Summary of Benefits

Gold HMO NG 6

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[1]	
Medical (per individual/per family) - applies only to those covered benefits indicated	$1,000 / $2,000
Brand Drugs (per individual/per family) - applies only to covered preferred and non-preferred brand drugs	$150 / $300
Annual Out of Pocket Maximum[2]	
Annual out of pocket maximum (per individual/per family)	$3,800 / $7,600
Lifetime Maximum	
There are no lifetime maximums for this plan	Unlimited
Preventive Care[3]	
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.	$35 / visit
Specialist Physician office visit for consultation, treatment, diagnostic testing, etc.	$75 / visit
Other Practitioner office visit, including acupuncture[4]	$35 / visit
Laboratory tests and services	$60 / visit
Radiology services (x-rays and diagnostic imaging)	$100 / visit
Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	$200 / procedure
Allergy testing	$75 / visit
Allergy injections	$35 / visit
Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)	
Outpatient surgery	30% coinsurance[6,8]
Infusion therapy (including but not limited to chemotherapy)	variable[5]
Dialysis	$0
Rehabilitation services: physical, occupational and speech therapy	$35 / visit
Habilitation services	$35 / visit
Radiation therapy	variable[5]
Hospitalization	
Inpatient services	30% coinsurance[6,8]
Organ transplant	30% coinsurance[6,8]
Inpatient rehabilitation	30% coinsurance[6,8]
Emergency and Urgent Care Services	
Emergency room services (waived if admitted to the hospital)	$200 / visit[8]
Urgent care services	$75 / visit
Medical Transportation	
Emergency medical transportation	$200[8]
Non-emergency medical transportation	$0[8]

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Covered Benefits cont.	*Copayments*
Maternity Care	
Prenatal and postpartum office visits	$0
Hospitalization	30% coinsurance[6,8]
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	variable[5]
Interruption of pregnancy	variable[5]
Durable Medical Equipment and Other Supplies	
Durable medical equipment	50% coinsurance[6,8]
Diabetic supplies	20% coinsurance[6]
Prosthetics and orthotics	$75 / visit
Mental Health Services	
Diagnosis and treatment of Severe Mental Illnesses for all members and Serious Emotional Disturbances for children, and other mental health conditions are covered with the cost-sharing listed below.[7]	
Office visits	$35 / visit
Group therapy	$35 / visit
Other outpatient items and services	$0
Inpatient	30% coinsurance[6,8]
Emergency psychiatric transportation	$200[8]
Non-emergency psychiatric transportation	$0[8]
Urgent care services	$75 / visit
Chemical Dependency Services	
Office visits	$35 / visit
Group therapy	$35 / visit
Other outpatient items and services	$0
Inpatient	30% coinsurance[6,8]
Emergency services for acute alcohol or drug detoxification	$200 / visit[8]
Emergency substance use disorder transportation	$200[8]
Non-emergency substance use disorder transportation	$0[8]
Urgent care services	$75 / visit
Skilled Nursing, Home Health and Hospice Services	
Skilled nursing facility services (maximum of 100 days per benefit period)	30% coinsurance[6,8]
Home health services (maximum of 100 visits per calendar year)	$35 / visit
Hospice care - inpatient	30% coinsurance[6,8]
Hospice care - outpatient	$0
Pediatric Vision Services	
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 Access Dental. Please refer to the Access Dental schedule of benefits for applicable cost-sharing information.	
Prescription Drug Coverage[9]	
Preferred Generic/Preferred Brand/Non-preferred medications up to 30 day supply	$20 / $35[8] / $70[8]
Preferred Generic/Preferred Brand/Non-preferred medications for a 90 day supply by mail order (for maintenance medications only)	$40 / $70[8] / $140[8]
Preventive prescription drugs including Preferred Generic and prescribed over-the-counter contraceptives	$0

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Notes

[1] In a family plan, each individual in the family must meet the Individual Deductible, until the Family Deductible is met. The Out-of-Pocket Maximum includes the deductible, copayments, and coinsurance. In an individual plan, the Member is responsible for all applicable deductibles, copayments, and coinsurance up to the Self-Only Out-of-Pocket Maximum. In a family plan, the Member is responsible for all deductibles, copayments, and coinsurance up to the Individual Out-of-Pocket Maximum, until the combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum. When the family's combined deductibles, copayments and coinsurance equal the Family Out-of-Pocket Maximum, all family members have met the Out-of-Pocket Maximum.

[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] Copayment depends on type and location of service.

[6] Of contracted rates

[7] Severe Mental Illnesses include: schizophrenia, schizoaffective disorder, bi-polar disorder (manic depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia nervosa and bulimia nervosa.

[8] Deductible applies

[9] Member cost-share will not exceed $200 per individual prescription of up to a 30-day supply of a covered oral anti-cancer drug.

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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