

# SHARP Health Plan

Small Group Plans

## Benefit Comparison

A guide to choosing the right plan for your business  
Effective January 1, 2026



Better health insurance matters.



# San Diegans choose Sharp Health Plan

With a range of solutions and provider networks, we have the right plan to meet your unique needs. Sharp Health Plan delivers high-quality, affordable health care, with direct access to Sharp HealthCare and The Sharp Experience from coverage to care.

## Committed to high-quality coverage

Our commitment to our members is at the heart of everything we do and has resulted in multiple local, state and national recognitions. Visit [sharphealthplan.com/honors](https://sharphealthplan.com/honors) to learn more.

## Local and nonprofit

We've been connecting San Diegans to health insurance since 1992. We're the largest locally based nonprofit commercial health plan, and we're honored to serve you.

## Quick and easy access to care

We're here to make sure you can safely receive the care you need, when you need it. We offer a number of options for care, including video and phone visits, After-Hours Nurse Advice, MinuteClinic® and more.

## Customizable

With a multitude of plan designs, four provider networks and a broad range of pricing options, you have the ability to tailor your plan to your business needs.



## Additional benefits included with every plan

The convenience of Sharp Health Plan extends beyond San Diego and standard business hours. All Sharp Health Plan members receive these value-added benefits.



### After-Hours Nurse Advice

Registered nurses are available through Sharp Nurse Connection® after hours and on weekends. They can talk with you about an illness or injury, help you decide where to seek care and provide advice on any of your health concerns.

Call 1-800-359-2002, 5 p.m. – 8 a.m., Monday to Friday, and 24 hours on weekends



### MinuteClinic

MinuteClinic is the medical clinic located in select CVS Pharmacy® stores. MinuteClinic provides convenient access to basic care to help you stay healthy on your schedule.<sup>4</sup>

[sharphealthplan.com/minuteclinic](http://sharphealthplan.com/minuteclinic)



### Global Travel Assistance Services

When faced with a medical need while traveling 100 miles or more away from home or in another country, we can connect you to doctors, hospitals, pharmacies and other services.

[sharphealthplan.com/travel](http://sharphealthplan.com/travel)



### Best Health® Wellness Program

Best Health is one of a select group of health plan wellness programs to receive national accreditation from the National Committee for Quality Assurance (NCQA). Offering robust online wellness tools, one-on-one health coaching and more, Best Health provides resources you can use to reach your health goals. Resources are available to members 18 years old and up.

[sharphealthplan.com/wellness](http://sharphealthplan.com/wellness)

<sup>1</sup> Voted 'Best Health Insurance' in the San Diego's Best Union-Tribune Readers Poll, 2021-25.

# Small Group Platinum 90 Plans effective January 1, 2026

	Platinum HMO NG 1	Platinum HMO NG 2	Platinum HMO NG 8	Platinum HMO NG 3	Platinum HMO NG 7	Platinum HMO NG 4
<b>Deductibles</b>						
Calendar Year Deductible (per individual / per family; applies only to those covered benefits indicated)	\$0	None	\$0	None	\$0	None
Calendar Year Deductible (per individual / per family for covered prescription drugs (preferred and non-preferred))	None	None	None	None	None	None
<b>Maximums</b>						
There are no lifetime maximums for this plan	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Maximum, Including Deductible (per individual / per family)	\$3,900 <sup>1</sup> / \$7,800 <sup>1</sup>	\$2,900 <sup>1</sup> / \$5,800 <sup>1</sup>	\$2,750 <sup>1</sup> / \$5,500 <sup>1</sup>	\$2,250 <sup>1</sup> / \$4,500 <sup>1</sup>	\$2,500 <sup>1</sup> / \$5,000 <sup>1</sup>	\$2,250 <sup>1</sup> / \$4,500 <sup>1</sup>
<b>Professional Services (per visit)</b>						
Primary Care Physician Office Visit (for consultation, treatment, diagnostic testing, etc.)	\$10	\$15	\$20	\$20	\$20	\$25
Specialist Physician Office Visit (for consultation, treatment, diagnostic testing, etc.)	\$20	\$15	\$30	\$30	\$30	\$40
Preventive Services <sup>2</sup>	\$0	\$0	\$0	\$0	\$0	\$0
Prenatal and Postpartum Office Visits	\$0	\$0	\$0	\$0	\$0	\$0
Allergy Testing	\$20	\$15	\$30	\$30	\$30	\$40
Allergy Injections	\$10	\$15	\$20	\$20	\$20	\$25
<b>Outpatient Services</b>						
Outpatient Surgery	\$125 / visit	\$250 / visit	\$150 / visit	\$500 / visit	\$250 / visit	\$500 / visit
Radiology Services (per visit, X-rays and diagnostic imaging)	\$15	\$10	\$40	\$10	\$10	\$0
Advanced Radiology (per visit)	\$100	\$100	\$150	\$100	\$100	\$100
Physical, Occupational and Speech Therapy (per visit)	\$10	\$15	\$20	\$20	\$20	\$25
<b>Hospitalization Services</b>						
Inpatient	\$300 / day (3-day max)	\$250 / day (3-day max)	\$250 / admission	\$500 / day (3-day max)	\$500 / admission	\$1,000 / admission
<b>Emergency / Urgent Care Services</b>						
Emergency Room (per visit, waived if admitted)	\$100	\$100	\$100	\$100	\$100	\$150
Urgent Care (per visit)	\$20	\$15	\$20	\$30	\$30	\$40
<b>Emergency Medical Transportation</b>						
Emergency Medical Transportation (in connection with hospital admission or emergency services)	\$100	\$100	\$100	\$100	\$100	\$150
<b>Prescription Drug Coverage</b>						
Drugs Administered in a Practitioner's Office, Hospital or Outpatient Facility	\$0	\$0	\$0	\$0	\$0	\$0
Preferred Generic / Preferred Brand / Non-Preferred / Specialty Medications up to 30-Day Supply	\$15 / \$35 / \$50 / 10% <sup>4</sup>	\$15 / \$35 / \$50 / 10% <sup>4</sup>	\$10 / \$25 / \$50 / 10% <sup>4</sup>	\$20 / \$35 / \$70 / 10% <sup>4</sup>	\$10 / \$25 / \$50 / 10% <sup>4</sup>	\$15 / \$35 / \$50 / 10% <sup>4</sup>
Preferred Generic / Preferred Brand / Non-Preferred Medications up to 90-Day Supply by Mail Order	\$30 / \$70 / \$100	\$30 / \$70 / \$100	\$20 / \$50 / \$100	\$40 / \$70 / \$140	\$20 / \$50 / \$100	\$30 / \$70 / \$100
Preferred Generic and Over-the-Counter Contraceptives for Women	\$0	\$0	\$0	\$0	\$0	\$0
<b>Durable Medical Equipment and Other Supplies</b>						
Durable Medical Equipment	50% coinsurance <sup>3</sup>					
Diabetic Supplies	20% coinsurance <sup>3</sup>					
Prosthetics and Orthotics (per visit)	\$20	\$15	\$30	\$30	\$30	\$40
<b>Mental Health Services</b>						
Outpatient Office Visit	\$10 / visit	\$15 / visit	\$20 / visit	\$20 / visit	\$20 / visit	\$25 / visit
Inpatient	\$250 / day (3-day max)	\$250 / day (3-day max)	\$250 / admission	\$250 / day (3-day max)	\$500 / admission	\$750 / admission
<b>Chemical Dependency Services</b>						
Outpatient Office Visit	\$10 / visit	\$15 / visit	\$20 / visit	\$20 / visit	\$20 / visit	\$25 / visit
Inpatient	\$250 / day (3-day max)	\$250 / day (3-day max)	\$250 / admission	\$250 / day (3-day max)	\$500 / admission	\$750 / admission
Emergency Services for Acute Drug or Alcohol Detoxification (waived if admitted)	\$100 / visit	\$150 / visit				
<b>Other</b>						
Skilled Nursing Facility Services (maximum of 100 days per benefit period)	\$100 / day (3-day max)	\$100 / day (3-day max)	\$70 / day (5-day max)	\$100 / day (3-day max)	\$70 / day (5-day max)	\$200 / admission
Home Health Services (maximum of 100 visits per calendar year)	\$10 / visit	\$15 / visit	\$20 / visit	\$20 / visit	\$20 / visit	\$25 / visit
Hospice Care - Inpatient	\$100 / day (3-day max)	\$250 / day (3-day max)	\$200 / admission	\$500 / day (3-day max)	\$0 / admission	\$200 / admission
Hospice Care - Outpatient (per visit)	\$0	\$0	\$0	\$0	\$0	\$0

<sup>1</sup> Copayments and deductibles for supplemental benefits (assisted reproductive technologies, chiropractic services, adult vision) do not apply to the annual out-of-pocket maximum.

<sup>2</sup> Includes preventive services with a rating of A or B from the U.S. Preventive Services Task Force; immunizations for children, adolescents and adults recommended by the Centers for Disease Control and Prevention; 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.

<sup>3</sup> Of contracted rates. <sup>4</sup> Up to \$250 per 30-day supply

Note: Infertility Treatment and Diagnosis, Artificial Insemination, and Assisted Reproductive Technologies (ART) benefits available upon request; ask your Sharp Health Plan sales representative or account manager for a quote.

# Gold 80 / Silver 70 / Bronze 60

effective January 1, 2026

	Gold HMO NG 5	Gold HMO NG 4	Gold HMO NG 1	Gold HMO NG 2	Gold HMO NG 3	Gold HMO NG 7	Gold HMO NG 6	Silver HMO NG 1	Silver HMO NG 2	Bronze HDHP NG 1
<b>Deductibles</b>										
Calendar Year Deductible (per individual / per family; applies only to those covered benefits indicated)	None	None	None	None	None	\$600 <sup>5</sup> / \$1,200 <sup>5</sup>	\$1,500 <sup>5</sup> / \$3,000 <sup>5</sup>	\$2,400 <sup>5</sup> / \$4,800 <sup>5</sup>	\$2,900 <sup>5</sup> / \$5,800 <sup>5</sup>	\$6,100 <sup>5</sup> / \$12,200 <sup>5</sup>
Calendar Year Deductible (per individual / per family for covered prescription drugs (preferred and non-preferred))	None	None	None	None	\$150 / \$300	None	\$150 / \$300	\$250 / \$500	\$0	Integrated
<b>Maximums</b>										
There are no lifetime maximums for this plan	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Maximum, Including Deductible (per individual / per family)	\$9,950 <sup>1</sup> / \$19,900 <sup>1</sup>	\$9,950 <sup>1</sup> / \$19,900 <sup>1</sup>	\$9,500 <sup>1</sup> / \$19,900 <sup>1</sup>	\$9,950 <sup>1</sup> / \$19,900 <sup>1</sup>	\$7,650 <sup>1</sup> / \$15,300 <sup>1</sup>	\$7,000 <sup>1</sup> / \$14,000 <sup>1</sup>	\$5,250 <sup>1</sup> / \$10,500 <sup>1</sup>	\$9,950 <sup>1</sup> / \$19,900 <sup>1</sup>	\$9,950 <sup>1</sup> / \$19,900 <sup>1</sup>	\$7,250 <sup>1</sup> / \$14,500 <sup>1</sup>
<b>Professional Services (per visit)</b>										
Primary Care Physician Office Visit (for consultation, treatment, diagnostic testing, etc.)	\$50	\$45	\$35	\$35	\$30	\$10	\$35	\$60	\$70	\$50 <sup>4</sup>
Specialist Physician Office Visit (for consultation, treatment, diagnostic testing, etc.)	\$55	\$50	\$55	\$55	\$55	\$20	\$55	\$65	\$70	\$50 <sup>4</sup>
Preventive Services <sup>2</sup>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Prenatal and Postpartum Office Visits	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Allergy Testing	\$55	\$50	\$55	\$55	\$55	\$20	\$55	\$65	\$70 <sup>4</sup>	\$50 <sup>4</sup>
Allergy Injections	\$50	\$45	\$35	\$35	\$30	\$10	\$35	\$60	\$70	\$50 <sup>4</sup>
<b>Outpatient Services</b>										
Outpatient Surgery	35% coinsurance <sup>3</sup>	45% coinsurance <sup>3</sup>	\$600 / visit	\$750 / visit	\$600 / visit	50% coinsurance <sup>3,4</sup>	30% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>
Radiology Services (per visit, X-rays and diagnostic imaging)	\$60	\$55	\$55	\$55	\$55	\$55	\$55	\$55 <sup>4</sup>	\$55 <sup>4</sup>	50% coinsurance <sup>3,4</sup>
Advanced Radiology (per visit)	35% coinsurance <sup>3</sup>	\$150	\$175	\$150	\$150	\$300	\$175	\$335 <sup>4</sup>	\$370 <sup>4</sup>	50% coinsurance <sup>3,4</sup>
Physical, Occupational and Speech Therapy (per visit)	\$50	\$45	\$35	\$35	\$30	\$10	\$35	\$60	\$70	\$50 <sup>4</sup>
<b>Hospitalization Services</b>										
Inpatient	35% coinsurance <sup>3</sup>	45% coinsurance <sup>3</sup>	\$1,500 / admission	\$1,000 / day	\$1,000 / day	50% coinsurance <sup>3,4</sup>	30% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>
<b>Emergency / Urgent Care Services</b>										
Emergency Room (per visit, waived if admitted)	\$360	\$100	\$300	\$200	\$175	50% coinsurance <sup>3,4</sup>	\$200 <sup>4</sup>	\$540	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>
Urgent Care (per visit)	\$55	\$50	\$55	\$55	\$55	\$20	\$55	\$65	\$70	\$50 <sup>4</sup>
<b>Emergency Medical Transportation</b>										
Emergency Medical Transportation (in connection with hospital admission or emergency services)	\$250	\$100	\$200	\$200	\$175	50% coinsurance <sup>3,4</sup>	\$200 <sup>4</sup>	\$200 <sup>4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>
<b>Prescription Drug Coverage</b>										
Drugs Administered in a Practitioner's Office, Hospital or Outpatient Facility	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Preferred Generic / Preferred Brand / Non-Preferred / Specialty Medications up to 30-Day Supply	\$20 / \$50 / \$70 / 20% <sup>6</sup>	\$20 / \$35 / \$70 / 20% <sup>6</sup>	\$20 / \$35 / \$70 / 20% <sup>6</sup>	\$20 / \$35 / \$70 / 20% <sup>6</sup>	\$20 / \$35 <sup>4</sup> / \$50 <sup>4</sup> / 20% <sup>4,6</sup>	\$10 / \$40 / \$70 / 20% <sup>6</sup>	\$20 / \$35 <sup>4</sup> / \$70 <sup>4</sup> / 20% <sup>4,6</sup>	\$20 / \$145 <sup>4</sup> / \$155 <sup>4</sup> / 20% <sup>4,6</sup>	\$20 / \$175 / \$200 / 20% <sup>6</sup>	\$20 <sup>4</sup> / \$70 <sup>4</sup> / \$100 <sup>4</sup> / 50% <sup>4,7</sup>
Preferred Generic / Preferred Brand / Non-Preferred Medications up to 90-Day Supply by Mail Order	\$40 / \$100 / \$140	\$40 / \$70 / \$140	\$40 / \$70 / \$140	\$40 / \$70 / \$140	\$40 / \$70 / \$140	\$20 / \$80 / \$140	\$40 / \$70 <sup>4</sup> / \$140 <sup>4</sup>	\$40 / \$290 <sup>4</sup> / \$310 <sup>4</sup>	\$40 / \$350 / \$400	\$40 <sup>4</sup> / \$140 <sup>4</sup> / \$200 <sup>4</sup>
Preferred Generic and Over-the-Counter Contraceptives for Women	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
<b>Durable Medical Equipment and Other Supplies</b>										
Durable Medical Equipment	50% coinsurance <sup>3</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>				
Diabetic Supplies	20% coinsurance <sup>3</sup>	20% coinsurance <sup>3</sup>	20% coinsurance <sup>3</sup>	20% coinsurance <sup>3</sup>	20% coinsurance <sup>3</sup>	50% coinsurance <sup>3,4</sup>				
Prosthetics and Orthotics (per visit)	\$55	\$50	\$55	\$55	\$55	\$20	\$55	\$65	\$70	\$50 <sup>4</sup>
<b>Mental Health Services</b>										
Outpatient Office Visit	\$50 / visit	\$45 / visit	\$35 / visit	\$35 / visit	\$30 / visit	\$10 / visit	\$35 / visit	\$60 / visit	\$70 / visit	\$0 <sup>4</sup>
Inpatient	35% coinsurance <sup>3</sup>	45% coinsurance <sup>3</sup>	\$750 / admission	\$90 / day	\$90 / day	50% coinsurance <sup>3,4</sup>	30% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>
<b>Chemical Dependency Services</b>										
Outpatient Office Visit	\$50 / visit	\$45 / visit	\$35 / visit	\$35 / visit	\$30 / visit	\$10 / visit	\$35 / visit	\$60 / visit	\$66 / visit	\$0 <sup>4</sup>
Inpatient	35% coinsurance <sup>3</sup>	45% coinsurance <sup>3</sup>	\$750 / admission	\$90 / day	\$90 / day	50% coinsurance <sup>3,4</sup>	30% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>
Emergency Services for Acute Drug or Alcohol Detoxification	\$360 / visit	\$100 / visit	\$300 / visit	\$200 / visit	\$175 / visit	50% coinsurance <sup>3,4</sup>	\$200 / visit <sup>4</sup>	\$540 / visit <sup>4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>
<b>Other</b>										
Skilled Nursing Facility Services (maximum of 100 days per benefit period)	35% coinsurance <sup>3</sup>	\$20 / day	\$175 / admission	\$150 / admission	\$25 / day	50% coinsurance <sup>3,4</sup>	30% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>
Home Health Services (maximum of 100 visits per calendar year)	\$50 / visit	\$45 / visit	\$35 / visit	\$35 / visit	\$30 / visit	\$10 / visit	\$35 / visit	\$60 / visit	\$70 / visit	\$50 / visit <sup>4</sup>
Hospice Care - Inpatient	\$150 / day	\$150 / day	\$0 / admission	\$150 / admission	\$150 / day	\$0 / admission <sup>4</sup>	30% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>	\$0 / admission <sup>4</sup>	\$0 / admission <sup>4</sup>
Hospice Care - Outpatient (per visit)	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0 <sup>4</sup>

<sup>1</sup> Copayments and deductibles for supplemental benefits (assisted reproductive technologies, chiropractic services, adult vision) do not apply to the annual out-of-pocket maximum.  
<sup>2</sup> Includes preventive services with a rating of A or B from the U.S. Preventive Services Task Force; immunizations for children, adolescents and adults recommended by the Centers for Disease Control and Prevention; 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.

<sup>3</sup> Of contracted rates. <sup>4</sup> Deductible applies. <sup>5</sup> Individuals enrolled in a family plan will reach the annual deductible maximum if the member meets the individual deductible maximum amount or if any combination of enrolled family members meets the family deductible maximum amount, whichever comes first. <sup>6</sup> Up to \$250 per 30-day supply. <sup>7</sup> Up to \$500 per 30-day supply  
 Note: Infertility Treatment and Diagnosis, Artificial Insemination, and Assisted Reproductive Technologies (ART) benefits available upon request; ask your Sharp Health Plan sales representative or account manager for a quote.

# Platinum 90 / Gold 80 / Silver 70 / Bronze 60 WOW Plans

effective January 1, 2026

	Platinum HMO NG WOW 1	Gold HMO NG WOW 1	Silver HMO NG WOW 1	Bronze HMO NG WOW 1
<b>Deductibles</b>				
Calendar Year Deductible (per individual / per family; applies only to those covered benefits indicated)	\$0	\$500 <sup>5</sup> / \$1,000 <sup>5</sup>	\$2,500 <sup>5</sup> / \$5,000 <sup>5</sup>	\$7,000 <sup>5</sup> / \$14,000 <sup>5</sup>
Calendar Year Deductible (per individual / per family for covered prescription drugs (preferred and non-preferred))	None	None	\$400 / \$800	\$500 / \$1,000
<b>Maximums</b>				
There are no lifetime maximums for this plan	Unlimited	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Maximum, Including Deductible (per individual / per family)	\$4,050 <sup>1</sup> / \$8,100 <sup>1</sup>	\$9,950 <sup>1</sup> / \$19,900 <sup>1</sup>	\$9,950 <sup>1</sup> / \$19,900 <sup>1</sup>	\$9,950 <sup>1</sup> / \$19,900 <sup>1</sup>
<b>Professional Services (per visit)</b>				
Primary Care Physician Office Visit (for consultation, treatment, diagnostic testing, etc.)	\$30	\$65	\$70	\$70 <sup>4,6</sup>
Specialist Physician Office Visit (for consultation, treatment, diagnostic testing, etc.)	\$60	\$65	\$70	\$70 <sup>4,6</sup>
Preventive Services <sup>2</sup>	\$0	\$0	\$0	\$0
Prenatal and Postpartum Office Visits	\$0	\$0	\$0	\$0
Allergy Testing	\$60	\$65	\$70	\$70 <sup>4,6</sup>
Allergy Injections	\$30	\$65	\$70	\$70 <sup>4,6</sup>
<b>Outpatient Services</b>				
Outpatient Surgery	\$400 / visit	35% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>
Radiology Services (per visit, X-rays and diagnostic imaging)	\$30	\$65	\$70 <sup>4</sup>	\$90 <sup>4</sup>
Advanced Radiology (per visit)	\$250	\$300	\$400 <sup>4</sup>	\$500 <sup>4</sup>
Physical, Occupational and Speech Therapy (per visit)	\$30	\$65	\$70	\$70 <sup>4</sup>
<b>Hospitalization Services</b>				
Inpatient	\$500 / day (5-day max)	\$900 / day (5-day max) <sup>4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>
<b>Emergency / Urgent Care Services</b>				
Emergency Room (per visit, waived if admitted)	\$225	\$350 <sup>4</sup>	\$600 <sup>4</sup>	50% coinsurance <sup>3,4</sup>
Urgent Care (per visit)	\$60	\$65	\$70	\$70 <sup>4,6</sup>
<b>Emergency Medical Transportation</b>				
Emergency Medical Transportation (in connection with hospital admission or emergency services)	\$100	\$200	\$200 <sup>4</sup>	50% coinsurance <sup>3,4</sup>
<b>Prescription Drug Coverage</b>				
Drugs Administered in a Practitioner's Office, Hospital or Outpatient Facility	\$0	\$0	\$0	\$0
Preferred Generic / Preferred Brand / Non-Preferred / Specialty Medications up to 30-Day Supply	\$10 / \$30 / \$50 / 20% <sup>8</sup>	\$20 / \$50 / \$75 / 30% <sup>8</sup>	\$20 / \$90 <sup>4</sup> / \$120 <sup>4</sup> / 40% <sup>4,8</sup>	\$20 <sup>4</sup> / 50% <sup>3,4,7</sup> / 50% <sup>3,4,7</sup> / 50% <sup>3,4,7</sup>
Preferred Generic / Preferred Brand / Non-Preferred Medications up to 90-Day Supply by Mail Order	\$20 / \$60 / \$100	\$40 / \$100 / \$150	\$40 / \$180 <sup>4</sup> / \$240 <sup>4</sup>	\$40 <sup>4</sup> / 50% <sup>3,4,7</sup> / 50% <sup>3,4,7</sup>
Preferred Generic and Over-the-Counter Contraceptives for Women	\$0	\$0	\$0	\$0
<b>Durable Medical Equipment and Other Supplies</b>				
Durable Medical Equipment	50% coinsurance <sup>3</sup>	50% coinsurance <sup>3</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>
Diabetic Supplies	20% coinsurance <sup>3</sup>	20% coinsurance <sup>3</sup>	20% coinsurance <sup>3,4</sup>	20% coinsurance <sup>3,4</sup>
Prosthetics and Orthotics (per visit)	\$60	\$65	\$70	\$70 <sup>4</sup>
<b>Mental Health Services</b>				
Outpatient Office Visit	\$30 / visit	\$65 / visit	\$70 / visit	\$70 / visit <sup>4,6</sup>
Inpatient	\$500 / day (5-day max)	\$900 / day (5-day max) <sup>4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>
<b>Chemical Dependency Services</b>				
Outpatient Office Visit	\$30 / visit	\$65 / visit	\$70 / visit	\$70 / visit <sup>4,6</sup>
Inpatient	\$500 / day (5-day max)	\$900 / day (5-day max) <sup>4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>
Emergency Services for Acute Drug or Alcohol Detoxification (waived if admitted)	\$225 / visit	\$350 <sup>4</sup>	\$600 <sup>4</sup>	50% coinsurance <sup>3,4</sup>
<b>Other</b>				
Skilled Nursing Facility Services (maximum of 100 days per benefit period)	\$100 / day (3-day max)	\$100 / day (3-day max) <sup>4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>
Home Health Services (maximum of 100 visits per calendar year)	\$30 / visit	\$65 / visit	\$70 / visit	\$70 / visit <sup>4</sup>
Hospice Care - Inpatient	\$100 / day (3-day max)	\$100 / day (3-day max) <sup>4</sup>	50% coinsurance <sup>3,4</sup>	50% coinsurance <sup>3,4</sup>
Hospice Care - Outpatient (per visit)	\$0	\$0	\$0	\$0

<sup>1</sup> Copayments and deductibles for supplemental benefits (assisted reproductive technologies, chiropractic services, adult vision) do not apply to the annual out-of-pocket maximum. <sup>2</sup> Includes preventive services with a rating of A or B from the U.S. Preventive Services Task Force; immunizations for children, adolescents and adults recommended by the Centers for Disease Control and Prevention; 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. <sup>3</sup> Of contracted rates <sup>4</sup> Deductible applies.

<sup>5</sup> Individuals enrolled in a family plan will reach the annual deductible maximum if the member meets the individual deductible maximum amount or if any combination of enrolled family members meets the family deductible maximum amount, whichever comes first. <sup>6</sup> Deductible applies after the first three non-preventive visits. <sup>7</sup> Member cost-share after deductible will not exceed \$500 per 30-day supply. <sup>8</sup> Up to \$250 per 30-day supply  
Note: Infertility Treatment and Diagnosis, Artificial Insemination, and Assisted Reproductive Technologies (ART) benefits available upon request; ask your Sharp Health Plan sales representative or account manager for a quote.

# Additional Platinum 90 / Gold 80 Plans\* effective January 1, 2026

	Sharp Platinum 90 HMO 0/15/10% + Child Dental	Sharp Platinum 90 HMO 0/20/250 + Child Dental	Sharp Gold 80 HMO 350/25/20% + Child Dental	Sharp Gold 80 HMO 250/35/600 + Child Dental
<b>Deductibles</b>				
Calendar Year Deductible (per individual / per family; applies only to those covered benefits indicated)	None	None	\$350 <sup>6</sup> / \$700 <sup>6</sup>	\$250 <sup>6</sup> / \$500 <sup>6</sup>
Calendar Year Deductible (per individual / per family for covered prescription drugs (preferred and non-preferred))	None	None	None	None
<b>Maximums</b>				
There are no lifetime maximums for this plan	Unlimited	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Maximum, Including Deductible (per individual / per family)	\$4,500 <sup>1</sup> / \$9,000 <sup>1</sup>	\$4,500 <sup>1</sup> / \$9,000 <sup>1</sup>	\$7,800 <sup>1</sup> / \$15,600 <sup>1</sup>	\$7,800 <sup>1</sup> / \$15,600 <sup>1</sup>
<b>Professional Services (per visit)</b>				
Primary Care Physician Office Visit (for consultation, treatment, diagnostic testing, etc.)	\$15	\$20	\$25	\$35
Specialist Physician Office Visit (for consultation, treatment, diagnostic testing, etc.)	\$30	\$30	\$50	\$55
Preventive Services <sup>2</sup>	\$0	\$0	\$0	\$0
Prenatal and Postpartum Office Visits	\$0	\$0	\$0	\$0
Allergy Testing	\$30	\$30	\$50	\$55
Allergy Injections	\$30	\$30	\$50	\$55
<b>Outpatient Services</b>				
Outpatient Surgery	10% coinsurance <sup>3</sup> / 10% coinsurance <sup>3</sup>	\$100 per visit / \$25 per visit	20% coinsurance <sup>3</sup> / 20% coinsurance <sup>3</sup>	\$300 per visit <sup>5</sup> / \$35 per visit
Radiology Services (per visit, X-rays and diagnostic imaging)	\$30 / visit	\$30 / visit	\$65 / visit	\$55 / visit
Advanced Radiology (per visit)	10% coinsurance <sup>3</sup>	\$100 / visit	20% coinsurance <sup>3</sup>	\$250 / visit <sup>5</sup>
Physical, Occupational and Speech Therapy (per visit)	\$15 / visit	\$20 / visit	\$25 / visit	\$35 / visit
<b>Hospitalization Services</b>				
Inpatient	10% coinsurance <sup>3</sup> / 10% coinsurance <sup>3</sup>	\$250 per day (5-day max) / \$0 per visit	20% coinsurance <sup>3</sup> / 20% coinsurance <sup>3</sup>	\$600 per day (5-day max) <sup>5</sup> / \$0 per visit
<b>Emergency / Urgent Care Services</b>				
Emergency Room (per visit, waived if admitted)	\$200 per visit / \$0	\$150 per visit / \$0	20% coinsurance <sup>3,5</sup> / \$0	\$250 per visit <sup>5</sup> / \$0
Urgent Care (per visit)	\$15	\$20	\$25	\$35
<b>Emergency Medical Transportation</b>				
Emergency Medical Transportation (in connection with hospital admission or emergency services)	\$150	\$150	20% coinsurance <sup>3,5</sup>	\$250 <sup>5</sup>
<b>Prescription Drug Coverage</b>				
Drugs Administered in a Practitioner's Office, Hospital or Outpatient Facility	\$0	\$0	\$0	\$0
Preferred Generic / Preferred Brand / Non-Preferred / Specialty Medications up to 30-Day Supply	\$10 / \$25 / \$40 / 10% <sup>4</sup>	\$5 / \$20 / \$30 / 10% <sup>4</sup>	\$15 / \$50 / \$80 / 20% <sup>4</sup>	\$15 / \$40 / \$70 / 20% <sup>4</sup>
Preferred Generic / Preferred Brand / Non-Preferred Medications up to 90-Day Supply by Mail Order	\$20 / \$50 / \$80	\$10 / \$40 / \$60	\$30 / \$100 / \$160	\$30 / \$80 / \$140
Preferred Generic and Over-the-Counter Contraceptives for Women	\$0	\$0	\$0	\$0
<b>Durable Medical Equipment and Other Supplies</b>				
Durable Medical Equipment	10% coinsurance <sup>3</sup>	10% coinsurance <sup>3</sup>	20% coinsurance <sup>3</sup>	20% coinsurance <sup>3</sup>
Diabetic Supplies	10% coinsurance <sup>3</sup>	10% coinsurance <sup>3</sup>	20% coinsurance <sup>3</sup>	20% coinsurance <sup>3</sup>
Prosthetics and Orthotics (per visit)	10% coinsurance <sup>3</sup>	10% coinsurance <sup>3</sup>	20% coinsurance <sup>3</sup>	20% coinsurance <sup>3</sup>
<b>Mental Health Services</b>				
Outpatient Office Visit	\$15 / visit	\$20 / visit	\$25 / visit	\$35 / visit
Inpatient	10% coinsurance <sup>3</sup> / 10% coinsurance <sup>3</sup>	\$250 per day (5-day max) / \$0 per visit	20% coinsurance <sup>3</sup> / 20% coinsurance <sup>3</sup>	\$600 per day (5-day max) <sup>5</sup> / \$0 per visit
<b>Chemical Dependency Services</b>				
Outpatient Office Visit	\$15 / visit	\$20 / visit	\$25 / visit	\$35 / visit
Inpatient	10% coinsurance <sup>3</sup> / 10% coinsurance <sup>3</sup>	\$250 per day (5-day max) / \$0 per visit	20% coinsurance <sup>3</sup> / 20% coinsurance <sup>3</sup>	\$600 per day (5-day max) <sup>5</sup> / \$0 per visit
Emergency Services for Acute Drug or Alcohol Detoxification	\$200 per visit / \$0	\$150 per visit / \$0	20% coinsurance <sup>3,5</sup> / \$0	\$250 per visit <sup>5</sup> / \$0
<b>Other</b>				
Skilled Nursing Facility Services (maximum of 100 days per benefit period)	10% coinsurance <sup>3</sup>	\$150 / day (5-day max)	20% coinsurance <sup>3,5</sup>	\$300 / day (5-day max) <sup>5</sup>
Home Health Services (maximum of 100 visits per calendar year)	10% coinsurance <sup>3</sup>	\$20 / visit	20% coinsurance <sup>3</sup>	\$30 / visit
Hospice Care - Inpatient	\$0 / admission	\$0 / admission	\$0 / admission	\$0 / admission
Hospice Care - Outpatient (per visit)	\$0	\$0	\$0	\$0

\* These plans are also available through Covered California™ on either the Performance or Premier network only, and plan copays on Plans available through Covered California might vary slightly.  
<sup>1</sup> Copayments and deductibles for supplemental benefits (assisted reproductive technologies, chiropractic services, adult vision) do not apply to the annual out-of-pocket maximum. <sup>2</sup> Includes preventive services with a rating of A or B from the U.S. Preventive Services Task Force; immunizations for children, adolescents and adults recommended by the Centers for Disease Control and Prevention; 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. <sup>3</sup> Of contracted rates. <sup>4</sup> Up to \$250 per 30-day supply.

<sup>5</sup> Deductible applies. <sup>6</sup> Individuals enrolled in a family plan will reach the annual deductible maximum if the member meets the individual deductible maximum amount or if any combination of enrolled family members meets the family deductible maximum amount, whichever comes first.  
 Note: Infertility Treatment and Diagnosis, Artificial Insemination, and Assisted Reproductive Technologies (ART) benefits available upon request; ask your Sharp Health Plan sales representative or account manager for a quote.

# Additional Silver 70 / Bronze 60 Plans\* effective January 1, 2026

	Sharp Silver 70 HMO 2500/55/35% + Child Dental	Sharp Silver 70 HMO 2500/55/35% - 300	Sharp Silver 70 HDHP HMO 3200/25%/25%	Sharp Bronze 60 HMO 5800/60/40% + Child Dental	Sharp Bronze 60 HDHP HMO 7200/0/0
<b>Deductibles</b>					
Calendar Year Deductible (per individual / per family; applies only to those covered benefits indicated)	\$2,500 <sup>6</sup> / \$5,000 <sup>6</sup>	\$2,500 <sup>6</sup> / \$5,000 <sup>6</sup>	\$3,200 <sup>4</sup> / \$6,400 <sup>4</sup>	\$5,800 <sup>6</sup> / \$11,600 <sup>6</sup>	\$7,200 <sup>4</sup> / \$14,400 <sup>4</sup>
Calendar Year Deductible (per individual / per family for covered prescription drugs (preferred and non-preferred))	\$300 / \$600	\$300 / \$600	Integrated	\$450 / \$900	Integrated
<b>Maximums</b>					
There are no lifetime maximums for this plan	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Annual Out-of-Pocket Maximum, Including Deductible (per individual / per family)	\$8,600 <sup>1</sup> / \$17,200 <sup>1</sup>	\$8,750 <sup>1</sup> / \$17,500 <sup>1</sup>	\$8,300 <sup>1</sup> / \$16,600 <sup>1</sup>	\$9,800 <sup>1</sup> / \$19,600 <sup>1</sup>	\$7,200 <sup>1</sup> / \$14,400 <sup>1</sup>
<b>Professional Services (per visit)</b>					
Primary Care Physician Office Visit (for consultation, treatment, diagnostic testing, etc.)	\$55	\$55	25% coinsurance <sup>3,5</sup>	\$60	\$0 <sup>5</sup>
Specialist Physician Office Visit (for consultation, treatment, diagnostic testing, etc.)	\$90	\$90	25% coinsurance <sup>3,5</sup>	\$95 <sup>5,7</sup>	\$0 <sup>5</sup>
Preventive Services <sup>2</sup>	\$0	\$0	\$0	\$0	\$0
Prenatal and Postpartum Office Visits	\$0	\$0	\$0	\$0	\$0
Allergy Testing	\$90	\$90	25% coinsurance <sup>3,5</sup>	\$95 <sup>5</sup>	\$0 <sup>5</sup>
Allergy Injections	\$90	\$90	25% coinsurance <sup>3,5</sup>	\$95 <sup>5</sup>	\$0 <sup>5</sup>
<b>Outpatient Services</b>					
Outpatient Surgery	35% coinsurance <sup>3,5</sup> / 35% coinsurance <sup>3</sup>	35% coinsurance <sup>3,5</sup> / 35% coinsurance <sup>3</sup>	25% coinsurance <sup>3,5</sup> / 25% coinsurance <sup>3,5</sup>	40% coinsurance <sup>3,5</sup> / 40% coinsurance <sup>3,5</sup>	\$0 <sup>5</sup> / \$0 <sup>5</sup>
Radiology Services (per visit, X-rays and diagnostic imaging)	\$90 / visit	\$90 / visit	25% coinsurance <sup>3,5</sup>	40% coinsurance <sup>3,5</sup>	\$0 <sup>5</sup>
Advanced Radiology (per visit)	35% coinsurance <sup>3,5</sup>	\$300 / visit <sup>5</sup>	25% coinsurance <sup>3,5</sup>	40% coinsurance <sup>3,5</sup>	\$0 <sup>5</sup>
Physical, Occupational and Speech Therapy (per visit)	\$55 / visit	\$55 / visit	25% coinsurance <sup>3,5</sup>	\$60 / visit	\$0 <sup>5</sup>
<b>Hospitalization Services</b>					
Inpatient	35% coinsurance <sup>3,5</sup> / 35% coinsurance <sup>3,5</sup>	35% coinsurance <sup>3,5</sup> / 35% coinsurance <sup>3,5</sup>	25% coinsurance <sup>3,5</sup> / 25% coinsurance <sup>3,5</sup>	40% coinsurance <sup>3,5</sup> / 40% coinsurance <sup>3,5</sup>	\$0 <sup>5</sup> / \$0 <sup>5</sup>
<b>Emergency / Urgent Care Services</b>					
Emergency Room (per visit, waived if admitted)	35% coinsurance <sup>3,5</sup> / \$0	35% coinsurance <sup>3,5</sup> / \$0	25% coinsurance <sup>3,5</sup> / \$0 <sup>5</sup>	40% coinsurance <sup>3,5</sup> / 0% coinsurance	\$0 <sup>5</sup> / \$0 <sup>5</sup>
Urgent Care (per visit)	\$55	\$55	25% coinsurance <sup>3,5</sup>	\$60	\$0 <sup>5</sup>
<b>Emergency Medical Transportation</b>					
Emergency Medical Transportation (in connection with hospital admission or emergency services)	35% coinsurance <sup>3,5</sup>	35% coinsurance <sup>3,5</sup>	25% coinsurance <sup>3,5</sup>	40% coinsurance <sup>3,5</sup>	\$0 <sup>5</sup>
<b>Prescription Drug Coverage</b>					
Drugs Administered in a Practitioner's Office, Hospital or Outpatient Facility	\$0	\$0	\$0	\$0	\$0
Preferred Generic / Preferred Brand / Non-Preferred / Specialty Medications up to 30-Day Supply	\$20 / \$75 <sup>5</sup> / \$105 <sup>5</sup> / 30% <sup>5,8</sup>	\$19 / \$85 <sup>5</sup> / \$110 <sup>5</sup> / 30% <sup>5,8</sup>	25% coinsurance <sup>3,5,8</sup>	\$20 / 40% <sup>3,5,9</sup> / 40% <sup>3,5,9</sup> / 40% <sup>3,5,9</sup>	\$0 <sup>5</sup> / \$0 <sup>5</sup> / \$0 <sup>5</sup> / \$0 <sup>5</sup>
Preferred Generic / Preferred Brand / Non-Preferred Medications up to 90-Day Supply by Mail Order	\$40 / \$150 <sup>5</sup> / \$210 <sup>5</sup>	\$38 / \$170 <sup>5</sup> / \$220 <sup>5</sup>	25% coinsurance <sup>3,5,8</sup>	\$40 / 40% <sup>3,5,9</sup> / 40% <sup>3,5,9</sup>	\$0 <sup>5</sup> / \$0 <sup>5</sup> / \$0 <sup>5</sup> / \$0 <sup>5</sup>
Preferred Generic and Over-the-Counter Contraceptives for Women	\$0	\$0	\$0	\$0	\$0
<b>Durable Medical Equipment and Other Supplies</b>					
Durable Medical Equipment	35% coinsurance <sup>3</sup>	35% coinsurance <sup>3</sup>	25% coinsurance <sup>3,5</sup>	40% coinsurance <sup>3,5</sup>	\$0 <sup>5</sup>
Diabetic Supplies	35% coinsurance <sup>3</sup>	35% coinsurance <sup>3</sup>	25% coinsurance <sup>3,5</sup>	40% coinsurance <sup>3,5</sup>	\$0 <sup>5</sup>
Prosthetics and Orthotics (per visit)	35% coinsurance <sup>3</sup>	35% coinsurance <sup>3</sup>	25% coinsurance <sup>3,5</sup>	40% coinsurance <sup>3,5</sup>	\$0 <sup>5</sup>
<b>Mental Health Services</b>					
Outpatient Office Visit	\$55 / visit	\$55 / visit	25% coinsurance <sup>3,5</sup>	\$60 / visit	\$0 / visit <sup>5</sup>
Inpatient	35% coinsurance <sup>3,5</sup> / 35% coinsurance <sup>3,5</sup>	35% coinsurance <sup>3,5</sup> / 35% coinsurance <sup>3,5</sup>	25% coinsurance <sup>3,5</sup> / 25% coinsurance <sup>3,5</sup>	40% coinsurance <sup>3,5</sup> / 40% coinsurance <sup>3,5</sup>	\$0 <sup>5</sup> / \$0 <sup>5</sup>
<b>Chemical Dependency Services</b>					
Outpatient Office Visit	\$55 / visit	\$55 / visit	25% coinsurance <sup>3,5</sup>	\$60 / visit	\$0 / visit <sup>5</sup>
Inpatient	35% coinsurance <sup>3,5</sup> / 35% coinsurance <sup>3,5</sup>	35% coinsurance <sup>3,5</sup> / 35% coinsurance <sup>3,5</sup>	25% coinsurance <sup>3,5</sup> / 25% coinsurance <sup>3,5</sup>	40% coinsurance <sup>3,5</sup> / 40% coinsurance <sup>3,5</sup>	\$0 <sup>5</sup> / \$0 <sup>5</sup>
Emergency Services for Acute Drug or Alcohol Detoxification	35% coinsurance <sup>3,5</sup> / \$0	35% coinsurance <sup>3,5</sup> / \$0	25% coinsurance <sup>3,5</sup> / \$0 <sup>5</sup>	40% coinsurance <sup>3,5</sup> / 0% coinsurance	\$0 <sup>5</sup> / \$0 <sup>5</sup>
<b>Other</b>					
Skilled Nursing Facility Services (maximum of 100 days per benefit period)	35% coinsurance <sup>3,5</sup>	35% coinsurance <sup>3,5</sup>	25% coinsurance <sup>3,5</sup>	40% coinsurance <sup>3,5</sup>	\$0 <sup>5</sup>
Home Health Services (maximum of 100 visits per calendar year)	35% coinsurance <sup>3</sup>	\$45 / visit	25% coinsurance <sup>3,5</sup>	40% coinsurance <sup>3,5</sup>	\$0 <sup>5</sup>
Hospice Care - Inpatient	\$0 / admission	\$0 / admission	\$0 / admission <sup>5</sup>	\$0 / admission	\$0 / admission <sup>5</sup>
Hospice Care - Outpatient (per visit)	\$0	\$0	\$0 <sup>5</sup>	\$0	\$0 <sup>5</sup>

\*These plans are also available through Covered California on either the Performance or Premier network only, and plan copays on Plans available through Covered California might vary slightly.  
<sup>1</sup> Copayments and deductibles for supplemental benefits (assisted reproductive technologies, chiropractic services, adult vision) do not apply to the annual out-of-pocket maximum.  
<sup>2</sup> Includes preventive services with a rating of A or B from the U.S. Preventive Services Task Force; immunizations for children, adolescents and adults recommended by the Centers for Disease Control and Prevention; 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. <sup>3</sup> Of contracted rates.

<sup>4</sup> In high-deductible health plans (HDHPs) linked to health savings accounts (HSAs), each individual in a family plan must meet an amount of either \$3,300 or the individual deductible, whichever is higher, until the family deductible is met. <sup>5</sup> Deductible applies. <sup>6</sup> Individuals enrolled in a family plan will reach the annual deductible maximum if the member meets the individual deductible maximum amount or if any combination of enrolled family members meets the family deductible maximum amount, whichever comes first. <sup>7</sup> Deductible applies after the first three non-preventive visits. <sup>8</sup> Up to \$250 per 30-day supply after pharmacy or integrated deductible. <sup>9</sup> Member cost-share after deductible will not exceed \$500 per 30-day supply. Note: Infertility Treatment and Diagnosis, Artificial Insemination, and Assisted Reproductive Technologies (ART) benefits available upon request; ask your Sharp Health Plan sales representative or account manager for a quote.

# Elite-rated health care

Sharp Health Plan has a family of health care providers close to where you live and work. In addition to our other regional partners, we offer affordable access to Sharp's award-winning medical groups, Sharp Rees-Stealy Medical Group and Sharp Community Medical Group. Both have been awarded "Elite" status, the highest possible rating for Standards of Excellence.<sup>1</sup> Providers are located throughout San Diego County, so no matter where you are, from Chula Vista to El Cajon to Del Mar, we've got you covered.



**2,700+ Doctors<sup>2</sup>**



**13 Hospitals<sup>2</sup>**



**10 Plan medical groups<sup>2</sup>**



**45+ Urgent care centers<sup>2</sup>**



**Large behavioral health network**



**MinuteClinic locations nationwide**

<sup>1</sup> Recipients of "Elite" status in the 2024 Standards of Excellence™ program by America's Physician Groups.

<sup>2</sup> The data shown here reflects the Choice Network as of September 2025. Coverage area includes but is not limited to the locations in this document. Service area does not include all San Diego County ZIP codes. Location of employer group headquarters must be within the Choice Network licensed service area.

# Supplemental benefits available with every plan

All plans include pediatric vision and dental benefits for members up to age 19.

<b>Chiropractic Services: American Specialty Health (ASH) Plans</b>	
CH5_40	\$5 per visit / 40 visits per year
CHB	\$10 per visit / 30 visits per year
CHD	\$10 per visit / 20 visits per year
<b>Acupuncture Services: ASH Plans</b>	
AC10_20	\$10 per visit / 20 visits per year
AC10_15	\$10 per visit / 15 visits per year
AC10_12	\$10 per visit / 12 visits per year
AC15_20	\$15 per visit / 20 visits per year
AC15_15	\$15 per visit / 15 visits per year
AC15_12	\$15 per visit / 12 visits per year
<b>Chiropractic + Acupuncture Services: ASH Plans</b>	
ACCH5_40	\$5 per visit / 40 visits per year
ACCH10_40	\$10 per visit / 40 visits per year
ACCH10_20	\$10 per visit / 20 visits per year
ACCH10_15	\$10 per visit / 15 visits per year
ACCH10_12	\$10 per visit / 12 visits per year
ACCH15_20	\$15 per visit / 20 visits per year
ACCH15_15	\$15 per visit / 15 visits per year
ACCH15_12	\$15 per visit / 12 visits per year
<b>Vision Services: Vision Service Plan (VSP)</b>	
VSOE	<p>\$10 per visit</p> <p>Eye exam: 1 every 12 months            Frames: 1 every 24 months            Lenses: 1 every 12 months</p>



# Network comparison

At Sharp Health Plan, we offer four provider networks to deliver cost-effective solutions to meet the unique needs of every employer. With a total of more than 2,700 doctors across our networks, we have an option that's right for you.<sup>1</sup> Participating physicians are subject to change; for the most current information, please visit [sharphealthplan.com/findadoctor](http://sharphealthplan.com/findadoctor).

Premier Network	Performance Network	Value Network	Choice Network
<p>A smaller, more select network offering the most value. This network covers a subset of San Diego County.</p> <ul style="list-style-type: none"> <li>• 1,300+ doctors</li> <li>• 10 hospitals</li> <li>• 2 medical groups</li> <li>• 25+ urgent care centers</li> <li>• 480+ pharmacies</li> </ul>	<p>An affordable network in San Diego County offering more choice for people living or working in the North County area.</p> <ul style="list-style-type: none"> <li>• 2,300+ doctors</li> <li>• 13 hospitals</li> <li>• 7 medical groups</li> <li>• 40 urgent care centers</li> <li>• 480+ pharmacies</li> </ul>	<p>A large network in San Diego County. This network is devoted to giving you the best possible care, service and value.</p> <ul style="list-style-type: none"> <li>• 2,500+ doctors</li> <li>• 13 hospitals</li> <li>• 9 medical groups</li> <li>• 40 urgent care centers</li> <li>• 460+ pharmacies</li> </ul>	<p>A broad network offering greater choice and covering all of San Diego County and southern Riverside County.</p> <ul style="list-style-type: none"> <li>• 2,700+ doctors</li> <li>• 13 hospitals</li> <li>• 10 medical groups</li> <li>• 45+ urgent care centers</li> <li>• 480+ pharmacies</li> </ul>



## Plan medical groups

Sharp Rees-Stealy Medical Group	●	●	●	●
Sharp Community Medical Group	●	●	●	●
SCMG Graybill		●	●	●
SCMG Palomar Health Medical Group		●	●	●
SCMG Graybill Temecula		●	●	●
Sharp Community Medical Group Inland North		●	●	●
Rady Children's Health Network		●	●	●
Greater Tri-Cities IPA			●	●
Optum Care Network–North County SD*			●	●
Independent Network				●



## Hospitals<sup>2</sup>

Sharp Chula Vista Medical Center	●	●	●	●
Sharp Coronado Hospital and Healthcare Center	●	●	●	●
Sharp Grossmont Hospital	●	●	●	●
Sharp Mary Birch Hospital for Women & Newborns	●	●	●	●
Sharp Memorial Hospital	●	●	●	●
Palomar Medical Center Escondido	●	●	●	●
Palomar Medical Center Poway	●	●	●	●
Rady Children's Hospital (2 locations)	●	●	●	●
Temecula Valley Hospital	●	●	●	●
Tri-City Medical Center		●	●	●
Southwest Healthcare–Inland Valley Medical Center		●	●	●
Southwest Healthcare–Rancho Springs Medical Center		●	●	●



## Pharmacies

Albertsons® / Sav-on® Pharmacy	●	●	●	●
Costco® Pharmacy	●	●	●	●
CVS Pharmacy locations, including those at Target®	●	●	●	●
Ralphs® Pharmacy	●	●	●	●
Sharp Rees-Stealy Pharmacy	●	●	●	●
Vons® / Safeway® Pharmacy	●	●	●	●
Walgreens® Pharmacy	●	●	●	●
Walmart® Pharmacy	●	●	●	●
Independently contracted neighborhood pharmacies	●	●	●	●

\*Primary Care Associates Medical Group is now Optum Care Network–North County SD.

<sup>1</sup> The data shown here reflects the Network information as of September 2025. Coverage area includes but is not limited to the locations in this document. Service area does not include all San Diego County ZIP codes. Employer group headquarters location must be within the network service area. To see if your business qualifies for this product at the preferred premium rates, please ensure that your company is headquartered within the network service area.

<sup>2</sup> Acute care facility locations only. The network also includes Sharp Mesa Vista Hospital and Sharp McDonald Center.





# SHARP Health Plan

Consider us your personal health care assistant®

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