The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.sharphealthplan.com or call 1-800-359-2002. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.sharphealthplan.com or call Sharp Health Plan at 1-800-359-2002 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** Individual / **$4,000** Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. Check your policy or plan document to see when the deductible starts over (usually, but not always the deductible resets January 1st).
Are there services covered before you meet your deductible?	Yes. Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Prescription drugs **$125** Individual / **$250** Family There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$7,000** Individual / **$14,000** Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, copayments for supplemental benefits (except prescription drugs), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.sharphealthplan.com or call 1-800-359-2002 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45 copay/visit; deductible does not apply	Not covered	None
	Specialist visit	$75 copay/visit; deductible does not apply	Not covered	Preauthorization is required, except for obstetric gynecologic services.
	Other practitioner office visit	$45 copay/visit; deductible does not apply	Not covered	Preauthorization is required.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$40 copay/visit (blood work); deductible does not apply $70 copay/visit (x-rays); deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	$300 copay/visit; deductible does not apply	Not covered	Preauthorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.sharphealthplan.com.	**Generic drugs (Tier 1)***	$15/30-day supply, $30/90-day supply	Not covered	***Pharmacy deductible applies to drugs on Tiers 1, 2, 3 and 4.** Brand drugs are not covered if a generic version is available, unless preauthorization is obtained. Preauthorization is required for certain generic drugs. 90-day supply copay applies to mail order only.
	Preferred brand drugs (Tier 2)*	$55/30-day supply, $110/90-day supply	Not covered	
	Non-preferred brand drugs (Tier 3)*	$85/30-day supply, $170/90-day supply	Not covered	
	Specialty drugs (Tier 4)*	20% coinsurance up to $250 per 30-day supply after pharmacy deductible	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance; deductible does not apply	Not covered	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance; deductible does not apply	Not covered	
If you need immediate medical attention	Emergency room care	$350 copay/visit (facility fee); deductible does not apply No charge/visit (physician fee); deductible does not apply	$350 copay/visit (facility fee); deductible does not apply No charge/visit (physician fee); deductible does not apply	Cost sharing waived if admitted to the hospital.
	Emergency medical transportation	$250 copay/trip	$250 copay/trip	None
	Urgent care	$45 copay/visit; deductible does not apply	$45 copay/visit; deductible does not apply	Services must be approved by your primary care provider and received at urgent care facilities affiliated with your Plan Medical Group. Out-of-Network services are covered only when you are outside of the Service Area for your Plan Network.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Preauthorization is required for non-emergency services. Out-of-network services are covered for emergency care only.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient office visits and group therapy	$45 copay/visit; deductible does not apply	Not covered	Preauthorization is required.
	Mental/Behavioral health other outpatient items and services	$45 copay/visit*; deductible does not apply	Not covered	Preauthorization is required. *Applies to intensive outpatient program and partial hospitalization program.
	Mental/Behavioral health inpatient facility fee and inpatient physician fee	20% coinsurance (facility fee/physician fee)	20% coinsurance (facility fee/physician fee)	Preauthorization is required for non-emergency services. Out-of-network services are covered for emergency care only.
	Substance use disorder outpatient office visits and group therapy	$45 copay/visit; deductible does not apply	Not covered	Preauthorization is required.
	Substance use disorder other outpatient items and services	$45 copay/visit*; deductible does not apply	Not covered	Preauthorization is required. *Applies to intensive outpatient program and partial hospitalization program.
	Substance use disorder inpatient facility fee and inpatient physician fee	20% coinsurance (facility fee/physician fee)	20% coinsurance (facility fee/physician fee)	Preauthorization is required for non-emergency services. Out-of-network services are covered for emergency care only.
If you are pregnant	Prenatal and postpartum office visits	No charge/visit; deductible does not apply	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, a copayment, coinsurance, or deductible (if applicable) may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Out-of-network services are covered for emergency care only.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$45 copay/visit; deductible does not apply	Not covered	Preauthorization is required. Coverage is limited to short-term, intermittent services, 100 visits/calendar year. Cost sharing is per visit.
	Rehabilitation services	$45 copay/visit; deductible does not apply	Not covered	Preauthorization is required. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	$45 copay/visit; deductible does not apply	Not covered	Preauthorization is required.
	Skilled nursing care	20% coinsurance	Not covered	Preauthorization is required. Coverage is limited to 100 days/benefit period.
	Durable medical equipment	20% coinsurance; deductible does not apply	Not covered	Preauthorization is required.
	Hospice services	Inpatient: No charge/admission; deductible does not apply Outpatient: No charge/visit; deductible does not apply	Not covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Eye exams are covered once every 12 months.
	Children's glasses	No charge	Not covered	Frames/lenses are covered once every 12 months.
	Children's dental check-up	No charge	Not covered	Limited to once every six months. Sharp Health Plan's pediatric dental benefits are provided by Access Dental. Please refer to the Access Dental schedule of benefits for further details about your pediatric dental benefits.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Chiropractic Care
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture
- Bariatric Surgery
- Habilitation Services
- Weight Loss Programs

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: California Department of Managed Health Care at 1-888-466-2219 or www.hmohelp.ca.gov, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? **Yes**.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

English
If you, or someone who you are helping, has questions about Sharp Health Plan, you have the right to obtain help and information in your language without any cost to you. To speak with an interpreter, call (800) 359-2002.

Español (Spanish)
Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Sharp Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al (800) 359-2002.

繁體中文 (Chinese)
如果您，或是您正在協助的對象，有關Sharp Health Plan代碼及範圍方面有疑問，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 (800) 359-2002。

Tiếng Việt (Vietnamese)
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Sharp Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi (800) 359-2002.

Tagalog (Tagalog – Filipino)
Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Sharp Health Plan, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa (800) 359-2002.

한국어(Korean)
만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Sharp Health Plan에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 (800) 359-2002로 전화하십시오.

Հայերեն (Armenian)
Եթե Դուք կամ Ձեր կողմից օգնություն ստացող անձը հարցեր ունի Sharp Health Plan մասին, Դուք իրավունք ունեք անվճար օգնություն և տեղեկություններ ստանալու Ձեր նախընտրած լեզվով: Թարգմանչի հետ խոսելու համար զանգահարե՛ք (800) 359-2002:

Persian
اگر شما، یا کسی که شما به او کمک میکنید در مورد Sharp Health Plan سوال دارید، این حق را دارید که
به زبان خود رایگان دریافت نمایید (800) 359-2002. و اطلاعات را به طور

Русский (Russian)
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Sharp Health Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону (800) 359-2002.

日本語 (Japanese)
ご本人様、またはお客様の身の回りの方でも、Sharp Health Planについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、(800) 359-2002までお電話ください。

العربية (Arabic)
إن كان لدى أو لديك شخص تساعده بخصوص أسئلة Sharp Health Plan ، فلديك الحق في الحصول على المساعدة والمعلومات
ب اتصل مترجم مع للتحدث. تكلفة اية دون من بلغتك الضرورية) (800) 359-2002.

ਪੰਜਾਬੀ (Punjabi)
ਜੇ ਤੁਹਾਨੂੰ , ਜਾਂ ਤੁਸੀ ਜਿਸ ਦੀ ਮਦਦ ਕਰ ਰਹੇ ਹੋ , Sharp Health Plan ਕੋਈ ਸਵਾਲ ਹੈ ਤਾਂ, ਤੁਹਾਨੂੰ ਬਿਨਾ ਕਿਸੇ ਕੀਮਤ 'ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ . ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, (800) 359-2002 ਤੇ ਕਾਲ ਕਰੋ .

ខ្មែរ (Mon Khmer, Cambodian)
ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងដែជួយ ម្នាសំណួរអ្ំពី Sharp Health Plan បេ, អ្នកម្នាសិេធិេេួលជំនួយនិងព័ែ៌ម្នាន ជៅកនុងភាសា ររស់អ្នក ជោយមិនអ្ស់ប្ាក់ ។ បេើមបីនិយាយជាមួយអ្នករកដប្រ សូម (800) 359-2002 ។

Hmoob (Hmong)
Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Sharp Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau (800) 359-2002.

हिंदी (Hindi)
यदि आपके, या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के Sharp Health Plan के बारे में प्रश्न हैं, तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुभाषिए से बात करने के लिए, (800) 359-2002 पर कॉल करें।

ภาษาไทย (Thai)
หากคุณ หรือคนที่คุณกาลังช่วยเหลือมีคาถามเกี่ยวกับ Sharp Health Plan คุณมีสิทธิที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณได้โดยไม่มีค่าใช้จ่าย พูดคุยกับล่าม โทร (800) 359-2002

Section 1557 Nondiscrimination Notice

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

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (such as large print, audio, accessible electronic formats, or other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Jamie Ryan, Director of Operations at (858) 499-8275. If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Sharp Health Plan
Appeal/Grievance Department
Attn: Jamie Ryan, Director of Operations
8520 Tech Way, Suite 200
San Diego, CA 92123-1450
Toll-free: 1-800-359-2002
1-800-735-2929 TTY
Fax: (619) 740-8572

You can file a grievance in person or by mail, fax, or you can also complete the online Grievance/Appeal form on the Plan's website sharphealthplan.com. If you need help filing a grievance, Jamie Ryan, Director of Operations is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2000
Specialist copayment	$75
Hospital (facility) coinsurance	20%
Other coinsurance	0%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$900
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$4,700

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2000
Specialist copayment	$75
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$125
Copayments	$2,300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$2,725

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2000
Specialist copayment	$75
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,200
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,510

Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.