Sutter Health Plus
Your Health Plan

HEALTH PLAN BENEFITS AND COVERAGE MATRIX

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.

(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 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 (a Family of one Member)	None
For any one Member in a Family of two or more Members	None
For an entire Family of two or more Members	None

Separate Annual Deductible for Prescription Drugs	
For self-only enrollment (a Family of one Member)	None
For any one Member in a Family of two or more Members	None
For an entire Family of two or more Members	None

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 (a Family of one Member)	$1,500
For any one Member in a Family of two or more Members	$1,500
For an entire Family of two or more Members	$3,000

Lifetime Maximum	
Lifetime maximum	None

Covered Services	Cost to Member
Preventive Care Services	
Eye exams for refraction	No charge
Family planning counseling and services	No charge
Hearing exams	No charge
Immunizations (including vaccines)	No charge
Prenatal care and preconception visits	No charge
Preventive and routine physical maintenance exams (including routine screening tests)	No charge
Preventive X-rays, screenings and laboratory tests as described in the "Your Benefits" chapter of the Evidence of Coverage and Disclosure Form (EOC)	No charge
Well-child preventive care exams	No charge
Professional Services	
Primary Care Physician (PCP) visit or non-specialist practitioner visit to treat an injury or illness	$20 copay per visit
Specialist visit	$20 copay per visit
Acupuncture	$20 copay per visit
Outpatient rehabilitation services	$20 copay per visit
Outpatient habilitation services	Not covered
Outpatient Services	
Outpatient surgery (facility fee)	No charge
Outpatient surgery (physician/surgeon fee)	No charge
Outpatient visit (non-office visit)	No charge
Laboratory tests	$20 copay per visit
Imaging (e.g. MRI, CT and PET scans)	$50 copay per procedure
Diagnostic and therapeutic X-rays and imaging	$20 copay per procedure

Hospitalization Services	
Facility fee (e.g. hospital room)	No charge
Physician/surgeon fees	No charge
Emergency and Urgent Care Services	
Emergency room facility fee	$100 copay per visit
Emergency room physician 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 consultations, exams and treatment	$20 copay per visit
Ambulance Services	
Ambulance services	$50 copay per trip
Prescription Drugs	
Covered outpatient items in accord with our drug formulary guidelines at network retail pharmacies or through mail-order service:	
Tier 1 - Most Generic Drugs and low-cost preferred brand name drugs	Retail: $10 copay per prescription for up to a 30-day supply 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 Sutter Health Plus's (SHP) pharmacy and therapeutics committee based on drug safety, efficacy and cost	Retail: $30 copay per prescription for up to a 30-day supply Mail-Order: $60 copay per prescription 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: $60 copay per prescription for up to a 30-day supply Mail-Order: $120 copay per prescription for up to a 100-day supply

Tier 4 - Specialty Drugs, self-administered drugs that require training or clinical monitoring, drugs that cost SHP more than $600 net of rebates for a one-month supply or bioengineered drugs	Specialty Pharmacy: 20% coinsurance for up to a 30-day supply Member cost share will not exceed $100 per prescription per 30-day supply.
Durable Medical Equipment	
Durable medical equipment	20% coinsurance
Mental/Behavioral Health & Substance Use Disorder Treatment Services (MH/SUD)	
MH/SUD inpatient facility fee (e.g. hospital room)	No charge
MH/SUD inpatient physician/surgeon fees	No charge
MH/SUD outpatient office visits – individual *(Individual outpatient MH/SUD evaluation and treatment services)*	$20 copay per visit
MH/SUD outpatient office visits – group *(Group outpatient MH/SUD evaluation and treatment services)*	$10 copay per visit
MH/SUD other outpatient services	No charge
Home Health Services	
Home health care (up to 100 visits per calendar year)	No charge
Pregnancy Services	
Delivery and all hospital inpatient services	No charge
Delivery and all professional inpatient services	No charge
Other Services	
Skilled Nursing Facility services (up to 100 days per benefit period)	$100 copay per day up to a maximum of 5 days per admission
The external prosthetic devices, orthotic devices and ostomy and urological supplies listed in the “Your Benefits” chapter of the EOC	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 of two or more” Deductible and OOPM. Once the “entire Family of two or more” Deductible amount is satisfied by any combination of Member Deductible payments, plan Copayment or Coinsurance amounts apply until the “entire Family of two or more” 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. a) Copayments apply per prescription for up to a 30-day supply of prescribed and Medically Necessary generic or brand-name drugs in accordance with formulary guidelines. All Medically Necessary prescription drug Cost Sharing contributes toward the annual OOPM.

   b) For plans with a Deductible that applies to prescription drugs, the annual Deductible does not apply to oral anti-cancer drugs. Member Cost Sharing for oral anti-cancer drugs shall not exceed $200 per prescription for up to a 30-day supply.

   c) 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. Cost Sharing for a 12-month supply of contraceptives, when applicable, will be 12 times the retail cost or four times the mail-order cost.

   d) Except for Specialty Drugs, up to a 100-day supply is available, at twice the 30-day Copayment price, through the mail-order pharmacy. Specialty Drugs are available for up to a 30-day supply through the Specialty Pharmacy.

   e) Drugs prescribed for sexual dysfunction have a 50% share of cost. For plans with a Deductible that applies to prescription drugs, the share of cost is applied after the Deductible is met. Some sexual dysfunction drugs, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.

4. Non-specialist practitioner office visits include therapy visits, other office visits not provided by either PCPs or Specialists or visits not specified in another benefit category.

5. Family planning counseling and services include all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This does not include termination of pregnancy or male sterilization procedures, which are covered under the Outpatient Care section of the “Your Benefits” chapter in the EOC and included in the Cost Sharing for the outpatient surgery services 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 visit (non-office visit) category 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.

8. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; Substance Use Disorder Transitional Residential Recovery Services in a non-medical residential recovery setting; Substance Use Disorder Treatment for Withdrawal; inpatient Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) and autism.
9. MH/SUD other outpatient services include, but are not limited to: mental health psychological testing; mental health outpatient monitoring of drug therapy; Substance Use Disorder Treatment for Withdrawal; day treatment such as partial hospitalization and intensive outpatient program; outpatient Behavioral Health Treatment for Pervasive Developmental Disorder and autism delivered at home; and other outpatient intermediate services that fall between inpatient care and regular 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 services require a referral from your PCP and many also require Prior Authorization by your PCP's medical group. Please consult the complete EOC for additional information on referral and Prior Authorization requirements.

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

Benefit Plan:

$15 Copayment per Visit

20 Visit Annual Combined Maximum Benefit
Acupuncture and Chiropractic

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 or coinsurance 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 Maximum Benefit 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, if performed by an OptumHealth participating chiropractor.
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. Any accommodation, service, supply or other item that is not related to the Member's condition, not likely to result in sustained improvement, or does not have defined endpoints, including maintenance, preventive or supportive care.
4. 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

OptumHealth of California, Inc.
Attn.: Grievance Coordinator
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 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;
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; and
23. Any accommodation, service, supply or other item that is not related to the Member's condition, not likely to result in sustained improvement, or does not have defined endpoints, including maintenance, preventive or supportive care.