GROUP ADMINISTRATION MANUAL

November 2012

WELCOME

Welcome to Sharp Health Plan. We are pleased that you have selected Sharp Health Plan to provide health benefits to your employees. We value your business and strive to offer the highest level of service available in the marketplace.

Sharp Health Plan offers quality, personal, economical and convenient medical coverage for your employees and their families. Sharp Health Plan provides for the health care needs of your employees through a network of quality physicians, hospitals and other providers throughout San Diego and southern Riverside Counties.

We have prepared this Group Administration Manual to assist you in the administration of Sharp Health Plan coverage. You will find this to be an important reference regarding health plan policies and procedures. This manual has been written with the Employer Group in mind. Your employees are provided with Member Handbooks that similarly assist them in understanding their health plan benefits and policies.

An additional resource will be your Group Agreement, which constitutes the legal and contractual agreement between Sharp Health Plan and the Employer Group and lists any special agreements. A Group Agreement will be provided to you upon the initial enrollment of the Group and each subsequent renewal period.

In the event of any discrepancies between the Group Administration Manual and the Group Agreement, the Group Agreement will govern in all cases.

A Dedicated Account Manager for You!

Each Employer Group has its own Account Manager. Your Account Manager is able to provide you with personalized service and timely updates of information when you need it. If you are unsure about how to contact your Account Manager, please call our Commercial Sales Department at 858-499-8229.

Personalized Customer Care Team for Your Employees.

Customer Care Representatives are available to provide personalized assistance and education for your employees**. Members who need assistance should always make the Customer Care team their first point of contact.** Customer Care Representatives are available from 8 a.m. to 6 p.m., Monday through Friday, toll-free at 1-800-359-2002. This phone number is also referenced on Member ID cards.

MISSION STATEMENT

It is our mission to ensure that the health care services rendered to our enrollees are always appropriate, of high quality, meet or exceed community standards and are provided in a caring, convenient, cost-effective and accessible manner.

To accomplish our mission and be recognized as a leader in San Diego managed care field, our commitments are to:

- Contribute to the integration of the Sharp HealthCare system;
- Create partnerships with employers, members and physicians;
- As a locally owned and operated health plan, be responsive and sensitive to local needs and an active participant in the San Diego community; and
- Be proactive in promoting and improving the health status of our members.

HOW TO USE THIS MANUAL

The purpose of this manual is to assist you by simplifying the process of administering your Sharp Health Plan benefits program.

Using the Table of Contents
The Table of Content lists each section by its title and then lists each subcategory within that section. Each section contains information on a specific procedure that you may encounter. Detailed instructions are included along with sample forms where applicable.

Using the Tabs
Each tab represents a major category under which specific procedures are listed.

Using the Sample Forms and Instructions
We have also included a sample of each of the most commonly used forms.

Using the Glossary of Terms
The Glossary of Terms section contains a list of terms used within this manual and their specific representations.

Updating Your Group Administration Manual
Please keep this manual handy, as we will be providing updated pages and sections as necessary. As you receive these updates, please be sure to remove any old pages and insert any new ones.

Storing Your Current Group Agreement and Rates
For convenience and ease of reference, we suggest that you store a copy of your fully executed Group Agreement and a copy of your group's current rates behind the appropriate tabs in this manual.

TABLE OF CONTENTS

MEMBERSHIP INFORMATION – SECTION 3 (continued)

ENROLLMENT/CANCELLATION PROCEDURES

IN THIS SECTION, YOU WILL FIND INFORMATION ABOUT:

NEW EMPLOYEES

To be eligible to enroll as a Member under Sharp Health Plan, an employee must:

- Be a full-time, active employee and satisfy the minimum hours per week requirement as defined in the Group Agreement.
- Have completed the waiting period defined in your Group Agreement.
    - Waiting periods are applied to:
        1. New full-time employees
        2. Employee status changes from part-time to full-time
        3. Rehired employees, unless otherwise defined by the Group Agreement
    - Sample waiting period calculation:
        - Group waiting period is 90 days
        - Employee hire date is May 3
        - Wait period will satisfy on August 3 and
        - Effective date of coverage for employee is September 1 (first day of following month)
- Work or reside within the Service Area of San Diego County and southern Riverside County.
- Satisfy all eligibility requirements as defined in your Group Agreement.
- Elect health care coverage through Sharp Health Plan by submitting a completed and signed Sharp Health Plan Enrollment Application within thirty-one (31) days of the eligibility effective date.
- Never have had coverage terminated for him/herself or any Dependents for cause by the Plan.

Each enrollee should be provided an enrollment kit. Please contact your Account Manager for a supply of these kits.

Important Reminder
Please send new enrollment applications as they occur. Timely notification of enrollment changes will help Sharp Health Plan serve Members in the following ways:

- Member eligibility will be visible to providers.
- Members will be able to access care on their effective dates.
- Billing adjustments will be processed and appear sooner.
- Members will receive their member identification card timely.

FORMERLY INELIGIBLE EMPLOYEES

An employee changing from part-time to full-time status will be eligible for coverage the first day of the month following the completion of the waiting period after becoming full time, as defined in the Group Agreement.

For example:

- Employee wait period is 90 days
- Employee who is part-time becomes full-time on June 15
- Employee satisfies wait period on September 15
- Effective date of coverage for employee is October 1

REHIRED EMPLOYEES

Employees who have been rehired will be subject to the re-hire waiting period as defined in your Group Agreement.

For example:

- Employee re-hired on January 15
- Employee re-hire wait period is 90 days
- Employee satisfies re-hire wait period April 15
- Effective date of coverage will be May 1

DEPENDENTS

A Dependent's eligibility for enrollment is contingent upon the Subscriber's eligibility for membership in Sharp Health Plan. Eligible Dependents include:

- The Spouse of an Enrolled Employee;
- The Dependent child of an Enrolled Employee or the Enrolled Employee's Spouse, who is either:
    - Under age 26; or
    - Who at the time of attaining age 26 is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition and is chiefly dependent upon the Enrolled Employee for support and maintenance. Proof of incapacity and dependence must be furnished to the Plan by the Enrolled Employee as outlined in the Group Agreement.
    - Any other person under age 26 for whom the Enrolled Employee or the Enrolled Employee's Spouse is (or was before the person's 18th birthday) the court-appointed guardian. The Plan may require the Eligible Employee to furnish evidence, on a periodic basis, of the IRS status, residency or guardianship of such person.

Please Note: An adult Dependent child enrolled in a grandfathered plan is only eligible for coverage as a Dependent with Sharp Health Plan if the adult child is not eligible for his or her own employer sponsored coverage. A grandfathered plan is a health benefit plan that was in existence on March 23, 2010, and continuously covered someone in that same plan since that date.

OPEN ENROLLMENT

Open Enrollment is generally held in the month preceding the effective date of your contract renewal. This is the time Eligible Employees may:

- Choose to enroll in Sharp Health Plan
- Add or delete family members to their coverage

As an Employer Group you may also make changes to the current plan design (e.g., adding or deleting benefits, changing employer contributions, waiting periods etc.) during this renewal period. Any changes made during Open Enrollment become effective on the renewal date.

To make Open Enrollment easier, your Account Manager is available to assist you, both in English and Spanish, by organizing the following activities:

- Presentation of benefits to employees
- On-site question and answer sessions
- Notices for distribution to employees
- Sharp Health Plan benefits comparison assistance

Regardless of how your company decides to communicate Open Enrollment information, Sharp Health Plan is available to assist you in giving your employees the opportunity to make an educated choice of health plans.

INITIAL ENROLLMENT

All newly Eligible Employees should be provided an enrollment kit at least thirty-one (31) days prior to their effective date of coverage. If additional enrollment materials are needed, please contact your Sharp Health Plan Account Manager to request additional supplies.

ENROLLING NEWLY ELIGIBLE MEMBERS AND DEPENDENTS

Eligible Employees who wish to enroll themselves and their Dependents in Sharp Health Plan must complete, sign and date the *Enrollment Application* form.

Please submit all completed forms to Sharp Health Plan. To avoid unnecessary delays in processing enrollment forms, please ensure the *Enrollment Application* form is fully completed and includes all of the following information:

- Group Name, Effective Date, and Reason for Application (e.g., hire date or rehire)
- All required Employee-specific information including:
  - Primary Care Physician (PCP) selection for Employee and any enrolling Dependents (PCP may be different for each member)
  - Dependent coverage selection an information
  - Employee signature in signature section at the bottom of the form

Important Reminder:
Completed enrollment forms should be sent immediately:

Sharp Health Plan Enrollment
8520 Tech Way, Ste. 200
San Diego, CA 92123-1450
(858) 499-8399 (fax)

1) The white and gold copies of the form should be submitted to Sharp Health Plan.
2) You should keep the employer's copy (pink) for your records.
3) The employee copy (yellow) should be given to the employee to be used as a temporary ID card.

A supply of *Enrollment Application* forms and enrollment kits can be requested from your Account Manager.

ADDING DEPENDENTS TO COVERAGE

Newborns

The newborn child of a Subscriber is automatically covered for the first thirty-one (31) days from the date of the newborn's birth. To continue coverage beyond the initial thirty-one (31) day period, an *Enrollment Application* for the newborn child must be submitted to Sharp Health Plan within the initial thirty-one (31) day period following birth. A birth certificate may be required as proof of Dependent status. If applicable, Sharp Health Plan may coordinate the cost of care if the newborn is also covered by another health insurance carrier.

Premium charges for a newborn will be as follows:

- If the date of birth falls on or before the 15th of the month, a premium will be charged for the month of birth.

- If the date of birth falls after the 15th of the month, a premium will be charged beginning the month following the month of birth.

A Subscriber must complete an *Enrollment Application* for a newborn even if the Subscriber currently has Dependent coverage, and the coverage does not require payment of any additional premiums.

Adoptees & Legal Custodians

Coverage for adopted children or children who have been placed in the legal custody of the Subscriber begins from the date physical custody of the child is obtained by the Subscriber as long as coverage for the child's medical expenses is not provided by a public or private agency or entity. The Dependent must be enrolled in Sharp Health Plan within thirty-one (31) days of placement or adoption. Coverage is effective on the date that the adopted child's birth parent(s) or other appropriate legal authority provides a signed copy of one of the following:

- A health facility minor release report.

- A medical authorization form or relinquishment form that grants the Subscriber the right to control health care of the adopted child.

In the absence of one of the documents listed above, coverage begins on the date that satisfactory evidence of the Subscriber's right to control the health care of the child exists.

LATE ENROLLMENT

Employees or their Dependents initially eligible for enrollment that do not enroll during an Open Enrollment period or within thirty-one (31) days of first becoming eligible, may enroll during the next Open Enrollment period.

If an employee or Dependent suffers an involuntary loss of other medical coverage, late enrollment is accepted if submitted within thirty-one (31) days of loss of coverage. In this case, Sharp Health Plan requires proof of loss of coverage (e.g., letter from insurance carrier). Coverage would be effective the first day of the month following the loss of other medical coverage.

WAIVING COVERAGE

Employees waiving coverage should complete the Enrollment Application and mark Decline Coverage in the "Reason for Application" section and sign and date the bottom of the form. It is advised to keep a copy of signed forms on file for reference as needed.

CANCELING EMPLOYEE AND DEPENDENT COVERAGE

Sharp Health Plan will terminate coverage for your employee and/or their Dependents upon directive from you (designated Benefits Coordinator). Any change that occurs after the initial enrollment must be submitted to Sharp Health Plan within thirty-one (31) days of the change using the *Enrollment Application* form. Your Group will continue to be liable for premiums during the period between loss of eligibility and receipt of this notice by Sharp Health Plan. Sharp Health Plan will not terminate a Member retroactively for any period during which your Group has collected the Member's share towards Premiums. Your Group is responsible for ensuring that the Member has not paid the Member's share of Premiums before notifying Sharp Health Plan of any retroactive terminations.

Employee

Coverage for an Employee may be terminated for any of the following reasons:

- Employment has ended
- Employee has a reduction in hours resulting in loss of eligibility
- Employee voluntarily requests to terminate coverage
- Employee takes a leave of absence (Sharp Health Plan will allow an employee to retain coverage upon your Group leave of absence policy.)

Termination date of benefits is always the last day of the last month the employee was eligible (e.g., employee terminates employment June 3, health coverage ends June 30)

Spouses

Coverage for a Spouse of a Member may be terminated for any of the following:

- An employee voluntarily requests coverage to be terminated
- A divorce decree has been finalized
- The spouse no longer resides or works in the Sharp Health Plan Service Area

Dependent Children

Coverage for a Dependent child of a Member may be terminated for any of the following:

- An employee voluntarily requests coverage to be terminated
- The Dependent child no longer resides or works in the Sharp Health Plan Service Area, unless there is a standing health coverage court order
- The Dependent child reaches the maximum Dependent age as defined by the Group Agreement or ceases to meet other Dependent eligibility requirements

CANCELING COVERAGE FOR CAUSE

A Member's eligibility in Sharp Health Plan ends when your Group policy coverage ends. However, individual membership may be terminated by Sharp Health Plan for any of the following reasons:

- Member commits an act of fraud or intentional misrepresentation of material fact to circumvent state or federal laws or the policies of the Plan, such as providing materially incomplete or incorrect enrollment or required updated information deliberately, including but not limited to incomplete or incorrect information regarding date of hire, date of birth, relationship to Enrolled Employee or Dependent, place of residence, other group health insurance or Workers' Compensation benefits, disability or student status.
- Member allows someone else to use their Member ID card.
- Member threatens the safety of Sharp Health Plan employees, Plan Providers, Members or other patients or engages in repeated behavior that substantially impairs Sharp Health Plan's ability to furnish or arrange services to the Member or other Members, or a Plan Provider's ability to provide services to other patients.
- If a Dependent is the sole offending party for any occurrence outlined above, then the Plan may terminate only the offending Dependent's coverage and coverage for the remaining Members in the family unit will remain effective.

If membership is terminated, the Member will be notified in writing and will be informed of the termination date. If eligibility is lost due to fraud or deception, Sharp Health Plan may recover from the Member the charges paid by Sharp Health Plan for covered services provided to the Member, plus Sharp Health Plan's cost for recovering those charges, including fees for legal counsel.

A Member may file a grievance disputing the cancellation of coverage, as described in the "What is the Grievance Process" section of the Member Handbook, within 180 working days after receiving notice that Sharp Health Plan has or will terminate coverage for cause.

Under no circumstances will membership be terminated due to health status or need for health care services. If a Member believes coverage was terminated or not renewed because of health status, a Member may request a review of cancellation by the Department of Managed Health Care.

TERMINATING GROUP COVERAGE

Your Group policy may be terminated by Sharp Health Plan under any of the following circumstances:

1. **The Group no longer meets the qualification requirements of Sharp Health Plan.**

   - If this occurs, Sharp Health Plan will notify you in writing and explain the disqualifying event(s), the date of termination and the final date of coverage. The Enrolled Employees and Dependents of your Group policy will be disenrolled within fifteen (15) days of your notification date.

2. **The Group fails to pay any amount due Sharp Health Plan by due date.**

   - Your Group will be given a 30-day grace period of continued coverage after the last day of paid coverage to pay the Premium owed for the month of coverage. The Group policy is subject to termination at the end of the grace period if the Premium is not paid by that date. Employer Group will be financially responsible for the full month's Premium for coverage provided during any portion of the grace period. For example, Premiums for the month of April are due by March 31. If payment is not received by March 31, the 30-day grace period will begin on April 1 and end on April 30. Coverage will end at 12:01am on May 1 if the April Premiums are not received by April 30. Employer Group will remain financially responsible for payment of April's Premium. For any premium received after the 10th of the coverage month, a late fee will be assessed.

   - Your Group may be eligible for reinstatement. Please contact your Account Manager to confirm your eligibility for reinstatement. If eligible, your Group will be required to pay all past due premiums, including any applicable late/reinstatement fees to Sharp Health Plan within fifteen (15) days of being terminated.

   - If your Group wishes to reinstate after the 15-day period, you must apply for coverage as a new Group. Sharp Health Plan may accept or reject such application at its sole discretion. Sharp Health Plan will reinstate Group only once during any twelve-month period.

3. **Your Group notifies Sharp Health Plan in writing of the intent to terminate coverage at least thirty-one (31) calendar days prior to the requested termination date. NOTE: As per California law (Health and Safety Code Section 1365), Sharp Health Plan is not permitted to retroactively terminate your group for non-payment of premium. Therefore, if your Group does not notify Sharp Health Plan of its intent to terminate coverage before the 1st day of the next coverage month,**

your Group will be responsible for payment for that coverage month. Example: Payment for April coverage is due on March 31. Your Group asked Sharp Health Plan for a 1 day extension to submit payment but then determined not to continue coverage. Your Group notifies Sharp Health Plan on April 2 of its decision and asks for coverage to be terminated retroactively to March 31. Since the April coverage month has already begun, Sharp Health Plan I required by law to continue coverage until April 30 and your Group will be responsible for payment of the full April premium.

4. **Your Group engages in fraud or deception in the use of services or facilities of Sharp Health Plan, or knowingly permits another to engage in fraud or deception. Sharp Health Plan may terminate your Group policy immediately upon written notification of termination to your Group.**

MEMBERSHIP CHANGES

IN THIS SECTION, YOU WILL FIND INFORMATION ABOUT:

CHANGE OF MEMBERS' PERSONAL INFORMATION

All Member name, address and Social Security Number changes should be reported to Sharp Health Plan as soon as possible. Your Employees can do this online at www.SharpHealthPlan.com or by submitting a Sharp Health Plan Enrollment Application. A permanent address change outside of the Sharp Health Plan Service Area terminates coverage for a Subscriber and/or eligible Dependent(s) thirty-one (31) days following the change of address. However, if the Subscriber or Dependent is working in the Service Area or there is a standing health coverage court order for a Dependent the Subscriber/or Dependant may remain eligible.

CHANGE OF PRIMARY CARE PHYSICIAN

Your Employees may change their Primary Care Physician (PCP) online at www.SharpHealthPlan.com or by *contacting our Customer Care Department.* In most cases, Sharp Health Plan will change the Member's PCP effective the first day of the following month. Changes are subject to the following:

- A participating Sharp Health Plan physician must be selected.
- Members may change their PCP up to once per month.

MILITARY RESERVE CHANGE OF STATUS

Active duty status is considered a qualifying COBRA event under USERRA provisions, (Uniformed Services Employment and Reemployment Rights Act of 1994) so the Subscriber may elect to continue group coverage. When the Subscriber returns to full-time employment, he/she is eligible to re-enroll for coverage without a waiting period.

MEMBER INFORMATION

IN THIS SECTION, YOU WILL FIND INFORMATION ABOUT:

CUSTOMER CARE

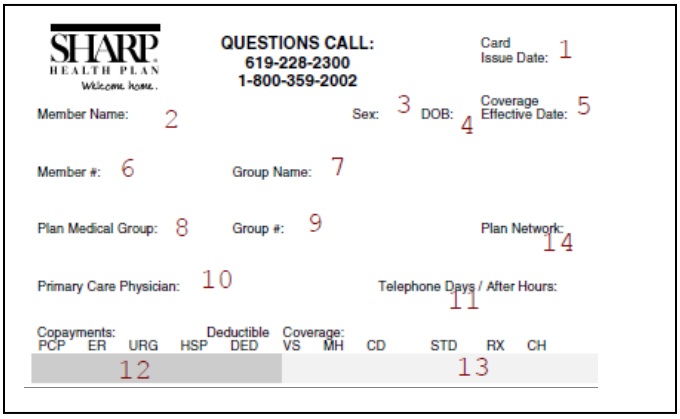
Customer Care is designed to provide information and assistance to all Sharp Health Plan Members. The Customer Care Department telephone number is 1-800-359-2002. Service hours are from 8 a.m. to 6 p.m., Monday through Friday. Callers are provided with an option to transfer to Nurse Connection is available after hours. The Customer Care team can also be contacted through email at customer.service@sharp.com.

The following information and assistance is available from our Customer Care team:

- Eligibility/benefit information
- Physician network updates and information
- Claim inquiries
- Sharp Health Plan policies and procedures
- Appeal & Grievance procedures
- Group coverage information
- Primary Care Physician changes
- Contract language interpretation
- ID card replacement

SHARP HEALTH PLAN MEMBER ID CARD

Sharp Health Plan Member ID cards are provided to all Members. The ID card contains the following information:



1. Date Card Was Issued
2. Member's Name
3. Member's Gender
4. Member's Date of Birth
5. Member's Effective Date of Coverage
6. Member's ID Number
7. Member's Employer
8. Medical Group of PCP
9. Employer's Group Number
10. Member's Primary Care Physician
11. Primary Care Physician's Phone Number
12. Copayments That Apply
    - PCP – Doctor Office Visit Copay
    - ER – Emergency Room Copay
    - URG – Urgent Care Copay
    - HSP – Hospital Copay
    - DED – In-patient Deductible
13. Coverage
    - VS – Vision Coverage Plan
    - MH – Mental Health Coverage Plan
    - CD – Chemical Dependency Coverage
    - STD – Standard Medical Coverage
    - RX – Pharmacy Coverage Plan
    - CH – Chiropractic Coverage Plan
14. Plan Network

The back of card includes important information on how to utilize and access Plan providers, emergency services and lists important telephone numbers.

COPAYMENTS

When a Member accesses care, Copayments are required at the time of service. The Copayments applicable to your Group are described in your Group Agreement. To protect Members from large out-of- pocket expenses, a limit called the Annual Maximum Copayment is placed on the dollar amount of Copayments a Member might have to pay during a calendar year. This maximum does not apply to supplemental benefits such as outpatient prescription drugs, chiropractic, chemical dependency, assisted reproductive technologies, or vision care.

A Member who refuses to pay a required Copayment may have coverage terminated at the discretion of Sharp Health Plan. In this case, charges for Covered Health Benefits may become the financial responsibility of the Member.

CLAIMS INFORMATION

All Providers contracted with the Plan are to bill Sharp Health Plan (or their contracted Medical Group) directly for covered benefits provided to Members. Members are not responsible to pay for covered benefits (except for Copayments and applicable deductibles and co-insurance amounts as applicable) unless a Member fails to obtain required pre-authorization when required, for non-emergency services, or has agreed in advance to pay for non-covered benefits.

A member may receive a bill under certain circumstances as follows:

- When a Member does not present a Sharp Health Plan ID card upon receiving care.
- When lab specimens and X-rays become separated from the HMO insurance information.
- Out-of-area medical care is provided.

If a Member receives a bill for a covered service, even though the Copayment was already paid, the most common reasons are:

- The Provider's files do not show that the Member is with Sharp Health Plan.
- The Provider is keeping the Member informed while they bill Sharp Health Plan.

A Member who receives a bill should call the physician's office number, which should be listed on the statement, and advise them that he/she is a Member of Sharp Health Plan. The Member should allow up to ninety (90) days for the Provider to send the bill to Sharp Health Plan and for the claim to be processed and paid. If a Member receives a "final" bill or collection notice, the Member should **immediately** contact Sharp Health Plan's Customer Care Department at 1-800-359-2002. The Customer Care Department will advise the provider of the Member's insurance information and direct him/her to withdraw the account from collections.

Members who pay for services that should have been covered by the Plan, can submit these charges for reimbursement. All claims must be submitted within sixty (60) days from the date of service to:

Sharp Health Plan Claims Department
8520 Tech Way, Ste. 200
San Diego, CA 92123-1450

ACCESS TO CARE FOR STANDARD BENEFITS

Sharp Health Plan is a Health Maintenance Organization (HMO). In an HMO, Members have access to a network of medical providers for their health care. Sharp Health Plan has several physician groups called Plan Medical Groups (PMG's) consisting of primary care and specialty physicians, and also contracts directly with physicians. Each Member selects a Primary Care Physician (PCP) from the Plan's Provider Directory. Subscribers and Dependents may select different PCPs.

The Member's PCP directs and arranges for all health care services. The Member's PCP will assess the Member's medical condition(s) which may require specialty care. If specialty care or hospitalization is required, the Member's PCP will coordinate services through their affiliated PMG network and/or with Sharp Health Plan.

Physicians within a PMG work together and are familiar with each others' practices and specialties. This ensures that the Member receives care from physicians who work together to develop an appropriate treatment plan. Only when the Member's PMG determines it cannot provide the necessary specialty care will the Member be referred outside the PMG network. Any referral outside of a Member's PMG requires the approval of Sharp Health Plan and/or the PMG.

REFERRALS

It is very important that Members understand the physician referral process within their PMG. If the following guidelines are not adhered to, the Member may become financially responsible for medical care.

1. The Member must have a referral from his/her PCP for specialty services or services rendered other than through their PCP. Please note that some specialty services do not require a referral, such as OB/GYN services for women within their PMG, mental health services, and supplemental benefit services (if applicable) such as chiropractic, chemical dependency, and vision services.

2. When the Member receives a referral from the PCP, the first visit must occur within sixty (60) days from the date of the referral.

3. All referral visits must be completed within the time frame indicated by the PCP on the referral form. If referral visits are not completed, the Member must obtain a new referral from the PCP.

4. The Member must be referred to a participating provider unless the PCP has received authorization from Sharp Health Plan or the PMG to refer the Member elsewhere. All authorizations must be approved in advance, and all referrals and continuations of referrals must be coordinated through the PCP.

ACCESS TO CARE FOR STANDARD BENEFITS (continued)

5. Referrals are valid only for the services specified. For example, if a referral states "consultation only" and a Member receives consultation and treatment, the Member may be responsible for payment associated with the treatment. All referral forms should be read carefully. A Member should consult with his/her PCP prior to obtaining services if a referral form is not issued to the patient.

6. If a Member changes a PCP while under the care of a specialist, all previous referrals become void. The Member must consult his/her new PCP to determine if additional referrals are medically necessary.

7. The PCP is responsible for notifying the Member of the status of a referral. Should the PCP's office fail to contact the Member, the Member should contact the PCP's office to follow-up.

EMERGENCY CARE

In an emergency, members should call 911 or go to the nearest hospital emergency room.

An emergency room Copayment is due at the time of the visit, unless the visit results in a hospital admission. In this case, the emergency room Copayment is waived and any inpatient hospital Copayment will apply.

EMERGENCY FOLLOW-UP CARE

Members should not return to a hospital emergency room for follow-up care unless it is a new medical emergency, or a Member is specifically instructed to do so by his/her PCP.

If these guidelines are not followed, charges for medical services may become the Member's responsibility.

URGENT CARE

Unforeseen injuries or acute illnesses that require immediate attention but are not life-threatening are considered urgent care situations. When an urgent care situation occurs, the Member must call his/her PCP for a referral prior to an urgent care visit except for situations that could jeopardize the Member's life or permanent health status.

An Urgent Care Copayment is due at the time of the visit.

HOSPITAL SERVICES

Inpatient and Outpatient hospital services are covered when provided by a Plan hospital (or other hospital in connection with Emergency Services) and authorized by Sharp Health Plan. A Copayment may be applicable, as defined by the Group Agreement

Non-emergency hospital services are covered if arranged by a Plan Physician and includes semi-private room and board (private room when Medically Necessary), general nursing care (special duty nursing when Medically Necessary), and related services, facilities and supplies associated with a hospital admission.

MENTAL HEALTH

Sharp Health Plan provides coverage for the diagnosis and Medically Necessary treatment of mental illnesses, including but not limited to Severe Mental Illnesses in Members of any age and Serious Emotional Disturbances in children.

> Severe Mental Illnesses include: schizophrenia, schizoaffective disorder, bi-polar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive development disorder, or autism, anorexia nervosa and bulimia nevorsa.
>
> Serious Emotional Disturbance (SED) means one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, to include Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and other pervasive developmental disorders no otherwise specified (including Atypical Autism), in accordance with diagnostic and statistical manual for Mental Disorders–IV-Text revisions(June 2000), other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. One or more of the following must also be true:

1) as a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either of the following occur:
    a) the child is at risk of removal from the home or has already been removed from the home; or
    b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year if not treated; or
2) the child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or
3) the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Mental health benefits include inpatient hospital services, partial hospital services and outpatient services when ordered and performed by a participating mental health professional. Members may also have coverage for treatment of other mental health conditions. Please see your Group's Health Plan Benefits and Coverage Matrix and Supplemental Benefits for detailed descriptions.

Members have direct access to Plan Providers of mental health services without obtaining a Primary Care Physician referral. Covered mental health benefits must be obtained through Plan Providers. Mental health services that are not provided by Plan Providers are not covered, and the Member will be responsible to pay for those services. Members should call our Customer Care Department at 1-800-359-2002 whenever they need mental health services. All calls are confidential.

WHAT IS THE GRIEVANCE PROCESS?

If Members are having problems with a Plan Provider or our health plan, we encourage them to give us a chance to help. Sharp Health Plan can assist in working out any issues. If Members ever have a question or concern, they can call our Customer Care Department toll free at 1-800-359-2002 and a Customer Care Representative will make every effort to assist.

Members may file a grievance with the Plan at any time. To begin the grievance process, Members can call toll-free, write or fax the Plan at:

Sharp Health Plan
Appeals and Grievances Department
8520 Tech Way, Ste. 200
San Diego, CA 92123-1450

Toll-Free: 1-800-359-2002
FAX: (858) 499-8244

If Members prefer to send a written grievance, they can send a detailed letter describing the grievance, or complete a Grievance Form that is available on the Plan's Web site: www.sharphealthplan.com, from any Plan Provider or directly from a Plan representative. Members may also call our Customer Care Department, and we will assist them in completing the form over the telephone**.**

Please refer to the Member Handbook (included with this Group Administration Manual) for more detailed information about the Plan's grievance process, including a description of all the resources available to Members who have a grievance or appeal with the Plan.

COORDINATING BENEFITS

If a Subscriber or enrolled Dependent is covered by both Sharp Health Plan and another health plan, Sharp Health Plan will coordinate benefits between the two plans. The goal of this kind of coordination is to maximize coverage for allowable expenses, minimize out-of-pocket costs, and prevent any payment duplication. Total payment from all coverage should never exceed 100% of the allowable expenses.

Sharp Health Plan coordinates benefits in accordance with the National Association of Insurance Commissioners' guidelines and California law. So that proper coordination is ensured, Subscribers must inform Sharp Health Plan of any other health coverage for which they or their enrolled Dependents may be eligible. If Sharp Health Plan pays out more benefits than appropriate, it may choose to recover any excess payment from the Subscriber, the plan with primary responsibility, or any other person or entity that benefited from the overpayment.

ORDER OF DETERMINATION

Certain rules are used to determine which of the plans will pay benefits first. The following rules will be applied in the order given below:

1. A plan with no Coordination of Benefits (COB) provision will determine its benefits before a plan with a COB provision.

2. A plan that covers a person as a Subscriber, rather than as a Dependent, will determine its benefits first.

3. When a claim is made for a covered Dependent child who is covered by more than one plan, the method of determining the order of benefits is known as the "Birthday Rule." Benefits are paid under the Birthday Rule as follows:

   The plan of the parent whose birthday falls earlier in the year pays first as the "primary payor." The year in which the parents were born is not a determining factor. If both parents have the same birthday, the plan which covered the parent longer will pay first as the "primary payor."

COORDINATING WITH MEDICARE

Subscribers will also need to advise Sharp Health Plan if they are eligible for Medicare benefits. Under certain circumstances, Sharp Health Plan may reduce its coverage to avoid duplication of benefits available from Medicare.

COORDINATING WITH MEDICARE (continued)

If the Group employs twenty (20) or more employees and the Subscriber is actively at work, Sharp Health Plan will be the Primary Payor for End Stage Renal Disease services for a Medicare eligible Member for the first twelve (12) consecutive months that the Member is enrolled in Sharp Health Plan.

If the Group employs one hundred (100) or more employees, Sharp Health Plan will be the Primary Payor of Covered Health benefits provided to a Totally Disabled Member enrolled with Medicare for that disability as required by Medicare laws and regulations. Medicare will be the Secondary Payor of Covered Health Benefits while the Subscriber remains employed by the Employer Group and the Totally Disabled Member is covered by Sharp Health Plan.

It should be noted that failure to cooperate with Sharp Health Plan in its efforts to coordinate benefits could result in termination of membership. If Members have any questions about benefit coordination, they should call the Customer Care Department.

COORDINATING WITH WORKERS' COMPENSATION

If a Member is entitled to benefits as a result of Workers' Compensation, Sharp Health Plan will not duplicate those benefits. It is the Member's responsibility to take whatever action is necessary to receive payment under Workers' Compensation laws, when such payments can reasonably be expected.

If Sharp Health Plan happens, for whatever reason, to duplicate benefits to which a Member is entitled to under Workers' Compensation laws, the Member is required to reimburse Sharp Health Plan.

In the event of a dispute arising between the Member and Workers' Compensation coverage regarding the ability to collect under Workers' Compensation laws, Sharp Health Plan will provide the benefits described in the Group Agreement until the dispute is resolved.

SUPPLEMENTAL BENEFITS

The following supplemental benefits may be applicable if you purchased the benefit riders described below. Refer to your Group Agreement to determine which supplemental benefits apply.

OUTPATIENT PRESCRIPTION DRUG BENEFIT

Prescription drugs are covered if all of the following are met:

- They are prescribed as medically necessary by a Sharp Health Plan provider;
- Included on the Sharp Health Plan drug formulary, or you have 3 tier pharmacy rider allowing coverage for non formulary medications; and
- They are purchased at a Plan pharmacy.

Please refer to your Group Agreement for prescription benefit coverage.

Drug Formulary

Sharp Health Plan physicians use a comprehensive drug formulary. All medications on this broad list of drugs are reviewed and approved by Sharp Health Plan physicians and clinical pharmacists for use by Members. The Sharp Health Plan formulary includes brand-name and FDA approved generic drugs. By purchasing generic drugs, Sharp Health Plan receives a quantity discount on a single drug instead of paying higher prices on small quantities of several different brands of the same drug. These savings help Sharp Health Plan keep the cost of medical care under control and maintain lower premiums for employers and employees.

In most cases, generic drugs will be prescribed unless a drug is specifically listed in the SHP drug formulary as “dispense brand name only.” Plan pharmacies will contact the prescribing Plan physician when a non-covered drug has been prescribed in an effort to obtain an equivalent medication that is covered by Sharp Health Plan.

Members must obtain all covered prescription drugs through the Plan pharmacies listed in the Provider Directory.

Prescription Drug Copayments

Members pay a series of Copayments based on the appropriate tier and pharmacy benefit

The prescription drug Copayment is listed in the member materials.

MAINTENANCE DRUG MAIL-ORDER SERVICE

Members can also have a prescription for Maintenance Drugs filled through the mail. This service saves Members time and money. Members can receive up to a ninety (90) day supply of an approved formulary Maintenance Drug for a reduced copay. In other words, Members pay one or two Copayment(s) for a ninety (90) day supply of a Maintenance Drug filled through the Mail-Order Service. Refer to your Group Agreement for pharmacy plan coverage information. For a list of the medications available through the Mail-Order Service please go to our website at www.SharpHealthPlan.com.

ACCESSING THE PRESCRIPTION DRUG BENEFIT WITHOUT AN ID CARD

As a general rule, Members should always present their Member ID card to the pharmacy at the time a prescription is filled. In the event a Member has lost his/her ID card or not yet received an ID card, and needs to access the prescription drug benefits, he/she should call SHP Customer Care for assistance. Our Customer Care Department will call the Plan pharmacist to verify eligibility or update the pharmacist's eligibility records on-line.

CHEMICAL DEPENDENCY SERVICES (SUPPLEMENTAL BENEFIT)

Sharp Health Plan provides coverage to all Members for short-term acute drug or alcohol detoxification as an Emergency Medical Condition. If you have purchased coverage for additional chemical dependency services benefits for your employees, Sharp Health Plan has contracted with Psychiatric Centers at San Diego (PCSD) to provide service for this supplemental benefit. Members have access to local facilities, supported by a wide variety of highly trained health care professionals such as psychiatrists, psychologists, clinical social workers and counselors. To access chemical dependency services, Members may call Sharp Health Plan's Customer Care Department at 1-800-359-2002 for assistance. All calls are confidential.

CHIROPRACTIC SERVICES (SUPPLEMENTAL BENEFIT)

If you have purchased coverage for chiropractic benefits for your employees, all services will be provided through American Specialty Health Plans (ASHP). Covered services include office visits and chiropractic appliances. The applicable Copayment is listed on the Member ID card.

Members may access their chiropractic benefits directly by calling a participating chiropractor from the American Specialty Health Plan directory or by contacting American Specialty Health Plan directly at 1-800-678-9133. Members may also find a participating provider through the ASHP's Web site at www.americanspecialtyhp.com.

VISION SERVICES (SUPPLEMENTAL BENEFIT)

Your Employer Group may have elected to include vision benefits. For these services, Sharp Health Plan has joined with Vision Service Plan (VSP) to offer a multi-option program of vision care.

VSP has an extensive nationwide network of optometrists and ophthalmologists who provide comprehensive vision care and materials to Members. This supplemental benefit rider is designed to encourage Members to maintain their vision through preventive eye care including a periodic vision examination. Your Plan may also provide an allowance for lenses, frames and contact lenses.

This is a direct access benefit. For a comprehensive list of providers in your area, please visit the Vision Service Plan web site at www.vsp.com or contact them directly at 1-800-877-7195.

Continuation of Coverage

IN THIS SECTION, YOU WILL FIND INFORMATION ABOUT:

CAL COBRA – APPLIES TO GROUPS WITH 2 – 19 ELIGIBLE EMPLOYEES*

California law requires that insurers and HMOs provide continuation coverage that is known as Cal COBRA.

*You employed fewer than 20 eligible employees on at least 50% of its working days during the previous calendar year.

YOUR OBLIGATIONS

Notify Sharp Health Plan of Certain Qualifying Events: You must notify Sharp Health Plan in writing within thirty (30) days of an Enrolled Employee's Cal COBRA Qualifying Event. Qualifying Events include:

- Termination of employment
- Reduction in hours worked

Notify Current Cal COBRA Qualified Beneficiaries of Your Intent to Terminate the Group Service Agreement:

If you terminate the Group Agreement with Sharp Health Plan and replace it with other coverage through another insurance carrier, you must notify all Cal COBRA Qualified Beneficiaries that they have the ability to choose to continue coverage through the new plan for the balance of their Cal COBRA coverage. They may not continue coverage under Sharp Health Plan. Sharp Health Plan will provide you upon request, with the names and last known addresses of enrolled Cal COBRA Qualified Beneficiaries upon request.

After you notify Sharp Health Plan of an Enrolled Employee's Cal COBRA Qualifying Event in writing within thirty (30) days of its occurrence, Sharp Health Plan will mail the Member a statement of Cal COBRA rights and obligations along with the necessary premium information, enrollment forms and instructions regarding Cal COBRA Continuation Coverage.

If the Qualified Beneficiary chooses to enroll in Cal COBRA continuation coverage, he or she must apply for coverage within sixty (60) days following the later of (1) the Qualifying Event or (2) the date he or she received a Cal COBRA notice from Sharp Health Plan of his or her right to elect coverage or (3) the date that coverage through the employer plan terminated. The Member must mail or deliver the application to:

Sharp Health Plan
Enrollment Department
8520 Tech Way, Ste. 200
San Diego, CA 92123-1450

If the Member fails to apply for Cal COBRA within sixty (60) days of the event, that Member will be disqualified from receiving Cal COBRA Continuation Coverage.

WHO MAY CHOOSE CAL COBRA

A Subscriber may choose Cal COBRA for one or all of the family members who were enrolled at the time of the qualifying event. In other words, the Subscriber can elect coverage for the spouse or one or more Dependent children without being covered under the Cal COBRA continuation coverage as a Subscriber.

If a child is born or placed for adoption with the former Subscriber during the period of Cal COBRA coverage, the child would be a Qualified Beneficiary and could be added to the Cal COBRA policy.

QUALIFYING EVENTS & SUBSEQUENT ELIGIBLE PERIOD OF COVERAGE

Termination of Employment	18 months*
Reduction in Hours	18 months*
Transfer to Ineligible Class	18 months*
Death of the Employee	36 months
Employee Becomes Eligible for Medicare	36 months
Dependent Child Becomes Ineligible (e.g. overage)	36 months

PAYMENT FOR CAL COBRA

The Member must pay Sharp Health Plan 110% of the applicable group rate charged for employees and their Dependents.

If the coverage is extended due to a determination by the Social Security Administration that the Qualified Beneficiary is totally disabled, pursuant to Title II or Title XVI of the Social Security Act, the Member must pay 150% of the applicable group rate for the additional period of coverage.

The Member must remit the first payment within forty-five (45) days of submitting the completed enrollment form to Sharp Health Plan. The first payment must cover the period from the last day of prior coverage to the present. There can be no gap between prior coverage and Cal COBRA continuation Coverage.

All subsequent payments must be made on the first day of each month. If payment is not received by the first of the month, Sharp Health Plan will send a letter warning that coverage may terminate if payment is not received by the Plan.

CHANGES IN BENEFITS UNDER CAL COBRA COVERAGE

If a Subscriber or any Dependents elect COBRA coverage, benefits will remain the same as the benefits for active Members of your current Group policy. If you change the benefits provided to active Members enrolled in your current Group policy, benefits will also change for Subscribers and Dependents on COBRA.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

The information presented below provides only a broad overview and is not intended to be legal advice or direction. COBRA contains complex rules and administrative procedures. You can obtain more information regarding COBRA administration from your legal counsel, Broker, COBRA Administrator or your regional office of the United States Department of Labor.

COBRA is a federal law that requires Employers with 20 or more employees to allow employees and their Dependents to continue enrollment in their employer-sponsored health plan upon the occurrence of a Qualifying Event. Sharp Health Plan will make COBRA coverage available to Members who are qualified according to COBRA law. However, Sharp Health Plan does not ensure your organization's full compliance with COBRA law.

ELIGIBILITY

COBRA coverage is available to Employees and their Dependents who are covered under the group plan at the time a Qualifying Event occurs. Members may elect to continue coverage immediately following one of the Qualifying Events listed below, in the event that the Qualifying Event causes a loss of coverage.

QUALIFYING EVENT	ELIGIBLE PERIOD OF COVERAGE
End of employment	18 Months*
Reduction in hours	18 Months*
Transfer to an ineligible class	18 Months*
Death of an employee	36 Months
Divorce or legal separation	36 Months
Employee becomes entitled to Medicare	36 Months
Dependent child becomes ineligible	36 Months

*If COBRA coverage was initially effective on or after January 1, 2003, and the eligible period of coverage is less than 36 months, members may elect to continue coverage through Cal COBRA for a period up to 36 months from the date that COBRA coverage was originally effective

CONTINUATION OF COVERAGE

Members eligible for continuation coverage must submit a COBRA election form according to your own guidelines along with a **Sharp Health Plan enrollment form.** Members will have sixty (60) days from notification of COBRA eligibility to make an election. This period is measured from the later of:

- The date the coverage is lost; or
- The date the COBRA election notice is sent.

If the **Sharp Health Plan enrollment form**, identifying COBRA election, is not received within the sixty (60) days, the right to elect COBRA continuation coverage will cease.

COBRA BILLING

Sharp Health Plan offers two billing options. Please refer to the Execution Page of the Group Agreement for further details of your contract with Sharp Health Plan.

- **Premium Bill -** Sharp Health Plan will include COBRA Premium dues on your regular billing statement for your group policy.
- **Direct Bill -** Sharp Health Plan will bill COBRA enrollees directly. The Member will be charged a 2% administrative fee in addition to the standard premium for the direct bill option. For Members receiving an extension of coverage after the initial period because they are disabled, the premium for the additional period will be increased to 150% of the applicable group rate.

Sharp Health Plan's billing options do not ensure your organization's full compliance with COBRA law.

COBRA NOTICES

The Employer Group is responsible for sending all notices, letters, and forms required under COBRA.

However, if you elect **Direct COBRA** services, Sharp Health Plan will send the following notices or letters to COBRA enrollees on your behalf (all other COBRA notices, letters and forms remain the responsibility of the Employer Group):

Notice of Termination of COBRA Coverage: Notice sent when COBRA coverage terminates before the end of the maximum coverage period for any of the following reasons:

a) Failure to make timely payment of COBRA premiums.
b) The Employer Group ceases to provide any group health plan to any employee.
c) The qualified beneficiary becomes covered under another group health plan after electing COBRA.
d) The qualified beneficiary becomes covered under Medicare after electing COBRA.
e) A disabled qualified beneficiary whose disability extends the maximum covered period to 29 months is determined not to be disabled before the end of the extended period.
f) The qualified beneficiary's COBRA coverage is terminated for cause (e.g., for submitting fraudulent claims) on the same basis as would apply to a similarly situated non-COBRA enrollee, as indicated in Section 7.3.5.

Notice of Availability of Open Enrollment Materials & Change in COBRA Premium: Notice sent upon the Employer Group's open enrollment period.

Notice of Availability of Individual Conversion: Notice sent 60 days prior to termination of the maximum period of COBRA coverage.

Notice of Premium not Received: Notice sent when Premium not received by due date or Premium received but is 50% less than total amount due.

Letter of Qualified Beneficiaries Attaining Age 65: Notice sent when COBRA may terminate early if, after the date of the COBRA election, a qualified beneficiary becomes entitled to Medicare. The letter will remind the beneficiary that COBRA coverage stops at Medicare entitlement, and it would require certification, as a condition of continuing COBRA, that the beneficiary has not yet become entitled to Medicare. If COBRA coverage is terminated early because of Medicare entitlement, then the Plan will provide a notice of termination of COBRA coverage, as mentioned above.

COBRA BENEFIT CHANGES

If a Subscriber or any Dependents elect COBRA coverage, benefits will remain the same as the benefits for active Members of your group policy. If benefits provided to active Members of the Group change, benefits will also change for Subscribers and Dependents on COBRA.

INDIVIDUAL CONVERSION

An Individual Conversion Plan is available for Sharp Health Plan Members who are not eligible for continuation coverage or become ineligible for coverage due to expiration of continuation coverage. *Members are responsible for initiating the conversion process.*

ELIGIBILITY

- A Member must have had at least three (3) months of continuous coverage by Sharp Health Plan immediately preceding the termination of coverage.

- The Member must contact the Customer Care Department directly within sixty-three (63) days from their last date of coverage through your Group policy. If a Member does not apply within those sixty-three (63) days, than eligibility for Individual Conversion will be lost. Individual Conversion Members must pay premiums directly to Sharp Health Plan within the sixty-three (63) day enrollment period.

The benefits offered will be the Conversion Plan available at the time the Member's coverage terminates. The benefits and costs under Individual Conversion will differ from the Group policy in effect at that time.

Individual Conversion eligibility with Sharp Health Plan ceases if:

- Nonpayment of premium occurs

- A Member becomes eligible for coverage by another group health care plan

- A Member is or becomes eligible for Medicare

- The Employer's Group Agreement is no longer in effect and the Employer signs an agreement with a different carrier

- Fraud, deception or misuse of Sharp Health Plan services occurs

- The member was terminated by Sharp Health Plan from the Plan, for good cause

- Your hospital, medical, or surgical expenses benefit program is self-insured

Interested Members must contact the Customer Care Department to inquire about current rates and benefits.

BILLING PROCEDURES

IN THIS SECTION, YOU WILL FIND INFORMATION ABOUT:

THE MONTHLY BILLING

Your bill is prepared on the first of each month for the following month's coverage. Payment is due before the first day of the coverage month as indicated on your statement. Late fees will be applied for any payments received after the tenth of the month.

PAY AS BILLED METHOD

You should always use the "Pay-as-Billed" payment method. This is the most accurate and efficient method for you and Sharp Health Plan. Review your bill, report any changes, and pay the total amount listed as due. Please do not alter your premium payment to account for changes. Any adjustments that you have made to your account will reflect on the next billing cycle. For instructions on how to report changes, please refer to the Correction to Group Statement section of this manual.

SUBMITTING PAYMENT

Make your check payable to **Sharp Health Plan**. Please write your group number on the face of the check and remit payment to:

Sharp Health Plan
P.O. Box 57248
Los Angeles, CA 90074-7248

If you have any questions regarding your billing statement, please contact our billing department at:

Groups with names beginning with A – L: (858) 499-8209
Groups with names beginning with M– Z: (858) 499-8392

CORRECTION TO GROUP STATEMENT FORM

Do not record premium adjustments on the *Employer Group/Subscriber Summary Report.* The *Correction to Group Statement Form is* provided in order for you to report additions, deletions or corrections of Members not reflected on the current Group Statement. Any premium adjustments will be reflected on the next bill.

The *Correction to Group Statement Form* only adjusts the Group Statement or bill. Please refer to the section titled *Membership Changes* for the procedures to report individual Member changes.

Please note the following regarding adjustments to the Group Statement:

- Retroactive premium adjustments can only occur within a thirty-one (31) day period of the current billing period.
- Please ensure all *Enrollment and Change* forms are forwarded to Sharp Health Plan on a timely basis.
- Your Group is responsible for premiums incurred as a result of late notification of terminations that exceed thirty-one (31) days.
- Terminated Subscribers and Dependents are responsible for payment of all claims and services incurred after their termination date. Sharp Health Plan is not responsible for claims or services paid due to errors in eligibility reporting or late reporting by you.

Please notify Sharp Health Plan's Enrollment Department of any adjustments not reflected on the Group Statement by completing the *Correction to Group Statement* or *Employee Termination Form.* Adjustments will be retroactively adjusted on the next billing statement.

Notification of terminations are expected to be received by Sharp Health Plan in a timely manner. Any notification of termination which is not reported within thirty-one (31) days from the date of termination will not receive full credit of premiums paid.

PREMIUM PAYMENTS

Group Statements are sent the first week of each month for the following month's coverage. Payment of the exact statement amount should be remitted to Sharp Health Plan and is due before the first day of the month of coverage. A past due letter will be sent to you if premiums are not received by the first of the month and a late fee will be assessed if not received by the 10th of the month. A late fee will be assessed on the subsequent bill.

For our clients with age banded rates, when an employee enters a new age band mid-year, the effective date of the increase in premium will be first of the month following the month of the employee's birthday. Using the example of an employee with a birthday of 9/17, the increase of premium resulting from the employee moving to a new age band would be effective 10/1.

Please mail your premium payment in the return envelope provided to:

Sharp Health Plan
P.O. Box 57248
Los Angeles, CA 90074-7248

Your Correction to Group Statement and supporting documentation (e.g. enrollment applications, copy of marriage license or birth certificate) can be faxed to (858) 499-8399 or mailed to:

Sharp Health Plan
Attn: Enrollment Department
8520 Tech Way, Ste. 200
San Diego, CA 92123-1450

FORMS & SUPPLIES

IN THIS SECTION, YOU WILL FIND A COPY OF THE FOLLOWING FORMS:

- **Supply Request Form**
- **Enrollment / Change Form**
- **Domestic Partner Form**
- **Member Grievance / Appeal Form**