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?	$8,700 Individual / $17,400 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.

(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	$35 copay/visit	Not covered	None
	Specialist visit	$65 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)	$40 copay/visit (blood work); $75 copay/visit (x-rays)	Not covered	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	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)	$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 (Tier 2)	$60/30-day supply, $120/90-day supply	Not covered	
	Non-preferred brand drugs (Tier 3)	$85/30-day supply, $170/90-day supply	Not covered	
	Specialty drugs (Tier 4)	20% coinsurance up to $250 per 30-day supply	Not covered	

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)	30% coinsurance	Not covered	Preauthorization is required.
	Physician/surgeon fees	30% coinsurance	Not covered	Preauthorization is required.
If you need immediate medical attention	Emergency room care	$350 copay/visit (facility fee) No charge/visit (physician fee)	$350 copay/visit (facility fee) No charge/visit (physician fee)	Cost sharing waived if admitted to the hospital.
	Emergency medical transportation	$250 copay/trip	$250 copay/trip	None
	Urgent care	$35 copay/visit	$35 copay/visit	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 when you are outside of the Service Area for your Plan Network. 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)	30% coinsurance	30% coinsurance	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 care out-of-area urgent care, 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	30% coinsurance	30% coinsurance	

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: $35 copay/visit; Group therapy: $35 copay/visit; Other outpatient services*: 30% coinsurance up to $35 copay/visit	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. 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 care or out-of-area urgent care, 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.

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 30% coinsurance (facility fee/physician fee)	Mental Health/Substance Use Disorder 30% coinsurance (facility fee/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 care or out-of-area urgent care, 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 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	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
		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	20% coinsurance	Not covered	Preauthorization is required. Coverage is limited to short-term, intermittent services, 100 visits/calendar year. Cost sharing is per visit.
	Rehabilitation services	$35 copay/visit	Not covered	Preauthorization is required. Includes physical therapy, speech therapy, and occupational therapy.
	Habilitation services	$35 copay/visit	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	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	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.

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

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

- Abortion
- Acupuncture
- Bariatric surgery

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)。

Tiế ng Việ t (Vietnamese)
CHÚ Ý: Nế u bạ n nói Tiế ng Việ t, có các dịch vụ hỗ trợ ngôn ngữ miễ n phí dành cho bạ n. Gọ i 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.

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。

Language Access Services (Cont.):

ةيبرعلا (Arabic):
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 ਸੇਿਾ 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: ถ้าคณพดภาษาไทยคณสามารถใช้บริการช่วยเหลือทางภาษาได้ 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*.

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	**$65**
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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$600
Coinsurance	$3,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,960**

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	**$65**
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:	
Cost Sharing	
Deductibles	$0
Copayments	$1,500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

The plan's overall deductible	**$0**
Specialist copayment	**$65**
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:	
Cost Sharing	
Deductibles	$0
Copayments	$1,200
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,250**

The plan would be responsible for the other costs of these EXAMPLE covered services.