# Summary of Benefits

**Sharp Performance Platinum 90 HMO 0/25 PCP + Child Dental**

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 EMPLOYERFOR SPECIFIC INFORMATION ON YOUR COVERAGE OR VISIT **SHARPHEALTHPLAN.COM** TO VIEW THE MEMBER HANDBOOK.

| Covered Benefits | Cost Share |
|---|---|
| **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 Maximum[1]** | |
| Annual out of pocket maximum (per individual/per family) | $5,000 / $10,000 |
| **Lifetime Maximum** | |
| There are no lifetime maximums for this plan | Unlimited |
| **Preventive Care[2]** | |
| 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. | $25 / visit |
| Specialist Physician office visit for consultation, treatment, diagnostic testing, etc. | $40 / visit |
| Other Practitioner office visit, including acupuncture[3] | $25 / visit |
| Laboratory tests and services | $25 / visit |
| Radiology services (x-rays and diagnostic imaging) | $45 / visit |
| Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT) | 15% coinsurance[4] |
| Allergy testing | $40 / visit |
| Allergy injections | $40 / visit |
| **Outpatient Services** (including but not limited to surgical, diagnostic and therapeutic services) | |
| Outpatient surgery facility fee | 10% coinsurance[4] |
| Outpatient Physician/Surgeon fee | 10% coinsurance[4] |
| Outpatient visit | 10% coinsurance[4] |
| Infusion therapy (including but not limited to chemotherapy) | 10% coinsurance[4] |
| Dialysis | 10% coinsurance[4] |
| Rehabilitation services: physical, occupational and speech therapy | $25 / visit |
| Habilitation services | $25 / visit |
| Radiation therapy | 10% coinsurance[4] |
| **Hospitalization** (including but not limited to inpatient services, organ transplant, and inpatient rehabilitation) | |
| Facility fee | 10% coinsurance[4] |
| Physician/surgeon fee | 10% coinsurance[4] |
| **Emergency and Urgent Care Services** | |
| Emergency room facility fee (waived if admitted to the hospital) | $250 / visit |
| Emergency room physician fee (waived if admitted to the hospital) | $0 |
| Urgent care services | $25 / 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** | |
| Contraceptives (including but not limited to all FDA-approved drugs, supplies, devices, implants, injections, and other products) | $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 |
| **Doula Services[7]** | |
| Prenatal and postpartum visits | $0 |
| **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 Services[5]** | |
| Office visits | $25 / visit |
| Group therapy | $25 / visit |
| Other outpatient items and services | 10% coinsurance up to $25 / visit |
| Inpatient facility fee | 10% coinsurance[4] |
| Inpatient physician fee | 10% coinsurance[4] |
| Emergency services facility fee (waived if admitted) | $250 / visit |
| Emergency services physician fee (waived if admitted) | $0 |
| Emergency psychiatric transportation | $150 |
| Non-emergency psychiatric transportation | $150 |
| Urgent care services | $25 / visit |
| **Substance Use Disorder Services[5]** | |
| Office visits | $25 / visit |
| Group therapy | $25 / visit |
| Other outpatient items and services | 10% coinsurance up to $25 / 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) | $250 / 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 | $25 / 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 (1 pair per year) or contact lenses in lieu of glasses | $0 |
| **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 Coverage[6,8]** | |
| Tier 1: Most generic drugs and low cost preferred brands (30 day supply/90 day supply). | $10 / $20 |
| 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). | $30 / $60 |
| 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). | $40 / $80 |
| Tier 4: 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 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] All medically necessary treatment of mental health and substance use disorders is covered under this plan.

[6] 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.

[7] Doula Services are covered up to the allowable visit limits at no charge for members enrolled in the Plan's Maternal Mental Health Case Management Program. This program is designed to assist mothers (prenatal, postpartum, and interpregnancy) with needs, such as understanding health care benefits, making appointments, and providing health plan and community resources. The Plan offers case management services to members who qualify, which includes members with a maternal mental health condition. Referrals are accepted from any source, including, but not limited to, treating providers (OB/GYN, PCP), members, and/or a facility utilization reviewer/case manager.

[8] Insulin prescription drug cost share will not exceed $35 for a 30 day supply on Tier 1 and Tier 2. At least one insulin for a given drug type in all forms and concentrations shall be on Tier 1 or Tier 2. If there is no Tier 1 or Tier 2 insulin prescription drug that is clinically appropriate, the Plan will limit the cost sharing for a higher tier drug to no more than $35 for a 30-day supply for an individual enrollee.

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.