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 PLUS (SHP) FOR ADDITIONAL INFORMATION.

BENEFIT PLAN NAME: City of Sacramento HDHP HMO (HSA-Compatible HDHP)

HEALTH SAVINGS ACCOUNT (HSA)-COMPATIBLE PLAN

Annual Deductible for Certain Medical Services (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	$2,800
For an entire Family of two or more Members	$4,000
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)	$3,000
For any one Member in a Family of two or more Members	$3,000
For an entire Family of two or more Members	$6,000

Lifetime Maximum	
Lifetime benefit maximum	None

Benefits	Member Cost Sharing
Preventive Care Services 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 and services, including preconception care visits (see Endnotes)	No charge
Routine preventive immunizations/vaccines	No charge
Routine preventive visits (e.g., well-child and well-woman exams), 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	$30 copay per visit after deductible
Other practitioner office visit (see Endnotes)	$30 copay per visit after deductible
Acupuncture services (see Endnotes)	$30 copay per visit after deductible
Sutter Walk-in Care visit, where available	$30 copay per visit after deductible
Specialist office visit	$30 copay per visit after deductible
Allergy services provided as part of a Specialist visit (includes testing, injections and serum)	$5 copay per visit after deductible
There is no Cost Sharing after the Deductible 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 after deductible
Outpatient rehabilitation services	$30 copay per visit after deductible
Outpatient habilitation services	Not covered
Outpatient surgery facility fee	$150 copay per visit after deductible
Outpatient surgery Professional fee	No charge after deductible
Outpatient visit (non-office visit, see Endnotes)	No charge after deductible
Non-preventive laboratory services	$10 copay per visit after deductible
Radiological and nuclear imaging (e.g., MRI, CT and PET scans)	$50 copay per procedure after deductible
Diagnostic and therapeutic imaging and testing (e.g., X-ray, mammogram, ultrasound, EKG/ECG, cardiac stress test and cardiac monitoring)	$10 copay per procedure after deductible
Hospitalization Services	
Inpatient facility fee (e.g., hospital room, medical supplies and inpatient drugs including anesthesia)	$250 copay per admission after deductible
Inpatient Professional fees (e.g., surgeon and anesthesiologist)	No charge after deductible
Emergency and Urgent Care Services	
Emergency room facility fee	$100 copay per visit after deductible
Emergency room Professional fee	No charge 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 consultations, exams and treatment	$30 copay per visit after deductible
Ambulance Services	
Medical transportation (including emergency and non-emergency)	$100 copay per trip after deductible

Prescription Drugs, Supplies, Equipment and Supplements	
Covered outpatient items obtained at a Participating Pharmacy through retail, mail order or Specialty Pharmacy services and in accordance with our drug formulary guidelines:	
Tier 1 - Most Generic Drugs and low-cost preferred brand name drugs	Retail: $10 copay per prescription after deductible for up to a 30-day supply Mail order: $20 copay per prescription after deductible for up to a 90-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 copay per prescription after deductible for up to a 30-day supply Mail order: $60 copay per prescription after deductible for up to a 90-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: $50 copay per prescription after deductible for up to a 30-day supply Mail order: $100 copay per prescription after deductible for up to a 90-day supply
Tier 4 - Drugs that are biologics, 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 copay per prescription after deductible for up to a 30-day supply
Durable Medical Equipment	
Durable medical equipment for home use	20% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge after deductible
Mental Health & Substance Use Disorder (MH/SUD) Services	
MH/SUD inpatient facility fee (see Endnotes)	$250 copay per admission after deductible
MH/SUD inpatient Professional fees (see Endnotes)	No charge after deductible

MH/SUD individual outpatient office visits (e.g., evaluation and treatment services)	$30 copay per visit after deductible
MH/SUD group outpatient office visits (e.g., evaluation and treatment services)	$15 copay per visit after deductible
MH/SUD other outpatient services (see Endnotes)	No charge after deductible
Maternity Care	
Routine prenatal care visits, after confirmation of pregnancy, and the first postnatal care 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., electronic or manual breast pump)	No charge
Labor and delivery inpatient facility fee (e.g., anesthesia and delivery services for all inpatient childbirth methods)	$250 copay per admission after deductible
Labor and delivery inpatient Professional fees (e.g., anesthesiologist, nurse midwife and obstetrician)	No charge after deductible
Other Services for Special Health Needs	
Skilled Nursing Facility services (up to 100 days per benefit period)	$200 copay per admission after deductible
Home health care (up to 100 visits per calendar year)	No charge after deductible
Hospice care	No charge after deductible

Endnotes:

1. Except for optional benefits, if elected, Deductibles and other Cost Sharing payments made by each Member in a Family contribute to the "entire Family of two or more Members" Deductible and Out-of-Pocket Maximum (OOPM). Each Family Member is responsible for the "one Member in a Family of two or more Members" Deductible and OOPM until the Family as a whole meets the "entire Family of two or more Members" Deductible and OOPM. Once the Family as a whole meets the "entire Family of two or more Members" OOPM, the plan pays all costs for Covered Services for all Family Members.

   For HDHPs, in a Family plan, an individual Family Member's "any one member in a Family of two or more Members" Deductible, if required, must be the higher of the specified "self-only enrollment" Deductible amount or the IRS minimum of $2,800 for plan year 2022. Once an individual Family Member's "any one member in a Family of two or more Members" Deductible

is satisfied, that Member will only be responsible for the Cost Sharing listed for each service. Other Family Members will be required to continue to contribute to the "any one member in a Family of two or more Members" Deductible until the "entire Family of two or more Members" Deductible is met. In a Family plan, an individual Family Member's out-of-pocket contribution is limited to the "any one Member in a Family of two or more Members" annual OOPM amount.

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 Deductible and OOPM.

   b) Member Cost Sharing for orally administered anticancer drugs shall not exceed $250 per prescription for up to a 30-day supply. Members may have a Cost Sharing maximum equal to or lower than $250 as the applicable maximum for oral anticancer drugs is determined by each plan's prescription drug benefits. Orally administered anticancer drugs follow applicable tier-based Cost Sharing. Refer to the Prescription Drugs, Supplies, Equipment and Supplements section of this matrix for Cost Sharing details. For High Deductible Health Plans (HDHPs), oral anticancer drugs on any tier are subject to the annual Deductible and the Cost Sharing maximum will not apply until after the Deductible is met.

   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 90-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) Some drugs prescribed for sexual dysfunction, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.

   f) Upon request from a Member or prescriber, a pharmacist may, but is not required to, dispense a partial fill of a prescription for an oral, solid dosage form of a Schedule II controlled substance in accordance with Section 4052.10 of the California Business and Professions Code. The Cost Sharing for a partial fill of a prescription will be prorated.

4. Other practitioner office visits include therapy visits and other office visits not provided by either PCPs or Specialists or visits not specified in another benefit category.

5. The family planning counseling and services benefit 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. Chiropractic services are not covered as part of the SHP medical plan.

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. This category 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 (non-office visit) Cost Sharing.

8. MH/SUD inpatient services 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 an acute psychiatric crisis; 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. Cost Sharing for services with Copayments is the lesser of the Copayment amount or allowed amount.

11. 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.

12. The deductible will be waived for drugs and services listed in the Internal Revenue Service Notice 2019-45 for the specified diagnoses. Applicable Copayments or Coinsurance will apply. Refer to *irs.gov/pub/irs-drop/n-19-45.pdf* for details.

13. 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.