

# Summary of Benefits

## Gold HMO NG 7

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

<i>Covered Benefits</i>	<i>Copayments</i>
<b>Annual Deductible<sup>1</sup></b>	
Medical (per individual/per family) - applies only to those covered benefits indicated	\$500 / \$1,000
<b>Annual Out of Pocket Maximum<sup>2</sup></b>	
Annual out of pocket maximum (per individual/per family)	\$6,850 / \$13,700
<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, treatment, diagnostic testing, etc.	\$10 / visit
Specialist Physician office visit for consultation, treatment, diagnostic testing, etc.	\$20 / visit
Other Practitioner office visit, including acupuncture <sup>4</sup>	\$10 / visit
Laboratory tests and services	\$20
Radiology services (x-rays and diagnostic imaging)	\$20
Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	\$250/ procedure
Allergy testing	\$20 / visit
Allergy injections	\$10 / visit
<b>Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)</b>	
Outpatient surgery	50% coinsurance <sup>5,8</sup>
Infusion therapy (including but not limited to chemotherapy)	variable <sup>6</sup>
Dialysis	\$0
Rehabilitation services: physical, occupational and speech therapy	\$10 / visit
Habilitation services	\$10 / visit
Radiation therapy	variable <sup>6</sup>
<b>Hospitalization</b>	
Inpatient services	50% coinsurance <sup>5,8</sup>
Organ transplant	50% coinsurance <sup>5,8</sup>
Inpatient rehabilitation	50% coinsurance <sup>5,8</sup>
<b>Emergency and Urgent Care Services</b>	
Emergency room services (waived if admitted to the hospital)	50% coinsurance <sup>5,8</sup>
Ambulance in connection with hospital admission or emergency services	50% coinsurance <sup>5,8</sup>
Urgent care services	\$20 / visit
<b>Maternity Care</b>	
Prenatal and postpartum office visits	\$10 / visit
Hospitalization	50% coinsurance <sup>5,8</sup>
Breastfeeding support, supplies and counseling	\$0

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## Covered Benefits cont.

## Copayments

<b>Family Planning Services</b>	
Injectable contraceptives (including but not limited to Depo Provera)	\$0
Voluntary sterilization - women	\$0
Voluntary sterilization - men	variable <sup>6</sup>
Interruption of pregnancy	variable <sup>6</sup>
<b>Durable Medical Equipment and Other Supplies</b>	
Durable medical equipment	50% coinsurance <sup>5,8</sup>
Diabetic supplies	20% coinsurance <sup>5</sup>
Prosthetics and orthotics	\$20 / visit
<b>Mental Health Services</b>	
<b>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.<sup>7</sup></b>	
Office visits	\$10 / visit
Group therapy	\$10 / visit
Other outpatient items and services	\$10 / visit
Inpatient	50% coinsurance <sup>5,8</sup>
<b>Chemical Dependency Services</b>	
Office visits	\$10 / visit
Group therapy	\$10 / visit
Other outpatient items and services	\$10 / visit
Inpatient	50% coinsurance <sup>5,8</sup>
Emergency services for acute alcohol or drug detoxification	50% coinsurance <sup>5,8</sup>
<b>Skilled Nursing, Home Health and Hospice Services</b>	
Skilled nursing facility services (maximum of 100 days per benefit period)	50% coinsurance <sup>5,8</sup>
Home health services (maximum of 100 visits per calendar year)	\$10 / visit
Hospice care - inpatient	\$0 / admission <sup>8</sup>
Hospice care - outpatient	\$0 / visit
<b>Pediatric Vision Services</b>	
Eye Exam	\$0 / visit
Glasses or contact lenses in lieu of glasses	1 pair per year, covered in full
<b>Pediatric Dental Services</b>	
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.	
<b>Prescription Drug Coverage<sup>9</sup></b>	
Preferred Generic/Preferred Brand/Non-preferred medications up to 30 day supply	\$10 / \$40 / \$70
Preferred Generic/Preferred Brand/Non-preferred medications for a 90 day supply by mail order (for maintenance medications only)	\$20 / \$80 / \$140
Preventive prescription drugs including Preferred Generic and prescribed over-the-counter contraceptives	\$0

## Notes

<sup>1</sup> In a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out-of-pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out-of-pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out-of-pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.

<sup>2</sup> Copayments for supplemental benefits (Assisted Reproductive Technologies, Chiropractic Services, Adult Vision, etc.) 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> "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.

<sup>5</sup> Of contracted rates

<sup>6</sup> Copayment depends on type and location of service.

<sup>7</sup> 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.

<sup>8</sup> Deductible applies

<sup>9</sup> Member cost-share will not exceed \$200 per individual prescription of up to a 30-day supply of a covered oral anti-cancer drug.

*Notes, cont.*

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.