



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 ?	\$0	See the Common Medical Events chart below for services this plan covers.
Are there services covered before you meet your deductible ?	N/A	N/A
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 ?	\$1,500 Individual / \$3,000 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 , 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 .

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



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay /visit	Not covered	None
	Specialist visit	\$20 copay /visit	Not covered	Preauthorization is required, except for obstetric gynecologic services.
	Preventive care/screening/immunization	No charge	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)	No charge/visit (blood work); No charge/visit (x-rays)	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge/visit	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	\$15/30-day supply, \$30/90-day supply	Not covered	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	\$30/30-day supply, \$60/90-day supply	Not covered	
	Non-preferred drugs	\$50/30-day supply, \$100/90-day supply	Not covered	
	Specialty drugs	Specialty follows the tier structure above	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)	No charge/visit	Not covered	Preauthorization is required.
	Physician/surgeon fees	No charge/visit	Not covered	Preauthorization is required.
If you need immediate medical attention	Emergency room care	\$75 copay /visit No charge/visit (physician fee)	\$75 copay /visit No charge/visit (physician fee)	Cost sharing waived if admitted to the hospital.
	Emergency medical transportation	No charge/trip	No charge/trip	None
				In most cases, services must be approved by your primary care provider and received at urgent care facilities affiliated with your Plan Medical Group. Out-of-Network services are covered only when you are outside of the Service Area for your Plan Network.
	Urgent care	\$20 copay /visit	\$20 copay /visit	Out-of-Network services are also covered for Medically Necessary treatment of a Mental Health or Substance Use Disorder, including, but not limited to, Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider and services received under a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court, these services do not require preauthorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$100 copay /admission	\$100 copay /admission	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. Out-of-network services are not covered unless services are for emergency or out-of-area urgent care, or services have been prior authorized, services are for Medically Necessary treatment of a Mental Health or Substance Use Disorder, including, but not limited to, Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider, or services received under a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court.
	Physician/surgeon fees	No charge/visit	No charge/visit	

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	Mental Health/Substance Use Disorder	Preauthorization is required. *Applies to intensive outpatient program and partial hospitalization program. Preauthorization is not required for Medically Necessary treatment of a Mental Health or Substance Use Disorder, including, but not limited to, Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider and services received under a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court. Out-of-network services are not covered unless services are for emergency or out-of-area urgent care, or services have been prior authorized, services are for Medically Necessary treatment of a Mental Health or Substance Use Disorder, including, but not limited to, Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider, or services received under a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court.
		Office visits: \$20 copay /visit (MH/SUD);	Office visits: Not covered	
		Group therapy: \$20 copay /visit (MH), \$7 copay /visit (SUD);	Group therapy: Not covered	
		Other outpatient services*: No charge/visit (MH/SUD)	Other outpatient services*: 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)	
	Inpatient services	Mental Health/Substance Use Disorder \$100 copay /admission (facility fee); No charge/visit (physician fee)	Mental Health/Substance Use Disorder \$100 copay /admission (facility fee); No charge/visit (physician fee)	Preauthorization is required for non-emergency services. Preauthorization is not required for Medically Necessary treatment of a Mental Health or Substance Use Disorder, including, but not limited to, Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider and services received under a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court. Out-of-network services are not covered unless services are for emergency or out-of-area urgent care, or services have been prior authorized, or services are for Medically Necessary treatment of a Mental Health or Substance Use Disorder, including, but not limited to, Behavioral Health Crisis Services provided by a 988 center or mobile crisis team or other provider, or services received under a Community Assistance Recovery and Empowerment (CARE) Agreement or CARE Plan approved by a court.
If you are pregnant	Office visits	No charge/visit;	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 (e.g. ultrasound). Out-of-
	Childbirth/delivery professional services	No charge/visit	No charge/visit	

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)	
	Childbirth/delivery facility services	\$100 copay /admission	\$100 copay /admission	network services are not covered unless services are for emergency or out-of-area urgent care, or services have been prior authorized.
If you need help recovering or have other special health needs	Home health care	No charge/visit	Not covered	Preauthorization is required. Coverage is limited to short-term, intermittent services, 100 visits/calendar year. Cost sharing is per visit.
	Rehabilitation services	\$20 copay /visit	Not covered	Preauthorization is required. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	\$20 copay /visit	Not covered	Preauthorization is required.
	Skilled nursing care	No charge/admission	Not covered	Preauthorization is required. Coverage is limited to 100 days/calendar year.
	Durable medical equipment	No charge	Not covered	Preauthorization is required.
	Hospice services	Inpatient: No charge/admission Outpatient: No charge/visit	Not covered	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	No charge/visit	Not covered	Eye exams are covered once every 12 months. Cost sharing for covered supplemental vision services do not count towards the out-of-pocket limit .
	Children's glasses	Discounted	Not covered	Limitations apply. Cost sharing for covered supplemental vision services do not count towards the out-of-pocket limit .
	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](#).)

- | | | |
|-----------------------|--|------------------------|
| • Cosmetic surgery | • Long-term care | • Private-duty nursing |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Routine foot care |

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

- | | | |
|---------------------|-------------------------|----------------------------|
| • Acupuncture | • Hearing aids | • Routine eye care (Adult) |
| • Bariatric surgery | • Infertility treatment | • Weight loss programs |
| • Chiropractic care | | |

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 bạ n nói Tiếng Việt t, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạ n. 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):

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

فارسی (Farsi): توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما تماس بگیرد (TTY:711) باشد می فراهم.

Русский (Russian):

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-800-359-2002 (телефайп: 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](http://www.sharphealthplan.com) or policy document at www.sharphealthplan.com.

ਪੰਜਾਬੀ (Punjabi):

ਪਿਆਰਨ ਧਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਪਿੰਚ ਸਹਾਇਤਾ ਮੇਰਾ 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: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ ฟรี โทร 1-800-359-2002 (TTY: 711).

Notice of Nondiscrimination

Sharp Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Sharp Health Plan does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Sharp Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Information in other formats (such as large print, audio, accessible electronic formats, or other formats) free of charge
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Customer Care at 1-800-359-2002. If you believe that Sharp Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with our Civil Rights Coordinator at:

Sharp Health Plan
Attn: Appeal/Grievance Department
8520 Tech Way, Suite 200
San Diego, CA 92123-1450
Telephone: 1-800-359-2002 (TTY: 711)
Fax: (619) 740-8572

You can file a grievance in person or by mail, fax, or you can also complete the online Grievance/Appeal form on the Plan's website sharphealthplan.com. 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](#) \$0
- [Specialist copayment](#) \$20
- Hospital (facility) [copayment](#) \$100
- 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	\$100
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$160

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](#) \$20
- Hospital (facility) [copayment](#) \$100
- 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	\$5,600
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$720

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

- The [plan's overall deductible](#) \$0
- [Specialist copayment](#) \$20
- Hospital (facility) [copayment](#) \$100
- Other [coinsurance](#) 0%

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	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$200

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