Summary of Benefits

Classic Plan (Active) SDPEBA HMO NG 2 L

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 Repetits

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN

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 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	\$(
Laboratory, radiology and other services for the early detection of disease when ordered by a Physician	\$(
Routine gynecological exams, immunizations and related laboratory services	\$(
Mammography	\$(
Prostate cancer screening	\$(
Colorectal cancer screenings including sigmoidoscopy and colonoscopy	\$0
Best Health SM Wellness Services	
On-line health education and wellness workshops and other wellness tools	\$(
Telephonic health coaching (weight management, tobacco cessation, stress management, physical activity, nutrition)	\$(
Professional Services	
Primary Care Physician office visit for consultation, treatment, diagnostic testing, etc.	\$20 / visi
Specialist Physician office visit for consultation, treatment, diagnostic testing, etc.	\$20 / visi
Laboratory tests and services	\$(
Radiology services (x-rays and diagnostic imaging)	\$0
Advanced radiology (including but not limited to MRI, MRA, MRS, CT scan, PET, MUGA, SPECT)	\$0 / visi
Allergy testing	\$20 / visi
Allergy injections	\$3 / visi
Outpatient Services (including but not limited to surgical, diagnostic and therapeutic services)	
Outpatient facility fee	\$0 / visi
Outpatient Physician/Surgeon fee	\$(
Infusion therapy (including but not limited to chemotherapy)	variable
Dialysis	\$(
Rehabilitation services: physical, occupational and speech therapy	\$20 / visi
Habilitation services	Not covered
Radiation therapy	variable
Hospitalization (including but not limited to inpatient services, organ transplant, and inpatient rehabilitation)	Variable
Facility fee	\$100 / admission
Physician/surgeon fee	\$1007 admission
	30
Emergency and Urgent Care Services Emergency room facility fee (waived if admitted to the hospital)	\$75 / visi
Emergency room physician fee (waived if admitted to the hospital)	\$/5 / VISI \$(
Urgent care services Medical Transportation	\$20 / visi
Emergency medical transportation	+1
Linergency medical dialisportation	\$(

Non-emergency medical transportation

\$0

Summary of Benefits

Classic Plan (Active) SDPEBA HMO NG 2 L

Covered Benefits Cost Share

Pernatal and postpartum office visits Pelwary and all impatient services - Hospital Selvery and all impatient services - Professional Selvery and all impatient services - Professional Seasetfeeding support, supplies and counseling Services (Impatient services - Professional Seasetfeeding support, supplies and counseling Services (Impatient services - Professional Seasetfeeding support, supplies and counseling Services (Impatient services (Indient of Depo Provera) Solutionary sterilization - women Solutionary st	Covered Benefits	Cost Share
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Reastfeeding support, supplies and courseling 30 Fortilization reaptives (including but not limited to Depo Provera) 6 6 Valuntary sterilization - women 50 50 Voluntary sterilization - women 50 50 Voluntary sterilization - women 50 50 Interruption of pregnancy (including but not limited to office visits, outpatient surgery, and inpatient services) 50 50 Interruption of pregnancy (including but not limited to office visits, outpatient surgery, and inpatient services) 50 50 Unable medical equipment and Other Supplies 50 50 Unable medical equipment and other supplies 50 50 Possible its supplies 50 50 Possible its supplies 50 50 Foresthetics and orthics \$20 70 Possible its supplies \$20 70 Office visits \$20 70 Office visits \$10 50 Inpatient facility fee \$10 50 Ingent care survices physician fee (waived if admitted) \$1 50 <t< td=""><td>Delivery and all inpatient services - Hospital</td><td>\$100 / admission</td></t<>	Delivery and all inpatient services - Hospital	\$100 / admission
Femily Planning Services 1.00 3.00 Injectable contraceptives (including but not limited to Depo Provera) 3.00 Voluntary sterilization - wome 5.75 Interruption of pregnancy (including but not limited to office vists, outpatient surgery, and inpatient services) 5.05 Interruption of pregnancy (including but not limited to office vists, outpatient surgery, and inpatient services) 5.00 Interfully services (diagnoss and treatment of underlying condition) 5.00 Durable medical equipment and Other Supplies 8.00 Durable medical equipment and Other Supplies 9.00 Possible Medical Equipment and Other Supplies 9.00 Possible Medical Equipment and Other Supplies 9.00 Prostal Agrand Agrand Agrand Supplies 9.00 Prostal Health Services 9.00 Prostal Health Services \$20 / visit Office visits \$20 / visit Office visits \$20 / visit Other outpatient items and services (see end note for included healthcare services) \$30 / visit Emergency services facility fee (waved if admitted) \$30 Emergency services physician fee (waved if admitted) \$30 Emergency services phys	Delivery and all inpatient services - Professional	\$0
Injectable contraceptives (including but not limited to Depo Provers) 50 Voluntary sterilization - women 50 Voluntary sterilization - women 575 Interruption of pregnancy (including but not limited to office visits, outpatient surgery, and inpatient services) 50 Interruption of pregnancy (including but not limited to office visits, outpatient surgery, and inpatient services) 50 Interruption of pregnancy (including but not limited to office visits, outpatient surgery, and inpatient services) 50 Unable (is applies) 50 Diabetic supplies 50 Orise diction supplies 50 Possible results of visits 50 Foresthetics and orthotics 50 Office visits 50 Office visits 50 Office visits 50 Office visits 50 Impatient facility fee 150 Impatient facility fee 50 Impatient facility fee (waived if admitted) 50 Emergency services physician fee waived if admitted) 50 Emergency services physician fee waived if admitted) 50 Origent case services 50 <td>Breastfeeding support, supplies and counseling</td> <td>\$0</td>	Breastfeeding support, supplies and counseling	\$0
Voluntary sterilization - women 30 Voluntary sterilization - men 375 Interruption of pregnancy (including but not limited to office visits, outpatient surgery, and inpatient services) 50 Interruption of pregnancy (including but not limited to office visits, outpatient surgery, and inpatient services) 50 Interruption of pregnancy (including but not limited to office visits, outpatient surgery, and inpatient services) 50 Durable Medical Equipment and Other Supplies 50 Durable medical equipment of present of visits of the company of the property of t	Family Planning Services	
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Infertility services (diagnosis and treatment of underlying condition) 50% coinsurance Durable Medical Equipment and Other Supplies 50 Durable in call equipment 50 Diabetic supplies 50 Prosthetics and orthotics \$50 visit Mental Health Services \$50 visit Office visits \$20 visit Group therapy \$20 visit Other outpatient items and services (see end note for included healthcare services) \$100 visits Inpatient physician fee \$100 visits Emergency services facility fee (waived if admitted) \$75 visit Emergency services physician fee (waived if admitted) \$0 Emergency services physician fee (waived if admitted) \$0 Emergency services physician fee (waived if admitted) \$0 Emergency psychiatric transportation \$0 Non-emergency psychiatric transportation \$0 Urgent care services \$20 visit Group therapy \$10 Other outpatient items and services (see end note for included healthcare services) \$10 Other outpatient items and services (see end note for included wair included in admitted) \$10	Voluntary sterilization - men	\$75
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Emergency services facility fee for alcohol or drug detoxification (waived if admitted) Emergency services physician fee for alcohol or drug detoxification (waived if admitted) Emergency substance use disorder transportation Non-emergency substance use disorder transportation Virgent care services Skilled Nursing, Home Health and Hospice Services Skilled nursing facility services (maximum of 100 days per benefit period) Home health services (cost share per visit - maximum of 100 visits per calendar year) Hospice care - inpatient \$75 / visit \$7	Inpatient facility fee	\$100 / admission
Emergency services physician fee for alcohol or drug detoxification (waived if admitted) Emergency substance use disorder transportation Non-emergency substance use disorder transportation Urgent care services Skilled Nursing, Home Health and Hospice Services Skilled nursing facility services (maximum of 100 days per benefit period) Home health services (cost share per visit - maximum of 100 visits per calendar year) Hospice care - inpatient \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$	Inpatient physician fee	\$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	Emergency services facility fee for alcohol or drug detoxification (waived if admitted)	\$75 / visit
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	Emergency services physician fee for alcohol or drug detoxification (waived if admitted)	\$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	Emergency substance use disorder transportation	\$0
Skilled Nursing, Home Health and Hospice ServicesSkilled nursing facility services (maximum of 100 days per benefit period)\$0 / admissionHome health services (cost share per visit - maximum of 100 visits per calendar year)\$0Hospice care - inpatient\$0	Non-emergency substance use disorder transportation	\$0
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Home health services (cost share per visit - maximum of 100 visits per calendar year) Hospice care - inpatient \$0	Skilled Nursing, Home Health and Hospice Services	
Hospice care - inpatient \$0	Skilled nursing facility services (maximum of 100 days per benefit period)	\$0 / admission
<u> </u>	Home health services (cost share per visit - maximum of 100 visits per calendar year)	\$0
Hospice care - outpatient \$0	Hospice care - inpatient	\$0
	Hospice care - outpatient	\$0

Summary of Benefits

Classic Plan (Active) SDPEBA HMO NG 2 L

Covered Benefits Cost Share

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 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 Benefits ¹	
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.