

Summary of Benefits

Select Plan
Sharp 30/40/750 - L
MEA HMO NG 3 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.SHARPEALTHPLAN.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 brand drug deductible (per individual/per family) - applies only to covered preferred and non-preferred brand drugs \$150¹ / \$300¹

Calendar year out of pocket maximum (per individual/per family)² \$3,000² / \$6,000²

Lifetime Maximum

There are no lifetime maximums for this plan Unlimited

Preventive Care³

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 HealthSM 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. \$30 / visit

Specialist Physician office visit for consultation, treatments, diagnostic testing, etc. \$40 / visit

Laboratory services \$0

Radiology services (x-rays) \$0

Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT) \$100 / procedure

Allergy testing \$40 / visit

Allergy injections \$10 / visit

Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)

Outpatient surgery \$325 / procedure

Infusion therapy (including but not limited to chemotherapy) Variable⁴

Dialysis \$0

Physical, occupational and speech therapy \$40 / visit

Radiation therapy Variable⁴

Hospitalization

Inpatient services \$750 / admission

Organ transplant \$750 / admission

Inpatient rehabilitation \$750 / admission

Emergency and Urgent Care Services

Emergency room services (waived if admitted to the hospital) \$100 / visit

Ambulance in connection with hospital admission or emergency services \$100

Urgent care services \$40 / visit

Maternity Care

Prenatal and postpartum office visits \$0

Hospitalization \$750 / 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 ⁵
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Durable Medical Equipment and Other Supplies

Durable medical equipment	50% coinsurance ⁵
Diabetic supplies	20% coinsurance ⁵
Prosthetics and orthotics	\$40 / 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.⁶

Office visits	\$30 / visit
Group therapy	\$30 / visit
Other outpatient items and services	\$30 / visit
Inpatient	\$750 / admission
Home-based applied behavioral analysis for treatment of pervasive developmental disorder or autism	\$30 / visit

Chemical Dependency Services

Office visits	\$30 / visit
Group therapy	\$30 / visit
Other outpatient items and services	\$30 / visit
Inpatient	\$750 / admission
Emergency services for acute alcohol or drug detoxification	\$100 / visit

Skilled Nursing, Home Health and Hospice Services

Skilled nursing facility services (maximum of 100 consecutive days per calendar year)	\$200 / admission
Home health services (maximum of 100 visits per calendar year)	\$40 / visit
Hospice care - inpatient	\$0
Hospice care - outpatient	\$0

Prescription Drug Coverage⁷

Preferred Generic/Preferred Brand/Non-preferred medications up to 30 day supply	\$20 / \$35 ¹ / \$70 ¹
Preferred Generic/Preferred Brand/Non-preferred medications up to 90 day supply by mail order (for maintenance medications only)	\$40 / \$70 ¹ / \$140 ¹
Preferred Generic and prescribed over-the-counter contraceptives for women	\$0

Notes

¹ After deductible. Covered brand name drugs are subject to a calendar year deductible.

² Copayments for supplemental benefits (Assisted Reproductive Technologies, Acupuncture, Chiropractic Services, and Vision) 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 Copayment depends on type and location of service.

⁵ Of contracted rates.

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 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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