

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 or by calling 1-855-315-5800.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0 individual/ \$0 family	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes, \$2,000 individual/ \$4,000 family per plan year for certain medical services. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes, \$3,000 individual/ \$6,000 family per plan year	The out-of-pocket limit 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 out-of-pocket limit?	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 out-of-pocket limit.
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 specific covered services, such as office visits.
Does this plan use a network of providers?	Yes, for a list of participating doctors and hospitals, go to sutterhealthplus.org or call 1-855-315-5800.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	Yes, oral approval is required.	The plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your plan document for additional information about excluded services.

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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 provider’s office or clinic	Primary care visit to treat an injury or illness	\$30 per visit after deductible	Not covered	---None---
	Specialist visit	\$30 per visit after deductible	Not covered	---None---
	Other practitioner office visit	Acupuncture: \$30 per visit after deductible Other: \$30 per visit after deductible	Not covered	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.
	Preventive care/screening/immunization	No Charge	Not covered	---None---
If you have a test	Diagnostic test (x-ray, blood work)	\$10 per encounter after deductible	Not covered	---None---
	Imaging (CT/PET scans, MRIs)	\$50 per procedure after deductible	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	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at optumrx.com or call 1-888-574-7417	Generic drugs	Retail: \$10 copay after deductible Mail Order: \$20 copay after deductible	Not covered	Retail: 30-day supply Mail Order: 90-day supply
	Preferred brand drugs	Retail: \$30 copay after deductible Mail Order: \$60 copay after deductible	Not covered	Retail: 30-day supply Mail Order: 90-day supply
	Non-preferred brand drugs	Retail: \$50 copay after deductible Mail Order: \$100 copay after deductible	Not covered	Retail: 30-day supply Mail Order: 90-day supply
	Specialty drugs	Retail: 10% coinsurance after deductible Mail Order: 10% coinsurance after deductible	Not covered	Retail: 30-day supply Mail Order: 30-day supply Sexual dysfunction medications have a 50% cost share and are limited to 8 doses per 30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 per procedure after deductible	Not covered	---None---
	Physician/surgeon fees	No charge after deductible	Not covered	---None---
If you need immediate medical attention	Emergency room services	Facility: \$100 per visit after deductible Professional: No Charge after deductible	Facility: \$100 after deductible Professional: No Charge after deductible	Does not apply if admitted directly to the hospital as an inpatient for covered services.
	Emergency medical transportation	\$100 per trip after deductible	\$100 per trip after deductible	---None---
	Urgent care	\$30 per visit after deductible	\$30 per visit after deductible	---None---
If you have a	Facility fee (e.g., hospital room)	\$250 per admission after deductible	Not covered	---None---

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		In-network Provider	Out-of-network Provider	
hospital stay	Physician/surgeon fee	No charge after deductible	Not covered	---None---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	Office Visit: \$30 after deductible (individual); \$15 after deductible (group) Other Outpatient: No charge after deductible	Not covered	---None---
	Mental/Behavioral health inpatient services	Facility: \$250 per admission after deductible Professional: No charge after deductible	Not covered	---None---
	Substance use disorder outpatient services	Office Visit: \$30 after deductible (individual); \$15 after deductible (group) Other Outpatient: No charge after deductible	Not covered	---None---
	Substance use disorder inpatient services	\$250 per admission after deductible	Not covered	---None---
If you are pregnant	Prenatal and postnatal care	Prenatal care: No Charge Postnatal care: No Charge for first visit, thereafter \$10 per visit after deductible	Not covered	---None---
	Delivery and all inpatient services	Facility: \$250 per admission after deductible Professional: No charge after deductible	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	
If you need help recovering or have other special health needs	Home health care	No Charge	Not covered	100 visits per plan year
	Rehabilitation services	Inpatient: \$200 per admission after deductible Outpatient: \$30 per visit after deductible	Not covered	---None---
	Habilitation services	Not covered	Not covered	---None---
	Skilled nursing care	\$200 per admission after deductible	Not covered	100 days per benefit period
	Durable medical equipment	20% coinsurance per item after deductible	Not covered	---None---
	Hospice service	No Charge	Not covered	---None---
If your child needs dental or eye care	Eye exam	No Charge	Up to \$45 max reimbursement	---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"> • Cosmetic surgery • Dental care • Hearing aids 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Private-duty nursing • Routine foot care • Weight loss programs

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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.)

- Acupuncture*
- Bariatric surgery
- Routine eye exam
- * Offered as rider in addition to core medical benefit through ACN Group of California
- Chiropractic care**
- ** Offered as rider, separate from core medical benefit plan through ACN Group of California

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, or the U.S. Department of Health and Human Services at 1-877-267-2323 EXT 61565 or 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.

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, and the California Department of Insurance at 1-800-927-HELP (4357) or 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

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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?

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 \$6,670
- Patient pays \$870

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
Total	\$7,540

Patient pays:

Deductibles	\$700
Copays	\$20
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$870

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

- Amount owed to providers: \$5,400
- Plan pays \$3,520
- Patient pays \$1,880

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
Total	\$5,400

Patient pays:

Deductibles	\$1,150
Copays	\$400
Coinsurance	\$250
Limits or exclusions	\$80
Total	\$1,880

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*Pending Regulatory Approval***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 ABHP HE07/HE57

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Deductible (Combined Medical and Pharmacy)

For self-only enrollment (a Family of one Member)	\$2,000
For any one Member in a Family of two or more Members ¹	\$2,600
For an entire Family of two or more Members.....	\$4,000

Deductible for Prescription Medications¹

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

Maximum Benefits

Unlimited

Out-of Pocket Maximum(Combined Medical and Pharmacy)²

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)	\$3,000
For any one Member in a Family of two or more Members ¹	\$3,000
For an entire Family of two or more Members.....	\$6,000

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

Professional Services (Plan Provider office visits)

You Pay

Primary care consultations, exams, and treatment, except as listed below ¹⁰	\$30 per visit after deductible
Specialist visit ¹⁰	\$30 per visit after deductible
Other practitioner office visit.....	\$30 per visit after deductible
Preventive and routine physical maintenance exams ³ (including routine screening tests).....	No Charge
Well-child preventive care exams ³	No Charge
Family planning counseling and services ⁴	No Charge
Eye exams for refraction ⁹	No Charge
Hearing exams ³	No Charge
Urgent care consultations, exams, and treatment.....	\$30 per visit after deductible
Outpatient Rehabilitation Services.....	\$30 per visit after deductible

Outpatient Services	You Pay
Outpatient Surgery Facility Fee.....	\$150 per procedure after deductible
Outpatient Surgery Physician Fee.....	No Charge after deductible
Outpatient visit (non-office visit).....	No Charge after deductible
Immunizations (including vaccines).....	No Charge
Laboratory Tests (non-preventive).....	\$10 per encounter after deductible
Preventive X-rays, screenings, and laboratory tests as described in the “Your Benefits” section.....	No Charge
Imaging (MRI, CT, and PET scans).....	\$50 per procedure after deductible
Diagnostic and therapeutic X-rays and imaging.....	\$10 per encounter after deductible

Hospitalization Services	You Pay
Facility Fee (e.g. hospital room).....	\$250 per admission after deductible
Physician/Surgeon Fee.....	No Charge after deductible
Inpatient Rehabilitation Services.....	\$200 per admission after deductible

Emergency Health Services	You Pay
Emergency Room Facility Fee.....	\$100 per visit, after deductible
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.

Ambulance Services	You Pay
Ambulance Services.....	\$100 per trip after deductible

Prescription Drug⁵	You Pay
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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 copay after deductible for up to a 30-day supply
Tier 2 ⁶	\$30 copay after deductible for up to a 30-day supply
Tier 3 ⁶	\$50 copay after deductible for up to a 30-day supply
Tier 4 ⁶	10% coinsurance after deductible for up to a 30-day supply

Sexual dysfunction medications have a 50% of cost and are limited to 8 doses per 30-day supply

For Drugs Filled Through Mail-Order Service

Tier 1.....	\$20 copay after deductible for up to a 90-day supply
Tier 2 ⁶	\$60 copay after deductible for up to a 90-day supply
Tier 3 ⁶	\$100 copay after deductible for up to a 90-day supply
Tier 4 ⁶	10% coinsurance after deductible for up to a 30-day supply

Except for sexual dysfunction medications, which are 50% of cost, 8 doses per 30-day supply

Durable Medical Equipment	You Pay
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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....	20% coinsurance per item after deductible
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Mental/Behavioral Health/Substance Use Disorder Treatment Services (MH/SUD)⁷	You Pay
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Mental/Behavioral Health/SUD Inpatient facility ¹¹	\$250 per admission after deductible
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)...	\$30 per individual visit after deductible
Mental/Behavioral Health/SUD Outpatient Office Visits – Group (Group outpatient MH/SUD evaluation and treatment services).....	\$15 per group visit after deductible
Mental/Behavioral Health/SUD Other Outpatient Services ¹²	No Charge after deductible

Pregnancy Services	You Pay
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Prenatal care and preconception visits ³	No Charge
Postnatal care ³	No Charge for first visit, thereafter \$10 per visit after deductible
Delivery and all inpatient services (Hospital).....	\$250 per admission after deductible
Delivery and all inpatient services (Professional).....	No Charge after deductible

Home Health Services	You Pay
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Home health care ⁸ (up to 100 visits per year).....	No Charge
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Other	You Pay
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Skilled nursing care ⁸	\$200 per admission after deductible
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the “Your Benefits” section.....	No Charge
Hospice Care.....	No Charge
Allergy Testing.....	\$5 per visit after deductible
Allergy Injection Services (including serum).....	\$5 per visit after deductible

HE07/HE57 2016 v1

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.