

Pending Regulatory Approval



**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [sutterhealthplus.org](http://sutterhealthplus.org) or by calling 1-855-315-5800.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$0 individual/ \$0 family	See the chart starting on page 2 for your costs for services this plan covers.
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes, <b>\$1,000</b> individual/ <b>\$2,000</b> family per plan year	The <b>out-of-pocket limit</b> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, copayments for optional benefit riders (if elected by your employer group) and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes, for a list of participating doctors and hospitals, go to <a href="http://sutterhealthplus.org">sutterhealthplus.org</a> or call 1-855-315-5800.	If you use an <b>in-network</b> doctor or other health care <b>provider</b> , this <b>plan</b> will pay some or all of the costs of covered services. Be aware, your in-network doctor may use an out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
Do I need a referral to see a <u>specialist</u> ?	Yes, oral approval is required.	The <b>plan</b> will pay some or all of the costs to see a <b>specialist</b> for covered services but only if you have the plan's permission before you see the <b>specialist</b> .
Are there services this plan doesn't cover?	Yes.	Some of the services this <b>plan</b> doesn't cover are listed on page 4. See your plan document for additional information about <b>excluded services</b> .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care <b>provider’s</b> office or clinic	Primary care visit to treat an injury or illness	\$25 per visit	Not covered	---None---
	Specialist visit	\$25 per visit	Not covered	---None---
	Other practitioner office visit	\$25 per visit	Not covered	---None---
	Preventive care/screening/immunization	No Charge	Not covered	---None---
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not covered	---None---
	Imaging (CT/PET scans, MRIs)	No Charge	Not covered	---None---
If you need drugs to treat your illness or condition	Generic drugs	<b>Retail:</b> \$10 copay <b>Mail Order:</b> \$20 copay	Not covered	<b>Retail:</b> 30-day supply <b>Mail Order:</b> 90-day supply
	Preferred brand drugs	<b>Retail:</b> \$20 copay <b>Mail Order:</b> \$40 copay	Not covered	<b>Retail:</b> 30-day supply <b>Mail Order:</b> 90-day supply
More information about <b>prescription</b>	Non-preferred brand drugs	<b>Retail:</b> \$50 copay <b>Mail Order:</b> \$100 copay	Not covered	<b>Retail:</b> 30-day supply <b>Mail Order:</b> 90-day supply

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Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
<u>drug coverage</u> is available at <a href="http://optumrx.com">optumrx.com</a> or call 1-888-574-7417	Specialty drugs	<b>Retail:</b> 10% coinsurance <b>Mail Order:</b> 10% coinsurance	Not covered	<b>Retail:</b> 30-day supply <b>Mail Order:</b> 30-day supply Sexual dysfunction medications have a 50% cost share and are limited to 8 doses per 30-day supply
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No Charge	Not covered	---None---
	Physician/surgeon fees	No Charge	Not covered	---None---
<b>If you need immediate medical attention</b>	Emergency room services	Facility: \$50 per visit Professional: No Charge	Facility: \$50 per visit Professional: No Charge	Does not apply if admitted directly to the hospital as an inpatient for covered services.
	Emergency medical transportation	No Charge	No Charge	---None---
	Urgent care	\$20 per visit	\$20 per visit	---None---
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No Charge	Not covered	---None---
	Physician/surgeon fee	No Charge	Not covered	---None---
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	No Charge	Not covered	---None---
	Mental/Behavioral health inpatient services	No Charge	Not covered	---None---
	Substance use disorder outpatient services	No Charge	Not covered	---None---
	Substance use disorder inpatient services	No Charge	Not covered	---None---
<b>If you are pregnant</b>	Prenatal and postnatal care	Prenatal: No Charge Postnatal care: No Charge for first visit, thereafter \$25 per visit	Not covered	---None---
	Delivery and all inpatient services	No Charge	Not covered	---None---

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Common Medical Event	Services You May Need	Your Cost If You Use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
<b>If you need help recovering or have other special health needs</b>	Home health care	No Charge	Not covered	100 visits per plan year
	Rehabilitation services	Inpatient: No Charge Outpatient: \$10 per visit	Not covered	---None---
	Habilitation services	Not covered	Not covered	---None---
	Skilled nursing care	No Charge	Not covered	100 days per benefit period
	Durable medical equipment	No Charge	Not covered	---None---
	Hospice service	No Charge	Not covered	---None---
<b>If your child needs dental or eye care</b>	Eye exam	No Charge	Not covered	---None---
	Glasses	Not covered	Not covered	---None---
	Dental check-up	Not covered	Not covered	---None---

**Excluded Services & Other Covered Services:**

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care</li> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>• Acupuncture*</li> </ul> <p>* Offered as rider in addition to core medical benefit through ACN Group of California</p>	<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Chiropractic care**</li> </ul> <p>** Offered as rider, separate from core medical benefit plan through ACN Group of California</p>	<ul style="list-style-type: none"> <li>• Infertility services***</li> </ul> <p>*** Offered as rider, separate from core medical benefit plan</p> <ul style="list-style-type: none"> <li>• Routine eye exam</li> </ul>

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### Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your right to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-315-5800. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 EXT 61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Sutter Health Plus at 1-855-315-5800 or TTY/TDD: 1-855 830 3500 or visit [www.sutterhealthplus.org](http://www.sutterhealthplus.org).

If this coverage is subject to ERISA, you may contact Sutter Health Plus at 1-855-315-5800 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), and the California Department of Insurance at 1-800-927-HELP (4357) or [www.insurance.ca.gov](http://www.insurance.ca.gov).

Additionally, a consumer assistance program can help you file your appeal:

Contact Department of Managed Health Care Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814 (888) 466-2219 or TTY/TDD: 1-877-688-9891 | <http://www.healthhelp.ca.gov> | [helpline@dmhc.ca.gov](mailto:helpline@dmhc.ca.gov)

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?

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The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

**Language Access Services**

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-315-5800.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-315-5800.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-315-5800.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-315-5800.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



### This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,370
- Patient pays \$170

#### Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
<b>Total</b>	<b>\$7,540</b>

#### Patient pays:

Deductibles	\$0
Copays	\$20
Coinsurance	\$0
Limits or exclusions	\$150
<b>Total</b>	<b>\$170</b>

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,670
- Patient pays \$730

#### Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>

#### Patient pays:

Deductibles	\$0
Copays	\$600
Coinsurance	\$250
Limits or exclusions	\$80
<b>Total</b>	<b>\$730</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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## 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.**

**BENEFIT PLAN NAME: City of Sacramento HMO ML39**

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#### **Out-of Pocket Maximum<sup>2</sup>**

You will not pay any more Cost Sharing if the amount you paid for Copayments, Coinsurance and Deductibles for covered services in a plan year total the following amounts:

For self-only enrollment (a Family of one Member) .....	\$1,000
For any one Member in a Family of two or more Members <sup>1</sup> .....	\$1,000
For an entire Family of two or more Members.....	\$2,000

NOTES: Optional dental, vision, chiropractic and acupuncture benefits will not apply towards the annual Out-of-Pocket Maximum.

#### **Lifetime Maximum**

**Unlimited**

#### **Deductible for Certain Services<sup>1</sup>**

For self-only enrollment (a Family of one Member) .....	\$0
For any one Member in a Family of two or more Members <sup>1</sup> .....	\$0
For an entire Family of two or more Members.....	\$0

#### **Deductible for Prescription Medications<sup>1</sup>**

For self-only enrollment (a Family of one Member).....	\$0
For any one Member in a Family of two or more Members <sup>1</sup> .....	\$0
For an entire Family of two or more Members.....	\$0

#### **Professional Services (Plan Provider office visits)**

**You Pay**

Primary care consultations, exams, and treatment, except as listed below <sup>10</sup> .....	\$25 per visit
Specialist visit <sup>10</sup> .....	\$25 per visit
Other practitioner office visit.....	\$25 per visit
Preventive and routine physical maintenance exams <sup>3</sup> (including routine screening tests).....	No Charge
Well-child preventive care exams <sup>3</sup> .....	No Charge
Family planning counseling and services <sup>4</sup> .....	No Charge
Eye exams for refraction <sup>9</sup> .....	No Charge
Hearing exams <sup>3</sup> .....	No Charge
Urgent care consultations, exams, and treatment.....	\$20 per visit

Outpatient Rehabilitation Services .....\$10 per visit

<b>Outpatient Services</b>	<b>You Pay</b>
Outpatient surgery (facility fee).....	No Charge
Outpatient surgery (physician/surgeon fees).....	No Charge
Outpatient visit (non-office visit).....	No Charge
Immunizations (including vaccines).....	No Charge
Laboratory Tests (non-preventive).....	No Charge
Preventive X-rays, screenings, and laboratory tests as described in the “Your Benefits” section.....	No Charge
Imaging (MRI, CT, and PET scans).....	No Charge
Diagnostic and therapeutic X-rays and imaging.....	No Charge

<b>Hospitalization Services</b>	<b>You Pay</b>
Facility Fee (e.g. hospital room).....	No Charge
Physician/Surgeon Fee.....	No Charge

<b>Emergency Health Services</b>	<b>You Pay</b>
Emergency Room Facility Fee.....	\$50 per visit
Emergency Room Physician Fee.....	No Charge

This 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.

<b>Ambulance Services</b>	<b>You Pay</b>
Ambulance Services.....	No Charge

<b>Prescription Drug<sup>5</sup></b>	<b>You Pay</b>
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

Tier 1.....	\$10 for up to a 30-day supply
Tier 2 <sup>6</sup> .....	\$20 for up to a 30-day supply
Tier 3 <sup>6</sup> .....	\$50 for up to a 30-day supply
Tier 4 <sup>6</sup> .....	10% coinsurance for up to a 30-day supply Member Cost Share will not exceed \$100 per prescription per 30-day supply (except for sexual dysfunction medications, which are 50% of cost, 8 doses per 30-day supply)

For Drugs Filled Through Mail-Order Service

Tier 1.....	\$20 for up to a 90-day supply
Tier 2 <sup>6</sup> .....	\$40 for up to a 90-day supply
Tier 3 <sup>6</sup> .....	\$100 for up to a 90-day supply
Tier 4 <sup>6</sup> .....	10% coinsurance for up to a 30-day supply Member Cost Share will not exceed \$100 per prescription per 30-day supply (except for sexual dysfunction medications, which are 50% of cost, 8 doses per 30-day supply)

<b>Durable Medical Equipment</b>	<b>You Pay</b>
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The durable medical equipment for home use listed in the “Your Benefits” section in accord with our durable medical equipment formulary guidelines.... No Charge

<b>Mental/Behavioral Health/Substance Use Disorder Treatment Services (MH/SUD)<sup>7</sup></b>	<b>You Pay</b>
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Mental/Behavioral Health/SUD Inpatient facility <sup>11</sup> .....	No Charge
Mental/Behavioral Health/SUD Inpatient Physician/Surgeon Fee.....	No Charge
Mental/Behavioral Health/SUD Outpatient Office Visits – Individual (Individual outpatient MH/SUD evaluation and treatment services)...	No Charge
Mental/Behavioral Health/SUD Outpatient Office Visits – Group (Group outpatient MH/SUD evaluation and treatment services).....	No Charge
Mental/Behavioral Health/SUD Other Outpatient Services <sup>12</sup> .....	No Charge

<b>Pregnancy Services</b>	<b>You Pay</b>
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Prenatal care and preconception visits <sup>3</sup> .....	No Charge
Delivery and all inpatient services (Hospital).....	No Charge
Delivery and all inpatient services (Professional).....	No Charge

<b>Home Health Services</b>	<b>You Pay</b>
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Home health care <sup>8</sup> (up to 100 visits per year).....	No Charge
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<b>Other</b>	<b>You Pay</b>
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Skilled nursing care <sup>8</sup> .....	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
Infertility Services (Treatment, Diagnosis, and Prescription Drugs, Including GIFT).....	50% Coinsurance
Allergy Testing.....	No Charge
Allergy Injection Services (including serum).....	No Charge

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Footnotes:

1. Medical or prescription services may be subject to a deductible. The member must pay for these services when services are incurred until the deductible is met in that plan year. Charges under the deductible are based on SHP's contracted rates with the provider of service.
2. Out of pocket maximum is the maximum amount an individual or family will pay for certain medical services in a plan year. This does include the overall deductible.
3. Including, but not limited to annual physical examinations, immunizations (adult and pediatric), maternity care (after initial diagnosis and pre-and post natal visits), well baby care up to age two, breast, cervical, prostate and colorectal cancer screenings. Preventive care services are available at no cost. For a complete list of preventive services please refer to the Combined Disclosure Form and Evidence of Coverage.
4. This category of 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."

5. Member cost sharing for oral anti-cancer drugs shall not exceed \$200 per prescription per 30-day supply. Copays 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. A 90-day supply is available, at twice the 30-day copay price, through the mail-order pharmacy. Prescription drug deductibles and copays contribute toward the plan year medical out-of-pocket maximum.
6. Subject to prior authorization.
7. Mental health/substance use disorder treatment services are covered under the core medical plan, typically with the same cost sharing as mental health services.
8. Up to 100 visits per year for home health care and 100 visits per benefit period for skilled nursing care.
9. Annual preventive refractive eye exam.
10. Member cost-sharing for a non-preventive service will be charged separately from a preventive service provided during an office visit.
11. 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.
12. 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.