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 PLAN (SHP) FOR ADDITIONAL INFORMATION.

(Important disclaimer regarding optional benefits: Cost Sharing and benefit information for optional benefits that may be 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: Bronze MS49 HMO

Annual Deductible for Certain Medical Services	
For self-only enrollment (Subscriber-only)	$5,800
For any one Member in a Family	$5,800
For an entire Family	$11,600
Separate Annual Deductible for Prescription Drugs	
For self-only enrollment (Subscriber-only)	$450
For any one Member in a Family	$450
For an entire Family	$900
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)	$9,800
For any one Member in a Family	$9,800
For an entire Family	$19,600

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.	
Family planning counseling, services and procedures, 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/video visit to treat an injury or illness	$60 copay per visit
Other practitioner office/video visit (see Endnotes)	$60 copay per visit
Acupuncture services (see Endnotes)	$60 copay per visit
Chiropractic services	Not covered
Sutter Walk-In Care office/video visit, where available	$60 copay per visit
Specialist office/video visit	$95 copay per visit after deductible, deductible waived for 1st 3 non-preventive visits
Allergy services provided as part of a Specialist visit (includes testing, injections and serum) There is no Cost Sharing after the Deductible 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.	$95 copay per visit after deductible, deductible waived for 1st 3 non-preventive visits
Medically administered drugs dispensed to a Participating Provider for administration (see Endnotes)	No charge
Outpatient rehabilitation services	$60 copay per visit

Outpatient habilitation services	$60 copay per visit
Outpatient surgery facility fee	40% coinsurance after deductible
Outpatient surgery Professional fee	40% coinsurance after deductible
Outpatient visit (nonoffice visit, see Endnotes)	40% coinsurance after deductible
Non-preventive laboratory services	$50 copay per visit
Radiological and nuclear imaging (e.g., MRI, CT and PET scans)	40% coinsurance after deductible
Diagnostic and therapeutic imaging and testing (e.g., X-ray, mammogram, ultrasound, EKG/ECG, cardiac stress test and cardiac monitoring)	40% coinsurance after deductible
Male sterilization/vasectomy services and procedures	No charge
Hospitalization Services	
Inpatient facility fee (e.g., hospital room, medical supplies and inpatient drugs including anesthesia)	40% coinsurance after deductible
Inpatient Professional fees (e.g., surgeon and anesthesiologist)	40% coinsurance after deductible
Emergency and Urgent Care Services	
Emergency room facility fee	40% coinsurance after deductible
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	$60 copay per visit
Ambulance Services	
Medical transportation (including emergency and nonemergency)	40% coinsurance after deductible
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: $20 copay per prescription for up to a 30-day supply Retail-90/Mail order: $40 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: 40% coinsurance up to $500 per prescription after pharmacy deductible for up to a 30-day supply Retail-90/Mail order: 40% coinsurance up to $1,000 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: 40% coinsurance up to $500 per prescription after pharmacy deductible for up to a 30-day supply Retail-90/Mail order: 40% coinsurance up to $1,000 per prescription after pharmacy deductible for up to a 100-day supply
Tier 4 - 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	40% coinsurance up to $500 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	40% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices (including special footwear)	40% coinsurance after deductible
Mental Health & Substance Use Disorder (MH/SUD) Services	
MH/SUD inpatient facility fee (see Endnotes)	40% coinsurance after deductible
MH/SUD inpatient Professional fees (see Endnotes)	40% coinsurance after deductible
MH/SUD individual outpatient office/video visit (e.g., evaluation and treatment services)	$60 copay per visit
MH/SUD group outpatient office/video visit (e.g., evaluation and treatment services)	$30 copay per visit

MH/SUD other outpatient services (see Endnotes)	40% coinsurance (maximum $60 per visit)
Children and Youth Behavioral Health Initiative (CYBHI) school site behavioral health services	No charge
Maternity Care	
Routine prenatal care visits, after confirmation of pregnancy, and the first postnatal care visit	No charge
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).	
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)	40% coinsurance after deductible
Labor and delivery inpatient Professional fees (e.g., anesthesiologist, nurse midwife and obstetrician)	40% coinsurance after deductible
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)	40% coinsurance after deductible
Home health care (up to 100 visits per calendar year)	40% coinsurance after deductible
Hospice care	No charge
Pediatric Dental and Vision Services (Provided through the end of the month in which the Member turns 19 years of age)	
Diagnostic and preventive Pediatric Dental Services (e.g., cleanings, exams, fluoride, sealants, space maintainers and X-rays)	No charge
Basic Pediatric Dental Services (e.g., periodontal maintenance services and restorative procedures)	See Pediatric Dental Addendum in EOC
Major Pediatric Dental Services (e.g., crowns and casts, endodontics, oral surgery, other periodontal services and prosthodontics)	See Pediatric Dental Addendum in EOC
Medically Necessary orthodontic Pediatric Dental Services	$1,000
Pediatric Vision Services: eye exam	No charge

Pediatric Vision Services: eyewear (one pair of glasses or contact lenses in lieu of glasses)	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, paid by the Member, 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 SHP’s CVS Caremark Retail-90 Network or through the CVS Caremark Mail Service Pharmacy. Most Specialty Drugs are only available for up to a 30-day supply through a CVS Caremark contracted Specialty Pharmacy. 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.

   Outpatient Prescription Drugs are not covered when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a plan or a plan provider, except when coverage is otherwise required in the context of Emergency Services and Care.
4. The "Other practitioner office/video 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, services and procedures" benefit does not include male sterilization services and procedures which are covered under the "Male sterilization/vasectomy services and procedures" benefit listed above. This benefit also does not include termination of pregnancy or abortion-related services which are 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. Certain medically administered drugs requires Prior Authorization from CVS Caremark and must be obtained from a Participating Pharmacy.
8. The "Outpatient visit (nonoffice 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 nonoffice setting.

   The "Outpatient visit (nonoffice visit)" benefit also includes storage of cryopreserved reproductive materials included in the Standard 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 visit (nonoffice visit)" Cost Sharing.

   When performed in an office setting, these services are covered under the PCP office visit, other practitioner office visit or specialist office visit benefit depending on which provider administers the service.
9. 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.
10. "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 Behavioral Health Crisis Services; 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.
11. Behavioral Health Crisis Services provided to a Member by a 988 center, mobile crisis team or other provider of Behavioral Health Crisis Services is covered regardless of whether the treatment is provided by a Participating Provider or an out-of-network provider. Prior Authorization is not required for this treatment and Cost Sharing will be based on the setting where the Member receives treatment.
12. "Children and Youth Behavioral Health Initiative (CYBHI) school site behavioral health services" include, outpatient non-specialty mental health and substance use disorder services (e.g., psychoeducation, screening and assessments, therapy, case management) provided to Members 25 years of age or younger at a school site, including on-campus, off-campus and mobile clinic locations, when the services are provided or arranged by a local educational agency (LEA) or public institution of higher education (IHE) that participate in the CYBHI Fee Schedule Program. The scope of services can be found in the CYBHI Fee Schedule available on the DHCS website at https://www.dhcs.ca.gov/CYBHI/Pages/Fee-Schedule.aspx.
13. Cost Sharing for services with Copayments is the lesser of the Copayment amount or allowed amount.
14. 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.

15. COVID-19 diagnostic and screening tests are covered at no Cost Share when provided by a Participating Provider and at the standard benefit Cost Sharing for the place of service when provided by a non-Participating Provider. COVID-19 vaccines and other preventive services are covered at no Cost Share when provided by a Participating or non-Participating Provider or Pharmacy. COVID-19 therapeutics are covered at no Cost Share when provided by a Participating or non-Participating Provider or Pharmacy.

    COVID-19 over-the-counter (OTC) tests with a prescription are covered at no Cost Share when obtained from a Participating or non-Participating Pharmacy. If a member purchases COVID-19 OTC tests from a Participating Pharmacy without a prescription, SHP will reimburse the Member for the cost of the tests, up to 8 tests per month. If a Member purchases COVID-19 OTC tests without a prescription from a non-Participating Pharmacy, reimbursement is limited to a quantity of 8 tests per month and up to $12 per test.

16. When outpatient benefits have Cost Sharing that includes "deductible waived for 1st 3 non-preventive visits", the Deductible is waived for the first three non-preventive visits combined.

17. 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.

18. When Covered Services are provided by a non-Participating Provider in accordance with the EOC, the Cost Sharing will be the same as Covered Services provided by a Participating Provider.