

# Summary of Benefits

## Select Plan SDPEBA HMO NG 3 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.SHARPEALTHPLAN.COM](http://WWW.SHARPEALTHPLAN.COM) TO VIEW THE MEMBER HANDBOOK.

### Covered Benefits

### Copayments

Covered Benefits	Copayments
<b>Annual Deductible and Out of Pocket Maximum</b>	
There are no deductibles for the medical benefits under this plan	\$0
Calendar year brand drug deductible (per individual/per family) - applies only to covered preferred and non-preferred brand drugs	\$150 <sup>1</sup> / \$300 <sup>1</sup>
Calendar year out of pocket maximum (per individual/per family) <sup>2</sup>	\$3,000 <sup>2</sup> / \$6,000 <sup>2</sup>
<b>Lifetime Maximum</b>	
There are no lifetime maximums for this plan	Unlimited
<b>Preventive Care<sup>3</sup></b>	
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
<b>Best Health<sup>SM</sup> Wellness Services</b>	
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
<b>Professional Services</b>	
Primary Care Physician office visit for consultation, treatments, diagnostic testing, etc.	\$30 / visit
Specialist Physician office visit for consultation, treatments, diagnostic testing, etc.	\$40 / visit
Laboratory services	\$0
Radiology services (x-rays)	\$0
Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	\$100 / procedure
Allergy testing	\$40 / visit
Allergy injections	\$10 / visit
<b>Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)</b>	
Outpatient surgery	\$325 / procedure
Infusion therapy (including but not limited to chemotherapy)	Variable <sup>4</sup>
Dialysis	\$0
Physical, occupational and speech therapy	\$40 / visit
Radiation therapy	Variable <sup>4</sup>
<b>Hospitalization</b>	
Inpatient services	\$750 / admission
Organ transplant	\$750 / admission
Inpatient rehabilitation	\$750 / admission
<b>Emergency and Urgent Care Services</b>	
Emergency room services (waived if admitted to the hospital)	\$100 / visit
Urgent care services	\$40 / visit
<b>Medical Transportation</b>	
Emergency medical transportation	\$100
Non-emergency medical transportation	\$100
<b>Maternity Care</b>	
Prenatal and postpartum office visits	\$0
Hospitalization	\$750 / admission
Breastfeeding support, supplies and counseling	\$0



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### Covered Benefits, continued

### Copayments

#### 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 <sup>5</sup>

#### Durable Medical Equipment and Other Supplies

Durable medical equipment	50% coinsurance <sup>5</sup>
Diabetic supplies	20% coinsurance <sup>5</sup>
Prosthetics and orthotics	\$40 / visit

#### Mental Health Services

**Diagnosis and treatment of Severe Mental Illnesses for all members, Serious Emotional Disturbances for children, and other mental health conditions are covered with the copayments listed below.<sup>6</sup>**

Office visits	\$30 / visit
Group therapy	\$30 / visit
Other outpatient items and services	\$30 / visit
Inpatient	\$750 / admission
Home-based applied behavioral analysis for treatment of pervasive developmental disorder or autism	\$30 / visit
Emergency psychiatric transportation	\$100
Non-emergency psychiatric transportation	\$100
Urgent care services	\$40 / visit

#### Chemical Dependency Services

Office visits	\$30 / visit
Group therapy	\$30 / visit
Other outpatient items and services	\$30 / visit
Inpatient	\$750 / admission
Emergency services for acute alcohol or drug detoxification	\$100 / visit
Emergency substance use disorder transportation	\$100
Non-emergency substance use disorder transportation	\$100
Urgent care services	\$40 / visit

#### Skilled Nursing, Home Health and Hospice Services

Skilled nursing facility services (maximum of 100 consecutive days per calendar year)	\$200 / admission
Home health services (maximum of 100 visits per calendar year)	\$40 / visit
Hospice care - inpatient	\$0
Hospice care - outpatient	\$0

#### Prescription Drug Coverage<sup>7</sup>

Preferred Generic/Preferred Brand/Non-preferred medications up to 30 day supply	\$20 / \$35 <sup>1</sup> / \$70 <sup>1</sup>
Preferred Generic/Preferred Brand/Non-preferred medications for a 90 day supply by mail order (for maintenance medications only)	\$40 / \$70 <sup>1</sup> / \$140 <sup>1</sup>
Preventive prescription drugs including Preferred Generic and prescribed over-the-counter contraceptives	\$0

#### Notes

<sup>1</sup> After deductible. Covered brand name drugs are subject to a calendar year deductible.

<sup>2</sup> Copayments for supplemental benefits (Assisted Reproductive Technologies, Acupuncture, Chiropractic Services, and Vision) do not apply to the annual out of pocket maximum.

<sup>3</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>4</sup> Copayment depends on type and location of service.

<sup>5</sup> Of contracted rates.

<sup>6</sup> 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.

<sup>7</sup> Member cost-share will not exceed \$200 per individual prescription of up to 30-day supply of a covered oral anti-cancer drug.

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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, and partial hospitalization. “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.