

Summary of Benefits

Classic Plan (Active)
SDPEBA HMO NG 2 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 SHARPEALTHPLAN.COM TO VIEW THE MEMBER HANDBOOK.

Covered Benefits

Cost Share

| Covered Benefits | Cost Share |
|--|-----------------------|
| Annual Deductible and Out of Pocket Maximum | |
| There are no deductibles for the medical benefits and pharmacy coverage under this plan | \$0 |
| Annual out of pocket maximum (per individual/per family) ¹ | \$1,500 / \$3,000 |
| Lifetime Maximum | |
| There are no lifetime maximums for this plan | Unlimited |
| Preventive Care² | |
| 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, treatment, diagnostic testing, etc. | \$20 / visit |
| Specialist Physician office visit for consultation, treatment, diagnostic testing, etc. | \$20 / 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) | \$0 / procedure |
| Allergy testing | \$20 / visit |
| Allergy injections | \$3 / visit |
| Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services) | |
| Outpatient facility fee | \$0 / procedure |
| Outpatient Physician/Surgeon fee | \$0 |
| Infusion therapy (including but not limited to chemotherapy) | variable ³ |
| Dialysis | \$0 |
| Rehabilitation services: physical, occupational and speech therapy | \$20 / visit |
| Habilitation services | Not covered |
| Radiation therapy | variable ³ |
| Hospitalization (including but not limited to inpatient services, organ transplant, and inpatient rehabilitation) | |
| Facility fee | \$100 / admission |
| Physician/surgeon fee | \$0 |
| Emergency and Urgent Care Services | |
| Emergency room facility fee (waived if admitted to the hospital) | \$75 / visit |
| Emergency room physician fee (waived if admitted to the hospital) | \$0 |
| Urgent care services | \$20 / visit |
| Medical Transportation | |
| Emergency medical transportation | \$0 |
| Non-emergency medical transportation | \$0 |

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| Maternity Care | |
| Prenatal and postpartum office visits | \$0 |
| Delivery and all inpatient services - Hospital | \$100 / admission |
| Delivery and all inpatient services - Professional | \$0 |
| Breastfeeding support, supplies and counseling | \$0 |
| 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 Services⁵ | |
| Office visits | \$20 / visit |
| Group therapy | \$20 / visit |
| Other outpatient items and services (see end note for included healthcare services) | \$0 / visit |
| Inpatient facility fee | \$100 / admission |
| Inpatient physician fee | \$0 |
| Emergency services facility fee (waived if admitted) | \$75 / visit |
| Emergency services physician fee (waived if admitted) | \$0 |
| Emergency psychiatric transportation | \$0 |
| Non-emergency psychiatric transportation | \$0 |
| Urgent care services | \$20 / visit |
| Substance Use Disorder Services⁵ | |
| Office visits | \$20 / visit |
| Group therapy | \$7 / visit |
| Other outpatient items and services (see end note for included healthcare services) | \$0 |
| Inpatient facility fee | \$100 / admission |
| Inpatient physician fee | \$0 |
| Emergency services facility fee for alcohol or drug detoxification (waived if admitted) | \$75 / 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 | \$20 / visit |
| Skilled Nursing, Home Health and Hospice Services | |
| Skilled nursing facility services (maximum of 100 days per benefit period) | \$0 / admission |
| Home health services (cost share per visit - maximum of 100 visits per calendar year) | \$0 |
| Hospice care - inpatient | \$0 |
| Hospice care - outpatient | \$0 |

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Prescription Drug Coverage⁶

| | |
|--|---------------------|
| Preferred Generic/Preferred Brand/Non-preferred medications up to 30 day supply | \$15 / \$30 / \$50 |
| Preferred Generic/Preferred Brand/Non-preferred medications for a 90 day supply by mail order (for maintenance medications only) | \$30 / \$60 / \$100 |
| Preventive prescription drugs including Preferred Generic and prescribed over-the-counter contraceptives | \$0 |

Supplemental Benefits¹

| | |
|--|------------------------------|
| 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

¹In 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 (Assisted Reproductive Technologies, Chiropractic Services, Vision, etc.) do not apply to the annual out of pocket maximum.

²Includes 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.

³Out 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).

⁴Of contracted rates

⁵All medically necessary treatment of mental health and substance use disorders is covered under this plan.

⁶Member 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.

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.