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.

(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 SD17 HDHP HMO

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	$2,700
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)	$5,650
For any one Member in a Family of two or more Members	$5,650
For an entire Family of two or more Members	$11,300

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" chapter of the Evidence of Coverage and Disclosure Form (EOC)	No charge
Well-child preventive care exams	No charge
Professional Services	
Primary Care Physician (PCP) visit or non-specialist practitioner visit to treat an injury or illness	$35 copay per visit after deductible
Specialist visit	$35 copay per visit after deductible
Acupuncture	$35 copay per visit after deductible
Outpatient rehabilitation services	$35 copay per visit after deductible
Outpatient habilitation services	$35 copay per visit after deductible
Outpatient Services	
Outpatient surgery (facility fee)	20% coinsurance after deductible
Outpatient surgery (physician/surgeon fee)	20% coinsurance after deductible
Outpatient visit (non-office visit)	20% coinsurance after deductible
Laboratory tests	$35 copay per visit after deductible
Imaging (e.g. MRI, CT and PET scans)	$50 copay per procedure after deductible

Diagnostic and therapeutic X-rays and imaging	$15 copay per procedure after deductible
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	20% coinsurance after deductible
Emergency room physician 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	$35 copay per visit after deductible
Ambulance Services	
Ambulance services	20% coinsurance after deductible
Prescription Drugs	
Covered outpatient items in accord with our drug formulary guidelines at network retail pharmacies or through mail-order service:	
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 100-day supply
Tier 2 - Preferred brand name drugs, non-preferred Generic Drugs and drugs recommended by Sutter Health Plus's (SHP) pharmacy and therapeutics committee based on drug safety, efficacy and cost	Retail: $20 copay per prescription after deductible for up to a 30-day supply Mail-Order: $40 copay per prescription 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: $40 copay per prescription after deductible for up to a 30-day supply Mail-Order: $80 copay per prescription after deductible for up to a 100-day supply
Tier 4 – Specialty Drugs, self-administered drugs that require training or clinical monitoring, drugs that cost SHP more than $600 net of rebates for a one-month supply or bioengineered drugs	Specialty Pharmacy: 20% coinsurance after deductible for up to a 30-day supply Member cost share will not exceed $250 per prescription after deductible for up to a 30-day supply.
Durable Medical Equipment	
Durable medical equipment	20% coinsurance after deductible
Mental/Behavioral Health & Substance Use Disorder Treatment Services (MH/SUD)	
MH/SUD inpatient facility fee (e.g. hospital room)	20% coinsurance after deductible
MH/SUD inpatient physician/surgeon fees	20% coinsurance after deductible
MH/SUD outpatient office visits – individual *(Individual outpatient MH/SUD evaluation and treatment services)*	$35 copay per visit after deductible
MH/SUD outpatient office visits – group *(Group outpatient MH/SUD evaluation and treatment services)*	$17.50 copay per visit after deductible
MH/SUD other outpatient services	20% coinsurance after deductible
Home Health Services	
Home health care (up to 100 visits per calendar year)	20% coinsurance after deductible
Pregnancy Services	
Delivery and all hospital inpatient services	20% coinsurance after deductible
Delivery and all professional inpatient services	20% coinsurance after deductible

Other Services	
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" chapter of the EOC	20% coinsurance after deductible
Hospice care	No charge after deductible
Pediatric Dental and Vision Services	
Diagnostic and preventive Pediatric Dental Services, such as exams, cleanings, X-rays, sealants and fluoride	No charge
Basic Pediatric Dental Services, such as restorative procedures and periodontal maintenance	See the 2018 Dental Copay Schedule in EOC
Major Pediatric Dental Services, such as crowns and casts, endodontics, other periodontics, prosthodontics and oral surgery	See the 2018 Dental Copay Schedule 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. 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 $2,700 for plan year 2018. 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 oral anti-cancer drugs shall not exceed $200 per prescription for up to a 30-day supply. This maximum Cost Sharing 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 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) Drugs prescribed for sexual dysfunction have a 50% share of cost applied after the Deductible is met. Some sexual dysfunction drugs, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.

4. Non-specialist practitioner office visits include therapy visits, other office visits not provided by either PCPs or Specialists or visits not specified in another benefit category.

5. 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 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.

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.

8. Inpatient MH/SUD services include, but are not limited to: 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.

9. MH/SUD other outpatient services include, but are not limited to: 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 delivered at home; and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
10. Cost Sharing for services with Copayments is the lesser of the Copayment amount or allowed amount.
11. Pediatric Vision Services include an eye exam and a complete pair of glasses (lenses and frame) or contact lenses. Available annually for individuals through the end of the month in which the enrollee turns 19 years of age.
12. In order to be covered, most services require a referral from your PCP and many also require Prior Authorization by your PCP's medical group. Please consult the complete EOC for additional information on referral and Prior Authorization requirements.

Sutter Health Plus
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Notice of Language Assistance

IMPORTANT: Can you read this? If not, Sutter Health Plus can have somebody help you read it. You may also be able to get this written in your language. For no-cost help, please call Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500). (English)

IMPORTANTE: ¿Puede leer esto? Si no puede, Sutter Health Plus puede proporcionarle alguien que le ayude a leerlo. También puede obtenerlo por escrito en su idioma. Llame a Sutter Health Plus Member Services al 1-855-315-5800 (TTY 1-855-830-3500), sin costo alguno. (Spanish)

重要提示：您能讀懂這份文件嗎？如果不能，Sutter Health Plus 可以找人幫助您讀它。您還可能得到用您的語言書寫的這份文件。若需要免費幫助，請致電 Sutter Health Plus 會員服務，電話號碼 1-855-315-5800 (TTY 1-855-830-3500)。(Chinese)

ملحوظة مهمة: هل أنت قادر على قراءة هذا؟ إذا لم تكن قادرًا فاعلم أن صَتر هيلث بلاس (Sutter Health Plus) قد يكون لديهم شخصًا يمكنه مساعدتك في قراءة هذا النص. كما يمكنك أيضًا أن تتلقاه مكتوبًا بلُغتك. للحصول على مساعدة مجانية، برجاء الاتصال بخدمات أعضاء صَتر هيلث بلاس (Sutter Health Plus Member Services) على هاتف 1-855-315-5800 (هاتف النص المرئي [TTY]1-855-830-3500). (Arabic)

ԿԱՐԵՎՈՐ ՏԵՂԵԿԱՏՎՈՒԹՅՈՒՆ. Կարո՞ղ եք կարդալ սա։ Եթե ոչ, Sutter Health Plus-ը կարող է տրամադրել մեկին, ով կօգնի Ձեզ կարդալ այն։ Դուք կարող եք նաև ստանալ այն գրված Ձեր լեզվով։ Անվճար օգնության համար խնդրում ենք զանգահարել Sutter Health Plus-ի Անդամների սպասարկման բաժին՝ 1-855-315-5800 (TTY 1-855-830-3500) հեռախոսահամարով։ (Armenian)

សារៈសំខាន់ៈ តើអ្នកអាចអានសេចក្តីនេះឬទេ? បើសិនមិនអាចទេ Sutter Health Plus **អាចមាននរណាម្នាក់ជួយអានវាជូនអ្នក ។ អ្នកក៏អាចនឹងឲ្យបានសេចក្តីនេះ សរសេរជាភាសារបស់អ្នកដែរ។ សំរាប់ជំនួយដោយឥតអស់ថ្លៃ សូមទូរស័ព្ទទៅ ផ្នែកសេវាសមាជិក** Sutter Health Plus **តាមលេខ** 1-855-315-5800 (TTY 1-855-830-3500)**។** (Cambodian)

نکته مهم: آیا می توانید این مطالب را بخوانید و بفهمید؟ اگر نمی توانید، Sutter Health Plus می تواند از فردی کمک بگیرد تا آنرا برایتان بخواند. همچنین امکان ترجمه این مطالب به زبان فارسی وجود دارد. برای دریافت خدمات و کمک رایگان، لطفا با دفتر خدمات اعضای Sutter Health Plus با شماره تلفن 1-855-315-5800 (TTY 1-855-830-3500) تماس بگیرید. (Farsi)

महत्वपूर्ण: क्या आप इसे पढ़ सकते/सकती हैं? यदि नहीं, तो सट्टर हेल्थ प्लस इसे पढ़ने में किसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा मे भी लिखवाने में समर्थ हो सकते/सकती हैं। निःशुल्क सहायता के लिए, कृपया 1-855-315-5800 (TTY 1-855-830-3500) पर सट्टर हेल्थ प्लस मेंबर सर्विसेस को कॉल करें। (Hindi)

LUS TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Yog koj nyeem tsis tau, Sutter Health Plus muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, peb tuaj yeem muab sau ua hom lus koj nyeem tau rau koj tib si. Yog koj xav tau kev pab pub dawb, thov hu rau Sutter Health Plus Lub Chaw Pab Cuam Tswv Cuab ntawm tus xov tooj 1-855-315-5800 (TTY 1-855-830-3500). (Hmong)

重要なお知らせ：これを読むことができます？読めない場合は、Sutter Health Plus が読むのをお手伝いします。あなたの言語で表示できるかもしれません。無料のご相談は、Sutter Health Plus Member Services、電話: 1-855-315-5800 (TTY 1-855-830-3500) まで。(Japanese)

중요: 귀하는 이것을 읽으실 수 있습니까? 만약 읽으실 수 없다면, Sutter Health Plus 에서 다른 사람에게 부탁하여 그것을 읽으실 수 있도록 도와드릴 수 있습니다. 또한 이것을 귀하의 사용 언어로 작성해 받으실 수도 있습니다. Sutter Health Plus 회원 서비스(1-855-315-5800 (TTY 1-855-830-3500))에 전화를 하시어 무상으로 도움을 받으십시오. (Korean)

ໝາຍເຫດ: **ທ່ານອ່ານໄດ້ຈົດໝາຍສະບັບນີ້ບໍ່**? **ຖ້າ**ທ່ານອ່ານບໍ່ໄດ້, **ທາງ** Sutter Health Plus **ມີ ພະນັກງານຊ່ວຍອ່ານໃຫ້ທ່ານ**. **ນອກຈາກນັ້ນ**, **ພວກເຮົາຍັງສາມາດຂຽນເປັນພາສາຂອງທ່ານໃຫ້ທ່ານອີກ ດ້ວຍ**. **ຖ້າ**ທ່ານ**ຕ້ອງ**ການ**ຄວາມ**ຊ່ວຍ**ເຫຼືອ**ໂດຍ**ບໍ່ເສຍ**ຄ່າ**ບໍລິການ, **ກະລຸນາ**ຕິດ**ຕໍ່ ໜ່ວຍ**ບໍລິການ **ຂອງ** Sutter Health Plus **ທີ່ໝາຍ**ເລກ**ໂທ**ລະ**ສັບ** 1-855-315-5800 (TTY 1-855-830-3500). (Laotian)

ਅਹਿਮ: ਕੀ ਤੁਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ, Sutter Health Plus (ਸੱਟਰ ਹੈਲਥ ਪਲਸ) ਕਿਸੇ ਤੋਂ ਇਹ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮੱਦਦ ਕਰਵਾ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਮੱਦਦ ਲਈ ਕਿਰਪਾ ਕਰ ਕੇ Sutter Health Plus Member Services ਨੂੰ 1-855-315-5800 (TTY 1-855-830-3500) ਉਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ВАЖНО: Вы можете это прочитать? Если нет, Sutter Health Plus может предоставить Вам кого-то, кто сможет помочь Вам прочитать это. Вы также можете получить это в письменной форме на своем языке. Для бесплатной помощи позвоните в Службу поддержки членов Sutter Health Plus по телефону 1-855-315-5800 (TTY 1-855-830-3500). (Russian)

MAHALAGA: Nababasa mo ba ito? Kung hindi, maaari kang bigyan ng Sutter Health Plus ng taong babasa para sa iyo. Maaari mo ding hilingin na isulat ito sa iyong wika. Para sa walang-gastos na tulong, mangyaring tumawag sa Sutter Health Plus Member Services sa. 1-855-315-5800 (TTY 1-855-830-3500). (Tagalog)

สำคัญ: คุณอ่านออกหรือไม่ ถ้าอ่านไม่ออก Sutter Health Plus สามารถให้คนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถขอรับเนื้อหานี้เป็นภาษาของคุณได้อีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย กรุณาโทรหา Sutter Health Plus Member Services ที่ 1-855-315-5800 (TTY 1-855-830-3500) (Thai)

QUAN TRỌNG: Qu. vị có thể đọc thông tin này không? Nếu không, Sutter Health Plus có thể yêu cầu ai đó đọc giúp cho qu. vị. Qu. vị cũng có thể nhận được thông tin này dưới dạng văn bản bằng ngôn ngữ của qu. vị. Để được hỗ trợ miễn phí, vui lòng gọi cho ban Dịch Vụ Thành Viên của Sutter Health Plus theo số 1-855-315-5800 (TTY 1-855-830-3500). (Vietnamese)