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.

(Important disclaimer regarding optional benefits: Cost Sharing and benefit information for optional benefits that may be elected by your employer group are not reflected on this Benefits and Coverage Matrix. Most optional benefits do not accrue to your 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: Vista HD26 HDHP HMO

HEALTH SAVINGS ACCOUNT (HSA)-COMPATIBLE PLAN

Annual Deductible for Certain Medical Services (Combined Medical and Pharmacy)

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-wom7bvvisits),zations/vaccine2A6ndnotepy16ndnotepy16

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	No charge after deductible
Outpatient habilitation services	Not covered
Outpatient surgery facility fee	No charge after deductible
Outpatient surgery Professional fee	No charge after deductible
Outpatient non-office visit (see Endnotes)	No charge after deductible
Non-preventive laboratory services	No charge after deductible
Radiological and nuclear imaging (e.g., MRI, CT and PET scans)	No charge after deductible
Diagnostic and therapeutic imaging and testing (e.g., X-ray, mammogram, ultrasound, EKG/ECG, cardiac stress test and cardiac monitoring)	No charge after deductible
Hospitalization Services	
Inpatient facility fee (e.g., hospital room, medical supplies and inpatient drugs including anesthesia)	$50 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	No charge 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 visit	No charge after deductible
Ambulance Services	
Medical transportation (including emergency and non-emergency)	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: No charge after deductible for up to a 30-day supply Retail-90/Mail order: No charge after deductible 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: No charge after deductible for up to a 30-day supply Retail-90/Mail order: No charge after deductible 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 *(These generally have a preferred and often less costly therapeutic alternative at a lower tier)*	Retail-30: No charge after deductible for up to a 30-day supply Retail-90/Mail order: No charge after deductible for up to a 100-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: No charge after deductible for up to a 30-day supply
Durable Medical Equipment, Prosthetics, Orthotics and Supplies	
Durable medical equipment for home use	No charge 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)	$50 copay per admission after deductible
MH/SUD inpatient Professional fees (see Endnotes)	No charge after deductible
MH/SUD individual outpatient office visit (e.g., evaluation and treatment services)	Office visit: No charge after deductible Telehealth visit: No charge after deductible
MH/SUD group outpatient office visit (e.g., evaluation and treatment services)	Office visit: No charge after deductible Telehealth visit: No charge 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	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)	$50 copay per admission after deductible
Labor and delivery inpatient Professional fees (e.g., anesthesiologist, nurse midwife and obstetrician)	No charge after deductible
Abortion Services	
Abortion (e.g., medication or procedural abortions) Abortion-related services, including pre-abortion and follow-up services	No charge after deductible
Other Services for Special Health Needs	
Skilled Nursing Facility services (up to 100 days per benefit period)	No charge 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 Deductible and Out-of-Pocket Maximum (OOPM). Each Family Member is responsible for the one Member in a Family Deductible and OOPM until the Family as a whole meets the entire Family Deductible and OOPM. Once the Family as a whole meets the entire Family 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 Deductible, if required, must be the higher of the specified self-only enrollment Deductible amount or the IRS minimum of $3,000 for plan year 2023. Once an individual Family Member s any one Member in a Family Deductible is satisfied, that Member will only be responsible for the listed Copayment or Coinsurance amount. Other Family Members will be required to continue to contribute to the any one Member in a Family Deductible until the entire Family 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 annual OOPM amount.

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 contributes toward your Deductible, if applicable, and OOPM.

   Outpatient Prescription Drugs are available for up to a 30-day supply through a retail

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.