

 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, [insert contact information]. 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 1-800-359-2002 to request a copy.

| Important Questions | Answers | | | Why This Matters: |
|---|---|---|---|---|
| What is the overall deductible ? | Tier 1: Sharp Health Plan Performance HMO Network \$0 | Tier 2: Aetna Open Choice PPO Network \$0 | Tier 3: Out-of-Network \$4,000 Individual / \$8,000 Family (Deductible resets January 1st) | 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 . |
| Are there services covered before you meet your deductible ? | Yes. Preventive care , Primary Care services and certain Mental Health 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 preventative services without cost sharing before you meet your deductible . See a list of covered services at www.healthcare.gov/coverage/preventative-care-benefits . |
| Are there other deductibles for specific services? | No. | | | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | Tier 1: Sharp Health Plan Performance HMO Network \$1,900 Individual / \$3,800 Family | Tier 2: Aetna Open Choice PPO Network \$6,650 Individual / \$13,300 Family | Tier 3: Out-of-Network \$15,600 Individual / \$31,200 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. |

| Important Questions | Answers | | | Why This Matters: |
|---|--|---|---|---|
| <p>What is not included in the out-of-pocket limit?</p> | <p>Premiums, copayments for supplemental benefits and health care this plan doesn't cover.</p> | | | <p>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</p> |
| <p>Will you pay less if you use a network provider?</p> | <p>Yes. For a list of in-network providers, see www.sharphealthplan.com or call 1-800-359-2002.</p> | | | <p>You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. You will pay the most if you use a Tier 3 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.</p> |
| <p>Do you need a referral to see a specialist?</p> | <p>Tier 1: Sharp Health Plan Performance HMO Network Yes.</p> | <p>Tier 2: Aetna Open Choice PPO Network No.</p> | <p>Tier 3: Out-of-Network No.</p> | <p>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.</p> |

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.sharphealthplan.com.



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 |
|--|--|---|---|--|---|
| | | Tier 1: Sharp Health Plan Performance HMO Network (You will pay the least) | Tier 2: Aetna Open Choice PPO Network | Tier 3: Out-of-Network (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 | \$35 copay /visit; deductible does not apply | \$40 copay /visit; deductible does not apply | 50% coinsurance | None |
| | Specialist visit | \$55 copay /visit; deductible does not apply | \$55 copay /visit; deductible does not apply | 50% coinsurance | Preauthorization is required, except for obstetric gynecologic services. |
| | Preventive care/screening/immunization | No charge; deductible does not apply | No charge; deductible does not apply | No charge; deductible does not apply | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | \$15 copay /visit (blood work); deductible does not apply | \$20 copay /visit (blood work); deductible does not apply | 50% coinsurance (blood work) | None |
| | | \$55 copay /visit (x-rays); deductible does not apply | \$55 copay /visit (x-rays); deductible does not apply | 50% coinsurance (x-rays) | |
| | Imaging (CT/PET scans, MRIs) | \$175 copay /visit; deductible does not apply | \$175 copay /visit; deductible does not apply | 50% coinsurance | Preauthorization is required. Precertification applies on Tier 2 and Tier 3. |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---|---|---|
| | | Tier 1: Sharp Health Plan Performance HMO Network (You will pay the least) | Tier 2: Aetna Open Choice PPO Network | Tier 3: Out-of-Network (You will pay the most) | |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.sharphealthplan.com | Generic drugs | \$16/30-day supply; deductible does not apply \$32/90-day supply; deductible does not apply | \$16/30-day supply; deductible does not apply \$32/90-day supply; deductible does not apply | \$16/30-day supply; deductible does not apply \$32/90-day supply; deductible does not apply | 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 | \$35/30-day supply; deductible does not apply \$70/90-day supply; deductible does not apply | \$35/30-day supply; deductible does not apply \$70/90-day supply; deductible does not apply | \$35/30-day supply; deductible does not apply \$70/90-day supply; deductible does not apply | |
| | Non-preferred brand drugs | \$70/30-day supply; deductible does not apply \$140/90-day supply; deductible does not apply | \$70/30-day supply; deductible does not apply \$140/90-day supply; deductible does not apply | \$70/30-day supply; deductible does not apply \$140/90-day supply; deductible does not apply | |
| | Specialty drugs | Specialty follows the tier structure above | Specialty follows the tier structure above | Specialty follows the tier structure above | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$600 copay /visit; deductible does not apply | \$600 copay /visit; deductible does not apply | 50% coinsurance | Preauthorization is required. Precertification applies on Tier 2 and Tier 3. |
| | Physician/surgeon fees | No charge/visit; deductible does not apply | \$40 copay /visit; deductible does not apply | 50% coinsurance | Preauthorization is required. Precertification applies on Tier 2 and Tier 3. |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|---|
| | | Tier 1: Sharp Health Plan Performance HMO Network (You will pay the least) | Tier 2: Aetna Open Choice PPO Network | Tier 3: Out-of-Network (You will pay the most) | |
| If you need immediate medical attention | Emergency room care | \$300 copay /visit; deductible does not apply (facility fee) No charge/visit; deductible does not apply (physician fee) | \$300 copay /visit; deductible does not apply (facility fee) No charge/visit; deductible does not apply (physician fee) | \$300 copay /visit; deductible does not apply (facility fee) No charge/visit; deductible does not apply (physician fee) | Cost sharing waived if admitted to the hospital. |
| | Emergency medical transportation | \$200 copay /trip; deductible does not apply | \$200 copay /trip; deductible does not apply | \$200 copay /trip; deductible does not apply | None. |
| | Urgent care | \$55 copay /visit; deductible does not apply | \$55 copay /visit; deductible does not apply | \$55 copay /visit | Urgent Care Services are covered at the Tier 1 cost share if approved by your Primary Care Provider , Plan Medical Group, or the Plan . For Urgent Care Services that are not prior Authorized, the applicable Tier 2 or Tier 3 cost share will apply. 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, do not require preauthorization and are covered at the Tier 1 cost share. |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|-----------------------------|------------------------------------|---|---|--|---|
| | | Tier 1: Sharp Health Plan Performance HMO Network (You will pay the least) | Tier 2: Aetna Open Choice PPO Network | Tier 3: Out-of-Network (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$1,500 copay /admission deductible does not apply | \$1,500 copay /admission deductible does not apply | 50% coinsurance | <p>Preauthorization is required for non-emergency services 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, do not require preauthorization and are covered at the Tier 1 cost share.</p> <p>Tier 2 and Tier 3 services are covered at the Tier 1 cost share if the service is for emergency care and 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. Precertification applies on Tier 2 and Tier 3.</p> |
| | Physician/surgeon fees | No charge/visit; deductible does not apply (physician fee) | No charge/visit; deductible does not apply (physician fee) | 50% coinsurance | |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|-----------------------|--|--|---|---|
| | | Tier 1: Sharp Health Plan Performance HMO Network (You will pay the least) | Tier 2: Aetna Open Choice PPO Network | Tier 3: Out-of-Network (You will pay the most) | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Mental Health/Substance Use Disorder | Mental Health/Substance Use Disorder | Mental Health/Substance Use Disorder | <u>Preauthorization</u> is required. 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. *Applies to intensive outpatient program and partial hospitalization program. |
| | | Office visits: \$35 <u>copay</u> /visit (MH/SUD); <u>deductible</u> does not apply | Office visits: \$35 <u>copay</u> /visit (MH/SUD); <u>deductible</u> does not apply | Office visits: 50% <u>coinsurance</u> (MH/SUD) | |
| | | Group therapy: \$25 <u>copay</u> /visit (MH); <u>deductible</u> does not apply \$7 <u>copay</u> /visit (SUD); <u>deductible</u> does not apply | Group therapy: \$25 <u>copay</u> /visit (MH); <u>deductible</u> does not apply \$7 <u>copay</u> /visit (SUD); <u>deductible</u> does not apply | Group therapy: 50% <u>coinsurance</u> (MH/SUD) | |
| | | Other outpatient services*: \$35 <u>copay</u> /visit (MH/SUD); <u>deductible</u> does not apply | Other outpatient services*: \$35 <u>copay</u> /visit (MH/SUD); <u>deductible</u> does not apply | Other outpatient services*: 50% <u>coinsurance</u> (MH/SUD) | |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|----------------------|---|---|---|---|---|
| | | Tier 1: Sharp Health Plan Performance HMO Network (You will pay the least) | Tier 2: Aetna Open Choice PPO Network | Tier 3: Out-of-Network (You will pay the most) | |
| | Inpatient services | Mental Health/Substance Use Disorder \$750 copay /admission deductible does not apply (facility fee) No charge/visit; deductible does not apply (physician fee) | Mental Health/Substance Use Disorder \$750 copay /admission deductible does not apply (facility fee) No charge/visit; deductible does not apply (physician fee) | Mental Health/Substance Use Disorder 50% coinsurance (facility fee/physician fee) | Preauthorization 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. Tier 2 and Tier 3 services are covered at the Tier 1 cost share if the service is for emergency care and 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. Precertification applies on Tier 2 and Tier 3 |
| If you are pregnant | Office visits | No charge/visit; deductible does not apply | No charge/visit; deductible does not apply | 50% coinsurance | Cost sharing does not apply to 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. Tier 2 and Tier 3 services are covered at the Tier 1 cost share if the service is for emergency care. Precertification for childbirth/delivery professional services and facility services applies on Tier 2 and Tier 3. |
| | Childbirth/delivery professional services | No charge/visit; deductible does not apply | No charge/visit; deductible does not apply | 50% coinsurance | |
| | Childbirth/delivery facility services | \$1,500 copay /admission deductible does not apply | \$1,500 copay /admission deductible does not apply | 50% coinsurance | |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|---|---|---|---|---|
| | | Tier 1: Sharp Health Plan Performance HMO Network (You will pay the least) | Tier 2: Aetna Open Choice PPO Network | Tier 3: Out-of-Network (You will pay the most) | |
| If you need help recovering or have other special health needs | Home health care | \$35 copay /visit; deductible does not apply | \$35 copay /visit; deductible does not apply | 50% coinsurance | Preauthorization is required. Coverage is limited to short-term, intermittent services, a combined maximum of 100 visits per calendar year across all tiers. Precertification applies on Tier 2 and Tier 3. |
| | Rehabilitation services | \$35 copay /visit; deductible does not apply | \$35 copay /visit; deductible does not apply | 50% coinsurance | Preauthorization is required. Precertification applies on Tier 2 and Tier 3 for inpatient service. |
| | Habilitation services | \$35 copay /visit; deductible does not apply | \$35 copay /visit; deductible does not apply | 50% coinsurance | Preauthorization is required. Precertification applies on Tier 2 and Tier 3 for inpatient service. |
| | Skilled nursing care | \$175 copay /admission; deductible does not apply | \$175 copay /admission; deductible does not apply | 50% coinsurance | Preauthorization is required. Coverage is limited to a combined maximum of 100 days per calendar year across all tiers. Precertification applies on Tier 2 and Tier 3. |
| | Durable medical equipment | 50% coinsurance ; deductible does not apply | 50% coinsurance ; deductible does not apply | 50% coinsurance | Preauthorization is required. Precertification applies on Tier 2 and Tier 3 for inpatient service. |
| | Hospice services | Inpatient: No charge/admission; deductible does not apply Outpatient: No charge/visit; deductible does not apply | Inpatient: No charge/admission; deductible does not apply Outpatient: No charge/visit; deductible does not apply | Inpatient: 50% coinsurance Outpatient: 50% coinsurance | Preauthorization is required. Precertification applies on Tier 2 and Tier 3 for inpatient service. |

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| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------|--|--|--|---|
| | | Tier 1: Sharp Health Plan Performance HMO Network (You will pay the least) | Tier 2: Aetna Open Choice PPO Network | Tier 3: Out-of-Network (You will pay the most) | |
| If your child needs dental or eye care | Children's eye exam | No charge/visit; deductible does not apply | Not covered | Not covered | Eye exams are covered once every 12 months. Sharp Health Plan's pediatric vision benefits are provided by VSP. Please refer to the VSP schedule of benefits for further details about your pediatric eye benefits. |
| | Children's glasses | No charge/visit; deductible does not apply | Not covered | Not covered | Frames/lenses are covered once every 12 months. Sharp Health Plan's pediatric vision benefits are provided by VSP. Please refer to the VSP schedule of benefits for further details about your pediatric eye benefits. |
| | Children's dental check-up | No charge/visit; deductible does not apply | Not covered | 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"> • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Private-duty nursing • Routine foot care |

| 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"> • Acupuncture • Bariatric surgery • Chiropractic care | <ul style="list-style-type: none"> • Hearing aids | <ul style="list-style-type: none"> • Routine eye care (Adult) • Weight loss programs |

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.sharphealthplan.com.

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 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: 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.

Русский (Russian):

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

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.sharphealthplan.com.

Language Access Services (Cont.):

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. تصل برقم 1-800-359-2002 (رقم هاتف الصم والبكم: 711).

ਪੰਜਾਬੀ (Punjabi):

ਧਿਆਨ ਧਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਿੰਦੇ ਹੋ, 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 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: ถ้านคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ 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. 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>.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.sharphealthplan.com.

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

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

* For more information about limitations and exceptions, see the [plan](#) or policy document at www.sharphealthplan.com.

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](#) \$55
- Hospital (facility) [copayment](#) \$1,500
- 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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$1,900 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$1,960 |

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](#) \$55
- Hospital (facility) [copayment](#) \$1,500
- 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 | \$2,800 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$1,100 |
| Coinsurance | \$200 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,320 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$55
- Hospital (facility) [copayment](#) \$1,500
- 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$1,100 |
| Coinsurance | \$100 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,200 |

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