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 (OOPM). 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: ELK GROVE UNIFIED SCHOOL DISTRICT $30 HMO

Annual Deductible For Certain 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 Medications	
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" section	No charge
Well-child preventive care exams	No charge
Professional Services	
Primary care visit or non-specialist practitioner visit to treat an injury or illness	$30 copayment per visit
Specialist visit	$30 copayment per visit
Acupuncture	$30 copayment per visit
Outpatient rehabilitation services	$30 copayment per visit
Outpatient habilitation services	Not covered
Outpatient Services	
Outpatient surgery (facility fee)	$100 copayment per visit
Outpatient surgery (physician/surgeon fee)	No charge
Outpatient visit (non-office visit)	$100 copayment per visit
Laboratory tests	No charge
Imaging (e.g. MRI, CT, and PET scans)	No charge
Diagnostic and therapeutic X-rays and imaging	No charge

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 copayment per visit
Emergency room physician fees	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 as an inpatient stay, the Cost Sharing for "Hospitalization Services" will apply.	
Urgent care consultations, exams, and treatment	$30 copayment per visit
Ambulance Services	
Ambulance services	No charge
Prescription Drug	
Covered outpatient items in accord with our drug formulary guidelines at network retail pharmacies or through mail-order service:	
For Drugs Filled at Outpatient Retail Pharmacies and Through Mail-Order Service	
Tier 1 - Most generic medications and low-cost preferred brands	Retail: $15 copayment per prescription for up to a 30-day supply Mail-Order: $30 copayment per prescription for up to a 100-day supply
Tier 2 - Preferred brand name and non-preferred generic medications	Retail: $25 copayment per prescription for up to a 30-day supply Mail-Order: $50 copayment per prescription for up to a 100-day supply

Tier 3 - Non-preferred brand medications	Retail: $50 copayment per prescription for up to a 30-day supply Mail-Order: $100 copayment per prescription up to a 100-day supply
Tier 4 - Specialty, some self-administered, or bioengineered medications Notes: Member cost share will not exceed $100 per prescription per 30-day supply. Medications prescribed for sexual dysfunction have a 50% share of cost and some, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.	Retail & Mail-Order: 10% coinsurance per prescription for up to a 30-day supply
Durable Medical Equipment	
The durable medical equipment for home use listed in the "Your Benefits" section in accord with our durable medical equipment formulary guidelines.	No charge
Mental/Behavioral Health/Substance Use Disorder Treatment Services (SUD)	
Mental/Behavioral Health/SUD inpatient facility	No charge
Mental/Behavioral Health/SUD inpatient physician/surgeon fees	No charge
Mental/Behavioral Health/SUD outpatient office visits – individual *(Individual outpatient MH/SUD evaluation and treatment services)*	$30 copayment per visit
Mental/Behavioral Health/SUD outpatient office visits – group *(Group outpatient MH/SUD evaluation and treatment services)*	$15 copayment per visit
Mental/Behavioral Health/SUD other outpatient services	$30 copayment per visit
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	
Skilled Nursing Facility services (up to 100 days per benefit period)	No charge
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the “Your Benefits” section	No charge
Hospice care	No charge

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Endnotes:

1. Family Deductibles (when applicable) and Out-of-Pocket Maximums (OOPM) are equal to two times the individual values. In a Family plan, an individual is only responsible for the single Deductible and the single OOPM. Deductibles and other cost sharing payments made by each individual in a Family contribute to the Family Deductible or OOPM. Once the Family Deductible amount is satisfied by any combination of individual Deductible payments, plan Copayments or Coinsurance amounts apply until the Family OOPM is reached, after which the plan pays all costs for covered services for all Family members.

2. Cost sharing amounts for all Essential Health Benefits, including the Deductible, accumulate toward the OOPM.

3. Member cost sharing for oral anti-cancer drugs shall not exceed $200 per prescription per 30-day supply. 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. Except for Tier 4 medications, a 100-day supply is available, at twice the 30-day Copayment price, through the mail-order pharmacy. Prescription drug cost sharing contributes toward the annual Deductible and OOPM.

4. Non-specialist practitioner office visits include therapy visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

5. Member cost-sharing will be charged as a separate Copayment from a preventive service provided during an office visit.

6. 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 “outpatient surgeries and certain other outpatient procedures.”

7. 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.

8. Inpatient Mental/Behavioral Health/SUD Services include: 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. Mental/Behavioral Health/SUD Other Outpatient Services include: 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.

10. Cost sharing for services with Copayments is the lesser of the Copayment amount or allowed amount.