Summary of Benefits

Sharp Bronze 60 HMO Performance

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 for Specific Services[1]	
Medical deductible (per individual/per family) - applies only to those covered benefits indicated	$6,300 / $12,600
Pharmacy deductible (per individual/per family) - applies to Tier 1, Tier 2, Tier 3, and Tier 4	$500 / $1,000
Annual Out of Pocket Maximum[1]	
Annual out of pocket maximum (per individual/per family)	$7,550 / $15,100
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℠ 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. (deductible applies after first 3 non-preventive visits)	$75 / visit[7]
Specialist Physician office visit for consultation, treatment, diagnostic testing, etc. (deductible applies after first 3 non-preventive visits)	$105 / visit[7]
Other Practitioner office visit, including acupuncture (deductible applies after first 3 non-preventive visits)[3]	$75 / visit[7]
Laboratory tests and services	$40 / visit
Radiology services (x-rays and diagnostic imaging)	100% coinsurance[4,7]
Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	100% coinsurance[4,7]
Allergy testing (deductible applies after first 3 non-preventive visits)	$105 / visit[7]
Allergy injections (deductible applies after first 3 non-preventive visits)	$105 / visit[7]
Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)	
Outpatient facility fee	100% coinsurance[4,7]
Outpatient Physician/Surgeon fee	100% coinsurance[4,7]
Outpatient visit	100% coinsurance[4,7]
Infusion therapy (including but not limited to chemotherapy)	100% coinsurance[4,7]
Dialysis	100% coinsurance[4,7]
Rehabilitation services: physical, occupational and speech therapy	$75 / visit
Habilitation services	$75 / visit
Radiation therapy	100% coinsurance[4,7]
Hospitalization (including but not limited to inpatient services, organ transplant, and inpatient rehabilitation)	
Facility fee	100% coinsurance[4,7]
Physician/surgeon fee	100% coinsurance[4,7]
Emergency and Urgent Care Services	
Emergency room facility fee (waived if admitted to the hospital)	100% coinsurance[4,7]
Emergency room physician fee (waived if admitted to the hospital)	$0
Urgent care services (deductible applies after first 3 non-preventive visits)	$75 / visit[7]
Medical Transportation	
Emergency medical transportation	100% coinsurance[4,7]
Non-emergency medical transportation	100% coinsurance[4,7]

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Covered Benefits cont.	*Copayments*
Maternity Care	
Prenatal and postpartum office visits	$0
Delivery and all inpatient services - Hospital	100% coinsurance[4,7]
Delivery and all inpatient services - Professional	100% coinsurance[4,7]
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[5,7]
Interruption of pregnancy	variable[5,7]
Durable Medical Equipment and Other Supplies	
Durable medical equipment	100% coinsurance[4,7]
Diabetic supplies	100% coinsurance[4,7]
Prosthetics and orthotics	100% coinsurance[4,7]
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.[6]	
Office visits	$0
Group therapy	$0
Other outpatient items and services	100% coinsurance up to $75 / visit[7]
Inpatient facility fee	100% coinsurance[4,7]
Inpatient physician fee	100% coinsurance[4,7]
Emergency services facility fee (waived if admitted)	100% coinsurance[4,7]
Emergency services physician fee (waived if admitted)	$0
Emergency psychiatric transportation	100% coinsurance[4,7]
Non-emergency psychiatric transportation	100% coinsurance[4,7]
Urgent care services	$0
Chemical Dependency Services	
Office visits	$0
Group therapy	$0
Other outpatient items and services	100% coinsurance up to $75 / visit[7]
Inpatient facility fee	100% coinsurance[4,7]
Inpatient physician fee	100% coinsurance[4,7]
Emergency services facility fee for acute alcohol or drug detoxification (waived if admitted)	100% coinsurance[4,7]
Emergency services physician fee for acute alcohol or drug detoxification (waived if admitted)	$0
Emergency substance use disorder transportation	100% coinsurance[4,7]
Non-emergency substance use disorder transportation	100% coinsurance[4,7]
Urgent care services	$0
Skilled Nursing, Home Health and Hospice Services	
Skilled nursing facility services (maximum of 100 days per benefit period)	100% coinsurance[4,7]
Home health services (cost share per visit - maximum of 100 visits per calendar year)	100% coinsurance[4,7]
Hospice care - inpatient	$0
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.	

Covered Benefits cont. | *Copayments*

Prescription Drug Coverage[8]	
Tier 1: Most generic drugs and low cost preferred brands (30 day supply/90 day supply).	100% coinsurance[4,7] (Up to $500 per 30-day supply after pharmacy deductible)
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).	100% coinsurance[4,7] (Up to $500 per 30-day supply after pharmacy deductible)
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).	100% coinsurance[4,7] (Up to $500 per 30-day supply after pharmacy deductible)
Tier 4: Drugs that are biologics, 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).	100% coinsurance[4,7] (Up to $500 per 30-day supply after pharmacy deductible)
Preventive prescription drugs including Preferred Generic and prescribed over-the-counter contraceptives	$0

Notes

[1]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 in-network services accumulate toward the deductible, if deductible applies to that service, and the out-of-pocket maximum. For the Bronze plan, deductible is waived for first 3 non-preventive office, specialist, or urgent care visits.

[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]"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.

[4]Of contracted rates

[5]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).

[6]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.

[7]Deductible applies

[8]Member cost-share will not exceed $200 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.