# 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 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: Peak ML86 HMO**

| **Annual Deductible for Certain Medical Services** | |
|---|---|
| For self-only enrollment (Subscriber-only) | $1,000 |
| For any one Member in a Family | $1,000 |
| For an entire Family | $2,000 |
| **Separate Annual Deductible for Prescription Drugs** | |
| For self-only enrollment (Subscriber-only) | None |
| For any one Member in a Family | None |
| For an entire Family | 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 (Subscriber-only) | $3,000 |
| For any one Member in a Family | $3,000 |
| For an entire Family | $6,000 |

| **Lifetime Maximum** | |
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| Lifetime benefit maximum | None |

| Benefits | Member Cost Sharing |
|---|---|
| **Preventive Care Services**<br>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, 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 visit to treat an injury or illness | Office visit: $20 copay per visit<br>Telehealth visit: $10 copay per visit |
| Other practitioner office visit (see Endnotes) | Office visit: $20 copay per visit<br>Telehealth visit: $10 copay per visit |
| Acupuncture services (see Endnotes) | $20 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: $20 copay per visit<br>Telehealth visit: $10 copay per visit |
| Allergy services provided as part of a Specialist visit (includes testing, injections and serum) | $20 copay per visit |

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| 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. | |
| Medically administered drugs dispensed to a Participating Provider for administration | No charge |
| Outpatient rehabilitation services | $20 copay per visit |
| Outpatient habilitation services | Not covered |
| Outpatient surgery facility fee | 20% coinsurance after deductible |
| Outpatient surgery Professional fee | 20% coinsurance after deductible |
| Outpatient visit (nonoffice visit, see Endnotes) | 20% coinsurance after deductible |
| 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) | $10 copay per procedure |
| Male sterilization/vasectomy services and procedures | No charge |
| **Hospitalization Services** | |
| Inpatient facility fee (e.g., hospital room, medical supplies and inpatient drugs including anesthesia) | 20% coinsurance after deductible |
| Inpatient Professional fees (e.g., surgeon and anesthesiologist) | 20% coinsurance after deductible |
| **Emergency and Urgent Care Services** | |
| Emergency room facility fee | 20% coinsurance after deductible |
| Emergency room Professional fee | 20% coinsurance after deductible |
| 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 | $20 copay per visit |
| **Ambulance Services** | |
| Medical transportation (including emergency and nonemergency) | No charge 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: $10 copay per prescription for up to a 30-day supply<br>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 for up to a 30-day supply<br>Retail-90/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<br>*(These generally have a preferred and often less costly therapeutic alternative at a lower tier)* | Retail-30: $60 copay per prescription for up to a 30-day supply<br>Retail-90/Mail order: $120 copay per prescription 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 | Specialty Pharmacy: 20% coinsurance up to $100 per prescription for up to a 30-day supply |
| **Durable Medical Equipment, Prosthetics, Orthotics and Supplies** | |
| Durable medical equipment for home use | 20% coinsurance after deductible |
| Ostomy and urological supplies; prosthetic and orthotic devices | No charge |
| **Mental Health & Substance Use Disorder (MH/SUD) Services** | |
| MH/SUD inpatient facility fee (see Endnotes) | 20% coinsurance after deductible |
| MH/SUD inpatient Professional fees (see Endnotes) | 20% coinsurance after deductible |
| MH/SUD individual outpatient office visit (e.g., evaluation and treatment services) | Office visit: $20 copay per visit<br>Telehealth visit: $10 copay per visit |

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| MH/SUD group outpatient office visit (e.g., evaluation and treatment services) | Office visit: $10 copay per visit<br>Telehealth visit: $10 copay per visit |
| MH/SUD other outpatient services (see Endnotes) | 20% coinsurance after deductible |
| 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 | Office/telehealth 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) | 20% coinsurance after deductible |
| Labor and delivery inpatient Professional fees (e.g., anesthesiologist, nurse midwife and obstetrician) | 20% coinsurance after deductible |
| **Abortion Services** | |
| Abortion (e.g., medication or procedural abortions)<br>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) | 20% coinsurance after deductible |
| 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, 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 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.

   Outpatient Prescription Drugs dispensed by non-participating pharmacies are not covered except for emergency or urgent situations, including drugs prescribed for treatment of a mental health and substance use disorder, or when dispensed as part of a Community Assistance, Recovery, and Empowerment (CARE) agreement or CARE plan approved by a court.
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, 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. 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 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.

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 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.
10. 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.
11. "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.
12. Cost Sharing for services with Copayments is the lesser of the Copayment amount or allowed amount.
13. 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.
14. 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.

15. 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;