




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, 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 1-800-359-2002 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$2,500 Individual / \$5,000 Family ( <a href="#">Deductible</a> resets January 1 <sup>st</sup> )	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. <a href="#">Prescription drugs</a> \$300 Individual / \$600 Family There are no other specific <a href="#">deductibles</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$8,750 Individual / \$17,500 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> 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 <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> 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> .

(HHS - OMB control number: 0938-1146/Expiration date: 05/31/2026)

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$55 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not covered	None
	<a href="#">Specialist</a> visit	\$90 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Preauthorization</a> is required, except for obstetric gynecologic services.
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$55 <a href="#">copay</a> /visit (blood work); <a href="#">deductible</a> does not apply \$90 <a href="#">copay</a> /visit (x-rays); <a href="#">deductible</a> does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$300 <a href="#">copay</a> /visit	Not covered	<a href="#">Preauthorization</a> is required.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.sharphealthplan.com">www.sharphealthplan.com</a>	Generic drugs (Tier 1)	\$19/30-day supply; <a href="#">deductible</a> does not apply \$38/90-day supply; <a href="#">deductible</a> does not apply	Not covered	Pharmacy <a href="#">deductible</a> applies to drugs on Tiers 2, 3 and 4. 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 (Tier 2)	\$85/30-day supply, \$170/90-day supply	Not covered	
	Non-preferred brand drugs (Tier 3)	\$110/30-day supply; \$220/90-day supply;	Not covered	
	<a href="#">Specialty drugs</a> (Tier 4)	30% <a href="#">coinsurance</a> up to \$250 per 30-day supply after pharmacy <a href="#">deductible</a>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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)	35% <a href="#">coinsurance</a> ;	Not covered	<a href="#">Preauthorization</a> is required.
	Physician/surgeon fees	35% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Preauthorization</a> is required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	35% <a href="#">coinsurance</a> (facility fee)  No charge/visit (physician fee); <a href="#">deductible</a> does not apply	35% <a href="#">coinsurance</a> (facility fee)  No charge/visit (physician fee); <a href="#">deductible</a> does not apply	<a href="#">Cost sharing</a> waived if admitted to the hospital.
	<a href="#">Emergency medical transportation</a>	35% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$55 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	\$55 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	In most cases, 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 when you are outside of the Service Area for your Plan Network. Out-of-Network services are also covered for Medically Necessary treatment of a Mental Health or Substance Use Disorder, including, but not limited to, Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider and services received under a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court, these services do not require preauthorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	35% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	<p><a href="#">Preauthorization</a> is required for non-emergency services except for Medically Necessary treatment of a Mental Health or Substance Use Disorder, including, but not limited to, Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider and services received under a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court. Out-of-network services are not covered unless services are for emergency or out-of-area urgent care, services have been prior authorized, services are for Medically Necessary treatment of a Mental Health or Substance Use Disorder, including, but not limited to, Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider, or services received under a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court.</p>
	Physician/surgeon fees	35% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	35% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p><b>If you need mental health, behavioral health, or substance abuse services</b></p>	<p>Outpatient services</p>	<p>Mental Health/Substance Use Disorder</p> <p>Office visits: \$55 <a href="#">copay</a>/visit; <a href="#">deductible</a> does not apply</p> <p>Group therapy: \$55 <a href="#">copay</a>/visit; <a href="#">deductible</a> does not apply</p> <p>Other outpatient services*: 35% coinsurance up to \$55 <a href="#">copay</a>/visit; <a href="#">deductible</a> does not apply</p>	<p>Mental Health/Substance Use Disorder</p> <p>Office visits: Not covered</p> <p>Group therapy: Not covered</p> <p>Other outpatient services*: Not covered</p>	<p><a href="#">Preauthorization</a> is required. *Applies to intensive outpatient program and partial hospitalization program.</p> <p><a href="#">Preauthorization</a> is not required for Medically Necessary treatment of a Mental Health or Substance Use Disorder, including, but not limited to, Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider and services received under a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court.</p> <p>Out-of-network services are not covered unless services are for emergency care or out-of-area urgent care, services have been prior authorized, services are for Medically Necessary treatment of a Mental Health or Substance Use Disorder, including, but not limited to, Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider, or services received under a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court.</p>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Inpatient services	Mental Health/Substance Use Disorder  35% <a href="#">coinsurance</a> (facility fee/physician fee); <a href="#">deductible</a> does not apply (physician fee)	Mental Health/Substance Use Disorder  35% <a href="#">coinsurance</a> (facility fee/physician fee); <a href="#">deductible</a> does not apply (physician fee)	<p><a href="#">Preauthorization</a> is required for non-emergency services. Preauthorization is not required for Medically Necessary treatment of a Mental Health or Substance Use Disorder, including, but not limited to, Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider and services received under a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court. Out-of-network services are not covered unless services are for emergency or out-of-area urgent care, services have been prior authorized, or services are for Medically Necessary treatment of a Mental Health or Substance Use Disorder, including, but not limited to, Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider, or services received under a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court.</p>
	Office visits	No charge/visit; <a href="#">deductible</a> does not apply	Not covered	<p><a href="#">Cost sharing</a> does not apply for <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 (e.g. ultrasound). Out-of-network services are not covered unless services are for emergency or out-of-area urgent care, or services have been prior authorized.</p>
	Childbirth/delivery professional services	35% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	35% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	
	Childbirth/delivery facility services	35% <a href="#">coinsurance</a>	35% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	<a href="#">Home health care</a>	\$45 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Preauthorization</a> is required. Coverage is limited to short-term, intermittent services, 100 visits/calendar year. <a href="#">Cost sharing</a> is per visit.
	<a href="#">Rehabilitation services</a>	\$55 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Preauthorization</a> is required. Includes physical therapy, speech therapy, and occupational therapy.
	<a href="#">Habilitation services</a>	\$55 <a href="#">copay</a> /visit; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Preauthorization</a> is required.
	<a href="#">Skilled nursing care</a>	35% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required. Coverage is limited to 100 days/benefit period.
	<a href="#">Durable medical equipment</a>	35% <a href="#">coinsurance</a> ; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Preauthorization</a> is required.
	<a href="#">Hospice services</a>	Inpatient: No charge/admission; <a href="#">deductible</a> does not apply  Outpatient: No charge/visit; <a href="#">deductible</a> does not apply	Not covered	<a href="#">Preauthorization</a> 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 Delta Dental. Please refer to the Delta 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](#).)

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"><li>• Chiropractic care</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul> | <ul style="list-style-type: none"><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long term care</li><li>• Non-emergency care when traveling outside the U.S..</li></ul> | <ul style="list-style-type: none"><li>• Private duty nursing</li><li>• Routine eye care (Adult)</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul> |
|--|---|--|

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

- |  |   |
|--|---|
| <ul style="list-style-type: none"><li>• Abortion</li><li>• Acupuncture</li></ul> | <ul style="list-style-type: none"><li>• Bariatric surgery</li></ul> |
|--|---|

**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>; California Department of Managed Health Care at 1-888-466-2219 or <http://www.HealthHelp.ca.gov>; Office of Personnel Management Multi State Plan Program at 1-800-318-2596 or <https://www.opm.gov/healthcare-insurance/multi-state-plan-program>. 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 on how 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 <http://www.HealthHelp.ca.gov>.

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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### Does this plan meet the 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 u 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):

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

### فارسی (Farsi):

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

### 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。

### تیبیر علا (Arabic):

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

## Language Access Services (Cont.):

### ਪੰਜਾਬੀ (Punjabi):

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

### ខ្មែរ (Mon Khmer, Cambodian):

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្បួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ

1-800-359-2002 (TTY: 711)។

### Hmoob (Hmong):

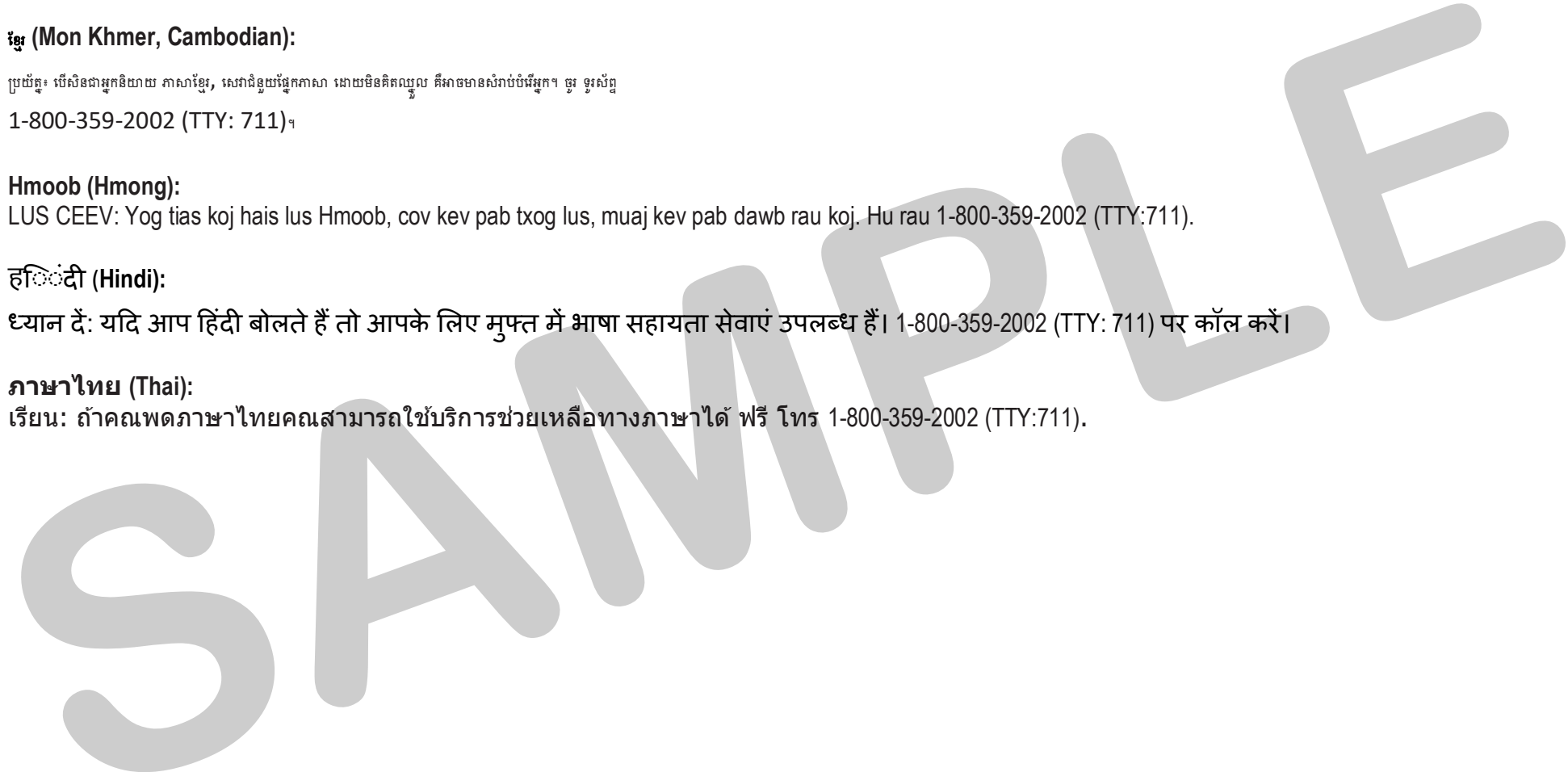
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-359-2002 (TTY:711).

### 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.*

### **PRA Disclosure Statement**

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,500
■ <a href="#">Specialist copayment</a>	\$90
■ Hospital (facility) <a href="#">coinsurance</a>	35%
■ Other <a href="#">coinsurance</a>	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>\$12,700</b>
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In this example, Peg would pay:

*Cost Sharing*

<a href="#">Deductibles</a>	\$2,500
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$3,000

*What isn't covered*

Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$6,260</b>
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### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,500
■ <a href="#">Specialist copayment</a>	\$90
■ Hospital (facility) <a href="#">coinsurance</a>	35%
■ Other <a href="#">coinsurance</a>	35%

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>\$5,600</b>
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In this example, Joe would pay:

*Cost Sharing*

<a href="#">Deductibles*</a>	\$300
<a href="#">Copayments</a>	\$1,900
<a href="#">Coinsurance</a>	\$300

*What isn't covered*

Limits or exclusions	\$20
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<b>The total Joe would pay is</b>	<b>\$2,520</b>
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### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$2,500
■ <a href="#">Specialist copayment</a>	\$90
■ Hospital (facility) <a href="#">coinsurance</a>	35%
■ Other <a href="#">coinsurance</a>	35%

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>\$2,800</b>
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In this example, Mia would pay:

*Cost Sharing*

<a href="#">Deductibles</a>	\$1,300
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$90

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$1,990</b>
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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 for the other costs of these EXAMPLE covered services