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

<table>
<thead>
<tr>
<th><strong>Important Questions</strong></th>
<th><strong>Answers</strong></th>
<th><strong>Why This Matters:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$1,000 Individual / $2,000 Family (Deductible resets January 1&quot;)</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care and primary care services are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. Prescription drugs $150 Individual / $300 Family</td>
<td>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.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$3,500 Individual / $7,000 Family</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, copayments for supplemental benefits (except prescription drugs), and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See <a href="http://www.sharphealthplan.com">www.sharphealthplan.com</a> or call 1-800-359-2002 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>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.</td>
</tr>
</tbody>
</table>
All *copayment* and *coinsurance* costs shown in this chart are after your *deductible* has been met, if a *deductible* applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 <em>copay</em> /visit; <em>deductible</em> does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$40 <em>copay</em> /visit; <em>deductible</em> does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/ screening/ immunization</td>
<td>No charge; <em>deductible</em> does not apply</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

*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 |
| | 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 | Preferred generic drugs | $20/30-day supply; *deductible* does not apply | Not covered |
| | 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 |

*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.*
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$150 copay/visit</td>
<td>$150 copay/visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$150 copay/visit</td>
<td>$150 copay/trip</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$40 copay/visit; deductible does not apply</td>
<td>$40 copay/visit; deductible does not apply</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>Mental Health/Substance Use Disorder</td>
<td><strong>Out-of-Network Provider</strong> (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Office visits: $30 copay/visit; deductible does not apply</td>
<td>Office visits: Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group therapy: $30 copay/visit; deductible does not apply</td>
<td>Group therapy: Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other outpatient services*: 30% coinsurance up to $30 / visit; deductible does not apply</td>
<td>Other outpatient services*: Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Inpatient services</strong></td>
<td><strong>Preauthorization</strong> is required. *Applies to intensive outpatient program and partial hospitalization program.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mental Health/Substance Use Disorder</td>
<td>Mental Health/Substance Use Disorder</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30% coinsurance (facility fee/physician fee)</td>
<td>30% coinsurance (facility fee/physician fee)</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No charge/visit; deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
</tbody>
</table>
### Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

#### Sharp Health Plan: SDPEBA Saver Plan (Active)

**Coverage Period:** 08/01/2020 – 07/31/2021  
**Coverage for:** Individual / Family | **Plan Type:** HMO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>$40 <strong>copay</strong>/visit</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$40 <strong>copay</strong>/visit; <strong>deductible</strong> does not apply</td>
<td>Not covered</td>
<td><strong>Preauthorization</strong> is required. Includes physical therapy, speech therapy, and occupational therapy.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>30% <strong>coinsurance</strong></td>
<td>Not covered</td>
<td><strong>Preauthorization</strong> is required. Coverage is limited to 100 days/calendar year.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>50% <strong>coinsurance</strong></td>
<td>Not covered</td>
<td><strong>Preauthorization</strong> is required.</td>
</tr>
</tbody>
</table>
| 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 |
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Sharp Health Plan: SDPEBA Saver Plan (Active)

Coverage Period: 08/01/2020 – 07/31/2021
Coverage for: Individual / Family | Plan Type: HMO

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)
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult and Child)
- Routine Foot Care
- 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.):
- 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; 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 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.
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)

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)

Tagalog (Tagalog – Filipino):

한국어 (Korean):

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

فارسی (Farsi):
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。

قبرعلا (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجاني. تصل برقم 2002-359-800-1 (رقم هاتف الصم والبكم: 711).

ਪੰਜਾਬੀ (Punjabi):
ਧਾਖਣ ਦੇੜਾ: ਜਦੋਂ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹਨ ਤਾਂ ਤੁਸੀਂ ਦ੍ਰਿਸ਼ਤੀ ਦੀ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਧਾਖਣ ਦੇੜਾ ਹੋਵੇ। 1-800-359-2002 (TTY:711) ਤੋਂ ਕਲਾਕ ਕਰੋ।

Mon Khmer (Cambodian):
សូម៏ ប្រការ ក្នុងករណី ដែលអ្នកប្រឈម៦ភាសា ដ៏មិនស្រើស្រួល ក៏មានសំរាប់ការជួយពិតជាក្នុងការស៊ីសំរោប់បំរុេហូង។
1-800-359-2002 (TTY: 711).

Hmoob (Hmong):

हिन्दी (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):
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).

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.
### Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

**Sharp Health Plan: SDPEBA Saver Plan (Active)**

**Coverage Period:** 08/01/2020 – 07/31/2021

**Coverage for:** Individual / Family | **Plan Type:** HMO

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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 **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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$800</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$2,700</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions $0
- The total Peg would pay is $3,500

---

### 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 0%

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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$150</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

**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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$20</td>
</tr>
</tbody>
</table>

**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.