Summary of Benefits

Covered California
Sharp Silver 70 Premier HMO

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE ANDPLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. PLEASE CONTACT YOUR EMPLOYER FOR SPECIFIC INFORMATION ON YOUR COVERAGE OR VISIT **SHARPHEALTHPLAN.COM** TO VIEW THE MEMBER HANDBOOK.

Covered Benefits	Cost Share
Annual Deductible for Specific Services[1]	
Calendar year medical deductible (per individual/per family) - applies only to those covered benefits indicated	$5,400 / $10,800
Calendar year pharmacy deductible (per individual/per family) - applies to Tier 2, Tier 3, and Tier 4	$150 / $300
Calendar year dental deductible (per individual/per family)	$0 / $0
Annual Out of Pocket Maximum[1]	
Annual out of pocket maximum (per individual/per family)	$9,100 / $18,200
Lifetime Maximum	
There are no lifetime maximums for this plan	Unlimited
Preventive Care[2]	
Well-baby and well-child (to age 18) physical exams, immunizations and related laboratory services	$0
Routine adult physical exams, immunizations and related laboratory services	$0
Laboratory, radiology and other services for the early detection of disease when ordered by a Physician	$0
Routine gynecological exams, immunizations and related laboratory services	$0
Mammography	$0
Prostate cancer screening	$0
Colorectal cancer screenings including sigmoidoscopy and colonoscopy	$0
Best Health® Wellness Services	
On-line health education and wellness workshops and other wellness tools	$0
Telephonic health coaching (weight management, tobacco cessation, stress management, physical activity, nutrition)	$0
Professional Services	
Primary Care Physician office visit for consultation, treatment, diagnostic testing, etc.	$50 / visit
Specialist Physician office visit for consultation, treatment, diagnostic testing, etc.	$90 / visit
Other Practitioner office visit, including acupuncture[3]	$50 / visit
Laboratory tests and services	$50 / visit
Radiology services (x-rays and diagnostic imaging)	$95 / visit
Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	$325 / visit
Allergy testing	$90 / visit
Allergy injections	$90 / visit
Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)	
Outpatient surgery facility fee	30% coinsurance[4]
Outpatient Physician/Surgeon fee	30% coinsurance[4]
Outpatient visit	30% coinsurance[4]
Infusion therapy (including but not limited to chemotherapy)	30% coinsurance[4]
Dialysis	30% coinsurance[4]
Rehabilitation services: physical, occupational and speech therapy	$50 / visit
Habilitation services	$50 / visit
Radiation therapy	30% coinsurance[4]
Hospitalization (including but not limited to inpatient services, organ transplant, and inpatient rehabilitation)	
Facility fee	30% coinsurance[4,6]
Physician/surgeon fee	30% coinsurance[4]
Emergency and Urgent Care Services	
Emergency room facility fee (waived if admitted to the hospital)	$450 / visit
Emergency room physician fee (waived if admitted to the hospital)	$0
Urgent care services	$50 / visit
Medical Transportation	
Emergency medical transportation	$250
Non-emergency medical transportation	$250

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Maternity Care	
Prenatal and postpartum office visits	$0
Delivery and all inpatient services - Hospital	30% coinsurance[4,6]
Delivery and all inpatient services - Professional	30% coinsurance[4]
Breastfeeding support, supplies and counseling	$0
Family Planning Services	
Injectable contraceptives (including but not limited to Depo Provera)	$0
Voluntary sterilization - women	$0
Voluntary sterilization - men	$0
Interruption of pregnancy (including but not limited to office visits, outpatient surgery, and inpatient services)	$0
Durable Medical Equipment and Other Supplies	
Durable medical equipment	20% coinsurance[4]
Diabetic supplies	20% coinsurance[4]
Prosthetics and orthotics	20% coinsurance[4]
Mental Health Services[5]	
Office visits	$50 / visit
Group therapy	$50 / visit
Other outpatient items and services	30% coinsurance up to $50 / visit
Inpatient facility fee	30% coinsurance[4,6]
Inpatient physician fee	30% coinsurance[4]
Emergency services facility fee (waived if admitted)	$450 / visit
Emergency services physician fee (waived if admitted)	$0
Emergency psychiatric transportation	$250
Non-emergency psychiatric transportation	$250
Urgent care services	$50 / visit
Substance Use Disorder Services[5]	
Office visits	$50 / visit
Group therapy	$50 / visit
Other outpatient items and services	30% coinsurance up to $50 / visit
Inpatient facility fee	30% coinsurance[4,6]
Inpatient physician fee	30% coinsurance[4]
Emergency services facility fee for alcohol or drug detoxification (waived if admitted)	$450 / visit
Emergency services physician fee for alcohol or drug detoxification (waived if admitted)	$0
Emergency substance use disorder transportation	$250
Non-emergency substance use disorder transportation	$250
Urgent care services	$50 / visit
Skilled Nursing, Home Health and Hospice Services	
Skilled nursing facility services (maximum of 100 days per benefit period)	30% coinsurance[4,6]
Home health services (cost share per visit - maximum of 100 visits per calendar year)	$45 / visit
Hospice care - inpatient	$0
Hospice care - outpatient	$0
Pediatric Vision Services	
Eye Exam	$0
Glasses or contact lenses in lieu of glasses	1 pair per year, covered in full
Pediatric Dental Services	
Sharp Health Plan's pediatric dental benefits are provided by Delta Dental. Please refer to the Delta Dental schedule of benefits for the applicable cost-sharing information.	

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Prescription Drug Coverage[7]	
Tier 1: Most generic drugs and low cost preferred brands (30 day supply/90 day supply).	$19 / $38
Tier 2: Non-preferred generic drugs, Preferred brand name drugs, and any other drugs recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on safety, efficacy and cost (30 day supply/90 day supply).	$60[6] / $120[6]
Tier 3: Non-preferred brand name drugs, drugs that are recommended by P&T committee based on safety, efficacy and cost, or drugs that generally have a preferred and often less costly therapeutic alternative at a lower tier (30 day supply/90 day supply).	$90[6] / $180[6]
Tier 4: Drugs that are biologics, drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies, drugs that require the enrollee to have special training or clinical monitoring; or drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) net of rebates (30 day supply).	20% coinsurance[4,6] (up to $250 per 30-day supply after pharmacy deductible)
Preventive prescription drugs including Preferred Generic and over-the-counter contraceptives	$0

Notes

[1] In a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out-of-pocket maximum amount. Cost sharing payments (deductibles, copayments

and coinsurance, but not premiums) made by each individual in a family contribute to the family deductible and out-of-pocket maximums.The family deductible may be satisfied by any combination of individual deductible payments, after which member copays or coinsurance apply until the family out of pocket maximum is reached. Once the family out-of-pocket maximum is reached, the plan pays all costs for covered services for all family members. Cost sharing payments for all covered benefits accumulate toward the deductible, if deductible applies to that service, and the out-of-pocket maximum.

[2] Includes preventive services with a rating of A or B from the US Preventive Services Task Force; immunizations for children, adolescents and adults recommended by the Centers of Disease Control; and preventive care and screenings supported by the Health Resources and Services Administration for infants, children, adolescents and women. If preventive care is received at the time of other services, the applicable copayment for such services other than preventive care may apply.

[3] "Other Practitioner Office Visits" includes: Therapy visits, office visits not provided by Primary Care Physicians or Specialty Physicians, and office visits not specified in another benefit category.

[4] Of contracted rates

[5] All medically necessary treatment of mental health and substance use disorders is covered under this plan.

[6] Deductible applies

[7] Member cost-share will not exceed $250 per individual prescription of up to a 30-day supply of a covered oral anti-cancer drug. 90-day supply cost share applies to maintenance medications filled by mail order only.

Note: Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).

Note: For “Mental Health Services”, “Office Visits” cost-share applies to outpatient office visits, psychological testing, and outpatient monitoring of drug therapy. "Group Therapy" cost-share applies to group mental health evaluation and treatment and group therapy sessions. “Other Outpatient Items and Services” cost-share applies to multidisciplinary treatment in an intensive outpatient psychiatric treatment program, partial hospitalization, and home-based behavioral health treatment for autism spectrum disorder. “Inpatient” cost-share applies to inpatient facility and physician services, mental health psychiatric observation and mental health crisis residential treatment.

Note: For “Substance Use Disorder Services”, “Office Visits” cost-share applies to outpatient office visits, medication treatment for withdrawal, and individual evaluation. "Group Therapy" cost-share applies to substance use disorder group evaluation and group therapy sessions. “Other Outpatient Items and Services” cost-share applies to day treatment programs, intensive outpatient programs, and partial hospitalization. “Inpatient” cost-share applies to the inpatient facility and physician services and substance use disorder transitional residential recovery services in a non-medical residential setting.

Note: The cost of developing an evaluation and the provisions of all health care services required or recommended pursuant to a Community Assistance, Recovery and Empowerment (CARE) Agreement or CARE Plan are covered whether the service is provided by a Plan provider or non-Plan provider. All services are covered without prior authorization and Cost Sharing, except prescription drugs.

Note: 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 of Behavioral Health Crisis Services can be provided by Plan providers or non-Plan providers. You will only pay the in-network cost sharing amount for any out-of-network Medically Necessary treatment of a Mental Health or Substance Use Disorder, provided by a 988 center, mobile crisis team or other provider of Behavioral Health Crisis Services.