Summary of Benefits

Bronze HDHP NG 1

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	Cost Share
Overall Annual Deductible[1]	
Integrated Medical and Pharmacy deductible - applies only to those covered benefits indicated	Self-Only Coverage: $6,100 Family Coverage: $6,100 / Individual $12,200 / Family
Annual Out of Pocket Maximum[1,2]	
Annual out of pocket maximum (per individual/per family)	Self-Only Coverage: $7,150 Family Coverage: $7,150 / Individual $14,300 / Family
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℠ 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.	$50 / visit[8]
Specialist Physician office visit for consultation, treatment, diagnostic testing, etc.	$50 / visit[8]
Other Practitioner office visit, including acupuncture[4]	$50 / visit[8]
Laboratory tests and services	50% coinsurance[5,8]
Radiology services (x-rays and diagnostic imaging)	50% coinsurance[5,8]
Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	50% coinsurance[5,8]
Allergy testing	$50 / visit[8]
Allergy injections	$50 / visit[8]
Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)	
Outpatient surgery facility fee	50% coinsurance[5,8]
Outpatient Physician/Surgeon fee	50% coinsurance[5,8]
Infusion therapy (including but not limited to chemotherapy)	variable[6,8]
Dialysis	$0[8]
Rehabilitation services: physical, occupational and speech therapy	$50 / visit[8]
Habilitation services	$50 / visit[8]
Radiation therapy	variable[6,8]
Hospitalization (including but not limited to inpatient services, organ transplant, and inpatient rehabilitation)	
Facility fee	50% coinsurance[5,8]
Physician/surgeon fee	50% coinsurance[5,8]
Emergency and Urgent Care Services	
Emergency room services (waived if admitted to the hospital)	50% coinsurance[5,8]
Emergency room physician fee (waived if admitted to the hospital)	50% coinsurance[5,8]
Urgent care services	$50[8]

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Medical Transportation	
Emergency medical transportation	50% coinsurance[5,8]
Non-emergency medical transportation	50% coinsurance[5,8]
Maternity Care	
Prenatal and postpartum office visits	$0
Delivery and all inpatient services - Hospital	50% coinsurance[5,8]
Delivery and all inpatient services - Professional	50% coinsurance[5,8]
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	$0[8]
Interruption of pregnancy (including but not limited to office visits, outpatient surgery, and inpatient services)	$0[8]
Durable Medical Equipment and Other Supplies	
Durable medical equipment	50% coinsurance[5,8]
Diabetic supplies	50% coinsurance[5,8]
Prosthetics and orthotics	$50 / visit[8]
Mental Health Services[7]	
Office visits	$0[8]
Group therapy	$0[8]
Other outpatient items and services	50% coinsurance[5,8]
Inpatient facility fee	50% coinsurance[5,8]
Inpatient physician fee	50% coinsurance[5,8]
Emergency services facility fee (waived if admitted)	50% coinsurance[5,8]
Emergency services physician fee (waived if admitted)	50% coinsurance[5,8]
Emergency psychiatric transportation	50% coinsurance[5,8]
Non-emergency psychiatric transportation	50% coinsurance[5,8]
Urgent care services	$50[8]
Substance Use Disorder Services[7]	
Office visits	$0[8]
Group therapy	$0[8]
Other outpatient items and services	50% coinsurance[5,8]
Inpatient facility fee	50% coinsurance[5,8]
Inpatient physician fee	50% coinsurance[5,8]
Emergency services facility fee for alcohol or drug detoxification (waived if admitted)	50% coinsurance[5,8]
Emergency services physician fee for alcohol or drug detoxification (waived if admitted)	50% coinsurance[5,8]
Emergency substance use disorder transportation	50% coinsurance[5,8]
Non-emergency substance use disorder transportation	50% coinsurance[5,8]
Urgent care services	$50[8]
Skilled Nursing, Home Health and Hospice Services	
Skilled nursing facility services (maximum of 100 days per benefit period)	50% coinsurance[5,8]
Home health services (cost share per visit - maximum of 100 visits per calendar year)	$50 / visit[8]
Hospice care - inpatient	$0[8]
Hospice care - outpatient	$0[8]
Pediatric Vision Services	
Eye Exam	$0
Glasses or contact lenses in lieu of glasses	1 pair/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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Prescription Drug Coverage[9]	
Preferred Generic/Preferred Brand/Non-preferred medications up to 30 day supply	$16[8]/ $70[8] / $100[8]
Preferred Generic/Preferred Brand/Non-preferred medications for a 90 day supply by mail order (for maintenance medications only)	$32[8]/ $140[8] / $200[8]
Preventive prescription drugs including Preferred Generic and over-the-counter contraceptives	$0

Notes

[1]In a high deductible health plan (HDHP), your Deductible and Out-of-Pocket Maximum work differently. In a Self-Only coverage plan, you must meet the Self-Only Deductible and the Self-Only Out-of-Pocket Maximum. Once you meet the Self-Only Deductible, Sharp Health Plan will pay for your services. The Self-Only Out-of-Pocket Maximum includes the deductible, copayments, and coinsurance. In a Family plan, each individual in the family must meet the Individual Deductible until the Family Deductible is met. Once an individual meets the Individual Deductible, Sharp Health will pay for services for that individual in the family. Once the Family Deductible is met, Sharp Health Plan will pay for services for the entire family. All family members have met the Family Out-of-Pocket Maximum when the family's combined deductibles, copayments, and coinsurance equal the Family 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]Of contracted rates

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

[8]Deductible applies.

[9]Once the deductible is met, member cost-share will not exceed $250 per individual prescription of up to a 30-day supply of 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.

Note: The cost of developing an evaluation and the provisions of all health care services required or recommended pursuant to a Community Assistance, Recovery and Empowerment (CARE) Agreement or CARE Plan are covered whether the service is provided by a Plan provider or non-Plan provider. All services are covered without prior authorization and Cost Sharing, except prescription drugs.

Note: Medically Necessary treatment of a Mental Health or Substance Use Disorder including but not limited to, Behavioral Health Crisis Services provided by a 988 center, or mobile crisis team or other provider of Behavioral Health Crisis Services can be provided by Plan providers or non-Plan providers. You will only pay the in-network cost sharing amount for any out-of-network Medically Necessary treatment of a Mental Health or Substance Use Disorder, provided by a 988 center, mobile crisis team or other provider of Behavioral Health Crisis Services.