




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 or call 1-800-359-2002 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible ? | \$4750 Individual / \$9,500 Family (Deductible resets January 1 st) | 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 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. \$85 Individual / \$170 Family for prescription drug coverage . There are no other specific deductible . | 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 ? | \$8,750 Individual / \$17,500 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 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 . |

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 (HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

 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 provider's office or clinic | Primary care visit to treat an injury or illness | \$45 copay /visit; deductible does not apply | Not covered | None |
| | Specialist visit | \$85 copay /visit; deductible does not apply | Not covered | Preauthorization is required, except for obstetric gynecologic services. |
| | 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 needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | \$50 copay /visit (blood work); deductible does not apply \$95 copay /visit (x-rays); deductible does not apply | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | \$325 copay /visit; 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 . | Generic drugs (Tier 1)* | \$16/30-day supply, \$32/90-day supply | Not covered | *Pharmacy deductible applies to drugs on Tiers 1, 2, 3 and 4. 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 (Tier 2)* | \$60/30-day supply, \$120/90-day supply | Not covered | |
| | Non-preferred brand drugs (Tier 3)* | \$90/30-day supply, \$180/90-day supply | Not covered | |
| | Specialty drugs (Tier 4)* | 20% coinsurance up to \$250 per 30-day supply after pharmacy deductible | Not covered | |

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

| 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) | 20% coinsurance ; deductible does not apply | Not covered | Preauthorization is required. |
| | Physician/surgeon fees | 20% coinsurance ; deductible does not apply | Not covered | Preauthorization is required. |
| If you need immediate medical attention | Emergency room care | \$400 copay /visit (facility fee); deductible does not apply No charge/visit (physician fee); deductible does not apply | \$400 copay/visit (facility fee); deductible does not apply No charge/visit (physician fee); deductible does not apply | Cost sharing waived if admitted to the hospital. |
| | Emergency medical transportation | \$255 copay /trip; deductible does not apply | \$255 copay /trip; deductible does not apply | None |
| | Urgent care | \$45 copay /visit; deductible does not apply | \$45 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 not covered unless services are for emergency care or out-of-area urgent care, or services have been prior authorized. |
| | Physician/surgeon fees | 30% coinsurance ; deductible does not apply | 30% coinsurance ; deductible does not apply | |

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

| 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 mental health, behavioral health, or substance abuse services | Outpatient services | Mental Health/Substance Use Disorder Office visits: \$45 copay /visit; deductible does not apply Group therapy: \$45 copay /visit; deductible does not apply Other outpatient services*: 20% coinsurance up to \$45 copay /visit; deductible does not apply | Mental Health/Substance Use Disorder Office visits: Not covered Group therapy: Not covered Other outpatient services*: Not covered | Preauthorization is required. *Applies to intensive outpatient program and partial hospitalization program. Out-of-network services are not covered unless services are for emergency care or out-of-area urgent care, or services have been prior authorized. |
| | Inpatient services | Mental Health/Substance Use Disorder 30% coinsurance ; (facility fee/physician fee); deductible does not apply to physician fee | Mental Health/Substance Use Disorder 30% coinsurance ; (facility fee/physician fee); deductible does not apply to physician fee | Preauthorization is required for non-emergency services. Out-of-network services are not covered unless services are for emergency care or out-of-area urgent care, or services have been prior authorized. |
| If you are pregnant | Office visits | No charge/visit; deductible does not apply | Not covered | Cost sharing does not apply for 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 (e.g. ultrasound). Out-of-network services are not covered unless services are for emergency care or out-of-area urgent care, or services have been prior authorized. |
| | Childbirth/delivery professional services | 30% coinsurance ; deductible does not apply | 30% coinsurance ; deductible does not apply | |
| | Childbirth/delivery facility services | 30% coinsurance | 30% coinsurance | |

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

| 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 | Home health care | \$45 copay /visit; deductible does not apply | Not covered | Preauthorization is required. Coverage is limited to short-term, intermittent services, 100 visits/calendar year. Cost sharing is per visit. |
| | Rehabilitation services | \$45 copay /visit; deductible does not apply | Not covered | Preauthorization is required. Includes physical therapy, speech therapy, and occupational therapy. |
| | Habilitation services | \$45 copay /visit; deductible does not apply | Not covered | Preauthorization is required. |
| | Skilled nursing care | 30% coinsurance | Not covered | Preauthorization is required. Coverage is limited to 100 days/benefit period. |
| | Durable medical equipment | 20% coinsurance ; deductible does not apply | Not covered | Preauthorization is required. |
| | Hospice services | Inpatient: No charge/admission; deductible does not apply Outpatient: No charge/visit; deductible does not apply | Not covered | Preauthorization 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. |

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

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- | | | |
|-----------------------|--|----------------------------|
| • Chiropractic care | • Hearing aids | • Private-duty nursing |
| • Cosmetic surgery | • Infertility treatment | • Routine eye care (Adult) |
| • Dental care (Adult) | • Long-term care | • Routine foot care |
| | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

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

- | | |
|---------------|---------------------|
| • Abortion | • Bariatric surgery |
| • Acupuncture | |

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](#).

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

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: Ձանգահարեք 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。

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

Language Access Services (Cont.):

(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 ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਪਿੱਛੇ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-800-359-2002 (TTY:711) 'ਤੇ ਕਾਲ ਕਰੋ।

ខ្មែរ (Mon Khmer, Cambodian):

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ

1-800-359-2002 (TTY: 711)។

Hmoob (Hmong):

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

हिंदी (Hindi):

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

ภาษาไทย (Thai):

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

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

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.* -----

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.

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 | \$4,750 |
| ■ Specialist copayment | \$85 |
| ■ Hospital (facility) coinsurance | 30% |
| ■ Other coinsurance | 20% |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles * | \$4,750 |
| Copayments | \$700 |
| Coinsurance | \$1,900 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$7,350 |

Managing Joe's Type 2 Diabetes

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$4,750 |
| ■ Specialist copayment | \$85 |
| ■ 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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles * | \$85 |
| Copayments | \$1,600 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,905 |

Mia's Simple Fracture

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

| | |
|---|---------|
| ■ The plan's overall deductible | \$4,750 |
| ■ Specialist copayment | \$85 |
| ■ Hospital (facility) coinsurance | 30% |
| ■ Other coinsurance | 20% |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles * | \$10 |
| Copayments | \$1,300 |
| Coinsurance | \$50 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,360 |

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