Sharp Health Plan

www.sharphealthplan.com

Customer Care 800-359-2002

SHARP Health Plan

2025

A Health Maintenance Organization (Standard Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8, *FEHB Facts* for details. This plan is accredited. See Section 1, *How This Plan Works*, page 13.

IMPORTANT
- Rates: Back Cover
- Changes for 2025: Page 15
- Summary of Benefits: Page 83

Serving: San Diego County
Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements.

Postal Employees and Annuitants are no longer eligible for this plan (unless currently under Temporary Continuation of Coverage).

Enrollment codes for this Plan:

YJ4 Standard Option – Self Only
YJ6 Standard Option – Self Plus One
YJ5 Standard Option – Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-937

RI 73-937

Important Notice from Sharp Health Plan About
Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that Sharp Health Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213, (TTY: 800-325-0778).

Potential Additional Premium for Medicare's High Income Members
Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return.** You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website: www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.

Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

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Introduction

This brochure describes the benefits of the Standard Option under contract (CS 2970) between Sharp Health Plan and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Our Customer Care Center may be reached at 800-359-2002 or through our website: www.sharphealthplan.com. The address for Sharp Health Plan's administrative office is:

Sharp Health Plan
8520 Tech Way #200
San Diego, CA 92123

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2025, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefits are effective January 1, 2025. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means Sharp Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.

- If the provider does not resolve the matter, call us at 800-359-2002 and explain the situation.
- If we do not resolve the issue:

CALL THE HEALTH CARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/
The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.
You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain family members on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise) or
  - Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26). A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual’s protected trait or traits, for example a member’s gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks.

Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask the pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"

- "About how long will it take?"
- "What will happen after surgery?"
- "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- https://psnet.ahrq.gov/issue/national-patient-safety-foundation. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these conditions may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events".

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC). Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plan, you should contact your carrier directly for address updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member, as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2025 benefits of your prior plan or option**. If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2024 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31-day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31-day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

If you are an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment.

You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC).

If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, or if you are a covered dependent child and you turn 26.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-359-2002 or visit our website at www.sharphealthplan.com.

- **Health Insurance Marketplace** If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.Healthcare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO) plan. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Sharp Health Plan holds the following accreditations by the National Committee for Quality Assurance (NCQA): NCQA Health Plan Accreditation (NCQA HPA), NCQA Health Equity Accreditation (NCQA HEA), and NCQA Wellness and Health Promotion Accreditation (NCQA WHP). To learn more about this plan's accreditation, please visit the following websites: NCQA HPA at www.ncqa.org/programs/health-plans/health-plan-accreditation-hpa/, NCQA HEA at www.ncqa.org/programs/health-equity-accreditation/, and NCQA WHP at www.ncqa.org/programs/health-plans/wellness-and-health-promotion-whp/. We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Sharp Health Plan offers a current and complete listing of physicians, clinics, pharmacies and more at www.sharphealthplan.com/findadoctor or contact us for a copy of our most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the Plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our Standard Option

Sharp Health Plan is a locally based, nonprofit health plan that has been serving San Diegans for over 30 years. Sharp Health Plan continues to be recognized in California and nationally for our high-quality health care and service. Visit www.sharphealthplan.com/honors to learn more.

Our Standard Plan offers comprehensive coverage with affordable copayments and no deductible for covered benefits. Sharp Health Plan has several medical groups from which you choose your primary care provider (PCP) and through which you receive health care services. Each enrolled family member can select their own PCP and medical group.

You obtain covered benefits through your PCP and from the Plan providers who are affiliated with your medical group. Your PCP will provide the appropriate services or referrals to other Plan providers. If you need specialty care, your PCP will refer you to a specialist. If you need to be hospitalized, your doctor will generally direct your care to the Plan hospital where your doctor has admitting privileges.

Our five-star Customer Care team is available to assist you with any questions you have about Plan providers or covered benefits. Information is also available online at sharphealthplan.com.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost sharing (copayments, coinsurance, and non-covered services and supplies).

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $7,000 for Self Only enrollment, and $14,000 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/healthcare-insurance/) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Sharp Health Plan is a locally based nonprofit health plan that has been serving San Diegans for over 30 years.
- Sharp Health Plan continues to be recognized in California and nationally for our affordable, high-quality health care and service for San Diegans of all ages. Visit www.sharphealthplan.com/honors to learn more.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this plan. You can view the complete list of these rights and responsibilities by visiting our website, Sharp Health Plan at www.sharphealthplan.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 800-359-2002, or write to Sharp Health Plan, Attention Customer Care Department 8520 Tech Way Suite 200, San Diego, CA 92123-1450. You may also visit our website at www.sharphealthplan.com.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.sharphealthplan.com/privacypractices to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies, or as otherwise required by law.

Service area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area includes San Diego County with the exception of Jacumba (91934), Borrego Springs (92004), Julian (92036) and Ranchita (92066).

Except in the case of an emergency, medical services must be obtained from a Sharp Health Plan network provider in this county to ensure coverage. For your convenience, your Plan Network is listed on your Sharp Health Plan Member identification card. Our provider directories are available online at www.sharphealthplan.com/findadoctor. You may also request a printed directory by calling Customer Care.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency or urgent care benefits (See Section 5(d) *Emergency Services/Accidents*). We will not pay for any other healthcare services out of our service area unless the services have prior Plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2025

Do not rely only on these change descriptions, this Section is not an official statement of benefits. For that go to Section 5. *Standard Option Benefits*. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes:

- This is Sharp Health Plan's first year with FEHB and therefore there are no program-wide changes.

Changes to this Plan

- This is Sharp Health Plan's first year with FEHB and therefore there are no changes to the Standard plan.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-359-2002 or email us at: customer.service@sharp.com. You may also request replacement cards through our online member portal at www.sharphealthplan.com/login. You can visit www.sharphealthplan.com/account to learn more about your online account and download the Sharp Health Plan app.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance as described in Section 4. *Your Cost for Covered Services.*

- **Balance Billing Protection**

FEHB Carriers must have clauses in their in-network (participating) provider agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in-network contracted amount. If an in-network provider bills you for covered services over your normal cost share (copayment and coinsurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to NCQA and Sharp Health Plan standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

We list Plan providers in the provider directory, which we update monthly. The list is also on our website at www.sharphealthplan.com/findadoctor.

The plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides case managers for complex conditions and can be reached at 800-359-2002 or visit our website at www.sharphealthplan.com for assistance.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update monthly. The provider directory can be found on our website at www.sharphealthplan.com/findadoctor.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care provider. This decision is important since your primary care provider provides or arranges for most of your health care. Each member of your family may select a different primary care provider.

- **Primary care**

Primary care providers specialize in different areas, and each specialty has its own benefits. A basic summary might help you narrow your search:

- **General Practitioner/Family Medicine (with or without Obstetrics)** focuses on healthcare for individuals and families of all ages. This includes routine and preventive care, treatment of acute and chronic illness, and coordination of your overall care. Some Family Medicine physicians also include Obstetrics (the care of women during pregnancy and childbirth).
- **Internal Medicine** focuses on adult patients and the aging process. Internists generally see patients over 18 years old. They also frequently care for patients with multiple ongoing health conditions. They provide preventive care, age-related screenings and health guidance.
- **Pediatrics** is a specialty which treats children from birth to their late teens. While pediatricians see healthy children for primary care, they also help children who have special or difficult health conditions. Pediatricians provide ongoing screenings, immunizations and preventive care throughout childhood.

Your primary care provider will provide most of your healthcare or give you a referral to see a specialist. You can also visit www.sharphealthplan.com/findadoctor for the most up-to-date listing of providers. If you want to change your primary care provider or if your primary care provider leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care provider will refer you to a specialist for needed care. When you receive a referral from your primary care provider, you must return to the primary care provider after the consultation, unless your primary care provider authorized a certain number of visits without additional referrals. The primary care provider must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care provider gives you a referral. However, members may see participating chiropractors (as described on page 39), or gynecologists at any time without a referral.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care provider will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

  Your primary care provider will create your treatment plan. The provider may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. If they decide to refer you to a specialist, ask if you can see your current specialist.

  If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
  - reduce our service area and you enroll in another FEHB plan;

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days

- **Hospital care**

Your Plan primary care provider or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Care Center immediately at 800-359-2002. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

You must get prior approval for certain services. Your primary care provider is responsible for requesting authorization from Sharp Health Plan or your medical group. Failure to do so will result in denied claims and you, the member, will be responsible for 100% of the total cost of services.

- **Inpatient hospital admission**

Precertification (also called prior authorization) is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care provider has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practices. Examples of procedures and services that need prior authorization are listed below. **This is not an all-inclusive list**. You should contact your primary care provider to verify whether a procedure or service needs prior authorization.

Examples of Procedures/Services Requiring Prior Authorization:

- Acute rehabilitation and behavioral health facility admissions
- Air ambulance and non-emergent ambulance transportation
- All bariatric-related consultations, services and surgical services
- Clinical trials
- Durable medical equipment
- Home health services, including but not limited to IV infusion, hospice
- Outpatient diagnostic procedures, including but not limited to CT, MRA, MRI, PET and SPECT
- Transplants
- Growth Hormone Treatment (GHT)
- Certain formulary and non-formulary prescription drugs

Services that are not authorized by your primary care provider, your plan medical group or Sharp Health Plan will not be covered.

- **How to request precertification for an admission or get prior authorization for other services**

First, your physician, your hospital, you, or your representative, is responsible for requesting authorization from Sharp Health Plan or your plan medical group before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-359-2002. You may also call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-359-2002. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must phone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Failure to obtain authorization for non-plan providers: If you fail to obtain prior authorization (also called precertification) from your plan or plan medical group for any service requiring such an authorization, you, the member, will be responsible for 100% of the total cost of services received from any non-plan provider. It is the responsibility of the member to ensure that prior authorization has been obtained for all services.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call Customer Care at 800-359-2002.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

- You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
- If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Costs for Covered Services

This is what you will pay out-of-pocket for covered care:

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., coinsurance and copayments) for the covered care you receive.
Coinsurance	Coinsurance is the percentage of covered expenses that a member is required to pay each time covered services are provided, subject to any maximums specified in this brochure. Coinsurance amounts are applied toward the catastrophic protection out-of-pocket maximum expense in most circumstances. Example: In our Plan, you pay 50% of covered expenses for infertility services and 20% for durable medical equipment.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy etc., when you receive certain services. Example: When you see your primary care provider, you pay copayment of $10 per office visit, and when you go in the hospital, you pay $100 per admission.
Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. There is no calendar year deductible. Note: If you change plans during Open Season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.
Differences between our Plan allowance and the bill	You should also see section *Important Notice About Surprise Billing – Know Your Rights* below that describes your protections against surprise billing under the No Surprises Act.
Your catastrophic protection out-of-pocket maximum	After your out-of-pocket expenses, including any applicable copayments and coinsurance total $3,000 for Self Only, or $6,000 for a Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services: • Premiums • Services including, but not limited to: - Acupuncture services - Chiropractic services - Routine vision exams - Routine hearing exams - Assisted reproductive technologies • Services provided by out-of-network providers that have not been prior authorized

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for more than your copayment or coinsurance for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the non-participating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan. Balance billing does not include your applicable copayment or coinsurance.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

In addition, your health plan adopts and complies with the surprise billing laws of California. For specific information on surprise billing, the rights, and protections you have, and your responsibilities go to www.sharphealthplan.com/members/notices-and-disclosures.

The Federal Flexible Spending Account Program - FSAFEDS

Healthcare FSA (HCFSA) – Reimburses an FSA participant for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, over-the-counter drugs and medications, vision and dental expenses, and much more) their tax dependents, and their adult children (through the end of the calendar year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. Standard Option Benefits

Page 83 is a benefit summary. Make sure that you review the benefits that are available under this option.

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Section 5. Standard Option Benefits Overview

This Plan offers a Standard Option. The benefit package is described in Section 5. Make sure that you review the benefits that are available under this option.

Section 5 is divided into subsections. Please read *Important Things You Should Keep in Mind* at the beginning of the subsections. Also, read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our Standard Option benefits, contact us at 800-359-2002 or on our website at www.sharphealthplan.com.

Standard Option Plan Overview

Our Standard Option plan provides upfront cost transparency:

- $0 deductible
- $30 primary care provider office visit copayment
- $30 specialist office visit copayment
- $30 urgent care copayment
- $100 emergency room copayment
- $500 per admission for inpatient hospital facility charge
- $250 per visit outpatient hospital facility charge

This plan includes several services covered with $0 copayment, such as:

- Preventive care
- Diagnostic services
  - X-rays and readings
  - Laboratory services and readings
  - Readings of MRI/MRA, CT scans, PET scans

The calendar year catastrophic limit is $3,000 Self Only / $6,000 Self Plus One or Self and Family.

The Standard Option is offered with our Performance Network. The Performance Network provides access to physicians and medical groups located throughout San Diego County. With the Performance Network, you will receive access to more than 2,200 physicians, including primary care physicians and specialists. Visit www.sharphealthplan.com for an overview of this service area and to verify if a provider is part of this network.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copayment applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- There is no calendar year deductible.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay
Diagnostic and treatment services	**Standard**
Professional services of physicians • In physician's office	$30 per office visit $30 per visit to your primary care provider $30 per visit to a specialist
Professional services of physicians • In an urgent care center • Office medical consultations • Second surgical opinion • Advance care planning	$30 per office visit $30 per visit for medical consultation or second surgical opinion
• During a hospital stay • In a skilled nursing facility	Nothing
• At home	$30 per medically necessary home visit
Not covered: • *Immunizations for occupational and foreign travel* • *Treatment that is not referred by a plan provider, or authorized by Sharp Health Plan or your medical group when required* • *Treatment that is not medically necessary*	*All charges*

Benefit Description	You pay
Telehealth services	**Standard**
• You may receive covered benefits via telehealth when available, determined by your Plan provider to be medically appropriate, and provided by a Plan provider. Medically necessary health care services appropriately delivered via telehealth are covered on the same basis and to the same extent as coverage for the same services received through in-person visits. This means you have the same cost-share and out-of-pocket maximum for in-person and telehealth services. The same authorization rules also apply.	$30 per visit to your primary care provider $30 per visit to a specialist
Non-Covered • *All other benefits not otherwise listed in the Policy.* • *Virtual visit with a provider that is not contracted with the Plan will not be covered.* Please Note: • Not all conditions may be treated or appropriate for treatment through a virtual visit provider. You may be referred to another more appropriate care setting.	*All charges*
Lab, X-ray and other diagnostic tests	**Standard**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-ray • Non-routine mammogram • Ultrasound • Electrocardiogram and EEG	Nothing
• Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	$100 per visit
Preventive care, adult	**Standard**
Routine physical every year **The following preventive services are covered at the time interval recommended at each of the links below.** • U.S Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV and colorectal cancer. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. • Individual counseling on prevention and reducing health risks.	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**Standard**
• Preventive care benefits for women such as pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines. • To build your personalized list of preventive services go to https://health.gov/myhealthfinder.	Nothing
• Routine screening mammogram	Nothing
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy: Medically supervised weight management program, weekly visits usually for a 6-month duration. • Family-centered programs when medically identified to support obesity prevention and management by an in-network provider: Wellness education programs, weekly classes for 10 to 12 weeks. Obesity screening and referral, for those persons below the USPSTF obesity prevention risk factor level: Wellness education programs, weekly classes for 10 to 12 weeks. Members are also encouraged to follow up with their primary care provider for lifestyle education. Note: Also see Section 5(h) for fitness and wellness discounts, programs and coaching.	In-network: nothing Out of network: not covered
• When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for oral anti-obesity medications.	
• When bariatric or metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.*	*All charges*

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**Standard**
• *Immunizations, boosters, and medications for travel or work-related exposure.* • *Immunizations and vaccines for travel and/or required for work, insurance, school, marriage, adoption, immigration, camp, volunteer work, licensure, certification or registration, sports or recreational activities are not covered. Immunizations that are not specifically listed on the most current version of the Recommended Adult Immunization Schedule/United States or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are not covered.* • *Physical examinations required for court hearings, travel, premarital, pre-adoption, employment or other non-preventive health reasons are not covered. Court-ordered or other statutorily required psychological evaluation, testing and treatment are not covered unless medically necessary and authorized by the Plan.*	*All charges*
Preventive care, children	**Standard**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org. • Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https://www.cdc.gov/vaccines/schedules/index.html.	Nothing
• You can also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy: Medically supervised weight management program, weekly visits usually for a 6-month duration. • Family-centered programs when medically identified to support obesity prevention and management by an in-network provider: Wellness education programs, weekly classes for 10 to 12 weeks. Obesity screening and referral, for those persons below the USPSTF obesity prevention risk factor level: Wellness education programs, weekly classes for 10 to 12 weeks. Members are also encouraged to follow up with their primary care provider for lifestyle education	In-network: nothing Out of network: not covered

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**Standard**
Note: Also see Section 5(h) for fitness and wellness discounts, programs and coaching.	In-network: nothing Out of network: not covered
• When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for oral anti-obesity medications.	
• When bariatric or metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	
Maternity care	**Standard**
Complete maternity (obstetrical) care, such as: • Prenatal and postpartum care • Screening for gestational diabetes • Screening and counseling for prenatal and postpartum depression	Nothing for routine prenatal care or the first postpartum care visit; $0 per office visit for all routine postpartum care visits thereafter Nothing for inpatient professional delivery services
Delivery: • Inpatient hospital services	$500 per admission
Breastfeeding and lactation support, supplies and counseling for each birth Note: Here are some things to keep in mind: You do not need to precertify your vaginal delivery; see page 20 for other circumstances, such as extended stays for you or your baby. • As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and postpartum period. Your coverage includes doula services for a member who is pregnant or has been pregnant in the last 12 months. Precertification of the doula provider is not required, but the doula provider must be in-network. Find an in-network doula provider at this location: www.sharphealthplan.com/findadoctor. Covered doula services include: - An initial visit, in-person or virtual (as available). - Up to eight additional visits (any combination of prenatal and postpartum visits), in-person or virtual, limited to one visit per day. - Support during labor and delivery (including labor and delivery resulting in a stillbirth, abortion or miscarriage). One prenatal visit or one postpartum visit can be provided on the same day as labor and delivery, stillbirth, abortion, or miscarriage support. - Up to two extended three-hour postpartum visits after the end of a pregnancy, in-person or virtual • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment.	Nothing

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**Standard**
• We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	Nothing
Not covered: • *Testing, services or supplies for conception by a surrogate who is not enrolled in Sharp Health Plan.* • *Devices and procedures to determine the sex of a fetus.* • *Elective home deliveries.*	*All charges*
Family planning	**Standard**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms • Genetic testing and counseling Note: See additional Family Planning and Prescription drug coverage Section 5(f). Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. Your provider will submit a prior authorization request with medical justification. The Plan has 24 hours to respond to your exception request after receiving all necessary documents. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	Nothing
Voluntary male sterilization	Nothing

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	**Standard**
Not covered: • *Reversal of voluntary surgical sterilization* • *Non-FDA-approved contraceptive supplies*	*All charges*
Infertility services	**Standard**
Infertility is defined as (1) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual intercourse without contraception, or (2) the presence of a demonstrated condition recognized by a physician as a cause of infertility. Diagnosis and treatment of infertility specific to: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	50% coinsurance
• Fertility drugs • Assisted Reproductive Technologies (ART) services and procedures: - In vitro fertilization (IVF) - Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) • Fertility preservation services for iatrogenic infertility • Provider-administered medications directly associated with the covered ART procedures up to an annual maximum of three cycles • Self-administered outpatient prescription medication for treatment for infertility up to an annual maximum of three cycles • Intracytoplasmic sperm injection (ICSI)	50% Coinsurance
Not covered: • *Infertility services after voluntary sterilization* • *The collection, preservation or purchase of sperm, ova or embryos* • *Any services relating to cryopreservation including, but not limited to, collection, storage, thawing, or procedures employing sperm, ova, or embryos that have been cryopreserved, unless medically necessary for fertility preservation when a covered medical treatment may directly or indirectly cause iatrogenic infertility.* • *Reversal of voluntary sterilization* • *Surrogacy services or supplies* • *Procedures that are not covered include, but are not limited to, Assisted Hatching, blastocyst transfer, multi-cell embryo transfer (TET), and any other procedures not specifically identified as covered* • *Any service, procedure or process that prepares the member for non-covered procedures* • *Services, procedures or processes provided to or performed on someone other than the member*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**Standard**
• *Testing, services or supplies for conception by a surrogate who is not enrolled in Sharp Health Plan.* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	**Standard**
• Testing and treatment	$30 per office visit
• Allergy injections	$10 per office visit
• Allergy serum	$10 copayment
Not covered: • *Provocative food testing including tolerance induction program* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**Standard**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page 44. • Respiratory and inhalation therapy • Cardiac rehabilitation following qualifying event/condition is provided for up to 12 sessions • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) • Proton Beam Radiation Therapy • Osteopathic Manipulative Treatment • Applied behavior analysis (ABA) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services* under *You need prior Plan approval for certain services* on page 18.	Nothing $30 per office visit to your primary care provider $30 per office visit to a specialist $25 group visit $250 per outpatient facility visit
• Medical foods for children under medical necessity • Medical foods for adults under medical necessity	20% coinsurance
• Dialysis – hemodialysis and peritoneal dialysis • Nutrition therapy • Intensity-Modulated Radiation Therapy (IMRT)	Nothing
Not covered: • *Alternative therapy*	*All charges*

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**Standard**
• *Sexual dysfunction treatment unless medically necessary for treatment of a mental health or substance use disorder.* • *Massage therapy not part of physical therapy plan*	*All charges*
Physical and occupational therapies	**Standard**
90 visits for the services of each of the following: • Qualified physical therapists • Occupational therapists • Cognitive Rehabilitation Therapy • Habilitative Therapy Note: We only cover therapy when a physician: • orders the care (Direct referral for evaluation and12 treatments. Prior authorization required for further treatments); • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed.	$30 per office visit $30 per outpatient visit Nothing per visit during covered inpatient admission
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	**Standard**
Speech therapy services are covered when determined to be medically necessary. Prior authorization is required.	$30 per office visit $30 per outpatient visit Nothing per visit during covered inpatient admission
Not covered: *Non-medically necessary services are not covered:* • *When services with the same treatment goals are available elsewhere, such as the school district or other community resources, or when another qualified professional, such as an occupational therapist, provides them.* • *Dysfunctions that are self-correcting, behavioral disorders or attention disorders.* • *When services do not require the skills of a qualified provider of speech therapy services.* • *When the member has reached therapeutic goals of the treatment plan or no further functional progress is expected.* • *When services are not habilitative, such as, respite care, day care, recreational care, residential treatment, social services, custodial care, or primarily educational services.* • *Idiopathic delays in speech development for children younger than 18 months of age.*	*All charges*

Benefit Description	You pay
Hearing services (testing, treatment, and supplies)	**Standard**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see *Section 5(a). Preventive care, children.*	$30 per office visit to a specialist
• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants *Note: For benefits for the devices, see Section 5(a)* Orthopedic and prosthetic devices.	$30 per office visit $500 per admission
Not covered: • *Hearing services that are not shown as covered* • *External hearing aids*	*All charges*
Vision services (testing, treatment, and supplies)	**Standard**
• Vision testing and examination • Annual eye refractions Note: See *Preventive care, children* for eye exams for children.	$30 per office visit
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Vision treatment or supplies. Medically necessary medical and surgical treats of eye conditions is covered.*	*All charges*
Foot care	**Standard**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$30 per office visit to your primary care provider $30 per office visit to a specialist
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above.* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).*	*All charges*

Benefit Description	You pay
Orthopedic and prosthetic devices	**Standard**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical procedures*. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services*.	$30 per office visit
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered* • *External hearing aids* • *Implantable and semi-implantable middle ear hearing aids*	*All charges*
Durable medical equipment (DME)	**Standard**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen • Dialysis equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • Speech generating devices • Blood glucose monitors (BGM)/Continuous Glucose monitors (CGM) • Insulin pumps/pods/tubeless insulin delivery systems • All supplies for Insulin Pumps/pods/tubeless insulin delivery system • Ostomy and Catheter Supplies	20% coinsurance (coinsurance applied per monthly rental or approved purchase price)

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay
Durable medical equipment (DME) (cont.)	**Standard**
Note: Your plan physician prescribes this equipment. Your prescribing physician will direct you to an affiliated vendor for authorized durable medical equipment. Wigs for hair loss due to the treatment of cancer	20% coinsurance (coinsurance applied per monthly rental or approved purchase price) Nothing Member pays all cost over $300
Not covered: • *Equipment that basically serves comfort or convenience functions (e.g., physical fitness equipment, trays, backpacks, wheelchair racing equipment).* • *DME that is primarily for the convenience of the member or caretaker.* • *Exercise and hygiene equipment.* • *Experimental or research equipment.* • *Devices not medical in nature such as sauna baths and elevators or modifications to the home or automobile.* • *Generators or accessories to make home dialysis equipment portable for travel.* • *Deluxe equipment such as items for comfort, convenience, upgrades or add-ons.* • *More than one piece of equipment that serves the same function, when the additional DME is not medically necessary.* • *Replacement of lost or stolen DME.*	*All charges*
Home health services	**Standard**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L. V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* • *Private duty nursing*	*All charges*
Chiropractic	**Standard**
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$10 per office visit
Not covered: • *Any services or treatments not approved by American Specialty Health Plans except for a New Patient Examination or Emergency Chiropractic Services* • *Any services or treatments not listed as covered in this benefit plan or not medically necessary*	*All charges*

Chiropractic - continued on next page

Benefit Description	You pay
Chiropractic (cont.)	**Standard**
• *Any services or treatments not provided by a Plan Chiropractor, except Emergency Chiropractic Services* • *Adjunctive therapy not associated with spinal, muscle or joint manipulation* • *Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances* • *Education program, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic training* • *Hospitalization, anesthesia, manipulation under anesthesia or other related services* • *Hypnotherapy, behavior training, sleep therapy or weight programs* • *Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology and any type of diagnostic radiology other than covered plain film studies* • *Physical therapy not related to a spinal or joint adjustment* • *Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order* • *Services not related to neuromuscular-skeletal disorders* • *Thermography* • *Transportation costs including local ambulance charges* • *Vitamins, minerals, nutritional supplements or other similar products*	*All charges*
Alternative treatments	**Standard**
Acupuncture – by a doctor of medicine or osteopathy, or licensed or certified acupuncture practitioner.	$10 per office visit
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Any services or treatments not approved by American Specialty Health Plans except for a New Patient Examination or Emergency Acupuncture Services* • *Any services or treatments not listed as covered in this benefit plan or not medically necessary* • *Any services or treatments not provided by a Plan Acupuncturist, except Emergency Acupuncture Services* • *Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances* • *Education program, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic training* • *Hospitalization, anesthesia, manipulation under anesthesia or other related services* • *Hypnotherapy, behavior training, sleep therapy or weight programs* • *Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology and any type of diagnostic radiology other than covered plain film studies*	*All charges*

Alternative treatments - continued on next page

Benefit Description	You pay
Alternative treatments (cont.)	**Standard**
• *Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order* • *Compounded medications* • *Services not related to nausea or pain* • *Thermography* • *Transportation costs including local ambulance charges* • *Vitamins, minerals, nutritional supplements or other similar products*	*All charges*
Educational classes and programs	**Standard**
Coverage is provided for: • Tobacco cessation programs, including individual/group/telephone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. • Diabetes self-management	Nothing for counseling for up to two quit attempts per year. Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence. Nothing for diabetic education.

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- There is no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	**Standard**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of severe obesity (bariatric surgery) including open or laparoscopic Roux-en-Y gastric bypass, laparoscopic adjustable gastric banding or vertical banded gastroplasty and sleeve gastrectomy • Insertion of internal prosthetic devices. See *5(a) Orthopedic and prosthetic devices* for device coverage information. • Treatment of burns Note: For female surgical family planning procedures see *Family Planning* Section 5 (a) Note: For male surgical family planning procedures see *Family Planning* Section 5(a) Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay inpatient benefits for a pacemaker inserted while admitted to the hospital and outpatient surgery benefits for a pacemaker inserted in an outpatient hospital facility.	$30 per visit to your primary care provider $30 per visit to a specialist $500 copayment per inpatient admission $250 copayment for outpatient surgery
Not covered: • *Reversal of voluntary sterilization*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**Standard**
• *Routine treatment of conditions of the foot (see* Foot care*)*	*All charges*
Reconstructive surgery	**Standard**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. • Gender Affirming Surgery • Facial Gender Affirming • Breast Reconstruction - Gender-affirming care and associated services are covered when medically necessary. Covered benefits include clinically appropriate services for the treatment of gender dysphoria, including medical, psychiatric, hormonal, and surgical treatments, according to the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC).	$500 copayment per inpatient admission $250 copayment for outpatient surgery
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*
Oral and maxillofacial surgery	**Standard**
Oral surgical procedure, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of maxillofacial cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$500 copayment per inpatient admission $250 copayment for outpatient surgery
Not covered: • *Oral implants and transplants*	*All charges*

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay
Oral and maxillofacial surgery (cont.)	**Standard**
• *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**Standard**
These **solid organ transplants** are covered and are subject to medical necessity review by the Plan. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas	$500 per admission
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. Transplants are subject to medical necessity review by the Plan. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis	$500 per admission

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard**
- Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	$500 per admission
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)	$500 per admission

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard**
- Hemoglobinopathy	$500 per admission
- Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia)	
- Myelodysplasia/Myelodysplastic syndromes	
- Paroxysmal Nocturnal Hemoglobinuria	
- Severe combined immunodeficiency	
- Severe or very severe aplastic anemia	
• Autologous transplants for	
- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia	
- Advanced Hodgkin's lymphoma with recurrence (relapsed)	
- Advanced non-Hodgkin's lymphoma with recurrence (relapsed)	
- Amyloidosis	
- Neuroblastoma	
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols.	$500 per admission
If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.	
• Allogeneic transplants for	
- Advanced Hodgkin's lymphoma	
- Advanced non-Hodgkin's lymphoma	
- Beta Thalassemia Major	
- Chronic inflammatory demyelination polyneuropathy (CIDP)	
- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	
- Multiple myeloma	
- Multiple sclerosis	
- Sickle Cell anemia	
• Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for	
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	
- Advanced Hodgkin's lymphoma	
- Advanced non-Hodgkin's lymphoma	
- Breast cancer	
- Chronic lymphocytic leukemia	
- Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)	
- Chronic myelogenous leukemia	
- Colon cancer	

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**Standard**
- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	$500 per admission
National Transplant Program (NTP) Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	$500 per admission
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Benefit Description	You pay
Anesthesia	**Standard**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- There is no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Note: When the calendar year deductible does not apply we indicate - "Deductible does not apply"	
Inpatient hospital	**Standard**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$500 per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services\ • Take-home items	Nothing
• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	20% coinsurance (copayment applied per monthly rental or purchase)
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**Standard**
• *Personal or comfort items or a private room in a hospital, unless medically necessary, are not covered*	*All charges*
Outpatient hospital or ambulatory surgical center	**Standard**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$250 copayment for outpatient surgery/procedure
Not covered: • *Blood and blood derivatives not replaced by the member*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**Standard**
Extended care benefit and Skilled Nursing Facility (SNF) services: Skilled Nursing Facility services are covered for up to a maximum of 100 days per Calendar Year in a semi-private room (unless a private room is medically necessary). Covered benefits for skilled nursing care are those services prescribed by a Plan provider and provided in a qualified licensed Skilled Nursing Facility. Covered benefits include: • Physician and skilled nursing on a 24–hour basis. Room and board. • X-ray and laboratory procedures. • Respiratory therapy. • Short-term physical, occupational and speech therapy. Medical social services. • Prescribed drugs and medications. • Blood, blood products and their administration. • Medical supplies, appliances and equipment normally furnished by the Skilled Nursing Facility.	$150 per admission
Not covered: • *Custodial care*	*All charges*

Benefit Description	You pay
Hospice care	**Standard**
Hospice services are covered for members diagnosed with a terminal illness, with a life expectancy of twelve months or less, and who elect hospice care for the illness instead of restorative services. Covered benefits include: • Nursing care • Medical social services • Home health aide services, skilled nursing services and homemaker services under the supervision of a qualified registered nurse • Physician services • Drugs • Pharmaceuticals, medical equipment and supplies • Counseling and social services with medical social services provided by a qualified social worker • Dietary counseling by a qualified provider • Bereavement services • Physical, occupational and speech therapy • Interdisciplinary team care with development and maintenance of an appropriate plan of care • Volunteer services • Short-term inpatient care arrangements	Nothing
Not covered: • *Independent nursing, homemaker services*	*All charges*
Ambulance	**Standard**
Local professional ambulance service when medically appropriate	$100 per trip

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

Emergencies within our service area

- If you have an emergency medical condition, call "911" or go to the nearest hospitable emergency room. It is not necessary to contact your PCP before calling "911" or going to a hospital if you believe you have an emergency medical condition.
- If you are unsure whether your condition requires emergency services, call your PCP (even after normal business hours). Your PCP can help decide the best way to get treatment and can arrange for prompt emergency room care. However, do not delay getting care if your PCP is not immediately available. Members are encouraged to use the "911" emergency response system appropriately when they have an emergency medical condition that requires an emergency response.
- If you go to an emergency room and you do not reasonably believe you are having an emergency, you may be responsible for payment.
- If you are hospitalized in an emergency, please notify your PCP or Sharp Health Plan within 48 hours or at the earliest time reasonably possible. This will allow your Plan physician to share your medical history with the hospital and help coordinate your care. If you are hospitalized outside of the service area, your Plan physician and the Plan may arrange for your transfer to a Plan hospital if your medical condition is sufficiently stable for you to be transferred.
- Paramedic ambulance services are covered when provided in conjunction with emergency services.
- Some non-Plan providers may require that you pay for emergency services and seek reimbursement from the Plan. On these occasions, obtain a complete bill of all services rendered and a copy of the emergency medical report, and forward them to the Plan right away for reimbursement. Go to www.sharphealthplan.com for a copy of the reimbursement request form.
- If you need follow-up care after you receive emergency services, call your PCP to make an appointment or for a referral to a specialist. Do not go back to the hospital emergency room for follow-up care, unless you are experiencing an emergency medical condition.
- You are not financially responsible for payment of emergency services, in any amount the plan is obligated to pay, beyond your copayment. You are responsible only for applicable copayments, as listed on the Summary of Benefits.

Emergencies outside our service area

Out-of-area medical services are covered only for urgent and emergency medical conditions resulting from unforeseen illness or injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the member returns to the service area. Out-of-area medical services will be covered to meet your immediate medical needs. Follow-up care for urgent and emergency services will be covered until it is clinically appropriate to transfer your care into the plan's service area. Follow-up care must be authorized by Sharp Health Plan.

The member pays an applicable copayment to the hospital for emergency services provided in a hospital emergency room. The member pays the same copayment for emergency services whether the hospital is a Plan hospital or not. The copayment is waived if the member is admitted to the hospital from its emergency room.

Benefit Description	You pay
Emergency within our service area	**Standard**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the emergency room copayment if you are admitted to the hospital.	$30 per visit to your primary care provider $30 per urgent care visit $100 per emergency care visit
Not covered: Elective care or non-emergency care *Emergency facility and professional services that are not required on an immediate basis for treatment of an emergency medical condition are not covered.*	*All charges*
Emergency outside our service area	**Standard**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the emergency room copayment if you are admitted to the hospital.	$30 per visit to your primary care provider $30 per urgent care visit $100 per emergency care visit
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	**Standard**
Professional ambulance service when medically appropriate (ground or air). Note: See 5(c) for non-emergency service.	$100 per trip
Not covered: *Ambulance services are not covered when a member does not reasonably believe that his or her medical condition is an emergency medical condition that requires ambulance transport services, unless for a nonemergency ambulance service listed as covered in this member handbook.* *Wheelchair transportation services (e.g., a private vehicle or taxi fare) are also not covered.*	*All charges*

Benefit Description	You pay
Accidental injury	**Standard**
Accidental injury	$100 copayment

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay
Professional services	**Standard**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Diagnosis and treatment of substance use disorders including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$30 per office visit $30 per urgent care visit $100 per emergency care visit
• Mental health treatment and counseling (including individual or group therapy visits)	$30 per individual visit $25 per group visit
• Substance use disorder treatment and counseling (including individual or group therapy visits)	$30 per individual visit $7 per group visit

Benefit Description	You pay
Diagnostics	**Standard**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing
Inpatient hospital or other covered facility	**Standard**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$500 per admission
Outpatient hospital or other covered facility	**Standard**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$30 per visit $500 per admission for half-way house and residential treatment Home-based applied behavioral analysis for treatment of pervasive developmental disorder or autism $30 per visit
Not covered: *The following services are not Covered Benefits:* • *Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation, custody, or visitation.*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- There is no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You must fill the prescription at network contracted retail or contracted specialty pharmacy for a specialty drug. Maintenance medications can be filled at a contracted mail order pharmacy.
- **We use a formulary**. We cover non-formulary drugs prescribed by a Plan doctor when medical necessity is established through the prior authorization process.
- **We have a managed formulary.** If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 855-298-4252 or visit www.sharphealtplan.com/search-drug-list to view a list of drugs.
- **These are the dispensing limitations.** When the prescription drug is filled at a Plan pharmacy, the pharmacy may dispense:
  - Up to a 90-day supply for maintenance drugs at retail or mail order
  - Up to a 30-day supply for non-maintenance drugs at retail pharmacy
  - Up to a 30-day supply for specialty drugs
- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand. If you receive a name brand drug when an FDA approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic
- **Why use generic drugs?** A generic drug is a medication created to be the same as an already marketed brand-name drug in dosage form, safety, strength, route of administration, performance characteristics, and intended use, which means that a generic drug works in the same way and provides the same clinical benefit as the brand-name drug and is less expensive to the member.
- **When you have to file a claim**. If you pay out-of-pocket in an emergency situation for a prescription that is covered by your plan, you can submit a request for reimbursement.

Benefit Description	You pay
Covered medications and supplies	**Standard**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.* • Insulin vials and pens • Diabetic supplies limited to: • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Drugs to treat gender dysphoria Sharp Health Plan follows WPATH criteria for gender dysphoria treatment drugs including gender affirming hormones including estrogen, progesterone, testosterone and puberty suppression hormone therapy. In addition, treatment may include reproductive medicine drugs. • Medications prescribed to treat obesity Contraceptive drugs and devices as listed in the Health Resources and Service Administration site https://www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. • Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. • Provider to submit a prior authorization request with medical justification. If you have difficulty accessing contraceptive coverage or other reproductive healthcare you can contact contraception@opm.gov. • Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits see Section 5(a) Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the *Tobacco Cessation Educational Classes and Programs* in Section 5(a)	Retail (30-day supply) • $16 for preferred generic drugs • $40 for preferred brand-name drugs • $80 for non-preferred drugs Mail Order (90-day supply) • $32 for preferred generic maintenance drugs • $80 preferred brand-name maintenance drugs • $160 for non-preferred maintenance drugs Note: If there is no generic equivalent available, you will still have to pay the brand name copayment.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**Standard**
Not covered • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications* • *Drugs that are prescribed solely for the purposes of losing weight, except when medically necessary for the treatment of severe (Class III) obesity. Members must be enrolled in a Sharp Health Plan approved comprehensive weight loss program prior to or concurrent with receiving the weight loss drug.*	*All charges*
Preventive medications	**Standard**
The following are covered: • Aspirin for members capable of pregnancy age 12-59 years at risk for preeclampsia (81mg) • Medication to reduce the risk of breast cancer • Medication to reduce the duration of COVID infections • Contraceptive agents to prevent pregnancy (including tablets, vaginal rings, condoms, spermicides) – does not include implanted contraceptives (IUD, contraceptive implant) • Folic acid for members capable of pregnancy age 55 years and under (400mcg, 800mcg) • Select bowel prep laxative combinations for colonoscopy • Fluoride tablets, solution (not toothpaste, rinses) for children ages 5 and under • Tobacco cessation medications, including prescribed over-the-counter medications, approved by the FDA to treat tobacco dependence • Statins for members age 40 through 75 for the primary prevention of cardiovascular disease Note: Preventive medications with a USPSTF A and B recommendation. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to http://www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations	Nothing when prescribed by a healthcare professional and filled by a network pharmacy
Anti-obesity drugs (GLP1)	$20
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs that are prescribed solely for the purposes of losing weight, except when medically necessary for the treatment of severe (Class III) obesity. Members must be enrolled in a Sharp Health Plan approved comprehensive weight loss program prior to or concurrent with receiving the weight loss drug.* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* • *Nonprescription medications*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage*.
- Plan dentists must provide or arrange your care.
- There is no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	**Standard**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	$30 per visit to your primary care physician provider $30 per visit to a specialist $30 per urgent care visit $100 per emergency room visit
Dental benefits	**Standard**
We have no other dental benefits.	

Section 5(h). Wellness and Other Special Features

Feature	
Feature	**Standard**
24/7 Access to your Health Care Information	**Sharp Health Plan Member Portal** One of the best ways to manage your plan is to create your Sharp Health Plan online account. Your online account will connect you to your coverage and give you quick, secure access to: • Check benefits, balances and costs • See claims and coverage documents • Change a primary care physician • View or print your member ID card • Choose paperless options • Set communication preferences • Share access to your account • And much more Plus, it's available on any device with internet access, including desktop and mobile. Visit www.sharphealthplan.com/login and follow the instructions to create an account. **Sharp Health Plan app** Designed for members, the official Sharp Health Plan app makes it easy to access your online account anytime, anywhere. Visit www.sharphealthplan.com/account. Activate your online account today to easily manage your plan.
Sharp Nurse Connection®	Registered nurses are available through Sharp Nurse Connection® after hours and on weekends. They can talk with you about an illness or injury, help you decide where to seek care and provide advice on any of your health concerns. Call 1-800-359-2002, 5 p.m. – 8 a.m., Monday to Friday and 24 hours on weekends and select the option to speak with a nurse.
Services for deaf and hearing impaired	Sharp Heath Plan provides free interpreter services at scheduled appointments. For language interpreter services, please call Customer Care at 1-800-359-2002. The hearing and speech impaired may dial "711" or use California's Relay Service's toll-free numbers to contact us: • 1-800-735-2922 Voice • 1-800-735-2929 TTY • 1-800-855-3000 Voz en español y TTY (teléfono de texto)
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future.

Feature - continued on next page

Feature	
Feature (cont.)	**Standard**
	• The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
High risk pregnancies	Sharp HealthCare has women's care centers that offer a wide range of perinatal services, top-notch facilities and compassionate, highly skilled specialists. Sharp has more affiliated perinatologists than anywhere else in San Diego – and uses state-of-the-art equipment to perform a range of diagnostic services from amniocentesis to DNA gene probe testing. If you are in need of highly specialized assistance, your OB/Gyn will refer you to a perinatologist who will provide comprehensive care from diagnosis through delivery.
Centers of excellence	Sharp Health Plan maintains centers of excellence for: • Stroke • Kidney transplant • Total joints
Travel benefit/services overseas	When faced with a medical emergency while traveling 100 miles or more away from home or in another country for less than 90 days, we can connect you to doctors, hospitals, pharmacies and other service providers. We partner with Assist America® to bring you key services including medical consultation, evaluation and referral, foreign hospital admission assistance, emergency medical evacuation, medical monitoring, prescription assistance, compassionate visits and more. To learn more visit www.sharphealthplan.com/travel.
Fitness and wellness discounts	Sharp Health Plan members can stay healthy with discounts on studios, gyms, online classes, and wellness products. • **Studio SWEAT OnDemand.** Over 50% off standard Studio SWEAT rates with unlimited access to on-demand and live streaming workouts. • **Active and Fit Direct™.** Access to 12,700+ gyms for a low monthly fee ($28) and 8,700+ premium exercise studios at discounted rates. • **ChooseHealthy®.** The ChooseHealthy program offers discounts on popular fitness and wellness products, alternative provider services, and a variety of resources to help you live better. To learn more visit www.sharphealthplan.com/discounts.
Wellness program and coaching	Best Health is a comprehensive wellness program available to all Sharp Health Plan members at no extra cost. Offering robust online wellness tools, one-on-one health coaching and more, Best Health provides resources you can use to reach your health goals. Visit www.sharphealthplan.com/wellness/best-health to learn more.

Feature - continued on next page

Feature	
Feature (cont.)	**Standard**
Behavioral health support	We believe your mental health is just as important as your physical health. Behavioral health care services are a covered benefit for members of all ages. No referral is needed to access outpatient therapy from a provider in your Plan network. To learn more visit www.sharphealthplan.com/bh.

Non-FEHB Benefits Available to Plan Members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 800-359-2002 or visit our website at www.shaphealthplan.com.

Term	Definition
Individual and Family Health Insurance Plans	If you or a family member are not eligible under the FEHB Program benefits, Sharp Health Plan offers individual and family health insurance plans. For more information, visit our website at: www.sharphealtplan.com/our-plans/individual-and-family-plans.
New to Medicare?	Whether you are eligible for Medicare coverage now, or will be soon, Sharp Health Plan is here to help you understand more about Medicare. For more information, visit our website at www.sharpmedicareadvantage.com. If you are turning 65 and need current year plan information, call one of our Medicare Representatives directly at 888-632-8724 (TTY: 711).

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition**. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services*.

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment and/or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form.

When you must file a claim – such as for services you receive outside the Plan's service area – complete the member reimbursement form found online at www.sharphealthplan.com/members/forms and submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the provider or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your medical claims to:

Sharp Health Plan
Attention: Claims Research
8520 Tech Way, Suite 200
San Diego, CA 92123-1450

For claims questions and assistance, call us at 800-359-2002, or at our website at www.sharphealthplan.com/members/forms.

Prescription drugs

If you receive prescription drugs from a non-network pharmacy in an emergency or urgent situation, please submit your receipts along with a Prescription Drug Claim Form found on our website at www.sharphealthplan.com/members/forms

Submit your prescription drug claims to:

CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Other supplies or services

If you receive services from a health care provider that requires you to submit the claim to us for reimbursement, you must obtain an itemized bill.

Submit your claims to:

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

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 If you disagree with our pre-service claim decision, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Care Department by writing Sharp Health Plan, Attention: Appeal/Grievance Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450 or calling 800-359-2002.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or their subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Sharp Health Plan, Attention: Appeal/Grievance Department, 8520 Tech Way, Suite 200, San Diego, CA 92123-1450; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4. In the case of a post-service claim, we have 30 days from the date we receive your request to:

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a) Pay the claim; or

b) Write to you and maintain our denial; or

c) Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3

If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employees Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

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OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OMP's review within 60 days. There are no other administrative appeals.

If you do not agree with OPM’s decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-359-2002. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p. m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under the plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits With Medicare and Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.sharphealthplan.com.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **TRICARE and CHAMPVA**

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar federal or state agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these state programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on www.benefeds.com/ or by phone at 877-888-3337, (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 800-MEDICARE (800-633-4227), (TTY 877-486-2048) or at www.medicare.gov.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-359-2002 or see our website at www.sharphealthplan.com.

We do not waive any costs if the Original Medicare Plan is your primary payor.

Please review the following examples which illustrates your cost share if you are enrolled in Medicare Part B.

Standard Option

Benefit Description: Deductible
Standard Option You pay without Medicare: N/A
Standard Option You pay with Medicare Part B: N/A

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum
Standard Option You pay without Medicare: $3,000 self only / $6,000 family
Standard Option You pay with Medicare Part B: $3,000 self only / $6,000 family

Benefit Description: Primary Care Provider
Standard Option You pay without Medicare: $30 copayment per visit
Standard Option You pay with Medicare Part B: $30 copayment per visit

Benefit Description: Specialist
Standard Option You pay without Medicare: $30 copayment per visit
Standard Option You pay with Medicare Part B: $30 copayment per visit

Benefit Description: Inpatient Hospital
Standard Option You pay without Medicare: $500 copayment per admission
Standard Option You pay with Medicare Part B: $500 copayment per admission

Benefit Description: Outpatient Hospital
Standard Option You pay without Medicare: $250 copayment per visit
Standard Option You pay with Medicare Part B: $250 copayment per visit

You can find out more information on how our plan coordinates benefits with Medicare by calling our Customer Care at 800-359-2002.

- **Tell us about your Medicare coverage**

  You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country.

  To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY 877-486-2048) or at www.medicare.gov.

  If you enroll in a Medicare Advantage plan, the following options are available to you:

  This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

  However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

  Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

  When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation		✓*
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Assisted Reproductive Technology (ART)

All treatments or procedures that include the handling of human eggs, sperm, and/or embryos to help an individual become pregnant. ART includes, but is not limited to, gamete intrafallopian transfer (GIFT), uterine embryo lavage, embryo transfer, in vitro fertilization (IVF), pronuclear state transfer (PROST), tubal embryo transfer (TET), zygote intrafallopian transfer (ZIFT), low tubal ovum transfer, intracytoplasmic sperm injection, cryopreservation (e.g., egg, embryo, sperm), and other third party-assisted ART methods (e.g., sperm donation, egg donation, Traditional Surrogates and Gestational Carriers, embryo donation).

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials cost categories

An approved clinical trail includes a phase I, phase II, phase III, or phase IV clinical trail that is considered in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded, conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs - costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trail or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs - costs related to conducting the clinical trail such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trails. This plan does not cover these costs.

Coinsurance

See Section 4, *Your Costs for Covered Services*, page 22.

Confinement/Confined

a) The period of time between admission to and discharge from an inpatient or outpatient hospital, AODA residential center, skilled nursing facility, or licensed ambulatory surgical center on the advice of your physician, and discharge there from; or b) the time spent in a hospital receiving emergency care for illness or injury. Hospital swing bed Confinement is considered the same as Confinement in a skilled nursing facility. If the Member is transferred to another facility for continued treatment of the same or related condition, it is one Confinement.

Specific to a skilled nursing facility (SNF), an inpatient stay begins on the day of admission into a skilled nursing facility. The 120 day SNF benefit renews when you haven't received any inpatient hospital care or skilled care in a skilled nursing facility for the same or a similar diagnosis for 60 days in a row. If you go into a hospital or a skilled nursing facility after one SNF benefit period has ended, a new benefit period begins.

There is no limit to the number of SNF Inpatient benefit periods. However, an additional 120 days is not available until skilled care has not been required for at least 60 consecutive days.

Copayment

See Section 4, *Your Costs for Covered Services*, page 22.

Cosmetic Surgery, Services or Procedures

Services and procedures that improve physical appearance but do not correct or improve a physiological function and that are not Medically Necessary unless the service or procedure meets the definition of Reconstructive Surgery.

Cost-Sharing

See Section 4, *Your Costs for Covered Services*, page 22.

Covered services

Care we provide benefits for, as described in this brochure. Also called covered benefits.

Custodial Care

Care that does not require the regular services of trained medical or health professionals, 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.

Deductible

See Section 4, *Your Costs for Covered Services*, page 22.

Experimental or Investigational Service

Any evaluation, treatment, therapy, or device which involves the application, administration or use of procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, or chemical compounds if, as determined by Sharp Health Plan, one of the following is true:

- Such evaluation, treatment, therapy, or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), and approval for marketing has not, in fact, been given at the time such service is furnished to the member.
- Such evaluation, treatment, therapy or device is provided pursuant to a written protocol that describes among its objectives the following: determinations of safety, efficacy, toxicity, maximum tolerated dosage(s) or efficacy in comparison to the standard evaluation, treatment, therapy or device.
- Such evaluation, treatment, therapy or device is delivered or should be delivered subject to the approval and supervision of an institutional review board or other entity as required and defined by federal regulations.
- Such evaluation, treatment, therapy, or device is the subject of an ongoing Phase I or II clinical trial, or experimental or research arm of a Phase III clinical trial.
- The consensus among experts, as expressed in published authoritative medical literature, is that further studies, research, or clinical investigations are necessary to determine maximum tolerated dosage(s), toxicity, safety, efficacy, or efficacy as compared with the standard means for treatment or diagnosis of the medical condition in question.

- There is no consensus among practicing physicians that the treatment, therapy, or device is safe and effective for the condition in question.
- Such evaluation, treatment, therapy or device is not yet considered the standard of care by a nationally recognized technology assessment organization, specialty society or medical review organization in treating patients with the same or similar condition

The sources of information that may be relied upon by Sharp Health Plan in determining whether a particular treatment is Experimental or Investigational include, but are not limited to, the following:

- The member's medical records.
- Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts.
- Peer-reviewed literature that meet the criteria of the National Institutes 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).
- The Cochrane Library.
- Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the Social Security Act.
- The American Hospital Formulary Service's Drug Information.
- The American Dental Association Accepted Dental Therapeutics.
- Any of the following reference compendia, if recognized by the federal Centers for Medicare s Clinical Pharmacology, (B) The National Comprehensive Cancer Network Drug and Biologics Compendium, or (C) The Thomson Micromedex DrugDex.
- Findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.
- Peer-reviewed abstracts accepted for presentation at major medical association meetings.

Group Health Coverage The agreement between Us and FEHB to provide health insurance coverage to Members.

Healthcare Professional A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.

Infertility Infertility is defined as (1) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual intercourse without contraception, or (2) the presence of a demonstrated condition recognized by a physician as a cause of infertility

Medical necessity A treatment or service necessary to protect life; to prevent illness or disability; to diagnose, treat or control illness, disease or injury; or to alleviate severe pain. The treatment or service should be:

- Based on generally accepted clinical evidence;
- Consistent with recognized standards of practice;
- Demonstrated to be safe and effective for the member's medical condition; and
- Provided at the appropriate level of care and setting based on the member's medical condition.

Plan allowance Plan allowance is the amount we use to determine our payment and your co-insurance for covered services. Plans determine their allowances in different ways.

	You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.
Post-Service Claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Plan Provider (Network Provider)	We use providers in a specific geographic area. Being a member of Sharp Health Plan means you agree to use the provider(s), hospital(s), Skilled Nursing Facility or Facilities, home health agency or agencies, pharmacy or pharmacies, medical transportation company or companies, laboratory or laboratories, diagnostic facility or facilities, durable medical equipment supplier(s), and other licensed health care entities or professionals who are part of your Plan Network, or who provide covered benefits through an agreement with Sharp Health Plan. When you enroll as a member you will choose a physician from our network of providers to be responsible for managing your health care. This is your primary care provider (PCP) and is the provider you contact first whenever you need health care services. Your PCP evaluates your total health needs and provides personal medical care in one or more medical fields.
Pre-Service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Primary Care Provider (PCP)	A Network Plan Provider who is primarily responsible for supervising, coordinating and providing initial care to you; for maintaining the continuity of your care; and providing or initiating referrals for covered benefits for you. Primary Care Providers include general and family practitioners, internists, pediatricians and qualified OB-GYNs who have the ability to deliver and accept the responsibility for delivering primary care services
Quantity Limits (QL)	Certain covered Drugs have limits on the maximum quantity allowed per prescription over a specific time period. The medications subject to Quantity Limits are shown on Our Drug List with the abbreviation “QL.” Some Quantity Limits are based on the manufacturer’s packaging, FDA labeling or clinical guidelines.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Step Therapy	Process specifying the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are prescribed. Sharp Health plan may require you to try one or more drugs to treat your medical condition before the Plan will cover a particular drug for the condition pursuant to a Step Therapy request. If your prescribing provider submits a request for Step Therapy exception, Sharp Health Plan shall make exceptions to Step Therapy when the criteria is met.
Restorative Surgery	Surgery to rebuild or correct a physical defect that has a direct adverse effect on the physical health of a body part, and for which the restoration or correction is Medically Necessary.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Surprise Bill

An unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Us/We

Us and We refer to Sharp Health Plan.

You

You refers to the enrollee and each covered family member.

Urgent Care Claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve pre-service claims and not post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Care at 800-359-2002. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

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Summary of Benefits for the Standard Option of Sharp Health Plan - 2025

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.sharphealthplan.com/members/your-coverage-documents.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Standard Option Benefits	You Pay	Page
• **Deductible**	Nothing (this plan does not have a deductible)	22
• **Maximum Out-of-Pocket (coinsurance, medical and pharmacy drug copayments)**	$3,000 Self Only/$6,000 Self Plus One or Self and Family	22
Medical services provided by physicians: Treatment services provided in the office	$30 office visit copayment (Primary Care Provider) $30 office visit copayment (Specialist)	28
Medical services provided by physicians: Diagnostic services provided in the office	Nothing	28
Services provided by a hospital and emergency services: Inpatient/Outpatient hospital services	Inpatient - $500/admission Outpatient - $250	49
Services provided by a hospital and emergency services: Emergency in-area	$100 copayment per emergency room visit (waived if you are admitted to the hospital)	53
Services provided by a hospital and emergency services: Emergency out-of-area	Doctor's Office - $30 Urgent Care Center - $30 Outpatient Hospital - $100 Accidental Injury - $100 copayment Ambulance - $100 (emergencies only)	53
Mental health and substance use disorder (MH/SUD) treatment:	Professional Services - $30 Diagnostics - $30 (MH/SUD office visit setting) Inpatient Hospital/Other Covered Facility - $500/admission (Preauthorization required) Outpatient Hospital or Other Covered Facility - $30 (Preauthorization required)	55
Prescription drugs: Retail pharmacy	Tier 1: Preferred Generic - $16 Tier 2: Preferred Brand - $40 Tier 3: Non-preferred medications - $80	58

Standard Option Benefits	You Pay	Page
Prescription drugs: Mail order	90-day supply (maintenance medications) Tier 1: Preferred Generic - $32 Tier 2: Preferred Brand - $80 Tier 3: Non-Preferred Medications - $160	58

2025 Rate Information for Sharp Health Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums **or** www.opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
California					
Standard Option Self Only	YJ4	$245.33	$81.77	$531.54	$177.18
Standard Option Self Plus One	YJ6	$539.72	$179.91	$1,169.40	$389.80
Standard Option Self and Family	YJ5	$588.79	$196.26	$1,275.71	$425.23