

Summary of Benefits

Covered California Sharp Gold 80 Performance HMO

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 WWW.SHARPHALTHPLAN.COM TO VIEW THE MEMBER HANDBOOK.

Covered Benefits

Copayments

| Covered Benefits | Copayments |
|--|------------------------------|
| Annual Deductible for Specific Services | |
| There are no deductibles for the medical benefits, drugs, and dental coverage covered under this plan | \$0 |
| Annual Out of Pocket Maximum¹ | |
| Annual out of pocket maximum (per individual/per family) | \$7,800 / \$15,600 |
| Lifetime Maximum | |
| There are no lifetime maximums for this plan | Unlimited |
| Preventive Care² | |
| 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 HealthSM 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. | \$30 / visit |
| Specialist Physician office visit for consultation, treatment, diagnostic testing, etc. | \$65 / visit |
| Other Practitioner office visit, including acupuncture ³ | \$30 / visit |
| Laboratory tests and services | \$40 / visit |
| Radiology services (x-rays and diagnostic imaging) | \$75 / visit |
| Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT) | 20% coinsurance ⁴ |
| Allergy testing | \$65 / visit |
| Allergy injections | \$65 / visit |
| Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services) | |
| Outpatient facility fee | 20% coinsurance ⁴ |
| Outpatient Physician/Surgeon fee | 20% coinsurance ⁴ |
| Outpatient visit | 20% coinsurance ⁴ |
| Infusion therapy (including but not limited to chemotherapy) | 20% coinsurance ⁴ |
| Dialysis | 20% coinsurance ⁴ |
| Rehabilitation services: physical, occupational and speech therapy | \$30 / visit |
| Habilitation services | \$30 / visit |
| Radiation therapy | 20% coinsurance ⁴ |
| Hospitalization (including but not limited to inpatient services, organ transplant, and inpatient rehabilitation) | |
| Facility fee | 20% coinsurance ⁴ |
| Physician/surgeon fee | 20% coinsurance ⁴ |
| Emergency and Urgent Care Services | |
| Emergency room services (waived if admitted to the hospital) | \$350 / visit |
| Emergency room physician fee (waived if admitted to the hospital) | \$0 |
| Urgent care services | \$30 / visit |
| Medical Transportation | |
| Emergency medical transportation | \$250 |
| Non-emergency medical transportation | \$250 |

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Covered Benefits cont.

Copayments

Maternity Care

| | |
|--|------------------------------|
| Prenatal and postpartum office visits | \$0 |
| Delivery and all inpatient services - Hospital | 20% coinsurance ⁴ |
| Delivery and all inpatient services - Professional | 20% 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 | variable ⁵ |
| Interruption of pregnancy | variable ⁵ |

Durable Medical Equipment and Other Supplies

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|---------------------------|------------------------------|
| Durable medical equipment | 20% coinsurance ⁴ |
| Diabetic supplies | 20% coinsurance ⁴ |
| Prosthetics and orthotics | 20% coinsurance ⁴ |

Mental Health Services

Diagnosis and treatment of Severe Mental Illnesses for all members and Serious Emotional Disturbances for children, and any mental health condition identified as a "mental disorder" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV), are covered with the cost-sharing listed below.⁶

| | |
|---|------------------------------------|
| Office visits | \$30 / visit |
| Group therapy | \$30 / visit |
| Other outpatient items and services | 20% coinsurance up to \$30 / visit |
| Inpatient facility fee | 20% coinsurance ⁴ |
| Inpatient physician fee | 20% coinsurance ⁴ |
| Emergency services facility fee (waived if admitted) | \$350 / visit |
| Emergency services physician fee (waived if admitted) | \$0 |
| Emergency psychiatric transportation | \$250 |
| Non-emergency psychiatric transportation | \$250 |
| Urgent care services | \$30 / visit |

Chemical Dependency Services

| | |
|--|------------------------------------|
| Office visits | \$30 / visit |
| Group therapy | \$30 / visit |
| Other outpatient items and services | 20% coinsurance up to \$30 / visit |
| Inpatient facility fee | 20% coinsurance ⁴ |
| Inpatient physician fee | 20% coinsurance ⁴ |
| Emergency services facility fee for acute alcohol or drug detoxification (waived if admitted) | \$350 / visit |
| Emergency services physician fee for acute alcohol or drug detoxification (waived if admitted) | \$0 |
| Emergency substance use disorder transportation | \$250 |
| Non-emergency substance use disorder transportation | \$250 |
| Urgent care services | \$30 / visit |

Skilled Nursing, Home Health and Hospice Services

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|---|------------------------------|
| Skilled nursing facility services (maximum of 100 days per benefit period) | 20% coinsurance ⁴ |
| Home health services (cost share per visit - maximum of 100 visits per calendar year) | 20% coinsurance ⁴ |
| Hospice care - inpatient | \$0 |
| Hospice care - outpatient | \$0 |

Pediatric Vision Services

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|--|----------------------------------|
| 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 Access Dental. Please refer to the Access Dental schedule of benefits for the applicable cost-sharing information.

Summary of Benefits

Covered Benefits cont.

Copayments

Prescription Drug Coverage⁷

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|--|---|
| Tier 1: Most generic drugs and low cost preferred brands (30 day supply/90 day supply). | \$15 / \$30 |
| 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). | \$55 / \$110 |
| 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). | \$80 / \$160 |
| 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 (Up to \$250 per 30-day supply) |
| 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 yet 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 in-network services accumulate toward the 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.

⁴Of contracted rates

⁵Out 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).

⁶Severe Mental Illnesses include: schizophrenia, schizoaffective disorder, bi-polar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa and bulimia nervosa. A child with Serious Emotional Disturbances is as defined in the current Member Handbook. Other mental health conditions include conditions identified as "mental disorders" in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM IV).

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 short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program, partial hospitalization, and home-based behavioral health treatment for pervasive developmental disorder or autism. "Inpatient" cost-share applies to inpatient facility and physician services, mental health psychiatric observation and mental health crisis residential treatment.

Note: For "Chemical Dependency 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.