Summary of Benefits

SDPEBA HMO NG 3 L

Select Plan (Active)

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
Annual Deductible for Specific Services[1,2]	
Calendar year medical deductible (per individual/per family) - applies only to those covered benefits indicated	$0
Calendar year pharmacy deductible (per individual/per family) - applies only to covered preferred and non-preferred brand drugs	$150 / $300
Annual Out of Pocket Maximum[2]	
Annual out of pocket maximum (per individual/per family)	$3,000 / $6,000
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[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.	$20 / visit
Specialist Physician office visit for consultation, treatment, diagnostic testing, etc.	$30 / visit
Laboratory tests and services	$0
Radiology services (x-rays and diagnostic imaging)	$0
Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	$50 / visit
Allergy testing	$30 / visit
Allergy injections	$10 / visit
Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)	
Outpatient facility fee	15% coinsurance[4]
Outpatient Physician/Surgeon fee	15% coinsurance[4]
Infusion therapy (including but not limited to chemotherapy)	Variable[5]
Dialysis	$0
Rehabilitation services: physical, occupational and speech therapy	$30 / visit
Habilitation services	$30 / visit
Radiation therapy	variable[5]
Hospitalization (including but not limited to inpatient services, organ transplant, and inpatient rehabilitation)	
Facility fee	$500 / admission
Physician/surgeon fee	$0
Emergency and Urgent Care Services	
Emergency room facility fee (waived if admitted to the hospital)	$100 / visit
Emergency room physician fee (waived if admitted to the hospital)	$0
Urgent care services	$30 / visit
Medical Transportation	
Emergency medical transportation	$0
Non-emergency medical transportation	$0

Summary of Benefits

SDPEBA HMO NG 3 L
Select Plan (Active)

Covered Benefits	Cost Share
Maternity Care	
Prenatal and postpartum office visits	$0
Delivery and all inpatient services - Hospital	$500 / admission
Delivery and all inpatient services - Professional	$0
Breastfeeding support, supplies and counseling	$0
Doula Services[10]	
Prenatal and postpartum visits	$0
Family Planning Services	
Contraceptives (including but not limited to all FDA-approved drugs, supplies, devices, implants, injections, and other products)	$0
Voluntary sterilization - women	$0
Voluntary sterilization - men	$0
Interruption of pregnancy (including but not limited to office visits, outpatient surgery, and inpatient services)	$0
Infertility services (diagnosis and treatment of underlying condition) and Fertility Services	
Primary Care Physician office visit	$20 / visit
Specialist Physician office visit	$30 / visit
Laboratory tests and services	$0
Radiology services (x-rays and diagnostic imaging)	$0
Outpatient facility fee	15% coinsurance[4]
Outpatient Physician/Surgeon fee	15% coinsurance[4]
Artificial Insemination and Assisted Reproductive Technologies (ART)[8]	variable[5]
Durable Medical Equipment and Other Supplies	
Durable medical equipment	50% coinsurance[4]
Diabetic supplies	20% coinsurance[4]
Prosthetics and orthotics	$30 / visit
Mental Health Services[6]	
Office visits	$20 / visit
Group therapy	$20 / visit
Other outpatient items and services (see end note for included healthcare services)	15% coinsurance[4]
Inpatient facility fee	$500 / admission
Inpatient physician fee	$0
Emergency services facility fee (waived if admitted)	$100 / visit
Emergency services physician fee (waived if admitted)	$0
Emergency psychiatric transportation	$0
Non-emergency psychiatric transportation	$0
Urgent care services	$30 / visit

Summary of Benefits

SDPEBA HMO NG 3 L
Select Plan (Active)

Covered Benefits	Cost Share
Substance Use Disorder Services[6]	
Office visits	$20 / visit
Group therapy	$7 / visit
Other outpatient items and services (see end note for included healthcare services)	15% coinsurance[4]
Inpatient facility fee	$500 / admission
Inpatient physician fee	$0
Emergency services facility fee for alcohol or drug detoxification (waived if admitted)	$100 / visit
Emergency services physician fee for alcohol or drug detoxification (waived if admitted)	$0
Emergency substance use disorder transportation	$0
Non-emergency substance use disorder transportation	$0
Urgent care services	$30 / visit
Skilled Nursing, Home Health and Hospice Services	
Skilled nursing facility services (maximum of 100 days per calendar year)	$200 / admission
Home health services (cost share per visit - maximum of 100 visits per calendar year)	$30 / visit
Hospice care - inpatient	$0
Hospice care - outpatient	$0
Prescription Drug Coverage[7,9]	
Preferred Generic/Preferred Brand/Non-preferred medications up to 30 day supply	$16 / $35[1] / $70[1]
Preferred Generic/Preferred Brand/Non-preferred medications for a 90 day supply by mail order (for maintenance medications only)	$32 / $70[1] / $140[1]
Preventive prescription drugs including Preferred Generic and over-the-counter contraceptives	$0
Supplemental Benefits[2]	
Chiropractic and Acupuncture services (maximum of 20 visits combined per benefit year)	$15 / visit

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 maximum amount. Cost sharing payments (copayments and coinsurance, but not premiums) made by each individual in a family contribute to the family out-of-pocket maximum. 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 out-of-pocket maximum. Copayments for supplemental benefits (Chiropractic Services, 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]Of contracted rates

[5]Out of pocket cost is based on type and location of service (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]All medically necessary treatment of mental health and substance use disorders is covered under this plan.

[7]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.

[8] For treatment of diagnosed Infertility. Including but not limited to Assisted Hatching, In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Intracytoplasmic Sperm Injections (ICSI), and Zygote Intrafallopian Transfer (ZIFT). Up to a maximum of three completed oocyte retrievals (egg retrievals) with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine (ASRM), using single embryo transfer when recommended and medically appropriate.

[9] Self-administered outpatient prescription medication for treatment of diagnosed Infertility is covered. Refer to the Sharp Health Plan Formulary to determine the tier placement of each prescribed fertility medication.

[10] Doula Services are covered at no charge up to the allowable visit limits for members in the Plan's Maternal Mental Health Case Management Program. This program is designed to assist mothers (prenatal, postpartum, and interpregnancy) with needs, such as understanding health care benefits, making appointments, and providing health plan and community resources. The Plan offers case management services to members who qualify, which includes members with a maternal mental health condition. Referrals are accepted from any source, including, but not limited to, treating providers (OB/GYN, PCP), members, and/or a facility utilization reviewer/case manager.

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.