Sutter Health Plus
Your Health Plan

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 or 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: Silver MS74 HMO

Annual Deductible for Certain Medical Services	
For self-only enrollment (a Family of one Member)	$2,250
For any one Member in a Family of two or more Members	$2,250
For an entire Family of two or more Members	$4,500
Separate Annual Deductible for Prescription Drugs	
For self-only enrollment (a Family of one Member)	$300
For any one Member in a Family of two or more Members	$300
For an entire Family of two or more Members	$600
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)	$8,200
For any one Member in a Family of two or more Members	$8,200
For an entire Family of two or more Members	$16,400

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.	
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	$55 copay per visit
Other practitioner office visit (see Endnotes)	$55 copay per visit
Acupuncture services (see Endnotes)	$55 copay per visit
Sutter Walk-in Care visit, where available	$55 copay per visit
Specialist office visit	$90 copay per visit
Allergy services provided as part of a Specialist visit (includes testing, injections and serum) There is no Cost Sharing 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.	$90 copay per visit
Medically administered drugs dispensed to a Participating Provider for administration	No charge

Outpatient rehabilitation services	$55 copay per visit
Outpatient habilitation services	$55 copay per visit
Outpatient surgery facility fee	30% coinsurance after deductible
Outpatient surgery Professional fee	30% coinsurance
Outpatient visit (non-office visit, see Endnotes)	30% coinsurance
Non-preventive laboratory services	$55 copay per visit
Radiological and nuclear imaging (e.g., MRI, CT and PET scans)	$300 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)	$90 copay per procedure
Hospitalization Services	
Inpatient facility fee (e.g., hospital room, medical supplies and inpatient drugs including anesthesia)	30% coinsurance after deductible
Inpatient Professional fees (e.g., surgeon and anesthesiologist)	30% coinsurance
Emergency and Urgent Care Services	
Emergency room facility fee	30% coinsurance after deductible
Emergency room Professional 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 for an inpatient stay, the Cost Sharing for "Hospitalization Services" will apply.	
Urgent Care consultations, exams and treatment	$55 copay per visit
Ambulance Services	
Medical transportation (including emergency and non-emergency)	30% coinsurance 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: $17 copay per prescription for up to a 30-day supply Mail order: $34 copay per prescription 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: $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 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: $110 copay per prescription after pharmacy deductible for up to a 30-day supply Mail order: $220 copay per prescription after pharmacy 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: 30% coinsurance up to $250 per prescription after pharmacy deductible for up to a 30-day supply
Durable Medical Equipment	
Durable medical equipment for home use	30% coinsurance
Ostomy and urological supplies; prosthetic and orthotic devices	30% coinsurance
Mental Health & Substance Use Disorder (MH/SUD) Services	
MH/SUD inpatient facility fee (see Endnotes)	30% coinsurance after deductible

MH/SUD inpatient Professional fees (see Endnotes)	30% coinsurance
MH/SUD individual outpatient office visits (e.g., evaluation and treatment services)	$55 copay per visit
MH/SUD group outpatient office visits (e.g., evaluation and treatment services)	$27.50 copay per visit
MH/SUD other outpatient services (see Endnotes)	30% coinsurance (maximum $55 per visit)
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)	30% coinsurance after deductible
Labor and delivery inpatient Professional fees (e.g., anesthesiologist, nurse midwife and obstetrician)	30% coinsurance
Other Services for Special Health Needs	
Skilled Nursing Facility services (up to 100 days per benefit period)	30% coinsurance after deductible
Home health care (up to 100 visits per calendar year)	$45 copay per visit
Hospice care	No charge
Pediatric Dental and Vision Services (Provided through the end of the month in which the Member turns 19 years of age)	
Diagnostic and preventive Pediatric Dental Services (e.g., cleanings, exams, fluoride, sealants, space maintainers and X-rays)	No charge

Basic Pediatric Dental Services (e.g., periodontal maintenance services and restorative procedures)	See Pediatric Dental Addendum in EOC
Major Pediatric Dental Services (e.g., crowns and casts, endodontics, oral surgery, other periodontal services and prosthodontics)	See Pediatric Dental Addendum in EOC
Medically Necessary orthodontic Pediatric Dental Services	$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

Endnotes:

1. Family Deductibles (when applicable) and Out-of-Pocket Maximums (OOPM) are equal to two times the "self-only" values. In a Family plan, a Member is only responsible for the "one Member in a Family" Deductible and OOPM. Deductibles and other Cost Sharing payments made by each Member in a Family contribute to the "entire Family of two or more" Deductible and OOPM. Once the "entire Family of two or more" Deductible amount is satisfied by any combination of Member Deductible payments, plan Copayment or Coinsurance amounts apply until the "entire Family of two or more" OOPM is reached, after which the plan pays all costs for Covered Services for all Family Members.

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 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 plans with a separate annual Deductible for prescription drugs, oral anticancer drugs on any tier are not subject to the prescription drug Deductible.

   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 100-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. 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.