## Summary of Benefits

### Sharp Platinum 90 HMO 0/20/250 + Child Dental (Pe/V/C)

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

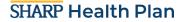
Annual out of pocket Maximum   Per Individual/per family  \$4,500 / \$9,0   Intelligent Maximum   Per Individual/per family  \$4,500 / \$9,0   Individual/per Services   Per Individual/per family  \$4,500 / \$9,0   Individual/per family fami	Covered Benefits	Cost Share
Annual out of pocket Maximum   Per Individual/per family  \$4,500 / \$9,0   Intelligent Maximum   Per Individual/per family  \$4,500 / \$9,0   Individual/per Services   Per Individual/per family  \$4,500 / \$9,0   Individual/per family fami	Annual Deductible for Specific Services	
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Lifetime Maximum         Unlinite           Preventive Carc?         Unlinite           Well-baby and well-child (to age 18) physical exams, immunizations and related laboratory services         Security           Routine adult physical exams, immunizations and related laboratory services         Security           Routine adult physical exams, immunizations and related laboratory services         Security           Routine gying cological exams, immunizations and related laboratory services         Security           Mammography         Prostate cancer screening           Colorectal cancer screening including sigmoidoscopy and colonoscopy         Security           Best Health "Wellness Services         Colorian health education and wellness workshops and other wellness tools           Telephonic health education and wellness workshops and other wellness tools         Security           Professional Services         \$20 viv           Primary Care Physician office visit for consultation, treatment, diagnostic testing, etc.         \$20 viv           Specialist Physician office visit for consultation, treatment, diagnostic testing, etc.         \$20 viv           Specialist Physician office visit for consultation, treatment, diagnostic testing, etc.         \$20 viv           Specialist Physician office visit for consultation, treatment, diagnostic testing, etc.         \$20 viv           Alaboratory tests and services         \$20 viv <th< td=""><td>Annual Out of Pocket Maximum<sup>1</sup></td><td></td></th<>	Annual Out of Pocket Maximum <sup>1</sup>	
There are no lifetime maximums for this plan  Preventive Care*  Routine adult physical exams, immunizations and related laboratory services Routine adult physical exams, immunizations and related laboratory services Routine adult physical exams, immunizations and related laboratory services Routine gynecological exams, immunizations and related laboratory services Mammography  Prostate cancer screening Colorectal cancer screening Colorectal cancer screenings including sigmoidoscopy and colonoscopy  Rest Health® Wellness Services On-line health adultation and wellness workshops and other wellness tools Telephonic health coaching (weight management, tobacco cessation, stress management, physical activity, nutrition)  Professional Services Primary Care Physician office visit for consultation, treatment, diagnostic testing, etc.  \$20 / vi Specialist Physician office visit for consultation, treatment, diagnostic testing, etc.  \$20 / vi Other Practitioner office visit for consultation, treatment, diagnostic testing, etc.  \$20 / vi Other Practitioner office visit for consultation, treatment, diagnostic testing, etc.  \$20 / vi Other Practitioner office visit for consultation, treatment, diagnostic testing, etc.  \$20 / vi Other Practitioner office visit for consultation, treatment, diagnostic testing, etc.  \$20 / vi Other Practitioner office visit for consultation, treatment, diagnostic testing, etc.  \$20 / vi Other Practitioner office visit for consultation, treatment, diagnostic testing, etc.  \$20 / vi Other Practitioner office visit for consultation, treatment, diagnostic testing, etc.  \$20 / vi Other Practitioner office visit for consultation, treatment, diagnostic testing, etc.  \$20 / vi Other Practitioner office visit for consultation, treatment, diagnostic testing, etc.  \$20 / vi Other Practitioner office visit for consultation, treatment, diagnostic testing, etc.  \$20 / vi Other Practitioner office visit for consultation, treatment, diagnostic diagnostic diagnostic diagnostic diagnostic diagnostic diagnostic dia	Annual out of pocket maximum (per individual/per family)	\$4,500 / \$9,000
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Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)  Allergy testing Allergy testing Allergy injections  Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)  Outpatient surgery facility fee Outpatient Physician/Surgeon fee  Outpatient Physician/Surgeon fee  Outpatient visit Outp	Laboratory tests and services	\$20 / visit
Allergy testing \$30 / vi Allergy injections \$30 / vi Allergy injections \$30 / vi Allergy injections \$30 / vi Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)  Outpatient Physician/Surgeon fee \$100 / vi Outpatient visit \$10 / vi Ou	Radiology services (x-rays and diagnostic imaging)	\$30 / visit
Allergy injections \$30 / vi  Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)  Outpatient surgery facility fee \$100 / vi Outpatient Physician/Surgeon fee \$25 / vi Outpatient visit \$10% coinsurance Infusion therapy (including but not limited to chemotherapy) \$10% coinsurance Dialysis \$100 / vi Habilitation services: physical, occupational and speech therapy \$20 / vi Habilitation services: physical, occupational and speech therapy \$20 / vi Radiation therapy \$10% coinsurance Hospitalization (including but not limited to, inpatient services, organ transplant, and inpatient rehabilitation) Facility fee \$250 / day, (5-day me Physician/Surgeon fee  Emergency and Urgent Care Services  Emergency and Urgent Care Services  Emergency orom facility fee (waived if admitted to the hospital) \$150 / vi Emergency room physician fee (waived if admitted to the hospital)  Urgent care services \$20 / vi  Medical Transportation \$1	Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	\$100 / visit
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Outpatient visit  Infusion therapy (including but not limited to chemotherapy)  Dialysis  Rehabilitation services: physical, occupational and speech therapy  Habilitation services  Rediation therapy  Hospitalization (including but not limited to, inpatient services, organ transplant, and inpatient rehabilitation)  Facility fee  Physician/surgeon fee  Emergency and Urgent Care Services  Emergency room facility fee (waived if admitted to the hospital)  Emergency room physician fee (waived if admitted to the hospital)  Urgent care services  Emergency medical transportation  Emergency medical transportation	Outpatient surgery facility fee	\$100 / visit
Infusion therapy (including but not limited to chemotherapy)  Dialysis  Rehabilitation services: physical, occupational and speech therapy  Habilitation services  Radiation therapy  Hospitalization (including but not limited to, inpatient services, organ transplant, and inpatient rehabilitation)  Facility fee  Hospitalization (including but not limited to, inpatient services, organ transplant, and inpatient rehabilitation)  Facility fee  Emergency and Urgent Care Services  Emergency room facility fee (waived if admitted to the hospital)  Emergency room physician fee (waived if admitted to the hospital)  Urgent care services  #20 / vi  #4 / Vi  #4 / Vi  #5 / Vi  #6 / Vi	Outpatient Physician/Surgeon fee	\$25 / visit
Dialysis 10% coinsurance Rehabilitation services: physical, occupational and speech therapy \$20 / vi Habilitation services \$20 / vi Habilitation services \$20 / vi Radiation therapy 10% coinsurance Hospitalization (including but not limited to, inpatient services, organ transplant, and inpatient rehabilitation) Facility fee \$250 / day, (5-day material fee) Fhysician/surgeon fee  Emergency and Urgent Care Services Emergency room facility fee (waived if admitted to the hospital) \$150 / vi Emergency room physician fee (waived if admitted to the hospital) Urgent care services \$20 / vi Medical Transportation Emergency medical transportation \$1	Outpatient visit	10% coinsurance <sup>4</sup>
Rehabilitation services: physical, occupational and speech therapy  Habilitation services  Radiation therapy  Rospitalization (including but not limited to, inpatient services, organ transplant, and inpatient rehabilitation)  Facility fee  Physician/surgeon fee  Emergency and Urgent Care Services  Emergency room facility fee (waived if admitted to the hospital)  Emergency room physician fee (waived if admitted to the hospital)  Urgent care services  ### Medical Transportation  Emergency medical transportation  \$1.0% coinsurance \$20 / vi	Infusion therapy (including but not limited to chemotherapy)	10% coinsurance <sup>4</sup>
Habilitation services \$20 / vi Radiation therapy 10% coinsurance Hospitalization (including but not limited to, inpatient services, organ transplant, and inpatient rehabilitation) Facility fee \$250 / day, (5-day management of the services) \$250 / day, (5-day m	Dialysis	10% coinsurance <sup>4</sup>
Radiation therapy Hospitalization (including but not limited to, inpatient services, organ transplant, and inpatient rehabilitation)  Facility fee \$250 / day, (5-day material services) Physician/surgeon fee  Emergency and Urgent Care Services  Emergency room facility fee (waived if admitted to the hospital) \$150 / vi  Emergency room physician fee (waived if admitted to the hospital)  Urgent care services \$20 / vi  Medical Transportation  Emergency medical transportation \$1	Rehabilitation services: physical, occupational and speech therapy	\$20 / visit
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Facility fee \$250 / day, (5-day many physician/surgeon fee Ferrican/surgeon fee Ferrican/surgeon fee Ferrican/surgeon fee Ferrican/surgeon fee Ferrican Surgeon fee Ferrican Surgeon facility fee (waived if admitted to the hospital) \$150 / vi Emergency room physician fee (waived if admitted to the hospital) \$150 / vi Ferrican Surgeon	Radiation therapy	10% coinsurance <sup>2</sup>
Physician/surgeon fee  Emergency and Urgent Care Services  Emergency room facility fee (waived if admitted to the hospital) \$150 / vi  Emergency room physician fee (waived if admitted to the hospital)  Urgent care services \$20 / vi  Medical Transportation  Emergency medical transportation \$1	Hospitalization (including but not limited to, inpatient services, organ transplant, and inpatient rehabilitation)	
Emergency and Urgent Care Services  Emergency room facility fee (waived if admitted to the hospital) \$150 / vi  Emergency room physician fee (waived if admitted to the hospital)  Urgent care services \$20 / vi  Medical Transportation  Emergency medical transportation \$1	Facility fee	\$250 / day, (5-day max)
Emergency room facility fee (waived if admitted to the hospital)  Emergency room physician fee (waived if admitted to the hospital)  Urgent care services \$20 / vi  Medical Transportation  Emergency medical transportation \$1	Physician/surgeon fee	\$0
Emergency room physician fee (waived if admitted to the hospital)  Urgent care services \$20 / vi  Medical Transportation  Emergency medical transportation \$1	Emergency and Urgent Care Services	
Urgent care services     \$20 / vi       Medical Transportation     \$1       Emergency medical transportation     \$1	Emergency room facility fee (waived if admitted to the hospital)	\$150 / visit
Medical Transportation       Emergency medical transportation     \$1.	Emergency room physician fee (waived if admitted to the hospital)	\$0
Emergency medical transportation \$1.	Urgent care services	\$20 / visit
	Medical Transportation	
Non-emergency medical transportation \$1.	Emergency medical transportation	\$150
	Non-emergency medical transportation	\$150



# **Summary of Benefits**

Sharp Platinum 90 HMO 0/20/250 + Child Dental (Pe/V/C)

Maternity Care	
Prenatal and postpartum office visits	
Delivery and all inpatient services - Hospital	\$250 / day, (5-day ma
Delivery and all inpatient services - Professional	\$2307 day,(5 day 111
Breastfeeding support, supplies and counseling	
Family Planning Services	
njectable contraceptives (including but not limited to Depo Provera)	
/oluntary sterilization - women	
/oluntary sterilization - men	
nterruption of pregnancy (including but not limited to office visits, outpatient surgery, and inpatient services)	
Durable Medical Equipment and Other Supplies	
Durable medical equipment	100% soinguran
	10% coinsuran
Diabetic supplies	10% coinsuran
Prosthetics and orthotics	10% coinsuran
Mental Health Services⁵	
Office visits	\$20 / v
Group therapy	\$20 / v
Other outpatient items and services	\$20 / v
npatient facility fee	\$250 / day, (5-day m
npatient physician fee	
Emergency services facility fee (waived if admitted)	\$150/\
Emergency services physician fee (waived if admitted)	
Emergency psychiatric transportation	\$
Non-emergency psychiatric transportation	\$
Jrgent care services	\$20 / v
Substance Use Disorder Services <sup>5</sup>	
Office visits	\$20/\
Group therapy	\$20 / \
Other outpatient items and services	\$20/\
npatient facility fee	\$250 / day, (5-day m
npatient physician fee	
Emergency services facility fee for alcohol or drug detoxification (waived if admitted)	\$150/\
Emergency services physician fee for alcohol or drug detoxification (waived if admitted)	
Emergency substance use disorder transportation	\$
Non-emergency substance use disorder transportation	\$
Jrgent care services	\$20/\
Skilled Nursing, Home Health and Hospice Services	
skilled nursing facility services (maximum of 100 days per benefit period)	\$150 / day, (5-day m
Home health services (cost share per visit - maximum of 100 visits per calendar year)	\$20/\
Hospice care - inpatient	
Hospice care - outpatient	
Pediatric Vision Services	
Eye Exam	
Glasses or contact lenses in lieu of glasses	1 pair per year, covered in



information.

## **Summary of Benefits**

Sharp Platinum 90 HMO 0/20/250 + Child Dental (Pe/V/C)

Cost Sharo

Cost Share	Covered Benefits
	Prescription Drug Coverage <sup>6</sup>
\$5 / \$10	Tier 1: Most generic drugs and low cost preferred brands (30 day supply/90 day supply).
\$20 / \$4(	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).
10% coinsurance (up to \$250 per 30-day supply	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).
\$0	Preventive prescription drugs including Preferred Generic and over-the-counter contracentives

#### Notes

Covered Panafita

- <sup>1</sup> 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.
- <sup>2</sup> 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.
- <sup>3</sup> "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.
- <sup>4</sup> Of contracted rates
- <sup>5</sup> All medically necessary treatment of mental health and substance use disorders is covered under this plan.
- <sup>6</sup> 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.

