



2024-2025 Schedule of Benefits & Coverage Matrix: Large Group non IHSS (County)

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE (EOC) AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Coverage Period

The Coverage Period for this plan is 07/01/24 through 6/30/25 (Plan year).

Plan Year Out-of-Pocket Maximum

You will not pay any more Cost Share during a plan year if the Copayments and Coinsurance you pay add up to one of the following amounts:

For Self-only enrollment (a Family of one Member)	\$1,000 per plan year
For an entire Family of two or more Members	\$2,000 per plan year

Plan Deductible

You must meet your Plan Deductible before your Cost Share applies (except those services that have “No charge”):

Medical Deductible	No Deductible
Pharmacy Deductible	No Deductible

Lifetime Maximum None

Professional Services (Plan Provider office visits)	Your Cost Share
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Primary Care Visits for evaluations and treatment	\$0 Copayment
Specialty Care Visits for consultations, evaluations and treatment	\$0 Copayment
Other Practitioner Office Visits*	\$0 Copayment
Routine physical maintenance exams, including well woman exams	\$0 Copayment
Well-child preventative exams	\$0 Copayment
Family planning counseling and consultations	\$0 Copayment
Scheduled prenatal care exams	\$0 Copayment
Routine eye exams with a Plan Optometrist	\$0 Copayment
Hearing exams	\$0 Copayment
Physical, occupational, and speech therapy	\$0 Copayment
Urgent care consultations, evaluations, and treatment	\$0 Copayment
Note: Urgent care includes Mental/Behavioral health and Chemical dependency (Substance Use Disorder) crisis intervention services.	
Chiropractic services	\$10 Copayment
Note: Up to 24 visits per member, per plan year	
Acupuncture services	\$10 Copayment
Note: Up to 24 visits per member, per plan year	

Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in person.

Outpatient Services	Your Cost Share
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Outpatient surgery facility fee	\$0 Copayment
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Outpatient Physician/surgeon fee	Included in Outpatient surgery facility fee
Outpatient Visit	\$0 Copayment
Immunizations	\$0 Copayment
X-rays	\$0 Copayment
Laboratory tests	\$0 Copayment
MRI, CT, and PET scans	\$0 Copayment
Rehabilitation/Habilitation services	\$0 Copayment
Covered individual health education counseling	\$0 Copayment
Covered health education programs	\$0 Copayment

Hospitalization Services	Your Cost Share
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Inpatient stay (facility fee)	\$0 Copayment
Physician/surgeon fee for surgery	Included in Inpatient stay (facility fee)

Emergency Health Coverage	Your Cost Share
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Emergency room facility fee	\$0 Copayment
Emergency room physician fee	Included in Emergency room facility fee

Note: Emergency room fees do not apply if admitted directly to the hospital as an inpatient for Covered Services.

Mental health and chemical dependency crisis intervention services	\$0 Copayment
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Ambulance Services	Your Cost Share
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Ambulance Services	\$0 Copayment
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Prescription Drug Coverage	Your Cost Share
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Covered outpatient items in accord with our drug formulary guidelines:

Generic drugs	At a Plan Pharmacy	\$0 Copayment
	Refills through our mail-order service	\$0 Copayment
Brand drugs	At a Plan Pharmacy	\$0 Copayment
	Refills through our mail-order service	\$0 Copayment

Drug Tiers	Categories
1	<ul style="list-style-type: none"> • Generic drugs • Low-cost Preferred Brand Drugs
2	<ul style="list-style-type: none"> • Brand name drugs

Mental/Behavioral Health (MH) Services	Your Cost Share
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Inpatient:

MH psychiatric hospitalization fee	\$0 Copayment
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MH psychiatric physician/surgeon fee	\$0 Copayment
MH psychiatric observation	\$0 Copayment
MH psychological testing	\$0 Copayment
MH individual and group treatment	\$0 Copayment
MH individual and group evaluation	\$0 Copayment
MH crisis residential program	\$0 Copayment

Outpatient:

MH office visits	\$0 Copayment
MH monitoring of drug therapy	\$0 Copayment
MH individual and group treatment	\$0 Copayment
MH individual and group evaluation	\$0 Copayment

Outpatient, Other Items and Services:

Applied behavior analysis and behavioral health treatment	\$0 Copayment
MH multidisciplinary treatment in an intensive outpatient psychiatric treatment program	\$0 Copayment
Neuropsychological testing	\$0 Copayment
MH partial hospitalization	\$0 Copayment
MH psychological testing	\$0 Copayment

Note: Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in-person.

Chemical Dependency (Substance Use Disorder) Services	Your Cost Share
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Inpatient:

Chemical dependency hospitalization fee	\$0 Copayment
Chemical dependency physician/surgeon fee	\$0 Copayment
Inpatient detoxification	\$0 Copayment
Individual and group treatment	\$0 Copayment
Individual and group chemical dependency counseling	\$0 Copayment
Individual and group evaluation	\$0 Copayment
Transitional residential recovery services	\$0 Copayment

Outpatient:

Chemical dependency office visits	\$0 Copayment
Chemical dependency individual and group evaluation	\$0 Copayment
Chemical dependency individual and group counseling	\$0 Copayment
Methadone Maintenance	\$0 Copayment

Outpatient, Other Items and Services:

Chemical dependency intensive outpatient programs	\$0 Copayment
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Chemical dependency day treatment programs \$0 Copayment

Note: Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in-person.

Durable Medical Equipment (DME)	Your Cost Share
DME	\$0 Copayment
Home Health Services	Your Cost Share
Home health care (up to 100 visits per benefit year)	\$0 Copayment
Other	Your Cost Share
Skilled Nursing Facility care (up to 100 days per benefit period)	\$0 Copayment
Hospice care	\$0 Copayment

Notes:

* Other Practitioner Office Visits include visits not provided by either Primary Care or Specialty Practitioners.