Summary of Benefits

Sharp Silver 70 HMO A w/Child Dental 1500/45/20%

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 (per individual/per family) - applies only to those covered benefits indicated	$1,500 / $3,000
Brand Drugs (per individual/per family) - applies only to covered formulary and non-formulary brand drugs	$500 / $1,000
There is no deductible for dental coverage under this plan.	$0
Annual Out of Pocket Maximum[1]	
Annual out of pocket maximum (per individual/per family)	$6,250 / $12,500
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[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.	$45 / visit
Specialist Physician office visit for consultation, treatment, diagnostic testing, etc.	$65 / visit
Other Practitioner office visit, including acupuncture[3]	$45 / visit
Laboratory tests and services	$45 / visit
Radiology services (x-rays and diagnostic imaging)	$65 / visit
Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	20% coinsurance[4,7]
Allergy testing	$65 / visit
Allergy injections	$45 / visit
Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)	
Outpatient surgery	20% coinsurance[4]
Infusion therapy (including but not limited to chemotherapy)	variable[5]
Dialysis	$0
Rehabilitation services: physical, occupational and speech therapy	$45 / visit
Habilitation services	$45 / visit
Radiation therapy	variable[5]
Hospitalization	
Inpatient services (facility fee/physician or surgeon fee)	20% coinsurance[4,7] / 20% coinsurance[4]
Organ transplant (facility fee/physician or surgeon fee)	20% coinsurance[4,7] / 20% coinsurance[4]
Inpatient rehabilitation (facility fee/physician or surgeon fee)	20% coinsurance[4,7] / 20% coinsurance[4]
Emergency and Urgent Care Services	
Emergency room services (waived if admitted to the hospital)	$250 / visit[7]
Ambulance in connection with hospital admission or emergency services	$250 [7]
Urgent care services	$90 / visit
Maternity Care	
Prenatal and postpartum office visits	$0 / visit
Hospitalization (facility fee/physician or surgeon fee)	20% coinsurance[4,7] / 20% coinsurance[4]
Breastfeeding support, supplies and counseling	$0

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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]
Infertility services (diagnosis and treatment of underlying condition)	50% coinsurance[4]
Durable Medical Equipment and Other Supplies	
Durable medical equipment	20% coinsurance[4]
Diabetic supplies	20% coinsurance[4]
Prosthetics and orthotics	$65 / 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.[6]	
Inpatient	20% coinsurance[4,7]
Office visits	$45 / visit
Home-based applied behavioral analysis for treatment of pervasive developmental disorder or autism	20% coinsurance[4]
Chemical Dependency Services	
Emergency services for acute alcohol or drug detoxification	$250 / visit[7]
Inpatient	20% coinsurance[4,7]
Office visits	$45 / visit
Skilled Nursing, Home Health and Hospice Services	
Skilled nursing facility services (maximum of 100 days per benefit period)	20% coinsurance[4,7]
Home health services (maximum of 100 visits per calendar year)	20% coinsurance[4]
Hospice care - inpatient	$0 / admission
Hospice care - outpatient	$0 / visit
Pediatric Vision Services	
Eye Exam	$0 / visit
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 the applicable cost-sharing information.	
Prescription Drug Coverage[8]	
Generic Formulary/Brand Formulary/Non-Formulary/Specialty medications up to 30 day supply	$15 / $50[7] / $70[7] / 20%[7]
Generic Formulary/Brand Formulary/Non-Formulary/Specialty medications up to 90 day supply by mail order (for maintenance medications only)	$30 / $100[7] / $140[7] / 20%[7]
Generic Formulary and prescribed over-the-counter contraceptives for women	$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 (copayments and coinsurance, but not yet 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.

[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, other office visits not provided by either Primary Care or Specialty Physicians or 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.

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).

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