

Summary of Benefits

Bronze HMO NG WOW 1

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.

Covered Benefits

Cost Share

Annual Deductible for Specific Services¹

| | |
|--|--------------------|
| Calendar year medical deductible (per individual/per family) - applies only to those covered benefits indicated | \$7,000 / \$14,000 |
| Calendar year pharmacy deductible (per individual/per family) - applies to covered preferred generic, preferred brand, and non-preferred drugs | \$500 / \$1,000 |
| Calendar year dental deductible (per individual/per family) | \$0 / \$0 |

Annual Out of Pocket Maximum^{1,2}

| | |
|--|--------------------|
| Annual out of pocket maximum (per individual/per family) | \$9,000 / \$18,000 |
|--|--------------------|

Lifetime Maximum

| | |
|--|-----------|
| There are no lifetime maximums for this plan | Unlimited |
|--|-----------|

Preventive Care³

| | |
|---|-----|
| 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

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|--|-----|
| 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. (deductible applies after first 3 non-preventive visits) | \$65 / visit ⁸ |
| Specialist Physician office visit for consultation, treatment, diagnostic testing, etc. (deductible applies after first 3 non-preventive visits) | \$65 / visit ⁸ |
| Other Practitioner office visit, including acupuncture (deductible applies after first 3 non-preventive visits) ⁴ | \$65 / visit ⁸ |
| Laboratory tests and services | \$15 / visit ⁸ |
| Radiology services (x-rays and diagnostic imaging) | \$90 / visit ⁸ |
| Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT) | \$450 / visit ⁸ |
| Allergy testing (deductible applies after first 3 non-preventive visits) | \$65 / visit ⁸ |
| Allergy injections (deductible applies after first 3 non-preventive visits) | \$65 / visit ⁸ |

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

| | |
|--|--------------------------------|
| Outpatient surgery facility fee | 50% coinsurance ^{5,8} |
| Outpatient Physician/Surgeon fee | 50% coinsurance ^{5,8} |
| Infusion therapy (including but not limited to chemotherapy) | variable ^{6,8} |
| Dialysis | \$0 ⁸ |
| Rehabilitation services: physical, occupational and speech therapy | \$65 / visit ⁸ |
| Habilitation services | \$65 / visit ⁸ |
| Radiation therapy | variable ^{6,8} |

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

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|-----------------------|--------------------------------|
| Facility fee | 50% coinsurance ^{5,8} |
| Physician/surgeon fee | 50% coinsurance ^{5,8} |

Emergency and Urgent Care Services

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|---|--------------------------------|
| Emergency room facility fee (waived if admitted to the hospital) | 50% coinsurance ^{5,8} |
| Emergency room physician fee (waived if admitted to the hospital) | \$0 ⁸ |
| Urgent care services (deductible applies after first 3 non-preventive visits) | \$65 / visit ⁸ |

Medical Transportation

| | |
|--------------------------------------|--------------------------------|
| Emergency medical transportation | 50% coinsurance ^{5,8} |
| Non-emergency medical transportation | 50% coinsurance ^{5,8} |

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Maternity Care

| | |
|--|--------------------------------|
| Prenatal and postpartum office visits | \$0 |
| Delivery and all inpatient services - Hospital | 50% coinsurance ^{5,8} |
| Delivery and all inpatient services - Professional | 50% coinsurance ^{5,8} |
| 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 | 50% coinsurance ^{5,8} |
| Diabetic supplies | 20% coinsurance ^{5,8} |
| Prosthetics and orthotics | \$65 / visit ⁸ |

Mental Health Services⁶

| | |
|--|---------------------------|
| Office visits (deductible applies after first 3 non-preventive visits) | \$65 / visit ⁸ |
| Group therapy (deductible applies after first 3 non-preventive visits) | \$65 / visit ⁸ |

| | |
|---|---|
| Other outpatient items and services | 50% coinsurance up to \$65 / visit ⁸ |
| Inpatient facility fee | 50% coinsurance ^{5,8} |
| Inpatient physician fee | 50% coinsurance ^{5,8} |
| Emergency services facility fee (waived if admitted) | 50% coinsurance ^{5,8} |
| Emergency services physician fee (waived if admitted) | \$0 ⁸ |
| Emergency psychiatric transportation | 50% coinsurance ^{5,8} |
| Non-emergency psychiatric transportation | 50% coinsurance ^{5,8} |
| Urgent care services (deductible applies after first 3 non-preventive visits) | \$65 / visit ⁸ |

Substance Use Disorder Services⁶

| | |
|--|---------------------------|
| Office visits (deductible applies after first 3 non-preventive visits) | \$65 / visit ⁸ |
| Group therapy (deductible applies after first 3 non-preventive visits) | \$7 / visit ⁸ |

| | |
|--|---|
| Other outpatient items and services | 50% coinsurance up to \$65 / visit ⁸ |
| Inpatient facility fee | 50% coinsurance ^{5,8} |
| Inpatient physician fee | 50% coinsurance ^{5,8} |
| Emergency services facility fee for alcohol or drug detoxification (waived if admitted) | 50% coinsurance ^{5,8} |
| Emergency services physician fee for alcohol or drug detoxification (waived if admitted) | \$0 ⁸ |
| Emergency substance use disorder transportation | 50% coinsurance ^{5,8} |
| Non-emergency substance use disorder transportation | 50% coinsurance ^{5,8} |
| Urgent care services (deductible applies after first 3 non-preventive visits) | \$65 / visit ⁸ |

Skilled Nursing, Home Health and Hospice Services

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|---|--------------------------------|
| Skilled nursing facility services (maximum of 100 days per benefit period) | 50% coinsurance ^{5,8} |
| Home health services (cost share per visit - maximum of 100 visits per calendar year) | \$65 / visit ⁸ |
| Hospice care - inpatient | 50% coinsurance ^{5,8} |
| 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 Delta Dental. Please refer to the Delta Dental schedule of benefits for the applicable cost-sharing information.

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Covered Benefits

Prescription Drug Coverage⁹

| | |
|--|---|
| Preferred Generic medications up to 30 day supply | \$16 ⁸ |
| Preferred Brand/Non-preferred medications up to 30 day supply | 50% coinsurance ^{5,8} (Up to \$500 per 30-day supply after pharmacy deductible) |
| Preferred Generic medications for a 90 day supply by mail order (for maintenance medications only) | \$32 ⁸ |
| Preferred Brand/Non-preferred medications for a 90 day supply by mail order (for maintenance medications only) | 50% coinsurance ^{5,8} (Up to \$500 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. For the Bronze plan, deductible is waived for first 3 non-preventive office or urgent care visits, including PCP, Specialist, Other Practitioner, and Outpatient Mental Health/Substance Abuse visits.² Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out of pocket maximum.

³ 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.

⁴ "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.

⁵ Of contracted rates

⁶ Out of pocket cost is based on type and location of services (e.g. outpatient surgery cost-share for outpatient surgery or specialist office visit cost-share for a service received during a specialist office visit).

⁷ All medically necessary treatment of mental health and substance use disorders is covered under this plan.

⁸ Deductible applies

⁹ 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.