Summary of Benefits

Gold HMO NG 3

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 **SHARPHEALTHPLAN.COM** TO VIEW THE MEMBER HANDBOOK.

Covered Benefits	Copayments
Annual Deductible for Specific Services[1,2]	
Calendar year medical deductible (per individual/per family) - applies only to those covered benefits indicated	$0 / $0
Calendar year pharmacy deductible (per individual/per family) - applies only to covered preferred and non-preferred brand drugs	$150 / $300
Calendar year dental deductible (per individual/per family)	$0 / $0
Annual Out of Pocket Maximum[3]	
Annual out of pocket maximum (per individual/per family)	$7,000 / $14,000
Lifetime Maximum	
There are no lifetime maximums for this plan	Unlimited
Preventive Care[4]	
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.	$30 / visit
Specialist Physician office visit for consultation, treatment, diagnostic testing, etc.	$55 / visit
Other Practitioner office visit, including acupuncture[5]	$30 / visit
Laboratory tests and services	$15 / visit
Radiology services (x-rays and diagnostic imaging)	$55 / visit
Advanced radiology (including but not limited to CT/PET scan, MRI, MRA, MRS, MUGA, SPECT)	$150 / procedure
Allergy testing	$55 / visit
Allergy injections	$30 / visit
Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)	
Outpatient surgery facility fee	$600 / procedure
Outpatient Physician/Surgeon fee	$0
Infusion therapy (including but not limited to chemotherapy)	variable[6]
Dialysis	$0
Rehabilitation services: physical, occupational and speech therapy	$30 / visit
Habilitation services	$30 / visit
Radiation therapy	variable[6]
Hospitalization (including but not limited to inpatient services, organ transplant, and inpatient rehabilitation)	
Facility fee	$1,000/ day[7]
Physician/surgeon fee	$0
Emergency and Urgent Care Services	
Emergency room services (waived if admitted to the hospital)	$175 / visit
Emergency room physician fee (waived if admitted to the hospital)	$0
Urgent care services	$55 / visit
Medical Transportation	
Emergency medical transportation	$175
Non-emergency medical transportation	$175

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Covered Benefits	Copayments
Maternity Care	
Prenatal and postpartum office visits	$0
Delivery and all inpatient services - Hospital	$720 / day[7]
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	variable[6]
Interruption of pregnancy	variable[6]
Durable Medical Equipment and Other Supplies	
Durable medical equipment	50% coinsurance[8]
Diabetic supplies	20% coinsurance[8]
Prosthetics and orthotics	$55 / visit
Mental Health Services[9]	
Office visits	$30 / visit
Group therapy	$25 / visit
Other outpatient items and services	$30 / visit
Inpatient facility fee	$90 / day[7]
Inpatient physician fee	$0
Emergency services facility fee (waived if admitted)	$175 / visit
Emergency services physician fee (waived if admitted)	$0
Emergency psychiatric transportation	$175
Non-emergency psychiatric transportation	$175
Urgent care services	$55 / visit
Substance Use Disorder Services[9]	
Office visits	$30 / visit
Group therapy	$7 / visit
Other outpatient items and services	$30 / visit
Inpatient facility fee	$90 / day[7]
Inpatient physician fee	$0
Emergency services facility fee for alcohol or drug detoxification (waived if admitted)	$175 / visit
Emergency services physician fee for alcohol or drug detoxification (waived if admitted)	$0
Emergency substance use disorder transportation	$175
Non-emergency substance use disorder transportation	$175
Urgent care services	$55 / visit
Skilled Nursing, Home Health and Hospice Services	
Skilled nursing facility services (maximum of 100 days per benefit period)	$25 / day
Home health services (cost share per visit - maximum of 100 visits per calendar year)	$30 / visit
Hospice care - inpatient	$150 / day
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 Delta Dental. Please refer to the Delta Dental schedule of benefits for applicable cost-sharing information.	

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Covered Benefits	Copayments
Prescription Drug Coverage[10]	
Preferred Generic/Preferred Brand/Non-preferred medications up to 30 day supply	$16 / $35[1] / $50[1]
Preferred Generic/Preferred Brand/Non-preferred medications for a 90 day supply by mail order (for maintenance medications only)	$32 / $70[1] / $100[1]
Preventive prescription drugs including Preferred Generic and prescribed over-the-counter contraceptives	$0

Notes

[1] Deductible applies. Covered brand name drugs are subject to a $150 calendar year Rx deductible.

[2] In a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out-of-pocket maximum amount. Cost sharing payments (deductibles, copayments and coinsurance, but not premiums) made by each individual in a family contribute to the family deductible and out-of-pocket maximums. The family deductible may be satisfied by any combination of individual deductible payments, after which member copays or coinsurance apply until the family out of pocket maximum is reached. 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 deductible, if deductible applies to that service, and the out-of-pocket maximum.

[3] Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) do not apply to the annual out of pocket maximum.

[4] 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.

[5] "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.

[6] Out of pocket cost is based on type and location of services (e.g. outpatient surgery cost-share for outpatient surgery or specialist office visit cost-share for a service received during a specialist office visit).

[7] Up to Out of Pocket Maximum

[8] Of contracted rates

[9] All medically necessary treatment of mental health and substance use disorders is covered under this plan.

[10] 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.

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