Sutter Health Plus
Your Health Plan

HEALTH PLAN BENEFITS AND COVERAGE MATRIX

THIS BENEFITS AND COVERAGE MATRIX (BCM) IS INTENDED TO HELP YOU COMPARE COVERAGE AND BENEFITS AND IS A SUMMARY ONLY. THIS BCM SHOWS THE AMOUNT YOU WILL PAY FOR COVERED SERVICES. FOR A DETAILED DESCRIPTION OF COVERAGE, BENEFITS AND LIMITATIONS, THE EVIDENCE OF COVERAGE AND DISCLOSURE FORM (EOC) SHOULD BE CONSULTED. PLEASE CONTACT SUTTER HEALTH PLUS (SHP) FOR ADDITIONAL INFORMATION.

(Important disclaimer regarding optional benefits: Cost Sharing and benefit information for acupuncture and chiropractic benefits elected by your employer group are not reflected on this Benefits and Coverage Matrix. Most optional benefits do not accrue to your Deductible, if applicable, and to your Out-of-Pocket Maximum. Please refer to the separate plan documents for elected optional benefits to determine Cost Sharing, Covered Services and any limitations or exclusions.)

BENEFIT PLAN NAME: Schools Insurance Group HMO

Annual Deductible for Certain Medical Services	
For self-only enrollment (Subscriber-only)	None
For any one Member in a Family	None
For an entire Family	None
Separate Annual Deductible for Prescription Drugs	
For self-only enrollment (Subscriber-only)	$100
For any one Member in a Family	$100
For an entire Family	$200
Annual Out-of-Pocket Maximum (OOPM) (Combined Medical and Pharmacy)	
You will not pay any more Cost Sharing if the amount you paid for Copayments, Coinsurance and Deductibles for Covered Services in a calendar year totals one of the following amounts:	
For self-only enrollment (Subscriber-only)	$1,500
For any one Member in a Family	$1,500
For an entire Family	$3,000

Lifetime Maximum	
Lifetime benefit maximum	None

Benefits	Member Cost Sharing
Preventive Care Services If you receive a non-Preventive Care Service during a preventive care visit, then you may be responsible for the Cost Sharing of the additional non-Preventive Care Service. In addition, if abnormalities are found during a preventive care exam or screening, such as a mammogram for breast cancer screening or a colonoscopy for colorectal cancer screening, then follow-up testing or procedures may be considered non-Preventive Care Services and Cost Sharing may apply. Please refer to the EOC for more information on Preventive Care Services.	
Annual eye exam for refraction	No charge
Family planning counseling and services, including preconception care visits (see Endnotes)	No charge
Routine preventive immunizations/vaccines	No charge
Routine preventive visits (e.g., well-child and well-woman visits), inclusive of routine preventive counseling, physical exams, procedures and screenings (e.g., screenings for diabetes and cervical cancer)	No charge
Routine preventive imaging and laboratory services	No charge
Preventive care drugs, supplies, equipment and supplements (refer to the SHP Formulary for a complete list)	No charge
Outpatient Services	
Primary Care Physician (PCP) office visit to treat an injury or illness	Office visit: $25 copay per visit Telehealth visit: $10 copay per visit
Other practitioner office visit (see Endnotes)	Office visit: $25 copay per visit Telehealth visit: $10 copay per visit
Acupuncture services (see Endnotes)	$25 copay per visit
Chiropractic services	Not covered
Sutter Walk-in Care visit, where available	Office/telehealth visit: $10 copay per visit

Specialist office visit	Office visit: $50 copay per visit Telehealth visit: $25 copay per visit
Allergy services provided as part of a Specialist visit (includes testing, injections and serum) There is no Cost Sharing for serum billed separately from the Specialist office visit or for allergy injections that are provided when the Specialist is not seen and no other services are received.	No charge
Medically administered drugs dispensed to a Participating Provider for administration	No charge
Outpatient rehabilitation services	$25 copay per visit
Outpatient habilitation services	Not covered
Outpatient surgery facility fee	$100 copay per visit
Outpatient surgery Professional fee	No charge
Outpatient non-office visit (see Endnotes)	No charge
Non-preventive laboratory services	$20 copay per visit
Radiological and nuclear imaging (e.g., MRI, CT and PET scans)	$50 copay per procedure
Diagnostic and therapeutic imaging and testing (e.g., X-ray, mammogram, ultrasound, EKG/ECG, cardiac stress test and cardiac monitoring)	$20 copay per procedure
Hospitalization Services	
Inpatient facility fee (e.g., hospital room, medical supplies and inpatient drugs including anesthesia)	$250 copay per admission
Inpatient Professional fees (e.g., surgeon and anesthesiologist)	No charge
Emergency and Urgent Care Services	
Emergency room facility fee	$100 copay per visit
Emergency room Professional fee	No charge
This emergency room Cost Sharing does not apply if admitted directly to the hospital as an inpatient for Covered Services. If admitted directly to the hospital for an inpatient stay, the Cost Sharing for “Hospitalization Services” will apply.	

Urgent Care visit	$25 copay per visit
Ambulance Services	
Medical transportation (including emergency and non-emergency)	$50 copay per trip
Outpatient Prescription Drugs, Supplies, Equipment and Supplements	
Covered Outpatient Prescription Drugs obtained at a Participating Pharmacy through retail, mail order or Specialty Pharmacy services and in accordance with SHP's drug formulary guidelines:	
Tier 1 - Most Generic Drugs and low-cost preferred brand name drugs	Retail-30: $10 copay per prescription for up to a 30-day supply Retail-90/Mail order: $20 copay per prescription for up to a 100-day supply
Tier 2 - Preferred brand name drugs, non-preferred Generic Drugs and drugs recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost	Retail-30: $30 copay per prescription after pharmacy deductible for up to a 30-day supply Retail-90/Mail order: $60 copay per prescription after pharmacy deductible for up to a 100-day supply
Tier 3 - Non-preferred brand name drugs or drugs that are recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost *(These generally have a preferred and often less costly therapeutic alternative at a lower tier)*	Retail-30: $60 copay per prescription after pharmacy deductible for up to a 30-day supply Retail-90/Mail order: $120 copay per prescription after pharmacy deductible for up to a 100-day supply
Tier 4 - Drugs that are biologics, drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars ($600) net of rebates for a one-month supply	Specialty Pharmacy: 20% coinsurance up to $100 per prescription after pharmacy deductible for up to a 30-day supply
Durable Medical Equipment, Prosthetics, Orthotics and Supplies	
Durable medical equipment for home use	20% coinsurance
Ostomy and urological supplies; prosthetic and orthotic devices	No charge

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Mental Health & Substance Use Disorder (MH/SUD) Services	
MH/SUD inpatient facility fee (see Endnotes)	$250 copay per admission
MH/SUD inpatient Professional fees (see Endnotes)	No charge
MH/SUD individual outpatient office visit (e.g., evaluation and treatment services)	Office visit: $25 copay per visit Telehealth visit: $10 copay per visit
MH/SUD group outpatient office visit (e.g., evaluation and treatment services)	Office visit: $12.50 copay per visit Telehealth visit: $10 copay per visit
MH/SUD other outpatient services (see Endnotes)	No charge
Maternity Care	
Routine prenatal care visits, after confirmation of pregnancy, and the first postnatal care visit Maternity care provided at office visits or other outpatient locations may include diagnostic tests and services described elsewhere in this BCM that result in Cost Sharing (e.g., see “Diagnostic and therapeutic imaging and testing” for ultrasounds and “Non-preventive laboratory services” for lab tests).	Office/telehealth visit: No charge
Breastfeeding counseling, services and supplies (e.g., double electric or manual breast pump)	No charge
Labor and delivery inpatient facility fee (e.g., anesthesia and delivery services for all inpatient childbirth methods)	$250 copay per admission
Labor and delivery inpatient Professional fees (e.g., anesthesiologist, nurse midwife and obstetrician)	No charge
Abortion Services	
Abortion (e.g., medication or procedural abortions) Abortion-related services, including pre-abortion and follow-up services	No charge

Other Services for Special Health Needs	
Skilled Nursing Facility services (up to 100 days per benefit period)	$100 copay per day up to a maximum of 5 days per admission
Home health care (up to 100 visits per calendar year)	No charge
Hospice care	No charge

Endnotes:

1. Family Deductibles (when applicable) and Out-of-Pocket Maximums (OOPM) are equal to two times the "self-only" values. In a Family plan, a Member is only responsible for the "one Member in a Family" Deductible and OOPM. Deductibles and other Cost Sharing payments made by each Member in a Family contribute to the "entire Family" Deductible and OOPM. Once the "entire Family" Deductible amount is satisfied by any combination of Member Deductible payments, plan Copayment or Coinsurance amounts apply until the "entire Family" OOPM is reached, after which the plan pays all costs for Covered Services for all Family Members.

2. Cost Sharing for all Essential Health Benefits, including that which accumulates toward an applicable Deductible, accumulates toward the OOPM.

3. Outpatient Prescription Drugs, when prescribed, are Medically Necessary generic or brand-name drugs in accordance with SHP's formulary guidelines. All Medically Necessary prescription drug Cost Sharing contributes toward your Deductible, if applicable, and OOPM.

   Outpatient Prescription Drugs are available for up to a 30-day supply through a retail Participating Pharmacy. Maintenance Drugs are available for up to a 100-day supply through the CVS Health Retail-90 Network or through the CVS Caremark Mail Service Pharmacy. Specialty Drugs are only available for up to a 30-day supply through CVS Specialty. Specialty Drugs are not exclusive to Tier 4 and, regardless of tier placement, have the same fill requirements.

   FDA-approved, self-administered hormonal contraceptives that are dispensed at one time for a Member by a provider, pharmacist or other location licensed or authorized to dispense drugs or supplies, may be covered at up to a 12-month supply. For a 12-month supply of contraceptives, applicable Cost Sharing will be up to four times the retail Cost Share.

4. The "Other practitioner office visit" benefit includes therapy visits and other office visits not provided by either PCPs or Specialists or visits not specified in another benefit.

5. The "Family planning counseling and services" benefit does not include male sterilization procedures, which are covered under the "Outpatient surgery" benefits listed above. This

benefit also does not include termination of pregnancy which is covered under the “Abortion Services” benefit category listed above.

6. Acupuncture is typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.
7. The “Outpatient non-office visit” benefit includes, but is not limited to, services such as outpatient chemotherapy, outpatient dialysis, outpatient radiation therapy, outpatient infusion therapy, sleep studies and similar outpatient services performed in a non-office setting. This benefit also includes storage of cryopreserved reproductive materials included in the fertility preservation services benefit. Storage of cryopreserved materials is not a per visit service and is typically billed on an annual basis at the “Outpatient non-office visit” Cost Sharing.
8. The “MH/SUD inpatient” benefits include, but are not limited to: inpatient psychiatric hospitalization, including inpatient psychiatric observation; inpatient Behavioral Health Treatment for autism spectrum disorder; treatment in a Residential Treatment Center; inpatient chemical dependency hospitalization, including medical detoxification and treatment for withdrawal symptoms; and prescription drugs prescribed in an inpatient setting, excluding a Residential Treatment Center. Refer to the Outpatient Prescription Drug benefit for coverage details for prescription drugs prescribed in a Residential Treatment Center.
9. “MH/SUD other outpatient services” include, but are not limited to: psychological testing; multidisciplinary intensive day treatment programs such as partial hospitalization and intensive outpatient programs; outpatient psychiatric observation for an acute psychiatric crisis; outpatient Behavioral Health Treatment for autism spectrum disorder delivered in any outpatient setting, including the home; and other outpatient intermediate services that fall between inpatient care and outpatient office visits.
10. Cost Sharing for services with Copayments is the lesser of the Copayment amount or allowed amount.
11. In order to be covered, most non-preventive care medical services require a referral from your PCP. Many of these services also require Prior Authorization by your PCP’s medical group or SHP. Please consult the EOC for complete details on referral and Prior Authorization requirements for all Covered Services.
12. For this Benefit Year, this benefit plan provides eligible Medicare beneficiaries with prescription drug coverage that is expected to pay on average as much as the standard Medicare Part D coverage in accordance with Centers for Medicare and Medicaid Services. The coverage is at least as good as the Medicare drug benefit and therefore considered “creditable coverage”. Refer to *Medicare.gov* for complete details.

Chiropractic and Acupuncture Schedule of Benefits Offered by ACN Group of California, Inc.

BENEFIT PLAN:

$15 Copayment per visit

20 visits combined Annual Benefit Maximum for Acupuncture and/or Chiropractic Services

CLAIMS DETERMINATION PERIOD:

Calendar Year

Your Group makes available to you and your eligible dependents a complementary health benefits program for chiropractic and acupuncture. This program is provided through an arrangement with the ACN Group of California, Inc. dba OptumHealth Physical Health of California (OptumHealth). OptumHealth monitors the quality of the care provided by participating OptumHealth providers.

How to Use the Program

With OptumHealth, you have direct access to more than 3,500 credentialed Chiropractors and over 950 credentialed Acupuncturists servicing California. You are not required to predesignate an OptumHealth provider or to obtain a medical referral from your primary care physician prior to seeking Chiropractic or Acupuncture Services. Additionally, you may change participating Chiropractors or Acupuncturists at any time.

Our program is designed for your convenience. You simply pay your Copayment at each visit. There are no deductibles or claim forms to fill out. Your OptumHealth provider coordinates all services and billing directly with OptumHealth.

Annual Benefits

Benefits include Chiropractic Services and Acupuncture Services that are Medically Necessary services rendered by an OptumHealth Participating Provider. In the case of Acupuncture Services, the services must be for Medically Necessary diagnosis and treatment to correct body imbalances and conditions such as low back pain, sprains and strains (such as tennis elbow or sprained ankle), nausea, headaches, menstrual cramps, carpal tunnel syndrome, and other conditions. In the case of Chiropractic Services, the services must be for Medically Necessary diagnosis and treatment to reduce pain and improve functioning of the neuromusculoskeletal system.

Calculation of Annual Benefit Maximum Limits

Each visit to an OptumHealth Participating Provider, as described below, requires a Copayment by the Member. A maximum number of visits to either an OptumHealth participating Chiropractor or participating Acupuncturist, or any combination of both, per Claims Determination Period will apply to each Member.

Chiropractic Services: Adjunctive therapy is allowed at each office visit. If adjunctive therapy is provided without a chiropractic adjustment, the adjunctive therapy will count as an office visit toward the maximum benefit. If an examination or re-examination is supplied without an adjustment, the examination or re-examination will count as an office visit toward the maximum benefit.

Acupuncture Services: Adjunctive therapy is allowed at each office visit. If adjunctive therapy is provided without acupuncture treatment, the adjunctive therapy will count as an office visit toward the maximum benefit. If an examination or re-examination is supplied without acupuncture treatment, the examination or re-examination will count as an office visit toward the maximum benefit.

Provider Eligibility

OptumHealth only contracts with duly licensed California Chiropractors and Acupuncturists. Members must use OptumHealth Participating Providers to receive their maximum benefit.

Types of Covered Services

Chiropractic Services:

1. An initial examination is performed by the OptumHealth participating Chiropractor to determine the nature of the Member's problem, and to provide, or commence, in the initial examination, Medically Necessary services that are Covered Services, to the extent consistent with professionally recognized standards of practice, and to prepare a treatment plan of services to be furnished. An initial examination will be provided to a Member if the Member seeks services from an OptumHealth participating Chiropractor for any injury, illness, disease, functional disorder or condition with regard to which the Member is not, at the time, receiving services from the OptumHealth participating

Chiropractor. A Copayment will be required for such examination.

2. Subsequent office visits, as set forth in a treatment plan, may involve a chiropractic adjustment, a brief re-examination and other services, in various combinations. A Copayment will be required for each visit to the office.
3. Adjunctive therapy, as set forth in a treatment plan, may involve therapies such as ultrasound, electrical muscle stimulation and other therapies.
4. A re-examination may be performed by the OptumHealth participating Chiropractor to assess the need to continue, extend or change a treatment plan. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a Copayment will be required.
5. X-rays and laboratory tests are a covered benefit to examine any aspect of the Member's condition.
6. Chiropractic appliances are payable up to a maximum of $50 per year when prescribed by an OptumHealth participating Chiropractor.

Acupuncture Services:

1. An initial examination is performed by the OptumHealth participating Acupuncturist to determine the nature of the Member's problem and to provide or commence, in the initial examination, Medically Necessary services that are Covered Services, to the extent consistent with professionally recognized standards of practice, and to prepare a treatment plan of services to be furnished. An initial examination will be provided to a Member if the Member seeks services from an OptumHealth participating Acupuncturist for any injury, illness, disease, functional disorder or condition with regard to which the Member is not, at that time, receiving services from an OptumHealth participating Acupuncturist. A Copayment will be required for such examination.
2. Subsequent office visits, as set forth in a treatment plan, may involve acupuncture treatment, a brief re-examination and other services, in various combinations. A Copayment will be required for each visit to the office.
3. A re-examination may be performed by the OptumHealth participating Acupuncturist to assess the need to continue, extend or change a treatment plan. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a Copayment will be required.

Important OptumHealth Addresses:

Member Correspondence

OptumHealth of California, Inc.
P.O. Box 880009
San Diego, CA 92168-0009

Grievances and Complaints

Attn.: Grievance Coordinator
OptumHealth of California, Inc.
P.O. Box 880009
San Diego, CA 92168-0009

Exclusions and Limitations

Benefits do not include services that are not described under the Covered Services or contained elsewhere in the Evidence Of Coverage (EOC) provided to a Member. The following accommodations, services, supplies, and other items are specifically excluded from coverage as referenced in the EOC:

1. Any accommodation, service, supply or other item determined by Health Plan not to be Medically Necessary;
2. Any accommodation, service, supply or other item not provided in compliance with the Managed Care Program;
3. Services provided for employment, licensing, insurance, school, camp, sports, adoption, or other non-Medically Necessary purposes, and related expenses for reports, including report presentation and preparation;
4. Examination or treatment ordered by a court or in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services under this document;
5. Experimental or investigative services unless required by an external, independent review panel as described in Section 16.5 of the EOC;
6. Services provided at a hospital or other facility outside of a Participating Provider's facility;
7. Holistic or homeopathic care including drugs and ecological or environmental medicine;
8. Services involving the use of herbs and herbal remedies;

9. Treatment for asthma or addiction (including but not limited to smoking cessation);
10. Any services or treatments caused by or arising out of the course of employment and are covered under Workers' Compensation;
11. Transportation to and from a provider;
12. Drugs or medicines;
13. Intravenous injections or solutions;
14. Charges for services provided by a provider to his or her family member(s);
15. Charges for care or services provided before the effective date of the Member's coverage under the Group Enrollment Agreement, or after the termination of the Member's coverage under the Group Enrollment Agreement, except as otherwise provided in the Group Enrollment Agreement;
16. Special nutritional formulas, food supplements such as vitamins and minerals, or special diets;
17. Sensitivity training, electrohypnosis, electronarcosis, educational training therapy, psychoanalysis, treatment for personal growth and development, and treatment for an educational requirement;
18. Claims by providers who or which are not Participating Providers, except for claims for out-of-network Emergency Services or Urgent Services, or other services authorized by Health Plan;
19. Ambulance services;
20. Surgical services;
21. Services relating to Member education (including occupational or educational therapy) for a problem not associated with a Chiropractic Disorder or Acupuncture Disorder, unless supplied by the provider at no additional charge to the Member or to Health Plan; and
22. Non-Urgent Services performed by a provider who is a relative of Member by birth or marriage, including spouse or Domestic Partner, brother, sister, parent or child.