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?	**$1,000** Individual / **$2,000** 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 **$150** Individual / **$300** 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?	**$3,500** Individual / **$7,000** 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	$30 copay/visit; deductible does not apply	Not covered	None
	Specialist visit	$40 copay/visit; deductible does not apply	Not covered	Preauthorization is required, except for obstetric gynecologic services.
	Other practitioner office visit	Not covered	Not covered	Not covered
	Preventive care/screening/ immunization	No charge; deductible does not apply	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)	No charge/visit; deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100 copay/procedure; 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	Preferred generic drugs	$20/30-day supply; **deductible does not apply** $40/90-day supply; **deductible does not apply**	Not covered	***Pharmacy deductible applies to preferred brand and non-preferred drugs.** 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, $70/90-day supply	Not covered	
	Non-preferred drugs*	$70/30-day supply, $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 (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)	30% coinsurance	Not covered	Preauthorization is required.
	Physician/surgeon fees	30% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	$150 copay/visit	$150 copay/visit	Cost sharing waived if admitted to the hospital.
	Emergency medical transportation	$150 copay/trip	$150 copay/trip	None
	Urgent care	$40 copay/visit; deductible does not apply	$40 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)	30% coinsurance	30% coinsurance	Preauthorization is required for non-emergency services. Out-of-network services are covered for emergency care only.
	Physician/surgeon fees	30% coinsurance	30% 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	$30 copay/visit; deductible does not apply	Not covered	Preauthorization is required.
	Mental/Behavioral health other outpatient items and services	$30 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	30% coinsurance (facility fee/physician fee)	30% 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	$30 copay/visit; deductible does not apply	Not covered	Preauthorization is required.
	Substance use disorder other outpatient items and services	$30 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	30% coinsurance (facility fee/physician fee)	30% 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	$40 copay/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	30% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	30% 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	$40 copay/visit	Not covered	Preauthorization is required. Coverage is limited to short-term, intermittent services, 100 visits/calendar year.
	Rehabilitation services	$40 copay/visit; deductible does not apply	Not covered	Preauthorization is required. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	30% coinsurance	Not covered	Preauthorization is required. Coverage is limited to 100 days/calendar year.
	Durable medical equipment	50% coinsurance	Not covered	Preauthorization is required.
	Hospice services	Inpatient: 30% coinsurance Outpatient: $40 copay/visit	Not covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered
	Children's glasses	Not covered	Not covered	Not covered
	Children's dental check-up	Not covered	Not covered	Not covered

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.)

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

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

- Bariatric Surgery
- Infertility Treatment (Does not include conception by artificial means)
- 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
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، تسهیالت زبانی بصورت رایگان برای شما تماس بگیرید (TTY:711) 1-800-359-2002 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): ةيبرعلا
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 ਪੰ ਜਾਬੀ ਬੋਲਿ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਧਿੱ ਚ ਸਹਾਇਤਾ ਸੇਿਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਿ ਹੈ। 1-800-359-2002 (TTY:711) ‘ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon Khmer, Cambodian):

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល 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: ถ้าคุณพดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ 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*.

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	$1000
Specialist copayment	$40
Hospital (facility) coinsurance	30%
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	$300
Copayments	$600
Coinsurance	$2,700
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$3,600

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

The plan's overall deductible	$1000
Specialist copayment	$40
Hospital (facility) coinsurance	30%
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*	$150
Copayments	$1,400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$1,850

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

The plan's overall deductible	$1000
Specialist copayment	$40
Hospital (facility) coinsurance	30%
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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$400
Copayments	$700
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,120

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.