Summary of Benefits

Classic Plan
Sharp 20/20/100 - L

MEA HMO NG 1 L

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 and Out of Pocket Maximum	
There are no deductibles for the medical benefits under this plan	$0
Calendar year out of pocket maximum (per individual/per family)[1]	$1,500[1] / $3,000[1]
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, treatments, diagnostic testing, etc.	$20 / visit
Specialist Physician office visit for consultation, treatments, diagnostic testing, etc.	$20 / visit
Laboratory services	$0
Radiology services (x-rays)	$0
Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	$0 / procedure
Allergy testing	$20 / visit
Allergy injections	$3/ visit
Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)	
Outpatient surgery	$0 / procedure
Infusion therapy (including but not limited to chemotherapy)	Variable[3]
Dialysis	$0
Physical, occupational and speech therapy	$20 / visit
Radiation therapy	Variable[3]
Hospitalization	
Inpatient services	$100 / admission
Organ transplant	$100 / admission
Inpatient rehabilitation	$100 / admission
Emergency and Urgent Care Services	
Emergency room services (waived if admitted to the hospital)	$75 / visit
Ambulance in connection with hospital admission or emergency services	$0
Urgent care services	$20 / visit
Maternity Care	
Prenatal and postpartum office visits	$20 / visit
Hospitalization	$100 / admission
Breastfeeding support, supplies and counseling	$0

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Covered Benefits, continued	*Copayments*
Family Planning Services	
Injectable contraceptives (including but not limited to Depo Provera)	$0
Voluntary sterilization - women	$0
Voluntary sterilization - men	$75
Interruption of pregnancy	$150
Infertility services (diagnosis and treatment of underlying condition)	50% coinsurance[4]
Durable Medical Equipment and Other Supplies	
Durable medical equipment	$0
Diabetic supplies	$0
Prosthetics and orthotics	$20 / visit
Mental Health Services	
Diagnosis and treatment of Severe Mental Illnesses for all members, Serious Emotional Disturbances for children, and other mental health conditions are covered with the copayments listed below.[5]	
Office visits	$20 / visit
Group therapy	$20 / visit
Other outpatient items and sevices	$20 / visit
Inpatient	$100 / admission
Home-based applied behavioral analysis for treatment of pervasive developmental disorder or autism	$0
Chemical Dependency Services	
Office visits	$20 / visit
Group therapy	$20 / visit
Other outpatient items and sevices	$20 / visit
Inpatient	$100 / admission
Emergency services for acute alcohol or drug detoxification	$75 / visit
Skilled Nursing, Home Health and Hospice Services	
Skilled nursing facility services (maximum of 100 consecutive days per calendar year)	$0
Home health services (maximum of 100 visits per calendar year)	$0
Hospice care - inpatient	$0
Hospice care - outpatient	$0
Prescription Drug Coverage[6]	
Preferred Generic/Preferred Brand/Non-preferred medications up to 30 day supply	$15 / $30 / $50
Preferred Generic/Preferred Brand/Non-preferred medications up to 90 day supply by mail order (for maintenance medications only)	$30 / $60 / $100
Preferred Generic and prescribed over-the-counter contraceptives for women	$0
Supplemental Benefits	
Chiropractic and Acupuncture services (maximum of 40 visits combined per benefit year)	$15 / visit
Hearing aids or ear molds (maximum up to $1000 every 36 months)	Variable[3]
Vision services (once every 12 months / Exam only)	$0
Artificial insemination services up to a lifetime maximum of three inseminations	50% coinsurance[4]

Notes

[1] Copayments for supplemental benefits (Assisted Reproductive Technologies, Acupuncture, Chiropractic Services, and Vision) do not apply to the annual 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] Copayment depends on type and location of service

[4] Of contracted rates

[5] 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.

[6] Member cost-share will not exceed $200 per individual prescription of up to 30-day supply of a covered oral anti-cancer drug.

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, and partial hospitalization. "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.

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