drug within that class becomes available over the counter.
- Replacement of lost or stolen drugs.
- Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a Plan or a Plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.

15. Private Duty Nursing

This Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except

as described in this EOC in SECTION 4 Benefit Descriptions, or as required by law.

16. Personal or Comfort Items

This Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.

17. Reversal of Voluntary Sterilization

This Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications, except as required by law.

18. Surrogate Services

This Plan does not cover health care costs of the surrogate after the embryo transfer procedure, including maternity services, except as required under the terms of the surrogate's health plan contract.

19. Therapies

This Plan does not cover the following physical and occupational therapies, except as required by law:

- Massage therapy, unless it is a component of a treatment Plan;
- Training or therapy for the treatment of learning disabilities or behavioral problems;
- Social skills training or therapy; and
- Vocational, educational, recreational, art, dance, music, or reading therapy.

20. Routine Physical Examination

The Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, pre-participation examination for athletic programs, or other non- preventive purpose, except as described under this EOC in SECTION 4 Benefit Descriptions, or as required by law.

21. Travel and Lodging

This Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in this EOC in SECTION 4 Benefit Descriptions, or as required by law.

22. Weight Control Programs and Exercise Programs

This Plan does not cover weight control programs and exercise programs, except as required by law.

6. GENERAL PROVISIONS

Members' Rights and Responsibilities

As a Member, you have a right to:

- Receive information about your rights and responsibilities.
- Receive information about your Plan, the services your Plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the Plan's member rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the Plan may impose certain limitations on those services.
- Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
- Choose a Health Care Provider in your Plan's network, and change to another doctor in your Plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in your Plan's network, including one with a specialist.
- Have an appointment with a Health Care Provider outside of your Plan's network when your Plan cannot provide timely access to care with an in-network Health Care Provider.
- Certain accommodations for your disability, including:
    - Equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
    - Full and equal access, as other members of the public, to medical facilities.
    - Extra time for visits if you need it.
    - Taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
    - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
    - To be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information

regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.

- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible dependent(s) on your Plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your Plan a second opinion by an Appropriately Qualified Health Care Provider.
- Expect your Plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your Plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or medical group leaves your Plan or you are a new Plan member.
- Have an Advanced Health Care Directive.
- Be fully informed about your Plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:

- Your Plan or Health Care Provider.
- Any care you receive, or access to care you seek.
- Any covered service or benefit decision that your Plan makes.
- Any improper charges or bills for care.
- Any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans- Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
- Not meeting your language needs.

- Know why your Plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your Plan.
- To ask for an Independent Medical Review if your Plan denied, modified, or delayed a health care service.

As a Plan Member, you have the responsibility to:

- Treat all Health Care Providers, Health Care Provider staff, and Plan staff with respect and dignity.
- Share the information needed with your Plan and Health Care Providers, to the extent possible, to help you get appropriate care.
- Participate in developing mutually agreed-upon treatment goals with your Health Care Providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your Plan or Health Care Providers.
- Notify your Plan if you have any changes to your name, address, or family members covered under your Plan.
- Timely pay any premiums, copayments, and charges for non-Covered Benefits.
- Notify your Plan as soon as reasonably possible if you are billed inappropriately.

Timely Access to Care

You have the right to appointments within the following timeframes:

Urgent Appointments	Wait Time
For services that do not require prior authorization, such as with your PCP	48 hours
For services that require prior authorization, such as with a Specialist	96 hours
Non-Urgent Appointments	**Wait Time**

Primary Care Appointment	10 business days
Specialist Appointment	15 business days
Appointment with a Mental Health or Substance Use Disorder (MHSUD) provider who is not a physician	10 business days
Follow-up appointment with a non-physician MHSUD provider for those undergoing a course of treatment	10 business days following prior appointment
Ancillary services (such as X-Ray, MRI, Physical Therapy, etc.)	15 business days

If you are unable to obtain an appointment with your provider within the time-elapsed standards noted above, you have the right to request authorization for Covered Benefits from a provider outside of Scripps Health Plan's service area or from a non-participating provider. Please note that the applicable waiting time for a particular appointment may be extended if your provider has determined that it will not be harmful to your health.

You may call your provider's office 24 hours a day, 7 days a week. If you contact your provider's office after business hours, you must receive a return call within 30 minutes.

If needed, free interpreter services are available to you at the time of your scheduled appointments. Requesting interpreter services will not delay scheduling your appointments. See the "Notice of Nondiscrimination & Availability of Language Assistance Services" section for more information.

You may call Scripps Health Plan during business hours at **1-844-337-3700** to speak with a Customer Service Representative, or for the hearing and speech impaired TTY: **1-888-515-4065**.

Public Policy Participation Procedure

This procedure enables you to participate in establishing public policy for Scripps Health Plan. It is not to be used as a substitute for the grievance procedure, complaints, inquiries, or requests for information. Public policy means acts performed by a plan or its employees and staff to assure the comfort, dignity and convenience of Members who rely on the plan's facilities to provide health care services to them, their families, and the public (Health and Safety Code Section 1369).

Please Follow These Procedures:

- Your recommendations, comments, or request to participate in the Public Policy Committee should be submitted in writing to the Senior Director of Service Operations, Melissa Halgas, at Halgas.Melissa@ScrippsHealth.org or **1-858-927-5854**,
- Your name, address, phone number, Member ID number and group number should be included with each communication,

- The policy issue should be stated so that it will be readily understood. Submit all relevant information and reasons for the policy issue with your letter,

- Policy issues will be heard at least quarterly as agenda items for meetings of the Board of Directors. Minutes of Board meetings will reflect decisions on public policy issues that were considered. If you have initiated a policy issue, appropriate extracts of the minutes will be furnished to you within ten (10) business days after the minutes have been approved.

Confidentiality of Medical Records and Personal Health Information

Scripps Health Plan protects the confidentiality/privacy of your personal health information. Personal and health information includes both medical information and individually identifiable information, such as your name, address, telephone number or social security number. Scripps Health Plan will not disclose this information without your authorization, except as permitted by law.

NOTE: A STATEMENT DESCRIBING SCRIPPS HEALTH PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Scripps Health Plan policies and procedures regarding our confidentiality and privacy practices are contained in the "Notice of Privacy Practices," which you may obtain either by calling the Customer Service Department at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**, or by accessing Scripps Health Plan's internet site located at **www.ScrippsHealthPlan.com** and printing a copy. If you are concerned that Scripps Health Plan may have violated your confidentiality and privacy rights, or you disagree with a decision we made about access to your personal and health information, you may contact Customer Service Department at **1-844-337-3700**, or for the hearing and speech impaired TTY: **1-888-515-4065**.

You have the right to request Scripps Health Plan communications containing medical information be communicated to you at a specific mailing address, email address, or telephone number. Scripps Health Plan will accommodate a confidential communications request, submitted by mail or electronically, in the form and format you request if it is readily producible. The confidential communications request is valid until you revoke the request, or a new confidential communications request is submitted. The confidential communications request will apply to all communications that disclose medical information or provider name and address related to your receipt of medical services. A confidential communications request will be implemented by Scripps Health Plan within seven (7) calendar days of receipt of an electronic transmission or within fourteen (14) calendar days of receipt by first-class mail. Scripps Health Plan will acknowledge receipt of the confidential communications request. You may obtain the status of your request by calling the Customer Service Department at **1-844-337-3700**, or for the hearing and speech impaired TTY: **1-888-515-4065**. If you would like to submit a confidential communications request form, please visit the Scripps Health Plan's internet site located at **www.ScrippsHealthPlan.com/privacy-and-confidentiality**. A copy of the form is available for print.

Scripps Health Plan will not release medical information related to a person or entity allowing a child to receive gender-affirming health care or mental healthcare in response to any civil action, including a foreign subpoena, based on another state's law that authorizes a person to bring a civil action against a person or entity that allows a child to receive gender-affirming health care or mental health care.

Scripps Health Plan will not release medical information to persons or entities who have requested that information and who are authorized by law to receive that information pursuant to Civil Code § 56.10(c), if the information is related to a person or entity allowing a child to receive gender-affirming health care or mental health care, and the information is being requested pursuant to another state's law that authorizes a person to bring a civil action against a person or entity who allows a child to receive gender-affirming health care or mental health care.

Scripps Health Plan will not cooperate with any inquiry or investigation by or provide medical information to, any individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify an individual and that is related to an individual seeking or obtaining an abortion or abortion-related services that are lawful under the laws of California, unless the request for medical information is authorized under Civil Code Section 56.110.

Scripps Health Plan will not knowingly disclose, transmit, transfer, share, or grant access to medical information in an electronic health records system or through a health information exchange that would identify an individual and that is related to an individual seeking, obtaining, providing, supporting, or aiding in the performance of an abortion that is lawful under the laws of California to any individual from another state, unless the disclosure, transmittal, transfer, sharing, or granting is authorized under any of the conditions listed in Civil Code Sections 56.110(a)(1), (2), (3) and (4).

Scripps Health Plan will disclose the content of health records containing medical information specified in Civil Code Section 56.110(a) to any of the following: (a) a patient, or their personal representative, consistent with the Patient Access to Health Records Act, (b) in response to an order of a California or federal court, but only to the extent clearly stated in the order and consistent with Penal Code Section 1543, if applicable, and only if all information about the patient's identity and records are protected from public scrutiny through mechanisms, including but not limited to, a sealed proceeding or court record, and (c) when expressly required by federal law that preempts California law, but only to the extent expressly required.

Access to Information

Scripps Health Plan may need information from medical providers, from other carriers or other entities, or from you, in order to administer Covered Benefits and eligibility provisions of this Agreement. You agree that any provider or entity can disclose to Scripps Health Plan that information that is reasonably needed by Scripps Health Plan. You agree to assist Scripps Health Plan in obtaining this information, if needed, (including signing any necessary authorizations) and to cooperate by providing Scripps Health Plan with information in your possession. Failure to assist

Scripps Health Plan in obtaining necessary information or refusal to provide information when reasonably needed may result in the delay or denial of Covered benefits until the necessary information is received. Any information received for this purpose by Scripps Health Plan will be maintained as confidential and will not be disclosed without your consent, except as otherwise permitted by law.

Non-Assignability

Covered Benefits of this Plan are not assignable.

Facilities

The Plan has established a network of physicians, hospitals, participating hospice agencies and non-physician health care practitioners in your service area. The PCP(s) you and your dependents select will provide telephone access 24 hours a day, 7 days a week so that you can obtain assistance and prior approval of Medically Necessary care. The hospitals in the Plan network provide access to 24-hour Emergency Services and Care. The list of the hospitals, physicians and participating hospice agencies in your service area indicates the location and phone numbers of these providers. In some cases, a non-Scripps Health Plan provider may provide Covered Benefits at an in-network facility where we have authorized you to receive care. You are not responsible for any amounts beyond your in-network cost share for the Covered Benefits you receive at an in-network facility where we have authorized you to receive care. Contact Customer Service at **1-844-337-3700** (or for the hearing and speech impaired TTY: **1-888-515-4065**), for information on Plan non-physician health care practitioners in your PCP Service Area.

Independent Contractors

Plan providers are neither agents nor employees of the Plan but are independent contractors. Scripps Health Plan conducts a process of credentialing and certification of all physicians who participate in the Scripps Health Plan network. However, in no instance shall the Plan be liable for the negligence, wrongful acts or omissions of any person receiving or providing services, including any physician, hospital, or other provider or their employees.

Website

Scripps Health Plan's website is located at **www.ScrippsHealthPlan.com**. Members with Internet access and a Web browser may view and download health care information.

Utilization Review Process

State law requires that health plans disclose to Members and health plan providers the process used to authorize or deny health care services under the plan. Scripps Health Plan has completed documentation of this process ("Utilization Review"), as required under Section 1363.5 of the California Health and Safety Code. To request a copy of the document describing this Utilization Review, call our Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**.

To request information about Utilization Review of behavioral health and substance use disorder services contact the Plan's MHSA, Magellan, by calling **1-866-272-4084** (or TTY: **711**).

Grievance Process

You, an authorized representative, or a provider on behalf of you, may file a grievance within one hundred and eighty (180) days of the Adverse Benefit Determination (ABD) or the incident or action that is the subject of the member's dissatisfaction, and must be submitted in one of the following ways:

1. Call our Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**, or
2. File an online Member Grievance on the Scripps Health Plan website at **www.ScrippsHealthPlan.com**, or
3. In writing, by sending information to:

Scripps Health Plan
Attention: Appeals and Grievances
10790 Rancho Bernardo Road, 4S-300
San Diego, California 92127

The grievance must clearly state the issue, such as the reasons for disagreement with the ABD or dissatisfaction with the Services received. Include the identification number listed on the Scripps Health Plan Identification Card, and any information that clarifies or supports your position.

For pre-service requests, include any additional medical information or scientific studies that support the medical necessity of the service. If you would like us to consider your grievance on an urgent basis, please write "urgent" on your request and provide your rationale.

If your grievance involves Mental Health or Substance Use Disorder Services, call Magellan at **1-866-272-4084** (or TTY: **711**).

You may submit written comments, documents, records, scientific studies and other information related to the claim that resulted in the ABD in support of the grievance. All information provided will be taken into account without regard to whether such information was submitted or considered in the initial ABD. Scripps Health Plan will acknowledge receipt of your request within five (5) calendar days. Standard grievances are resolved within 30 calendar days. You have the right to review the information that we have regarding your grievance. Upon request and free of charge, this information will be provided to you, including copies of all relevant documents, records and other information. To make a request, contact our Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**.

If Scripps Health Plan upholds the ABD, that decision becomes the Final Adverse Benefit Decision (FABD). Upon receipt of an FABD, the following options are available to you:

- For FABDs involving medical judgment, you may pursue an Independent Medical Review (IMR) with the Department of Managed Health Care. Please refer to the process as described in the "Department of Managed Health Care Review" section.

- For FABDs involving benefit, you may pursue a grievance or an IMR with the Department of Managed Health Care. Please refer to the process as described in the "Department of Managed Health Care Review" section.

Urgent Decision:

An urgent grievance is resolved within 72 hours upon receipt of the request, but only if Scripps Health Plan determines the grievance meets one of the following:

- The standard appeal timeframe could seriously jeopardize your life, health, or ability to regain maximum function, or

- The standard appeal timeframe would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment, or

- A physician with knowledge of your medical condition determines that your grievance is urgent, or

- You believe that your enrollment has been or will be improperly canceled, rescinded, or not renewed.

If Scripps Health Plan determines the grievance request does not meet one of the above requirements, the grievance will be processed as a standard request. Note: If you believe your condition meets the criteria above, you have the right to contact the California Department of Managed Health Care (DMHC) at any time to request an IMR or submit a grievance regarding a cancellation, rescission, or non-renewal of coverage, at **1-888-466-2219** (TDD **1-877-688-9891**), without first filing an appeal with us.

Experimental or Investigational Denials:

Scripps Health Plan does not cover experimental or investigational drugs, devices, procedures or therapies. However, if Scripps Health Plan denies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational and you meet the eligibility criteria set out below, you may request an IMR of Scripps Health Plan's decision from the DMHC.

DMHC does not require you to exhaust Scripps Health Plan's appeal process before requesting an IMR of ABD's based on experimental or investigational services. In such cases, you may immediately contact DMHC to request an IMR. You pay no application or processing fees of any kind for this review. If you decide not to participate in the DMHC review process you may be giving up any statutory right to pursue legal action against us regarding the disputed health care service.

We will send you an application form and an addressed envelope for you to request this review with any grievance disposition letter denying coverage. You may also request an application form

by calling our Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**, or write to us at Scripps Health Plan:

Scripps Health Plan
Attention: Experimental and Investigational
10790 Rancho Bernardo Road, 4S-300
San Diego, California 92127

To qualify for this review, all the following conditions must be met:

1. You have a life threatening or seriously debilitating condition. The condition meets either or both of the following descriptions:

    a. A life-threatening condition or a disease is one where the likelihood of death is high unless the course of the disease is interrupted. A life-threatening condition or disease can also be one with a potentially fatal outcome where the end point of clinical intervention is the Member's survival,

    b. A seriously debilitating condition or disease is one that causes major irreversible morbidity.

2. Your medical group physician must certify that either (a) standard treatment has not been effective in improving your condition, (b) standard treatment is not medically appropriate, or (c) there is no standard treatment option covered by this plan that is more beneficial than the proposed treatment,

3. The proposed treatment must either be:

    a. Recommended by a Scripps Health Plan provider who certifies in writing that the treatment is likely to be more beneficial than standard treatments,

    b. Requested by you or by a licensed board certified or board eligible doctor qualified to treat your condition. The treatment requested must be likely to be more beneficial for you than standard treatments based on two documents of scientific and medical evidence from the following sources:

        i. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized standards,

        ii. Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database of Health Services Technology Assessment Research (HSTAR),

        iii. Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act,

iv. Either of the following: The American Hospital Formulary Service's Drug Information, or the American Dental Association Accepted Dental Therapeutics,

v. Any of the following references, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: the Elsevier Gold Standard's Clinical Pharmacology, the National Comprehensive Cancer Network Drug and Biologics Compendium, or the Thomson Micromedex DrugDex,

vi. Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services, and

vii. Peer reviewed abstracts accepted for presentation at major medical association meetings.

In all cases, the certification must include a statement of the evidence relied upon.

You must ask for this review within six (6) months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or 72-hour grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

Within three (3) business days of receiving notice from the DMHC of your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your doctor.

Any newly developed or discovered relevant medical records that we or a Scripps Health Plan provider identifies after the initial documents are sent will be immediately forwarded to the reviewing panel. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request (or within seven (7) days if your doctor determines that the proposed treatment would be significantly less effective if not provided promptly). This timeframe may be extended by up to three (3) days for any delay in receiving necessary records.

Independent Medical Review Involving a Disputed Health Care Service

You or an authorized representative may request an Independent Medical Review (IMR) of Disputed Health Care Services from the DMHC if you believe that Health Care Services eligible for coverage and payment under your Scripps Health Plan have been improperly denied, modified or delayed, in whole or in part, by Scripps Health Plan or one of its providers because the service is deemed not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for this review. You have the right to provide information in support of the request for an IMR.

Scripps Health Plan must provide you with an IMR application form and Scripps Health Plan's Final Appeal Benefit Determination (FABD) letter that states its position on the Disputed Health Care Service.

Eligibility: The DMHC will look at your application for IMR to confirm that:

1. One or more of the following conditions have been met:

    a. Your provider has recommended a health care service as Medically Necessary, or

    b. You have had urgent care or Emergency Services and Care that a provider determined was Medically Necessary, or

    c. You have been seen by a Scripps Health Plan provider for the diagnosis or treatment of the medical condition for which you want an IMR.

2. The disputed health care service has been denied, changed, or delayed by us or your medical group, based in whole or in part on a decision that the health care service is deemed not Medically Necessary, and

3. You have filed a complaint with Scripps Health Plan or your medical group and the disputed decision is upheld or the complaint is not resolved after 30 days. If your complaint requires urgent review you need not participate in our complaint process for more than 72 hours. The DMHC may waive the requirement that you follow our complaint process in extraordinary and compelling cases. Members are not required to participate in the Plan's grievance process prior to seeking an IMR of the decision to deny coverage of an experimental or investigational therapy.

You must ask for this review within six (6) months of the date you receive a denial notice from us in response to your grievance, or from the end of the 30 day or 72-hour grievance period, whichever applies. This application deadline may be extended by the DMHC for good cause.

If your case is eligible for an IMR, the dispute will be submitted to an Independent Medical Review Organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of Scripps Health Plan. The IRO will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of medical professionals knowledgeable in the treatment of your condition, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither you nor Scripps Health Plan will control the choice of expert reviewers.

The IRO will render its analysis and recommendations on your IMR case in writing, and in layperson's terms to the maximum extent practical. For standard reviews, the IRO must provide its determination and the supporting documents, within 30 days of receipt of the application for

review. For urgent cases, if a physician determines that the proposed therapy would be significantly less effective if not promptly initiated, the IMR decision is rendered within 72 hours.

Department of Managed Health Care Review

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (**1-844-337-3700**) or TTY at (**1-888-515-4065**) for the hearing and speech impaired and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

In the event that Scripps Health Plan should cancel or refuse to renew enrollment for you, or your dependents and you feel that such action was due to health or utilization of Covered Benefits, you or your dependents may request a review by the DMHC Director.

Appeal Rights Following Grievance Procedure

If you do not achieve resolution of your complaint through the grievance process described under the sections, "Grievance Procedures," "Experimental or Investigational Denials," "Independent Medical Review Involving a Disputed Health Care Service" and "Department of Managed Health Care Review," you have additional dispute resolution options, as outlined below:

1. Eligibility issues. Issues of eligibility should be referred directly to your HR Benefits Manager or our Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**.

2. Coverage Issues. A coverage issue concerns the denial or approval of health care services substantially based on a finding that the provision of a particular service is included or excluded as a Covered Benefit under this member handbook. It does not include a plan or contracting provider decision regarding a Disputed Health Care Service. If you are dissatisfied with the outcome of Scripps Health Plan's internal appeal process or if you have been in the process for 30 days or more, you may request review by the DMHC, proceed to court, or initiate voluntary mediation or binding arbitration. If you initiate voluntary mediation and are not successful in resolving your dispute, you may request review by the DMHC.

3. Malpractice and Bad Faith. You must proceed directly to court.

4. Disputed Health Care Service Issue. A decision regarding a disputed health care service relates to the practice of medicine and is not a coverage issue and includes decisions as to whether a particular service is not Medically Necessary, or experimental or investigational. If you are dissatisfied with the outcome of Scripps Health Plan's internal grievance process or if you have been in the process for 30 days or more, you may request an IMR from the DMHC. If you are dissatisfied with the IMR determination, you may proceed to court.

Alternate Arrangements

Scripps Health Plan will make a reasonable effort to secure alternate arrangements for the provision of care by another Plan provider without additional expense to you in the event a Plan provider's contract is terminated or a Plan provider is unable or unwilling to provide care to you.

If such alternate arrangements are not made available, or are not deemed satisfactory to the Board, then Scripps Health Plan will provide all services and/or Covered Benefits of the Agreement to you on a fee-for-service basis (less any applicable copayments), and the limitation contained herein with respect to use of a Plan provider shall be of no force or effect.

Such fee-for-service arrangements shall continue until any affected treatment plan has been completed or until such time as you agree to obtain services from another Plan provider, your enrollment is terminated, or your enrollment is transferred to another plan administered by the Board, whichever occurs first. In no case, however, will such fee-for-service arrangements continue beyond the term of the Plan, unless the Extension of Benefits provision applies to you.

Renewal Provision

This Agreement does not automatically renew. If Employer complies with all the terms of this Agreement, Scripps Health Plan will offer to renew the Agreement at least sixty (60) days prior to the Termination Date by doing one of the following:

- Extending the term of this Agreement and making other amendments – including but not limited to amendments to the Subscription Charges and Premiums and Other fees described in the Combined Evidence of Coverage and Disclosure form,
- Providing Employer with a new Group Agreement to become effective immediately after the termination of this Agreement.

7. TERMINATION OF GROUP MEMBERSHIP – CONTINUATION OF COVERAGE

Termination of Benefits

Your coverage under the Plan ends on the earliest of the following dates or for the following reasons:

- The last day of the month in which you leave the company or change your employment status to an ineligible class, unless a different date has been agreed to between Scripps Health Plan and the Employer,
- The date the Plan is terminated,
- Thirty (30) days after being notified of non-payment of Premiums,
- The date coverage ends for any employee class or group to which you belong,
- The date you waive coverage,
- The last day of the month in which you retire, or
- The date you die. Coverage for your eligible dependents will terminate at the end of the month in which your death occurs,
- Threatening life of medical staff, providers, or other members,
- Fraud or Deception.

Coverage for your dependents, if applicable, ends on the earliest of the following dates:

- On the date your coverage ends,
- The last day of the month in which his or her 26th birthday occurs (unless such dependent(s) qualify to continue beyond age 26 as described in the Section "Who is Covered" under "Eligibility and Enrollment."),
- Thirty (30) days after being notified of non-payment of Premiums for dependent coverage, or

For a child who is entitled to coverage through a Qualified Medical Child Support Order (QMCSO), coverage ends on the last day of the month in which the earliest of the following occurs:

- The Plan Administrator is supplied with satisfactory written evidence that the QMCSO ceases to be effective,
- The employee who is ordered by the QMCSO to provide coverage is no longer eligible for the Plan,
- The Employer terminates family or dependent coverage,
- The required contribution is not paid, or
- They are no longer eligible for dependent coverage under the terms of the Plan.

If the Employer terminates the Plan, coverage for a child who is entitled to coverage through a QMCSO will end on the date that the Plan is terminated.

Coverage for a domestic partner ends the last day of the month in which the domestic partnership ends.

If the Subscriber no longer lives or works in the Plan service area, coverage will be terminated for the Subscriber and all their Dependents. Special arrangements may be available for Dependents who are full-time students, Dependents of Subscribers who are required by court order to provide coverage, and Dependents and Subscribers who are long-term travelers. Please contact our Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065** to request information explaining these arrangements, including how long coverage is available.

In the event of termination for nonpayment, for members who are hospitalized or undergoing treatment for an ongoing condition, please contact us to request continued care by calling our Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**.

In the event any Member believes that his or her benefits under this Agreement have been terminated because of his or her health status or health requirements, the Member may seek from the Department of Managed Health Care, review of the termination as provided in California Health and Safety Code Section 1365(b).

Reinstatement

Since the coverage of these Covered Benefits are provided as part of a group health plan, reinstatement terms and conditions are related to eligibility requirements of your employer. If you cancel or your coverage is terminated, contact your employer's HR Benefits Manager. Reinstatement terms and conditions are described in the Group Agreement, which may be requested from your employer.

Cancellation

No benefits will be provided for services rendered after the effective date of cancellation, except as specifically provided under the Extension of Benefits and COBRA provisions in this booklet.

Extension of Benefits

If a person becomes totally disabled while validly covered under this Plan and continues to be totally disabled on the date group coverage terminates, Scripps Health Plan will extend the benefits of this Plan, subject to all limitations and restrictions, for Covered Benefits and supplies directly related to the condition, illness or injury causing such total disability until the first to occur of the following: (1) the date the covered person is no longer totally disabled, (2) 12 months from the date group coverage terminated, (3) the date on which the covered person's maximum benefits are reached, (4) the date on which a replacement carrier provides coverage to the person without limitation as to the totally disabling condition. No extension will be granted unless Scripps Health Plan receives written certification by a Plan physician of such total disability within ninety (90) days of the date on which coverage was terminated, and thereafter at such reasonable intervals as determined by Scripps Health Plan.

Individual Continuation of Benefits, COBRA and/or Cal-COBRA

COBRA:

If a Member is entitled to elect continuation of group coverage under the terms of the Consolidated Omnibus Budget Reconciliation Act (COBRA) as amended, the following applies: The COBRA group continuation coverage is provided through federal legislation and allows an enrolled active or retired employee or his/her enrolled family member who lose their regular group coverage because of certain "qualifying events" to elect continuation for 18, 29, or 36 months.

An eligible active or retired employee or his/her family member(s) is entitled to elect this coverage provided an election is made within sixty (60) days of notification of eligibility and the required premiums are paid. The benefits of the continuation coverage are identical to the group plan and the cost of coverage shall be 102% of the applicable group premiums rate. No employer contribution is available to cover the premiums.

Children born to or placed for adoption with the Member during a COBRA continuation period may be added as dependents, provided the employer or COBRA administrator is properly notified of the birth or placement for adoption, and such children are enrolled within thirty (30) days of the birth or placement for adoption.

Two qualifying events allow Members to request the continuation coverage for 18 months:

1. The covered employee's separation from employment (voluntary of involuntary) for reasons other than gross misconduct,
2. Reduction in the covered employee's hours to less than half-time.

The Member's 18-month period may also be extended to twenty-nine (29) months if the Member or any one of the qualified beneficiaries in your family was disabled and meets certain requirements on or before the date of termination or reduction in hours of employment, or is determined to be disabled under the Social Security Act within the first sixty (60) days of the initial qualifying event and before the end of the 18-month period (non-disabled eligible family members are also entitled to this 29-month extension).

Four qualifying events allow an active or retired employee's enrolled family member(s) to elect the continuation coverage for up to (thirty-six) 36 months.

1. Death of a covered employee,
2. Divorce or legal separation of the covered employee or retiree from a spouse, or termination of a domestic partner,
3. A dependent child ceases to be a dependent child,
4. The primary COBRA Member becomes entitled to Medicare.

If elected, COBRA continuation coverage is effective on the date coverage under the group plan terminates. The COBRA continuation coverage will remain in effect for the specified time or until one of the following events terminates the coverage:

1. The termination of all employer provided group health plans, or
2. The Member fails to pay the required premium(s) on a timely basis, or
3. The Member becomes covered by another health plan without limitations as to preexisting conditions, or
4. The Member becomes eligible for Medicare benefits, or
5. The first day of the month beginning thirty (30) days after the Social Security Administration determines that the individual initially determined to have been disabled is no longer disabled.

You will receive notice from your employer of your eligibility for COBRA continuation coverage if your employment is terminated or your hours are reduced. Contact your (former) employing

agency directly if you need more information about your eligibility for COBRA group continuation coverage.

If the Member is enrolled in COBRA and is contributing to the cost of the coverage, the Employer shall be responsible for collecting and submitting all Premium contributions to Scripps Health Plan in the manner and for the period established under this plan.

Cal-COBRA:

COBRA members who became eligible for COBRA coverage on or after January 1, 2003, and who reach the 18-month or 29-month maximum available under COBRA, may elect to continue medical coverage under Cal-COBRA for a maximum period of thirty-six (36) months from the date the Member's continuation of coverage began under COBRA.

Scripps Health Plan of California is responsible for notifying COBRA Members of their right to possibly continue medical coverage under Cal-COBRA, at least ninety (90) calendar days before their COBRA coverage will end. If the Member elects to apply for continuation of coverage under Cal-COBRA, the Member must submit the Cal-COBRA enrollment form to Scripps Health Plan by first-class mail or other reliable means within sixty (60) days of being notified of their right to continue medical coverage under Cal-COBRA.

If elected, the Cal-COBRA medical coverage will begin after the COBRA coverage ends. COBRA Members must exhaust all the COBRA coverage to which they are entitled before they can become eligible to continue coverage under Cal-COBRA. In no event will continuation of group coverage under COBRA, Cal-COBRA or a combination of COBRA and Cal-COBRA be extended for more than three (3) years or thirty-six (36) months from the date the qualifying event has occurred, which originally entitled the Member to continue group coverage under this Plan. In the event a Member becomes Medicare eligible after enrolling in Cal-COBRA, the Cal-COBRA coverage may be terminated.

Monthly rates for Cal-COBRA coverage shall be no more than 110% of the applicable group monthly rates. Rates are subject to change at renewal.

Cal-COBRA Members must submit monthly premium payments directly to Scripps Health Plan. The initial monthly premium must be paid within forty-five (45) days of the date the Member provided a completed enrollment form to the Plan. Failure to submit the correct amount within the initial forty-five (45)-day period will disqualify the Member from continuation of coverage. Subsequent monthly premium payments must equal an amount sufficient to pay any required amounts that are due by the first of each month. There is a thirty (30)-day grace period after which time, coverage will be terminated.

The COBRA Member should contact Scripps Health Plan for more information about continuing coverage.

8. PAYMENT BY THIRD PARTIES

Third Party Recovery Process and the Member's Responsibility

If a Member is injured or becomes ill due to the act or omission of another person (a "third party"), Scripps Health Plan, or the Member's designated medical group, with respect to services required as a result of that injury, provide the benefits of the Plan and have an equitable right to restitution, reimbursement or other available remedy to recover the amounts Scripps Health Plan paid for services provided to the Member from any recovery (defined below) obtained by or on behalf of the Member, from or on behalf of the third party responsible for the injury or illness or from uninsured/underinsured motorist coverage.

This right to restitution, reimbursement or other available remedy is against any recovery the Member receives as a result of the injury or illness, including any amount awarded to or received by way of court judgment, arbitration award, settlement or any other arrangement, from any third party or third party insurer, or from uninsured or underinsured motorist coverage, related to the illness or injury (the "recovery"), without regard to whether the Member has been "made whole" by the recovery.

The right to restitution, reimbursement or other available remedy is with respect to that portion of the total recovery that is due for the benefits paid in connection with such injury or illness, will be calculated in accordance with California Civil Code Section 3040.

The Member Is Required To:

- Notify Scripps Health Plan or the Member's designated medical group in writing of any actual or potential claim or legal action which such Member expects to bring or has brought against the third party arising from the alleged acts or omissions causing the injury or illness, not later than thirty (30) days after submitting or filing a claim or legal action against the third party, and
- Agree to fully cooperate and execute any forms or documents needed to enforce this right to restitution, reimbursement or other available remedies, and
- Agree in writing to reimburse Scripps Health Plan for Covered Benefits paid by Scripps Health Plan from any recovery when the recovery is obtained from or on behalf of the third party or the insurer of the third party, or from uninsured or underinsured motorist coverage, and
- Provide a lien calculated in accordance with California Civil Code section 3040. The lien may be filed with the third party, the third party's agent or attorney, or the court unless otherwise prohibited by law, and
- Periodically respond to information requests regarding the claim against the third party and notify Scripps Health Plan and the Member's designated medical group, in writing, within 10 days after any recovery has been obtained.

A Member's failure to comply with the requirements listed above shall not in any way act as a waiver, release, or relinquishment of the rights of Scripps Health Plan or the Member's designated medical group. Further, if the Member receives services from a Plan hospital for such injuries or illness, the hospital has the right to collect from the Member the difference between the amount paid by Scripps Health Plan and the hospital's reasonable and necessary charges for such services when payment or reimbursement is received by the Member for medical expenses. The hospital's right to collect shall be in accordance with California Civil Code Section 3045.1.

Workers' Compensation

No Covered Benefits are provided for or incident to any injury or disease arising out of, or in the course of, any employment for salary, wage or profit if such injury or disease is covered by any workers' compensation law, occupational disease law or similar legislation. However, if Scripps Health Plan provides payment for such services it will be entitled to establish a lien upon such other benefits up to the reasonable cash value of Covered Benefits provided by Scripps Health Plan for the treatment of the injury or disease as reflected by the providers' usual billed charges.

Coordination of Benefits

When a person who is covered under this group Plan is also covered under another group plan, or selected group, or blanket disability insurance contract, or any other contractual arrangement or any portion of any such arrangement whereby the members of a group are entitled to payment of or reimbursement for hospital or medical expenses, such person will not be permitted to make a "profit" on a disability by collecting benefits in excess of actual value or cost during any calendar year.

Instead, payments will be coordinated between the plans in order to provide for "allowable expenses" (these are the expenses that are incurred for services and supplies covered under at least one of the plans involved) up to the maximum Covered Benefit value or amount payable by each plan separately. If the covered person is also entitled to Covered Benefits under any of the conditions as outlined under the Limitations for Duplicate Coverage provision, Covered Benefits received under any such condition will not be coordinated with the benefits of this Plan.

The following rules determine the order of Covered Benefit payments: When the other plan does not have a coordination of benefits provision, it will always provide its benefits first. Otherwise, the plan covering the member as a Subscriber will provide its benefits before the plan covering the member as a Dependent.

Except for cases of claims for a dependent child whose parents are separated or divorced, the plan which covers the dependent child of a person whose date of birth (excluding year of birth) occurs earlier in a calendar year, shall determine its benefits before a plan which covers the dependent child of a person whose date of birth (excluding year of birth) occurs later in a calendar year. If either plan does not have the provisions of this paragraph regarding dependents, which results either in each plan determining its benefits before the other or in each plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth

in the plan which does not have the provisions of this paragraph shall determine the order of benefits.

1. In the case of a claim involving expenses for a dependent child whose parents are separated or divorced, plans covering the child as a dependent shall determine their respective benefits in the following order: First, the plan of the parent with custody of the child; then, if that parent has remarried, the plan of the stepparent with custody of the child; and finally the plan(s) of the parent(s) without custody of the child,

2. Notwithstanding #1 above, if there is a court decree which otherwise establishes financial responsibility for the medical, dental or other health care expenses of the child, then the plan which covers the child as a dependent of the parent with that financial responsibility shall determine its benefits before any other plan which covers the child as a dependent child,

3. If the above rules do not apply, the plan which has covered the Member for the longer period of time shall determine its benefits first, provided that:

    a. A plan covering a Member as a laid-off or retired employee, or as a dependent of such an employee, shall determine its benefits after any other plan covering that person as an employee, other than a laid-off or retired employee, or such dependent, and

    b. If either plan does not have a provision regarding laid-off or retired employees, which results in each plan determining its benefits after the other, then the provisions of a. above shall not apply.

If this Plan is the primary carrier with respect to a covered person, then this Plan will provide its benefits without reduction because of benefits available from any other plan.

When this Plan is secondary in the order of payments, and Scripps Health Plan is notified that there is a dispute as to which plan is primary, or that the primary plan has not paid within a reasonable period of time, this Plan will provide the benefits that would be due as if it were the primary plan, provided that the covered person: (1) assigns to Scripps Health Plan the right to receive benefits from the other plan to the extent of the difference between the value of the benefits which Scripps Health Plan actually provides and the value of the benefits that Scripps Health Plan would have been obligated to provide as the secondary plan; (2) agrees to cooperate fully with Scripps Health Plan in obtaining payment of benefits from the other plan; and (3) allows Scripps Health Plan to obtain confirmation from the other plan that the benefits which are claimed have not previously been paid.

If payments which should have been made under this Plan in accordance with these provisions have been made by another Plan, Scripps Health Plan may pay to the other Plan the amount necessary to satisfy the intent of these provisions. This amount shall be considered as benefits paid under this Plan. Scripps Health Plan shall be fully discharged from liability under this Plan to the extent of these payments.

If payments have been made by Scripps Health Plan in excess of the maximum amount of payment necessary to satisfy these provisions, Scripps Health Plan shall have the right to recover

the excess from any person or other entity to or with respect to whom such payments were made.

Scripps Health Plan may release to or obtain from any organization or person any information, which Scripps Health Plan considers necessary for the purpose of determining the applicability of and implementing the terms of these provisions or any provisions of similar purpose of any other Plan. Any person claiming benefits under this Plan shall furnish Scripps Health Plan with such information as may be necessary to implement these provisions.

9. DEFINITIONS

1. **Accidental Injury** - Definite trauma resulting from a sudden unexpected and unplanned event, occurring by chance, caused by an independent external source.

2. **Active Labor -** Labor at a time at which either there is inadequate time to effect safe transfer to another hospital prior to delivery or a transfer may pose a threat to the health and safety of the member or the unborn child.

3. **Activities of Daily Living (ADL)** - Mobility skills required for independence in normal everyday living. Recreational, leisure, or sports activities are not included.

4. **Adverse Benefit Determination (ABD)** - A decision by Scripps Health Plan to deny, reduce, terminate, or decline to pay for all or part of a Covered Benefit that is based on: determination of an individual's eligibility to participate in this Scripps Health Plan; determination that a benefit is not covered; determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

5. **Advanced Health Care Directive** means a legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.

6. **Agreement** - See Group Agreement.

7. **Allowed Amount** - The maximum amount that a Plan is willing to pay for covered health care services based upon a contracted rate for Plan providers or, for non-Plan providers, the lessor of provider's billed charges, the Reasonable and Customary Charge, or a negotiated rate agreed to by the Plan and the non-Plan provider. For Emergency Services and Care performed by non-Plan providers, the Allowed Amount is the provider's billed charges or the negotiated rate agreed to by the Plan and the non-Plan provider.

8. **Appeal** – Complaint regarding (1) payment has been denied for services that you already received, or (2) a medical provider, or (3) your coverage under this Evidence Of Coverage (EOC), including an adverse benefit determination as set forth under the Affordable Care Act (4) you tried to get prior authorization to receive a service and were denied, or (5) you disagree with the amount that you must pay.

9. **Appropriately Qualified Health Care Provider** means a Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

10. **Approved Clinical Trial** means a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life- Threatening disease or condition that meets at least one of the following:
    a. The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
        i. The National Institutes of Health.
        ii. The federal Centers for Disease Control and Prevention.
        iii. The Agency for Healthcare Research and Quality.
        iv. The federal Centers for Medicare and Medicaid Services.
        v. A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs.
        vi. A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
        vii. One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
            1. The United States Department of Veterans Affairs.
            2. The United States Department of Defense.
            3. The United States Department of Energy.
    b. The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.
    c. The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

11. **Authorization (Prior Authorization)** – Approval of a request for covered medical services, issued in response to a request for prior authorization.

12. **Authorized Representative** - An individual designated by the Member to receive Protected Health Information about the Member for purposes of assisting with a claim, an Appeal, a Grievance, or other matter. The Authorized Representative must be designated by the Member in writing on a form approved by Scripps Health Plan.

13. **Basic Health Care Services** - Physician services, including consultation and referral; hospital inpatient services and ambulatory care services; diagnostic laboratory and diagnostic and

therapeutic radiologic services; home health services; preventive health services; emergency health care services, including ambulance and ambulance transport services and out-of-area coverage; pasteurized donor human milk pursuant to Health and Safety Code Section 1635; and hospice care pursuant to Health and Safety Code Section 1368.2.

14. **Behavioral Health Treatment** – Professional services and treatment programs, including applied behavior analysis and evidence-based intervention programs that develops or restore, to the maximum extent practicable, the functioning of an individual with autism spectrum disorder.

15. **Bereavement Services** - Services available to the immediate surviving family

16. **Biomarker Testing -** The analysis of an individual's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes, but is not limited to, single-analyte tests, multiplex panel tests, and whole genome sequencing.

17. **Brand Name Drugs** - Drugs which are FDA approved either (1) after a new drug application, or (2) after an abbreviated new drug application and which has the same brand name as that of the manufacturer with the original FDA approval.

18. **Calendar Year** –The 12-month consecutive period beginning on January 1 and ending December 31 of the same calendar year.

19. **Case Management** - A collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality, cost-effective outcomes.

20. **Chiropractic Services -**Treatment provided by a licensed Doctor of Chiropractic. Treatment utilizes Chiropractic manipulation of the spine and other joints and musculoskeletal soft-tissues, physical agents and therapeutic procedures, such as ultrasound, heat, range of motion testing, and therapeutic exercise, to improve a Member's musculoskeletal and, neuromuscular systems.

21. **Chronic Condition –** A health **condition** or **disease** that is persistent or otherwise long-lasting in its effects or a **disease** that comes with time. The term **chronic** is often applied when the course of the **disease** lasts for more than three months.

22. **Claim Determination Period** - The period of time from when a claim for medical services is received by the health plan and the time either reimbursement is rendered, or the claim is rejected or denied.

23. **Coinsurance -** A percentage of the cost of a Covered Benefit that an enrollee pays after the enrollee has paid the deductible, if a deductible applies, such as Outpatient Prescription Drugs.

24. **Community Paramedicine Program** – As defined in Section 1815, a program developed by a local EMS agency and approved by the Emergency Medical Services Authority to provide community paramedicine services consisting of one (1) or more of the program specialties under the direction of medical protocols developed by the local EMS agency that are consistent with the minimum medical protocols established by the authority.

25. **Copayment** – A fixed dollar amount that a Member is required to pay for specific Covered Benefits.

26. **Cosmetic Surgery** – Surgery that is performed to alter or reshape normal structures of the body to improve appearance.

27. **Covered Benefits** means those Medically Necessary services and supplies that you are entitled to receive under a group agreement, and which are described in this Evidence of Coverage or under California health plan law.

28. **Custodial or Domiciliary Care** – Care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board or meet the activities of daily living (which may include nursing care, training in personal hygiene and other forms of self-care or supervisory care by a physician); or care furnished to a Member who is mentally or physically disabled, and

    a. Who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the Member to live outside an institution providing such care, or
    b. When, despite such treatment, there is no reasonable likelihood that the disability will be so reduced.

29. **Creditable Coverage** – Includes (1) any individual or group policy, health care service plan, self-insured employer plan, or any other entity that arranges or provides medical, hospital, and surgical coverage not designed to supplement other plans; (2) The federal Medicare program; (3) The Medi-Cal (Medicaid) program; (4) Any other publicly sponsored program, provided in this state or elsewhere, of medical, hospital, and surgical care; (5) 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (CHAMPUS); (6) A medical care program of the Indian Health Service or of a tribal organization; (7) A state health benefits risk pool; (8) A health plan offered under 5 U.S.C.A. Chapter 89 (FEHBP); (9) A public health plan as defined by the Health Insurance Portability and Accountability Act of 1996; (10) A health benefit plan under 22 U.S.C.A. 2504(e) of the Peace Corps Act.

30. **Deductible -** A calendar year amount which the Member must pay for specific Covered Benefits, after which the Plan will pay for all costs, less any copayment or coinsurance.

31. **Dependent** - The spouse, domestic partner, or child of an eligible employee, subject to applicable terms of the health care plan contract covering the employee.

32. **Dental Care and Services** - Services or treatment on or to the teeth or gums whether or not caused by accidental injury, including any appliance or device applied to the teeth or gums.

33. **Disposable devices** – Include Medically Necessary disposable devices to administer Outpatient Prescription Drugs such as spacers and inhalers, for the administration of aerosol Outpatient Prescription Drugs, and syringes for self-injectable inpatient drugs that are not dispensed in pre-filled syringes.

34. **Disputed Health Care Service** - Any Health Care Service eligible for coverage and payment under your Scripps Health Plan that has been denied, modified or delayed by Scripps Health Plan or one of its contracting providers, in whole or in part because the service is deemed not Medically Necessary.

35. **Domestic Partner** - A state registered domestic partner or an individual who is personally related to the Subscriber by a domestic partnership that meets the following requirements:

    a. Neither person is married to someone else or is a member of another domestic partnership that has not been terminated, dissolved, or adjudged a nullity,
    b. The two persons are not related by blood in a way that would prevent them from being married to each other in this state,
    c. Both persons capable of consenting to the domestic partnership,
    d. Both persons are at least 18 years of age,
    e. Either of the following:

        - Both persons are of the same sex, or
        - One or both persons meet the eligibility criteria under Title II of the Social Security Act as defined in Section 402(a) of Title 42 of the United States Code for old-age insurance benefits of Title XVI of the Social Security Act as defined in Section 1381 of Title 42 of the United States Code for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both persons are over 62 years of age.

    f. Both file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division. The domestic partnership is deemed created on the date when both partners meet the above requirements.

36. **Domiciliary Care** - Care provided in a hospital or other licensed facility because care in the patient's home is not available or is unsuitable.

37. **Drug Tier** - A group of prescription drugs that correspond to a specified cost sharing tier in the health plan's prescription drug coverage. The tier in which a prescription drug is placed determines the enrollee's portion of the cost for the drug.

38. **Dues** - The monthly prepayment that is made to the Plan on behalf of each Member by the contract holder.

39. **Durable Medical Equipment (DME)** - Equipment designed for repeated use, which is Medically Necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable

medical equipment includes wheelchairs, hospital beds, respirators, and other items that the Plan determines are durable medical equipment.

40. **Effective Date** - The date on which health insurance coverage comes into effect.

41. **Eligible Employee** - An employee who is eligible for insurance coverage based upon the stipulations of the group health insurance plan and the employer.

42. **Emergency Medical Condition** means a medical condition, manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
    a. Placing the patient's health in serious jeopardy;
    b. Serious impairment to bodily functions; or
    c. Serious dysfunction of any bodily organ or part.

43. **Emergency Services and Care** means (1) medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility; and/or (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.

44. **Employer (Contract holder)** - Any person, firm, proprietary or non-profit corporation, partnership, public agency, or association that has at least two (2) employees and that is actively engaged in business or service, in which a bona fide employer-employee relationship exists, in which the majority of employees were employed within this state, and which was not formed primarily for the purposes of buying health care coverage or insurance.

45. **Evidence of Coverage** means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

46. **Exception Request** - A request for coverage of a Prescription Drug. If an enrollee or prescribing Health Care Provider submits an exception request for coverage of a Outpatient Prescription Drug, the health plan must cover the Prescription Drug when the drug is determined to be Medically Necessary to treat the enrollee's condition. Exception requests must be submitted through the Pharmacy Prior Authorization form.

47. **Exclusion** - Specific conditions, services, or treatments for which the plan will not provide coverage.

48. **Exigent Circumstances** – When a Member is suffering from a health condition that may

seriously jeopardize the Member's life, health or ability to regain maximum function, or when a Member is undergoing a current course of treatment that will require use of a non-formulary drug.

49. **Experimental Services** means drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

50. **External Exception Review** - An objective review of a requested service performed by physicians unaffiliated with your Plan. A Member may request an External Exception if Scripps Health Plan denies, modifies, or delays a health care service or treatment.

51. **Family** - The Subscriber and all enrolled dependents.

52. **Formulary** - Is the complete list of drugs preferred for use and eligible for coverage under the Outpatient Prescription Drug benefit of the Plan. Formulary is also known as an Outpatient Prescription Drug list.

53. **Generic Drugs** - A medication that is equivalent in dosage, safety, strength, how it is taken, quality, performance, and intended use as its brand-name counterpart. Generic medications may differ in color, size, or shape, but the Food and Drug Administration requires that they have the same strength, purity, and quality as their brand counterparts. A generic medication can be produced once the manufacturer of the brand medication is required to allow other manufacturers the opportunity to produce it.

54. **Genetic Test** - An analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detect genotypes, mutations, or chromosomal changes.

55. **Grievance** – Complaint regarding dissatisfaction with the care or services that you received from your plan or some other aspect of the plan.

56. **Group Agreement (Agreement)** - The Agreement issued by the Plan to the contract holder that establishes the services Members are entitled to from the Plan.

57. **Hemophilia Infusion Provider** - A provider who has an agreement with Scripps Health Plan to provide hemophilia therapy products and necessary supplies and services for covered home infusion and home intravenous injections by Members.

58. **Health Care Provider** means any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health services.

59. **Hospice Service or Hospice Program** - A specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of a Member who is experiencing the last phases of life due to the existence of a terminal disease, to provide supportive care to the primary caregiver and the family of the hospice patient, and meets all of the following criteria:

a. Considers the Member and the Member's family in addition to the Member, as the unit of care,
b. Utilizes an Interdisciplinary Team to assess the physical, medical, psychological, social, and spiritual needs of the Member and the Member's family,
c. Requires the Interdisciplinary Team to develop an overall plan of care and to provide coordinated care which emphasizes supportive services, including, but not limited to, home care, pain control, and short-term inpatient services. Short-term inpatient services are intended to ensure both continuity of care and appropriateness of services for those Members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver,
d. Provides for the palliative medical treatment of pain and other symptoms associated with a terminal disease but does not provide for efforts to cure the disease,
e. Provides for bereavement services following the Member's death to assist the family to cope with social and emotional needs associated with the death of the Member,
f. Actively utilizes volunteers in the delivery of hospice services,
g. Provides services in the Member's home or primary place of residence to the extent appropriate based on the medical needs of the Member,
h. Is provided through a participating hospice agency.

60. **Home Health Aide Services** - Services providing for the personal care of the terminally ill Member and the performance of related tasks in the Member's home in accordance with the plan of care in order to increase the level of comfort and to maintain personal hygiene and a safe, healthy environment for the Member. Home health aide services shall be provided by a person who is certified by the California Department of Health Services as a home health aide pursuant to Chapter 8 of Division 2 of the Health and Safety Code.

61. **Homemaker Services** - Services that assist in the maintenance of a safe and healthy environment and services to enable the Member to carry out the treatment plan.

62. **Hospital** - Either a, b, or c, below:

    a. A licensed and accredited health facility which is primarily engaged in providing, for compensation from Members, medical, diagnostic, and surgical facilities for the care and treatment of sick and injured Members on an inpatient basis, and which provides such facilities under the supervision of a staff of physicians and 24-hour-a-day nursing service by registered nurses. A facility which is principally a rest home, nursing home or home for the aged is not included, or
    b. A psychiatric hospital licensed as a health facility accredited by the Joint Commission on Accreditation of Health Care Organizations, or
    c. A "psychiatric health facility" as defined in Section 1250.2 of the Health and Safety Code.

63. **Iatrogenic Infertility** – Infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment.

64. **Independent Medical Review (IMR)** means a review of your Plan's denial, modification, or delay of your request for health care services or treatment. The review is provided by the

Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your Plan related to medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature, and payment disputes for emergency or urgent medical services. Your Plan must pay for the services if an IMR decides you need it.

65. Infertility means a condition or status characterized by any of the following:

1. A licensed physician's findings, based on the patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors, consistent with generally accepted medical standards such as those of the ASRM and the Centers for Disease Control and Prevention (CDC). This definition shall not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility.

2. A person's inability to reproduce either as an individual or with their partner without medical intervention.

3. The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. "Regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

66. Interdisciplinary Team - Hospice care team that includes, but is not limited to, the Member and the Member's family, a physician and surgeon, a registered nurse, a social worker, a volunteer, and a spiritual caregiver.

67. Inpatient - An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician.

68. Intensive Outpatient Program - An outpatient Mental Health or Substance Use Disorder treatment program utilized when a Member's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week.

69. Investigational Services means those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

a. Testing is not complete; and
b. The efficacy and safety of such services in human subjects are not yet established; and
c. The service is not in wide usage.

70. Life-Threatening means either or both of the following:

a. Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

b. Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

71. Limitations - Any maximums that a health insurance plan imposes on specific benefits.

72. Medical Direction - Services provided by a licensed physician and/or surgeon who is charged with the responsibility of acting as a consultant to the Interdisciplinary Team, a consultant to the Member's PCP, as requested, with regard to pain and symptom management, and liaison with physicians and surgeons in the community. For purposes of this section, the person providing these services shall be referred to as the "Medical Director."

73. Medical Group - An organization of physicians who are generally located in the same facility and provide Covered Benefits to Members. For Mental Health or Substance Use Disorder services, this definition includes the Mental Health Services Administrator.

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

75. Medically Necessary means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:
   a. In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care.
   b. Clinically appropriate in terms of type, frequency, extent, site, and duration.
   c. Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider.

76. Medicare - The program of medical care coverage set forth in Title XVIII of the Social Security Act as amended by Public Law 89- 97 or as thereafter amended.

77. Member means a subscriber, enrollee, enrolled employee, or dependent of a subscriber or an enrolled employee, who has enrolled in the Plan and for whom coverage is active or live.

78. Mental Health Condition - Mental health conditions listed in the most recent editions of the International Classification of Diseases or the Diagnostic and Statistical Manual of Mental Disorders.

79. Mental Health or Substance Use Disorder means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

80. **Mental Health Service Administrator (MHSA)** – The Mental Health Service Administrator that Scripps Health Plan has contracted with to provide mental health services to Members.

81. **Mental Health Services** - Services provided to treat a mental health condition.

82. **MHSA Participating Provider** - A provider who has an agreement in effect with the MHSA for the provision of Mental Health or Substance Use Disorder services. Health Care Providers include psychiatrists; registered psychologists, registered psychologist assistants, or psychology trainees; associate marriage and family therapists or marriage and family therapist trainees; qualified autism service providers or qualified autism service professionals; associate clinical social workers; and associate professional clinical counselors or professional clinical counselor trainees; and persons who are licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

83. **Mobile Integrated Health Program** – A team of licensed health care practitioners, operating within their scope of practice, who provide mobile health services to support the Emergency Medical System (EMS) system.

84. **Network Specialty Pharmacy** - Select participating pharmacies contracted to provide covered specialty drugs. These pharmacies offer 24-hour clinical services and provide prompt home delivery of specialty drugs. To select a specialty pharmacy, the Member may go to **www.ScrippsHealthPlan.com** or call our Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**.

85. **Non-Contracting Providers** – A provider who is not contracted to provide services to Plan Members.

86. **Non-Formulary Drugs** - Drugs determined by Scripps Health Plan's Pharmacy and Therapeutics Committee as products that do not have a clear advantage over Formulary Drug alternatives. Benefits may be provided for Non-Formulary drugs and are always subject to the Non- Formulary copayment and must be authorized by Scripps Health Plan.

87. **Non-Participating Pharmacy** - A pharmacy which does not participate in the Scripps Health Plan Pharmacy Network.

88. **Occupational Therapy** - Treatment under the direction of a physician and provided by a certified occupational therapist, utilizing arts, crafts, or specific training in daily living skills, to improve and maintain a Member's ability to function.

89. **Open Enrollment Period** - A fixed time period designated by the Employer to initiate enrollment or change enrollment from one plan to another.

90. **Orthosis** - An orthopedic appliance or apparatus used to support, align, prevent or correct deformities or to improve the function of movable body parts.

91. **Out-of-Area Follow-up Care** - Non-emergent Medically Necessary out-of-area services to evaluate the Member's progress after an initial emergency or urgent service.

92. **Out-of-Pocket Cost** - Copayments, coinsurance, and the applicable deductible, plus all costs for health care services that are not covered by the health plan.

93. **Out-of-Pocket Maximum** - An annual limitation on all cost-sharing for which Members are responsible under the plan. This limit does not apply to premiums, balance-billed charges from out of network Health Care Providers or services that are not covered by the plan.

94. **Outpatient** - An individual receiving service under the direction of a Plan provider, but not as an inpatient.

95. **Outpatient Facility** - A licensed facility, not a physician's office, or a hospital that provides medical and/or surgical services on an outpatient basis.

96. **Outpatient Prescription Drug** means a self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.

97. **Partial Hospitalization Program/Day Treatment** – An outpatient treatment program that may be free-standing or hospital-based and provides services at least 5 hours per day, 4 days per week. Members may be admitted directly to this level of care or transferred from acute inpatient care following stabilization.

98. **Participating Hospice Agency** - An entity which:

    a. Provides hospice services to terminally ill Members and holds a license, currently in effect, as a hospice pursuant to Health and Safety Code Section 1747, or a home health agency licensed pursuant to Health and Safety Code Sections 1726 and 1747.1 which has Medicare certification, and
    b. Either has contracted with Scripps Health Plan or has received prior approval from Scripps Health Plan of California to provide hospice service benefits pursuant to the California Health and Safety Code Section 1368.2.

99. **Participating Pharmacy** - A pharmacy which participates in the Scripps Health Plan Pharmacy Network. These participating pharmacies have agreed to a contracted rate for covered prescriptions for Scripps Health Plan Members. To locate a participating pharmacy, the Member may go to **www.ScrippsHealthPlan.com** or call our Customer Service Department toll free at **1-844-337-3700** or for the hearing and speech impaired TTY: **1-888-515-4065**.

100. **PCP Service Area** - Geographic area served by the PCP's medical group.

101. **Period of Care** - The time when the PCP pre-certifies that the Member still needs and remains eligible for hospice care even if the Member lives longer than one (1) year. A period of care starts the day the Member begins to receive hospice care and ends when the 60 or 90-day period has ended.

102. **Period of Crisis** - A period in which the Member requires continuous care to achieve palliation or management of acute medical symptoms.

103. Pharmacy Benefit Manager – A third-party benefits administrator providing outpatient pharmacy benefits for Plan Members.

104. Physical Therapy - Treatment provided by a physician or under the direction of a physician and provided by a registered physical therapist, certified occupational therapist or licensed doctor of podiatric medicine. Treatment utilizes physical agents and therapeutic procedures, such as ultrasound, heat, range of motion testing, and massage, to improve a Member's musculoskeletal, neuromuscular and respiratory systems.

105. Physician - An individual licensed and authorized to engage in the practice of medicine or osteopathy.

106. Plan –Scripps Health Plan.

107. Plan Hospital - A hospital licensed under applicable state law contracting specifically with Scripps Health Plan to provide Covered Benefits to Members under the Plan.

108. Plan Non-Physician Health Care Practitioner - A health care professional who is not a physician and has an agreement with one of the contracted medical groups, Plan hospitals or Scripps Health Plan to provide Covered Benefits to Members when referred by a PCP. For all Mental Health or Substance Use Disorder services, this definition includes MHSA Participating Providers.

109. Plan of Care - A written plan developed by the attending physician and/or surgeon, the "medical director" (as defined under "Medical Direction") or physician and surgeon designee, and the Interdisciplinary Team that addresses the needs of a Member and family admitted to the hospice program. The hospice shall retain overall responsibility for the development and maintenance of the plan of care and quality of services delivered.

110. Plan Provider - A provider who has an agreement with Scripps Health Plan to provide Plan Covered Benefits to Members and a MHSA Participating Provider.

111. Plan Service Area - Designated geographical area within which a Member must live or work to be eligible for enrollment in this Plan.

112. Plan Specialist - A physician other than a PCP, psychologist, licensed clinical social worker, or licensed marriage and family therapist who has an agreement with Scripps Health Plan to provide services to Members either according to an authorized referral by a PCP, or for OB/GYN physician services. For Mental Health or Substance Use Disorder services, this definition includes MHSA Participating Providers.

113. Premium - Total amount paid to the Plan for health insurance coverage. This is typically a monthly charge. Within the context of group health insurance coverage, the premium is paid in whole or in part by the employer on behalf of the employee and/or the employee's dependents.

114. Prescription - An oral, written, or electronic order by a prescribing provider for a Member that contains the name of the Prescription Drug, the quantity of the prescribed drug, the date of issue, the name and contact information of the prescribing provider, the signature of the prescribing provider if the prescription is in writing, and if requested by the member, the medical condition or purpose for which the drug is being prescribed.

115. Prescription Drug or "drug'' means a drug approved by the federal Food and Drug Administration (FDA) for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug'' or "Prescription Drug'' includes:(A) disposable devices that are Medically Necessary for the administration of a covered Prescription Drug, such as spacers and inhalers for the administration of aerosol Outpatient Prescription Drugs; (B) syringes for self-injectable Prescription Drugs that are not dispensed in pre-filled syringes; (C) drugs, devices, and FDA-approved products covered under the Prescription Drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products; and (D) at the option of the health plan, any vaccines or other health care benefits covered under the Plan's Prescription Drug benefit.

116. Preventive Health Services - Those primary preventive medical Covered Benefits provided by a physician, including related laboratory services, for early detection of disease.

117. Primary Care Physician (PCP) - A general practitioner, board-certified or eligible family practitioner, internist, obstetrician/gynecologist or pediatrician who has contracted with the Plan as a PCP to provide primary care to Members and to refer, authorize, supervise and coordinate the provision of all Covered Benefits to Members in accordance with the Agreement.

118. Prior Authorization - A requirement that the Member or the prescribing provider obtain an authorization for a service or Prescription Drug before the Plan will cover the service or drug. The health plan shall grant a prior authorization when it is Medically Necessaryfor the enrollee to obtain the service or drug.

119. Prosthesis - An artificial part, appliance or device used to replace or augment a missing or impaired part of the body.

120. Psychiatric Emergency Medical Condition means a mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

121. Reasonable and Customary Charge - The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service.

122. Reconstructive Surgery - Surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or

disease to do either of the following: (1) to improve function, or (2) to create a normal appearance to the extent possible, including dental and orthodontic services that are an integral part of this surgery for cleft palate procedures.

123. Rehabilitation – Inpatient or outpatient care furnished to an individual disabled by injury or illness, in order to develop or restore an individual's ability to function to the maximum extent practical. Rehabilitation services may consist of physical therapy, occupational therapy, and/or respiratory therapy. Covered Benefits for speech therapy are described in Speech Therapy in the Benefit Descriptions section.

124. Residential Care - Mental Health services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for Members who do not require acute inpatient care.

125. Respiratory Therapy - Treatment, under the direction of a physician and provided by a certified respiratory therapist, to preserve or improve a Member's pulmonary function.

126. Respite Care Services - Short-term inpatient care provided to the Member only when necessary to relieve the family members or other persons caring for the Member.

127. Scripps Health Plan Services or "Plan" - A health care service plan licensed by the California Department of Managed Health Care.

128. Scripps Health Plan – Covered Benefits provided under this Combined Evidence of Coverage and Disclosure Form.

129. Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

130. Service Area means the geographic area designated by the plan within which a plan shall provide health care services.

131. Services - Medically Necessary health care services and Medically Necessary supplies furnished incident to those services.

132. Skilled Nursing Facility - A facility with a valid license issued by the California Department of Health Services as a "skilled nursing facility" or any similar institution licensed under the laws of any other state, territory, or foreign country.

133. Skilled Nursing Services - Nursing services provided by or under the supervision of a registered nurse under a plan of care developed by the Interdisciplinary Team and the Member's Plan provider to a Member and Member's family that pertain to the palliative, supportive services required by a Member with a terminal illness. Skilled nursing services include, but are not limited to, Member assessment, evaluation and case management of the medical nursing needs of the Member, the performance of prescribed medical treatment for pain and symptom control, the provision of emotional support to both the Member and Member's family, and the instruction of caregivers in providing personal care to the Member.

Skilled nursing services provide for the continuity of services for the Member and Member's family and are available on a 24-hour on-call basis.

134. Social Service/Counseling Services - Counseling and spiritual services that assist the Member and Member's family to minimize stresses and problems that arise from social, economic, psychological, or spiritual needs by utilizing appropriate community resources, and maximize positive aspects and opportunities for growth.

135. Special Food Products - A food product which is both of the following:

a. Prescribed by a physician or nurse practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of Appropriately Qualified Health Care Provider with expertise germane to, and experience in the treatment and care of, PKU. It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving,
b. Used in place of normal food products, such as grocery store foods, used by the general population.

136. Specialty Drugs - Specialty drugs are specific drugs used to treat complex or chronic conditions which usually require close monitoring such as multiple sclerosis, hepatitis, rheumatoid arthritis, cancer, and other conditions that are difficult to treat with traditional therapies. Specialty drugs are listed in Scripps Health Plan's Outpatient Drug Formulary. Specialty drugs may be self-administered in the home by injection by the patient or family member (subcutaneously or intramuscularly), by inhalation, orally or topically. Infused or IV medications are not included as specialty drugs. These drugs may also require special handling, may require special manufacturing processes, and may have limited prescribing or limited pharmacy availability. Specialty drugs must be considered safe for self-administration by Scripps Health Plan's Pharmacy and Therapeutics Committee, must be obtained from a Scripps Health Plan specialty pharmacy and may require prior authorization for medical necessity by Scripps Health Plan.

137. Speech Therapy - Treatment under the direction of a physician and provided by a licensed speech pathologist or speech therapist, to improve or retrain a Member's vocal skills which have been impaired by diagnosed illness or injury.

138. Stabilize or Stabilization - When, in the opinion of the treating physician, or other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician, the Member's medical condition is such that, within reasonable medical probability, no material deterioration of the Member's condition is likely to result from, or occur during, the release or transfer of the Member.

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

140. Step Therapy - A process specifying the sequence in which different Prescription Drugs for a given medical condition are prescribed. The Plan may require the enrollee to try one or more drugs to treat the Member's medical condition before the Plan will cover a particular drug. If the Member's prescribing provider submits a request for step therapy exception, the Plan shall make exceptions to step therapy when the criteria is met. All requests for Step Therapy must be submitted using Pharmacy Prior Authorization form.

141. Sub-Acute Care - Skilled nursing or skilled rehabilitation provided in a hospital or skilled nursing facility to Members who require skilled care such as nursing services, physical, occupational or speech therapy, a coordinated program of multiple therapies or who have medical needs that require daily Registered Nurse monitoring. A facility which is primarily a rest home, convalescent facility or home for the aged is not included.

142. Subscriber - Person enrolled who is responsible for payment of premiums to the plan, and whose employment or other status, except family dependency, is the basis for eligibility for enrollment under this plan.

143. Substance Use Disorder Condition - For the purposes of this Plan, means any disorders caused by or relating to the recurrent use of alcohol, drugs, and related substances, both legal and illegal, including but not limited to, dependence, intoxication, biological changes and behavioral changes.

144. Terminal Disease or Terminal Illness - A medical condition resulting in a prognosis of life of one (1) year or less, if the disease follows its natural course.

145. Total Disability

a. In the case of an employee or Member otherwise eligible for coverage as an employee, a disability which prevents the individual from working with reasonable continuity in the individual's customary employment or in any other employment in which the individual reasonably might be expected to engage, in view of the individual's station in life and physical and mental capacity,
b. In the case of a dependent, a disability which prevents the individual from engaging with normal or reasonable continuity in the individual's customary activities or in those in which the individual otherwise reasonably might be expected to engage, in view of the individual's station in life.

146. Trans-Inclusive Health Care means comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

147. Triage to Alternate Destination Program – A program defined in Section 1819, a program developed by a local EMS agency and approved by the Emergency Medical Services Authority

to provide triage paramedic assessments consisting of one (1) or more specialties operating under triage and assessment protocols developed by the local EMS agency that are consistent with the minimum triage and assessment protocols established by the authority.

148. Urgent Care Services - Services rendered outside of the PCP Service Area (other than Emergency Services and Care) which are Medically Necessary to prevent serious deterioration of a Member's health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until the Member returns to the PCP Service Area.

149. Volunteer Services - Services provided by trained hospice volunteers who have agreed to provide service under the direction of a hospice staff Member who has been designated by the hospice to provide direction to hospice volunteers. Hospice volunteers may provide support and companionship to the Member and Member's family during the remaining days of the Member's life and to the surviving family following the Member's death.

10. SERVICE AREA

You may enroll in the Scripps Health Plan using either your residential or work ZIP Code. If you use your residential ZIP Code, all enrolled dependents must reside in the health plan's Service Area. When you use your work ZIP Code, all enrolled dependents must receive all Covered Benefits (except emergency and urgent care) within the health plan's Service Area, even if they do not reside in that area.

Zip Code	City	County
91903	Alpine	San Diego
91902	Bonita	San Diego
91908	Bonita	San Diego
92003	Bonsall	San Diego
92055	Camp Pendleton	San Diego
92007	Cardiff By The Sea	San Diego
92008	Carlsbad	San Diego
92009	Carlsbad	San Diego
92010	Carlsbad	San Diego
92011	Carlsbad	San Diego
92013	Carlsbad	San Diego
92018	Carlsbad	San Diego
91909	Chula Vista	San Diego
91910	Chula Vista	San Diego
91911	Chula Vista	San Diego
91912	Chula Vista	San Diego
91913	Chula Vista	San Diego
91914	Chula Vista	San Diego
91915	Chula Vista	San Diego
91921	Chula Vista	San Diego
92118	Coronado	San Diego
92178	Coronado	San Diego
92014	Del Mar	San Diego
91917	Dulzura	San Diego
92019	El Cajon	San Diego
92020	El Cajon	San Diego
92021	El Cajon	San Diego
92022	El Cajon	San Diego
92023	Encinitas	San Diego
92024	Encinitas	San Diego
92025	Escondido	San Diego
92026	Escondido	San Diego
92027	Escondido	San Diego
92029	Escondido	San Diego
92030	Escondido	San Diego
92033	Escondido	San Diego
92046	Escondido	San Diego

92028	Fallbrook	San Diego
92088	Fallbrook	San Diego
91932	Imperial Beach	San Diego
91933	Imperial Beach	San Diego
91935	Jamul	San Diego
92037	La Jolla	San Diego
92038	La Jolla	San Diego
92039	La Jolla	San Diego
92092	La Jolla	San Diego
92093	La Jolla	San Diego
91941	La Mesa	San Diego
91942	La Mesa	San Diego
91943	La Mesa	San Diego
91944	La Mesa	San Diego
92040	Lakeside	San Diego
91945	Lemon Grove	San Diego
91946	Lemon Grove	San Diego
91950	National City	San Diego
91951	National City	San Diego
92049	Oceanside	San Diego
92051	Oceanside	San Diego
92052	Oceanside	San Diego
92054	Oceanside	San Diego
92056	Oceanside	San Diego
92057	Oceanside	San Diego
92059	Pala	San Diego
92060	Palomar Mountain	San Diego
92061	Pauma Valley	San Diego
92064	Poway	San Diego
92074	Poway	San Diego
92065	Ramona	San Diego
92067	Rancho Santa Fe	San Diego
92091	Rancho Santa Fe	San Diego
92101	San Diego	San Diego
92102	San Diego	San Diego
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92119	San Diego	San Diego
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92195	San Diego	San Diego
92196	San Diego	San Diego
92197	San Diego	San Diego
92198	San Diego	San Diego
92199	San Diego	San Diego
92068	San Luis Rey	San Diego
92069	San Marcos	San Diego
92078	San Marcos	San Diego
92079	San Marcos	San Diego
92096	San Marcos	San Diego
92143	San Ysidro	San Diego

92173	San Ysidro	San Diego
92070	Santa Ysabel	San Diego
92071	Santee	San Diego
92072	Santee	San Diego
92075	Solana Beach	San Diego
91976	Spring Valley	San Diego
91977	Spring Valley	San Diego
91978	Spring Valley	San Diego
91979	Spring Valley	San Diego
91980	Tecate	San Diego
91987	Tecate	San Diego
92082	Valley Center	San Diego
92081	Vista	San Diego
92083	Vista	San Diego
92084	Vista	San Diego
92085	Vista	San Diego

11. IMPORTANT CONTACTS

Company	Phone No.	Web Address
Scripps Health Plan	**1-844-337-3700** TTY: **1-888-515-4065**	**www.ScrippsHealthPlan.com**
MedImpact	**1-844-282-5343** TTY: **711**	**www.medimpact.com** • Prescription Drug Coverage tab • follow the link under the Prescription Drug Formulary or Contact MedImpact sections to the MedImpact Member Portal
Magellan (Mental Health Service Administrator)	**1-866-272-4084** TTY: **711**	**magellanhealthcare.com** • Claims PO Box 710220 San Diego, CA 92171 • Grievances PO Box 710190 San Diego, CA 92171

American Specialty Health	**1-800-678-9133** TTY: **711**	**www.ashlink.com** • Acupuncture and Chiropractic Providers tab • Follow the link to visit the ASH website
Doctor on Demand (Tele-Health)	**1-800-997-6196**	**www.doctorondemand.com/Scripps**

12. NOTICE OF NONDISCRIMINATION & AVAILABILITY OF LANGUAGE ASSISTANCE SERVICES

In addition to the State of California nondiscrimination requirements, Scripps Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Scripps Health Plan does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. To assist Members in accessing services, Scripps Health Plan:

1. Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    a. Qualified sign language interpreters,
    b. Written information in other formats (large print, audio, accessible electronic formats, other formats).

2. Provides free language services to people whose primary language is not English, such as:
    a. Qualified interpreters,
    b. Information written in other languages.

If you need these services, contact Scripps Health Plan Customer Service by calling **1-844-337-3700 (TTY: 1-888-515-4065)**.

If you believe that Scripps Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance to the Plan Compliance Officer or the Appeals and Grievance Department by mail, in person, telephonically, fax, email or online. If you need help filing a grievance, we are available to help you. Mail or in person:

Scripps Health Plan
Attn: Appeals & Grievances
10790 Rancho Bernardo Road, 4S-300
San Diego, California 92127
Phone: 1-844-337-3700
TTY: 1-888-415-4065
Fax: 1-858-260-5879
Email: SHPSAppealsAndGrievancesDG@scrippshealth.org
Online: www.scrippshealthplan.com

If your health problem is urgent, you already filed a complaint and are not satisfied with the decision, or it has been more than thirty (30) days since you filed a complaint, you may submit an Independent Medical Review/Complaint Form with the Department of Managed Health Care (DMHC). You may submit a complaint form by calling the DMHC Help Desk at 1-888-466-2219 (TDD: 1-877-688-9891) or online at www.dmhc.ca.gov/FileaComplaint.

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/smartscreen/main.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html/

Spanish (Español)

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-337-3700 (TTY: 1-888-515-4065). Scripps Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Chinese (中文)

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 1-844-337-3700 (TTY 1-888-515-4065）。 Scripps Health Plan 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Vietnamese (Tiếng Việt)

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-337-3700 (TTY: 1-888-515-4065). Scripps Health Plan tuân thủ luật dân quyền hiện hành của Liên

bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Tagalog (Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-337-3700 (TTY: 1-888-515-4065). Sumusunod ang Scripps Health Plan sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

Korean (한국어)

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-337-3700
(TTY: 1-888-515-4065) 번으로 전화해 주십시오. Scripps Health Plan 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Armenian (հայերեն)

Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-844-337-3700 (TTY (հեռատիպ)՝ 1-888-515-4065): Scripps Health Plan-ը հետևում է քաղաքացիական իրավունքների մասին գործող դաշնային օրենքներին և խտրականություն չի ցուցաբերում՝ ռասայի, մաշկի գույնի, ազգային պատկանելության, տարիքի, հաշմանդամության կամ սեռի հիման վրա:

Persian (Farsi) فارسی

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (4065-515-1-888: TTY) 3700-337-844-1 تماس بگیرید.

Scripps Health Plan از قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت افراد قایل نمی شود.

Russian (русском)

Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-337-3700 (телетайп: 1-888-515-4065). Scripps Health Plan соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

Japanese (日本)

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。1-844-337-3700

（TTY: 1-888-515-4065）まで、お電話にてご連絡ください。Scripps Health Plan は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害または性別に基づく差別をいたしません。

Arabic (العربية)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-337-3700 (رقم هاتف الصم والبكم: 1-888-515-4065). يلتزم Scripps Health Plan بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.

Punjabi (ਪੰਜਾਬੀ ਦੇ)

ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-844-337-3700 (TTY: 1-888-515-4065) 'ਤੇ ਕਾਲ ਕਰੋ। Scripps Health Plan ਲਾਗੂ ਸੰਘੀ ਨਾਗਰਿਕ ਹੱਕਾਂ ਦੇ ਕਾਨੂੰਨਾਂ ਦੀ ਪਾਲਣਾ ਕਰਦੀ ਹੈ ਅਤੇ ਨਸਲ, ਰੰਗ, ਰਾਸ਼ਟਰੀ ਮੂਲ, ਉਮਰ, ਅਸਮਰਥਤਾ, ਜਾਂ ਲਿੰਗ 'ਤੇ ਅਧਾਰ 'ਤੇ ਵਿਤਕਰਾ ਨਹੀਂ ਕਰਦੀ ਹੈ।

Mon Khmer (ខ្មែរ)

បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-844-337-3700 (TTY: 1-888-515-4065)។Scripps Health Plan អនុវត្តតាមច្បាប់សិទ្ធិពលរដ្ឋនៃ សហព័ន្ធដែលសមរម្យនិងមិនមានការរើសអើស លើមូលដ្ឋាន នៃពូជសាសន៍ ពណ៌សម្បុរ សញ្ជាតិដើម អាយុ ពិការភាព ឬភេទ។

Hmong (Hmoob)

Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-337-3700 (TTY: 1-888-515-4065). Scripps Health Plan ua raws cov kev cailij choj yuam siv ntawm Tsom Fwv Nrub Nrab Teb Chaw hais txog pej xeem cov cai (Federal civil rights laws) thiab tsis ciav-cais leejtwg vim nws hom neeg, nqaij tawv, lub tebchaws tuaj, hnub nyoog, kev tsis taus, los yog poj niam txiv.

Hindi (हिंदी)

यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-337-3700 (TTY: 1-888-515-4065) पर कॉल करें। Scripps Health Plan लागू होने योग्य संघीय नागरिक अधिकार क़ानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।

Thai (ไทย)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-844-337-3700 (TTY: 1-888-515-4065). Scripps Health Plan ได้ปฏิบัติตามรัฐบัญญัติด้านสิทธิ์ที่เหมาะสม และไม่ได้แบ่งแยกทางชาติพันธุ์ สีผิว เชื้อชาติ อายุ ความทุพพลภาพ หรือเพศ

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