Sharp Health Plan: Sharp Platinum 90 HMO 0/15 + Child Dental 1 Coverage Period: 01/01/2017– 12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.sharphealthplan.com or by calling 1-800-359-2002.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$4,000** Individual / **$8,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, copayments for supplemental benefits, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network **providers**, see www.sharphealthplan.com or call 1-800-359-2002.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I 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 the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	Not covered	——————none——————
	Specialist visit	$40 copay/visit	Not covered	Prior authorization is required, except for obstetric and gynecologic services.
	Other practitioner office visit	$15 copay/visit	Not covered	Prior authorization is required.
	Preventive care/screening/immunization	No charge	Not covered	Prior authorization may be required.
If you have a test	Laboratory tests	$20 copay/visit	Not covered	Prior authorization is required.
	Diagnostic test (x-ray, blood work)	$40 copay/visit	Not covered	Prior authorization is required.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	Prior authorization is required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.sharphealthplan.com .	Tier 1	$5/30-day supply $10/90-day supply	Not covered	Brand drugs are not covered if a generic version is available, unless prior authorization is obtained. Prior authorization is required for certain generic drugs. 90-day supply cost-share applies to maintenance medications filled by mail order only.
	Tier 2	$15/30-day supply $30/90-day supply	Not covered	
	Tier 3	$25/30-day supply $50/90-day supply	Not covered	
	Tier 4	10% coinsurance up to $250 per 30-day supply	Not covered	

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	Prior authorization is required.
	Physician/surgeon fees	10% coinsurance	Not covered	——————none——————
If you need immediate medical attention	Emergency room facility fee Emergency room physician fee	$150 copay/visit (facility fee) $0 (physician fee)	$150 copay/visit (facility fee) $0 (physician fee)	Cost-share waived if admitted.
	Emergency medical transportation	$150 copay/trip	$150 copay/trip	——————none——————
	Urgent care	$15 copay/visit	$15 copay/visit	Services must be approved by your primary care provider in San Diego county. Out-of-network services are covered only when out of the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	10% coinsurance	Prior authorization is required for non-emergency services. Out-of-network services are covered for emergency care only.
	Physician/surgeon fee	10% coinsurance	10% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits and group therapy	$15 copay/visit	Not covered	Prior authorization is required.
	Mental/Behavioral health other outpatient items and services	$15 copay/visit*	Not covered	Prior authorization is required. *Applies to intensive outpatient program and partial hospitalization program
	Mental/Behavioral health inpatient facility fee and inpatient physician fee	10% coinsurance	10% coinsurance	Prior authorization is required for non-emergency services. Out-of-network services are covered for emergency care only.
	Substance use disorder outpatient office visits and group therapy	$15 copay/visit	Not covered	Prior authorization is required.
	Substance use disorder other outpatient items and services	$15 copay/visit*	Not covered	Prior authorization is required. *Applies to intensive outpatient program and partial hospitalization program
	Substance use disorder inpatient facility fee and inpatient physician fee	10% coinsurance	10% coinsurance	Prior authorization is required for non-emergency services. Out-of-network services are covered for emergency care only.
If you are pregnant	Prenatal and postnatal care	No cost share	Not covered	——————none——————
	Delivery and all inpatient services	10% coinsurance	10% coinsurance	Out-of-network services are covered for emergency care only.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Prior authorization is required. Coverage is limited to 100 days per calendar year.
	Rehabilitation services	$15 copay/ visit	Not covered	Prior authorization is required.
	Habilitation services	$15 copay/ visit	Not covered	Prior authorization is required.
	Skilled nursing care	10% coinsurance	Not covered	Prior authorization is required. Coverage is limited to 100 days per benefit period.
	Durable medical equipment	10% coinsurance	Not covered	Prior authorization is required.
	Hospice service	No cost share	Not covered	Prior authorization is required.
If your child needs dental or eye care	Eye exam	No cost share	Not covered	Limited to one exam per year.
	Glasses	No cost share	Not covered	Limited to one pair of glasses per year.
	Dental check-up	No cost share	Not covered	Limited to 2 in a 12 month period. Sharp Health Plan's pediatric dental benefits are provided by Access Dental. Please refer to the Access Dental schedule of benefits for further details about your pediatric dental benefits.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

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

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact Sharp Health Plan at 1-800-359-2002. You may also contact the California Department of Managed Health Care at 1-888-466-2219 or www.hmohelp.ca.gov, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Sharp Health Plan at 1-800-359-2002 or the California Department of Managed Health Care at 1-888-466-2219 or www.hmohelp.ca.gov. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/heatlhreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-359-2002.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,860
- **Patient pays** $680

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$170
Coinsurance	$360
Limits or exclusions	$150
Total	**$680**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,830
- **Patient pays** $570

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Copays	$400
Coinsurance	$130
Limits or exclusions	$40
Total	**$570**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call **1-800-359-2002** or visit us at **www.sharphealthplan.com**.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.sharphealthplan.com or call 1-800-359-2002 to request a copy.