

 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](http://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](http://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 <a href="#">deductible</a> ?                                | \$0  | See the Common Medical Events chart below for services this <a href="#">plan</a> covers.  |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | N/A  | N/A   |
| Are there other <a href="#">deductibles</a> for specific services?              | No.  | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$2,600 Individual / \$5,200 Family  | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, <a href="#">copayments</a> for supplemental benefits (except prescription drugs), and health care this <a href="#">plan</a> doesn't cover. | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="http://www.sharphealthplan.com">www.sharphealthplan.com</a> or call 1-800-359-2002 for a list of <a href="#">network providers</a> .   | This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | Yes.   | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .  |

| Common Medical Event  | Services You May Need  | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|---|--|--|--|---|
|   |  | In Network Provider<br>(You will pay the least)          | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you visit a health care provider's office or clinic</b>   | Primary care visit to treat an injury or illness   | \$20 <a href="#">copay</a> /visit                        | Not covered  | None  |
|   | <a href="#">Specialist</a> visit   | \$30 <a href="#">copay</a> /visit                        | Not covered  | <a href="#">Preauthorization</a> is required, except for obstetric gynecologic services.  |
|   | Other practitioner office visit  | \$20 <a href="#">copay</a> /visit                        | Not covered  | <a href="#">Preauthorization</a> is required.   |
|   | <a href="#">Preventive care</a> / <a href="#">screening</a> / <a href="#">immunization</a> | No charge  | Not covered  | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are preventive. Then check what your <a href="#">plan</a> will pay for.                                |
| <b>If you have a test</b>   | <a href="#">Diagnostic test</a> (x-ray, blood work)  | No charge/visit (blood work)<br>No charge/visit (x-rays) | Not covered  | None  |
|   | Imaging (CT/PET scans, MRIs)   | \$100 <a href="#">copay</a> /procedure                   | Not covered  | <a href="#">Preauthorization</a> is required.   |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.sharphealthplan.com">www.sharphealthplan.com</a> . | Preferred generic drugs  | \$19/30-day supply,<br>\$38/90-day supply                | Not covered  | Brand drugs are not covered if a generic version is available, unless <a href="#">preauthorization</a> is obtained. <a href="#">Preauthorization</a> is required for certain generic drugs. 90-day supply copay applies to mail order only. |
|   | Preferred brand drugs  | \$30/30-day supply,<br>\$60/90-day supply                | Not covered  |   |
|   | Non-preferred drugs  | \$70/30-day supply,<br>\$140/90-day supply               | Not covered  |   |

| Common Medical Event                    | Services You May Need                            | What You Will Pay                               |  | Limitations, Exceptions, & Other Important Information   |
|---|--|---|--|--|
|   |  | In Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)   | \$300 <a href="#">copay</a> /procedure          | Not covered  | <a href="#">Preauthorization</a> is required.  |
|   | Physician/surgeon fees                           | No charge/visit                                 | Not covered  |  |
| If you need immediate medical attention | <a href="#">Emergency room care</a>              | \$100 <a href="#">copay</a> /visit              | \$100 <a href="#">copay</a> /visit                 | <a href="#">Cost sharing</a> waived if admitted to the hospital.   |
|   | <a href="#">Emergency medical transportation</a> | \$100 <a href="#">copay</a> /trip               | \$100 <a href="#">copay</a> /trip                  | None   |
|   | <a href="#">Urgent care</a>                      | \$30 <a href="#">copay</a> /visit               | \$30 <a href="#">copay</a> /visit                  | 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)               | \$300 <a href="#">copay</a> /day (3-day max)    | \$300 <a href="#">copay</a> /day (3-day max)       | <a href="#">Preauthorization</a> is required for non-emergency services. Out-of-network services are covered for emergency care only.  |
|   | Physician/surgeon fees                           | No charge/visit                                 | No charge/visit                                    |  |

| Common Medical Event   | Services You May Need   | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|--|---|--|--|---|
|  |   | In Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)   |   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Mental/Behavioral health outpatient office visits and group therapy         | \$20 <a href="#">copay</a> /visit  | Not covered  | <a href="#">Preauthorization</a> is required.   |
|  | Mental/Behavioral health other outpatient items and services                | \$20 <a href="#">copay</a> /visit*   | Not covered  | <a href="#">Preauthorization</a> is required. *Applies to intensive outpatient program and partial hospitalization program.   |
|  | Mental/Behavioral health inpatient facility fee and inpatient physician fee | \$300 <a href="#">copay</a> /day (3-day max) (facility fee)<br>No charge/visit (physician fee) | \$300 <a href="#">copay</a> /day (3-day max) (facility fee)<br>No charge/visit (physician fee) | <a href="#">Preauthorization</a> 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           | \$20 <a href="#">copay</a> /visit  | Not covered  | <a href="#">Preauthorization</a> is required.   |
|  | Substance use disorder other outpatient items and services                  | \$20 <a href="#">copay</a> /visit*   | Not covered  | <a href="#">Preauthorization</a> is required. *Applies to intensive outpatient program and partial hospitalization program.   |
|  | Substance use disorder inpatient facility fee and inpatient physician fee   | \$300 <a href="#">copay</a> /day (3-day max) (facility fee)<br>No charge/visit (physician fee) | \$300 <a href="#">copay</a> /day (3-day max) (facility fee)<br>No charge/visit (physician fee) | <a href="#">Preauthorization</a> is required for non-emergency services. Out-of-network services are covered for emergency care only.   |
| <b>If you are pregnant</b>   | Prenatal and postpartum office visits                                       | \$20 <a href="#">copay</a> /visit  | Not covered  | <a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> (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                                   | No charge/visit  | No charge/visit  |   |
|  | Childbirth/delivery facility services                                       | \$300 <a href="#">copay</a> /day (3-day max)   | \$300 <a href="#">copay</a> /day (3-day max)   |   |

| Common Medical Event  | Services You May Need                     | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information  |
|---|---|--|--|---|
|   |   | In Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most) |   |
| <b>If you need help recovering or have other special health needs</b> | <a href="#">Home health care</a>          | \$20 <a href="#">copay</a> /visit  | Not covered  | <a href="#">Preauthorization</a> is required. Coverage is limited to short-term, intermittent services, 100 visits/calendar year.   |
|   | <a href="#">Rehabilitation services</a>   | \$20 <a href="#">copay</a> /visit  | Not covered  | <a href="#">Preauthorization</a> is required. Includes physical therapy, speech therapy, and occupational therapy.  |
|   | <a href="#">Habilitation services</a>     | \$20 <a href="#">copay</a> /visit  | Not covered  | <a href="#">Preauthorization</a> is required.   |
|   | <a href="#">Skilled nursing care</a>      | \$200 <a href="#">copay</a> /day (3-day max)   | Not covered  | <a href="#">Preauthorization</a> is required. Coverage is limited to 100 days/benefit period.   |
|   | <a href="#">Durable medical equipment</a> | 50% <a href="#">coinsurance</a>  | Not covered  | <a href="#">Preauthorization</a> is required.   |
|   | <a href="#">Hospice services</a>          | Inpatient:<br>\$500 <a href="#">copay</a> /day (3-day max)<br><br>Outpatient:<br>No charge/visit | Not covered  | <a href="#">Preauthorization</a> is required.   |
| <b>If your child needs dental or eye care</b>                         | 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.)

- 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](http://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](http://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](http://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

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-800-359-2002 (TTY:711).

### Español (Spanish)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-359-2002 (TTY:711).

### 繁體中文 (Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-359-2002 (TTY:711)。

### Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-359-2002 (TTY:711).

### Tagalog (Tagalog – Filipino):

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-359-2002 (TTY:711).

### 한국어 (Korean):

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-359-2002 (TTY:711) 번으로 전화해 주십시오.

### Հայերեն (Armenian):

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-359-2002 (TTY (հեռատիպ)՝ 711).

فارسی (Farsi):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما تماس بگیرید (1-800-359-2002 (TTY:711) با. باشد می فراهم.

## Language Access Services (Cont.):

### Русский (Russian):

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.  
Звоните 1-800-359-2002 (телетайп: 711).

### 日本語 (Japanese):

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-359-2002 (TTY:711) まで、お電話にてご連絡ください。

### (Arabic): قبير علا

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-359-2002 (رقم هاتف الصم والبكم: 711).

### ਪੰਜਾਬੀ (Punjabi):

ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਿ ਰੇ, ਤਾਂ ਭਾਸ਼ਾ ਧਿੰ ਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY:711) 'ਤੇ ਕਾਲ ਕਰੋ।

### ខ្មែរ (Mon Khmer, Cambodian):

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតលុយ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ

1-800-359-2002 (TTY: 711)។

### Hmoob (Hmong):

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

### हिंदी (Hindi):

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-359-2002 (TTY: 711) पर कॉल करें।

### ภาษาไทย (Thai):

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ ฟรี โทร 1-800-359-2002 (TTY:711).



### Notice of Nondiscrimination

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

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Information in other formats (such as large print, audio, accessible electronic formats, or other formats) free of charge
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Customer Care at 1-800-359-2002. If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with our Civil Rights Coordinator at:

Sharp Health Plan  
Attn: Appeal/Grievance Department  
8520 Tech Way, Suite 200  
San Diego, CA 92123-1450  
Telephone: 1-800-359-2002 (TTY: 711)  
Fax: (619) 740-8572

You can file a grievance in person or by mail, fax, or you can also complete the online Grievance/Appeal form on the Plan's website [sharphealthplan.com](http://sharphealthplan.com). Please call our Customer Care team at 1-800-359-2002 if you need help filing a grievance. You can also file a discrimination complaint if there is a concern of discrimination based on race, color, national origin, age, disability, or sex 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>.

**Notice of Nondiscrimination (Cont.)**

The California Department of Managed Health Care is responsible for regulating health care service plans. If your Grievance has not been satisfactorily resolved by Sharp Health Plan or your Grievance has remained unresolved for more than 30 days, you may call toll-free the Department of Managed Care for assistance:

- 1-888-HMO-2219 Voice
- 1-877-688-9891 TDD

The Department of Managed Care's Internet Web site has complaint forms and instructions online:  
<http://www.hmohelp.ca.gov>.

----- *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](#) \$0
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$300
- 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> |         |
|---------------------|---------|
| Deductibles         | \$0     |
| Copayments          | \$1,100 |
| Coinsurance         | \$0     |

| <i>What isn't covered</i>         |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$1,100</b> |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$300
- 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> |         |
|---------------------|---------|
| Deductibles         | \$0     |
| Copayments          | \$1,200 |
| Coinsurance         | \$300   |

| <i>What isn't covered</i>         |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$1,500</b> |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$30
- Hospital (facility) [copayment](#) \$300
- Other [coinsurance](#) 50%

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

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> |       |
|---------------------|-------|
| Deductibles         | \$0   |
| Copayments          | \$500 |
| Coinsurance         | \$20  |

| <i>What isn't covered</i>         |              |
|-----------------------------------|--------------|
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$520</b> |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.