Sutter Health Plus
Your Health Plan

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.

PENDING REGULATORY APPROVAL

BENEFIT PLAN NAME: SILVER INDIVIDUAL (2017)

Annual Deductible For Certain Services	
For self-only enrollment (a Family of one Member)	$2,500
For any one Member in a Family of two or more Members	$2,500
For an entire Family of two or more Members	$5,000

Separate Annual Deductible for Prescription Medications	
For self-only enrollment (a Family of one Member)	$250
For any one Member in a Family of two or more Members	$250
For an entire Family of two or more Members	$500

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)	$6,800
For any one Member in a Family of two or more Members	$6,800
For an entire Family of two or more Members	$13,600

Lifetime Maximum	
Lifetime maximum	None

Covered Services	Cost to Member
Preventive Care Services	
Family planning counseling and services	No charge
Hearing exams	No charge
Immunizations (including vaccines)	No charge
Prenatal care and preconception visits	No charge
Preventive and routine physical maintenance exams (including routine screening tests)	No charge
Preventive X-rays, screenings, and laboratory tests as described in the "Your Benefits" section	No charge
Well-child preventive care exams	No charge
Professional Services	
Primary care visit or non-specialist practitioner visit to treat an injury or illness	$35 copay per visit
Specialist visit	$70 copay per visit
Acupuncture	$35 copay per visit
Outpatient rehabilitation services	$35 copay per visit
Outpatient habilitation services	$35 copay per visit
Outpatient Services	
Outpatient surgery (facility fee)	20% coinsurance
Outpatient surgery (physician/surgeon fee)	20% coinsurance
Outpatient visit (non-office visit)	20% coinsurance
Laboratory tests	$35 copay per visit
Imaging (e.g. MRI, CT, and PET scans)	$300 copay per procedure
Diagnostic and therapeutic X-rays and imaging	$70 copay per procedure

Hospitalization Services	
Facility fee (e.g. hospital room)	20% coinsurance after deductible
Physician/surgeon fees	20% coinsurance after deductible
Emergency and Urgent Care Services	
Emergency room facility fee	$350 copay per visit
Emergency room physician fee	No charge
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 as an inpatient stay, the Cost Sharing for "Hospitalization Services" will apply.	
Urgent care consultations, exams, and treatment	$35 copay per visit
Ambulance Services	
Ambulance services	$250 copay per trip after deductible
Prescription Drug	
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 and Through Mail-Order Service	
Tier 1 - Most generic medications and low-cost preferred brands	Retail: $15 copay per prescription for up to a 30-day supply Mail-Order: $30 copay per prescription for up to a 100-day supply

Tier 2 - Preferred brand name and non-preferred generic medications	Retail: $55 copay per prescription after pharmacy deductible for up to a 30-day supply Mail-Order: $110 copay per prescription after pharmacy deductible for up to a 100-day supply
Tier 3 - Non-preferred brand medications	Retail: $80 copay per prescription after pharmacy deductible for up to a 30-day supply Mail-Order: $160 copay per prescription after pharmacy deductible for up to a 100-day supply
Tier 4 - Specialty, some self-administered, or bioengineered medications Notes: Member cost share will not exceed $250 per prescription per 30-day supply. Medications prescribed for sexual dysfunction have a 50% share of cost and some, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.	Retail & Mail-Order: 20% coinsurance after pharmacy deductible for up to a 30-day supply
Durable Medical Equipment	
The durable medical equipment for home use listed in the “Your Benefits” section in accord with our durable medical equipment formulary guidelines	20% coinsurance

Mental/Behavioral Health/Substance Use Disorder Treatment Services (SUD)	
Mental/Behavioral Health/SUD inpatient facility	20% coinsurance after deductible
Mental/Behavioral Health/SUD inpatient physician/surgeon fees	20% coinsurance after deductible
Mental/Behavioral Health/SUD outpatient office visits – individual *(Individual outpatient MH/SUD evaluation and treatment services)*	$35 copay per visit
Mental/Behavioral Health/SUD outpatient office visits – group *(Group outpatient MH/SUD evaluation and treatment services)*	$17.50 copay per visit
Mental/Behavioral Health/SUD other outpatient services	20% coinsurance after deductible (maximum $35 per visit)
Home Health Services	
Home health care (up to 100 visits per calendar year)	$45 copay per visit
Pregnancy Services	
Delivery and all hospital inpatient services	20% coinsurance after deductible
Delivery and all professional inpatient services	20% coinsurance after deductible
Other	
Skilled Nursing Facility services (up to 100 days per benefit period)	20% coinsurance after deductible
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the “Your Benefits” section	20% coinsurance
Hospice care	No charge

Pediatric Dental and Vision Services	
Diagnostic and preventive pediatric dental services under age 19, such as exams, cleanings, X-rays sealants and fluoride	No charge
Basic pediatric dental services under age 19, such as restorative procedures and periodontal maintenance	See the 2017 Dental Copay Schedule in EOC
Major pediatric dental services under age 19, such as crowns and casts, endodontics, other periodontics, prosthodontics, and oral surgery	See the 2017 Dental Copay Schedule in EOC
Medically necessary orthodontic pediatric dental services under age 19	$1,000
Pediatric vision services: eye exam	No charge
Pediatric vision services: eyewear (one pair of glasses or contact lenses in lieu of glasses)	No charge

MI03 2017 v1

Endnotes:

1. Family Deductibles (when applicable) and Out-of-Pocket Maximums (OOPM) are equal to two times the individual values. In a Family plan, an individual is only responsible for the single Deductible and the single OOPM. Deductibles and other cost sharing payments made by each individual in a Family contribute to the Family Deductible or OOPM. Once the Family Deductible amount is satisfied by any combination of individual Deductible payments, plan Copayments or Coinsurance amounts apply until the Family OOPM is reached, after which the plan pays all costs for covered services for all Family members.

2. Cost sharing amounts for all Essential Health Benefits, including the Deductible, accumulate toward the OOPM.

3. Member cost sharing for oral anti-cancer drugs shall not exceed $200 per prescription per 30-day supply. 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. Except for Tier 4 medications, a 100-day supply is available, at twice the 30-day Copayment price, through the mail-order pharmacy. Prescription drug cost sharing contributes toward the annual Deductible and OOPM.

4. Non-specialist practitioner office visits include therapy visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

5. Member cost-sharing will be charged as a separate Copayment from a preventive service provided during an office visit.
6. Family planning counseling and 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."
7. 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.
8. 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.
9. Cost sharing for services with Copayments is the lesser of the Copayment amount or allowed amount.
10. Pediatric Vision Services include an eye exam and a complete pair of glasses (lenses and frame) or contact lenses. Annually under age 19.