Platinum HMO NG 3

Summary of Benefits

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN 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.

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\$100

Non-emergency medical transportation

Summary of Benefits

Covered Benefits Copayments Maternity Care

Maternity Care	
Prenatal and postpartum office visits	\$0
Delivery and all inpatient services - Hospital	\$500 / day (3-day max)
Delivery and all inpatient services - Professional	\$0
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	variable ⁴
Interruption of pregnancy	variable ⁴
Durable Medical Equipment and Other Supplies	
Durable medical equipment	50% coinsurance ⁵
Diabetic supplies	20% coinsurance ⁵
Prosthetics and orthotics	\$30 / visit
Mental Health Services ⁶	
Office visits	\$20 / visit
Group therapy	\$20 / visit
Other outpatient items and services	\$20 / visit
Inpatient facility fee	\$250 / day (3-day max)
Inpatient physician fee	\$0
Emergency services facility fee (waived if admitted)	\$100 / visit
Emergency services physician fee (waived if admitted)	\$0
Emergency psychiatric transportation	\$100
Non-emergency psychiatric transportation	\$100
Urgent care services	\$30 / visit
Substance Use Disorder Services ⁶	
Office visits	\$20 / visit
Group therapy	\$7 / visit
Other outpatient items and services	\$20 / visit
Inpatient facility fee	\$250 / day (3-day max)
Inpatient physician fee	\$0
Emergency services facility fee for alcohol or drug detoxification (waived if admitted)	\$100 / visit
Emergency services physician fee for alcohol or drug detoxification (waived if admitted)	\$0
Emergency substance use disorder transportation	\$100
Non-emergency substance use disorder transportation	\$100
Urgent care services	\$30 / visit
Skilled Nursing, Home Health and Hospice Services	
Skilled nursing facility services (maximum of 100 days per benefit period)	\$100 / day (3-day max)
Home health services (cost share per visit - maximum of 100 visits per calendar year)	\$20 / visit
Hospice care - inpatient	\$500 / day (3-day max)
Hospice care - outpatient	\$0
Pediatric Vision Services	
Eye Exam	\$0
Glasses or contact lenses in lieu of glasses	1 pair/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 applicable cost-sharing information.



Summary of Benefits

Covered Benefits Copayments

Prescription Drug Coverage ⁷	
Preferred Generic/Preferred Brand/Non-preferred medications up to 30 day supply	\$16 / \$35 / \$70
Preferred Generic/Preferred Brand/Non-preferred medications for a 90 day supply by mail order (for maintenance medications only)	\$32 / \$70 / \$140
Preventive prescription drugs including Preferred Generic and prescribed over-the-counter contraceptives	\$0

Notes

¹In a family plan, an individual is responsible only for the single out-of-pocket maximum amount. Cost sharing payments (copayments and coinsurance, but not premiums) made by each individual in a family contribute to the family out-of-pocket maximum. 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 out-of-pocket maximum. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out of pocket maximum.

²Includes 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.

⁴Out of pocket cost is based on type and location of service (e.g. outpatient surgery cost-share for outpatient surgery or specialist office visit cost-share for a service received during a specialist office visit).

⁵Of contracted rates

⁶All medically necessary treatment of mental health and substance use disorders is covered under this plan.

⁷Member 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.

