

Summary of Benefits

Covered California
Sharp Platinum 90 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 SHARPHALTHPLAN.COM TO VIEW THE MEMBER HANDBOOK.

Covered Benefits

Copayments

Annual Deductible for Specific Services

There are no deductibles for the medical benefits, pharmacy, and dental coverage under this plan \$0

Annual Out of Pocket Maximum¹

Annual out of pocket maximum (per individual/per family) \$4,500 / \$9,000

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 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. \$15 / visit

Specialist Physician office visit for consultation, treatment, diagnostic testing, etc. \$30 / visit

Other Practitioner office visit, including acupuncture³ \$15 / visit

Laboratory tests and services \$15 / visit

Radiology services (x-rays and diagnostic imaging) \$30 / visit

Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT) 10% coinsurance⁴

Allergy testing \$30 / visit

Allergy injections \$30 / visit

Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)

Outpatient surgery facility fee 10% coinsurance⁴

Outpatient Physician/Surgeon fee 10% coinsurance⁴

Outpatient visit 10% coinsurance⁴

Infusion therapy (including but not limited to chemotherapy) 10% coinsurance⁴

Dialysis 10% coinsurance⁴

Rehabilitation services: physical, occupational and speech therapy \$15 / visit

Habilitation services \$15 / visit

Radiation therapy 10% coinsurance⁴

Hospitalization (including but not limited to inpatient services, organ transplant, and inpatient rehabilitation)

Facility fee 10% coinsurance⁴

Physician/surgeon fee 10% coinsurance⁴

Emergency and Urgent Care Services

Emergency room facility fee (waived if admitted to the hospital) \$150 / visit

Emergency room physician fee (waived if admitted to the hospital) \$0

Urgent care services \$15 / visit

Medical Transportation

Emergency medical transportation \$150

Non-emergency medical transportation \$150

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Maternity Care

Prenatal and postpartum office visits	\$0
Delivery and all inpatient services - Hospital	10% coinsurance ⁴
Delivery and all inpatient services - Professional	10% 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

Durable medical equipment	10% coinsurance ⁴
Diabetic supplies	10% coinsurance ⁴
Prosthetics and orthotics	10% coinsurance ⁴

Mental Health Services⁶

Office visits	\$15 / visit
Group therapy	\$15 / visit
Other outpatient items and services	10% coinsurance up to \$15 / visit
Inpatient facility fee	10% coinsurance ⁴
Inpatient physician fee	10% coinsurance ⁴
Emergency services facility fee (waived if admitted)	\$150 / visit
Emergency services physician fee (waived if admitted)	\$0
Emergency psychiatric transportation	\$150
Non-emergency psychiatric transportation	\$150
Urgent care services	\$15 / visit

Substance Use Disorder Services⁶

Office visits	\$15 / visit
Group therapy	\$15 / visit
Other outpatient items and services	10% coinsurance up to \$15 / visit
Inpatient facility fee	10% coinsurance ⁴
Inpatient physician fee	10% coinsurance ⁴
Emergency services facility fee for alcohol or drug detoxification (waived if admitted)	\$150 / visit
Emergency services physician fee for alcohol or drug detoxification (waived if admitted)	\$0
Emergency substance use disorder transportation	\$150
Non-emergency substance use disorder transportation	\$150
Urgent care services	\$15 / visit

Skilled Nursing, Home Health and Hospice Services

Skilled nursing facility services (maximum of 100 days per benefit period)	10% coinsurance ⁴
Home health services (cost share per visit - maximum of 100 visits per calendar year)	10% coinsurance ⁴
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 Coverage⁷

Tier 1: Most generic drugs and low cost preferred brands (30 day supply/90 day supply).	\$5 / \$10
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).	\$15 / \$30
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).	\$25 / \$50
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).	10% coinsurance ⁴ (up to \$250 per 30-day supply)
Preventive prescription drugs including Preferred Generic and prescribed over-the-counter contraceptives	\$0

Notes

¹ In 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.

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 Out 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).

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

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.