Summary of Benefits

Basic HMO Option
Sharp HealthCare HMO NG 2 L

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.SHARPHEALTHPLAN.COM TO VIEW THE MEMBER HANDBOOK.

Covered Benefits	*Copayments*
Annual Deductible and Out of Pocket Maximum	
There are no deductibles for the medical benefits and pharmacy coverage covered under this plan	$0
Annual out of pocket maximum (per individual/per family)[1]	$1,500 / $3,000
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[SM] 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.	$20 / visit
Specialist Physician office visit for consultation, treatment, diagnostic testing, etc.	$30 / visit
Medically necessary physician home visit	$35 / visit
Laboratory tests and services	$0
Radiology services (x-rays and diagnostic imaging)	$0
Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	$0 / procedure
Allergy testing	$30 / visit
Allergy injections	$3 / visit
Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)	
Outpatient facility fee	$100 / procedure
Physician/Surgeon fee	$0
Infusion therapy (including but not limited to chemotherapy)	$0
Dialysis	$0
Rehabilitation services: physical, occupational and speech therapy	$30 / visit
Habilitation services	Not covered
Radiation therapy	$0
Hospitalization (Incluing but not limited to inpatient services, organ transplant, and inpatient rehabilitation)	
Facility fee	$250 / admission
Physician/surgeon fee	$0
Emergency and Urgent Care Services	
Emergency room services facility fee (waived if admitted to the hospital)	$100 / visit
Emergency room services physician fee (waived if admitted to the hospital)	$0
Urgent care services	$30 / visit
Medical Transportation	
Emergency medical transportation	$100
Non-emergency medical transportation	$100

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Covered Benefits cont.	*Copayments*
Maternity Care	
Prenatal and postpartum office visits	$0
Delivery and all inpatient services - Hospital	$250 / admission
Delivery and all inpatient services - Professional	$0
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	$75
Interruption of pregnancy	$150
Infertility services (diagnosis and treatment of underlying condition)	50% coinsurance[3]
Durable Medical Equipment and Other Supplies	
Durable medical equipment (copay applied per rental or purchase per calendar year)	$50
Diabetic supplies	$0
Prosthetics and orthotics	$30 / visit
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.[4]	
Office visits	$20 / visit
Group therapy	$20 / visit
Other outpatient items and sevices	$20 / visit
Home-based applied behavioral analysis for treatment of pervasive developmental disorder or autism	$0 / visit
Inpatient facility fee	$250 / admission
Inpatient physician fee	$0
Emergency services facility fee (waived if admitted)	$100 / visit
Emergency services physician fee (waived if admitted)	$0
Emergency psychiatric transportation	$100
Non-emergency psychiatric transportation	$100
Urgent care services	$30 / visit
Chemical Dependency Services	
Office visits	$20 / visit
Group therapy	$20 / visit
Other outpatient items and sevices	$20 / visit
Inpatient facility fee	$250 / admission
Inpatient physician fee	$0
Emergency services facility fee for acute alcohol or drug detoxification (waived if admitted)	$100 / visit
Emergency services physician fee for acute alcohol or drug detoxification (waived if admitted)	$0
Emergency substance use disorder transportation	$100
Non-emergency substance use disorder transportation	$100
Urgent care services	$30 / visit
Skilled Nursing, Home Health and Hospice Services	
Skilled nursing facility services (maximum of 100 days per benefit period)	$50 / admission
Home health services (cost share per visit - maximum of 100 visits per calendar year)	$0
Hospice care - inpatient	$0
Hospice care - outpatient	$0

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Covered Benefits cont.	*Copayments*
Prescription Drug Coverage[5]	
Preferred Generic/Preferred Brand/Non-preferred medications up to 30 day supply	$10 / $25 / $50
Preferred Generic/Preferred Brand/Non-preferred medications for a 90 day supply by mail order (for maintenance medications only)	$20 / $50 / $100
Preventive prescription drugs including Preferred Generic and prescribed over-the-counter contraceptives	$0
Supplemental Benefits[1]	
Hearing aid allowance (every 36 months)	$1,000
Vision services: Eye exam once every 12 months / Frame and Lenses once every 12 months / Frame allowance / Contact allowance	$25 / $25 / $150 / $150

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-out-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. Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Vision, etc.) do not apply to the annual 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]Of contracted rates

[4]Severe 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).

[5]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 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.

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