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: Gold MS42 HMO

Annual Deductible For Certain Medical Services	
For self-only enrollment (a Family of one Member)	$1,000
For any one Member in a Family of two or more Members	$1,000
For an entire Family of two or more Members	$2,000

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)	$6,750
For any one Member in a Family of two or more Members	$6,750
For an entire Family of two or more Members	$13,500

Lifetime Maximum	
Lifetime benefit maximum	None

Benefits	Member Cost Sharing
Preventive Care Services	
Eye exams for refraction	No charge
Family planning counseling and services (see Endnotes)	No charge
Immunizations (including vaccines)	No charge
Prenatal care and preconception visits	No charge
Routine preventive medical exams, procedures and screenings (e.g. hearing exams, colorectal cancer screenings, well-child exams and well-woman exams)	No charge
Routine preventive imaging and laboratory services	No charge
Preventive care drugs and supplies (refer to the Sutter Health Plus Formulary for a complete list)	No charge
Outpatient Services	
Primary Care Physician (PCP) office visit to treat an injury or illness	$30 copay per visit
Other practitioner office visit (includes Sutter Walk-in Care visit, if available, see Endnotes)	$30 copay per visit
Specialist office visit	$50 copay per visit
Acupuncture (see Endnotes)	$30 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.	$50 copay per visit
Outpatient rehabilitation services	$30 copay per visit
Outpatient habilitation services	$30 copay per visit
Outpatient surgery facility fee	$500 copay per visit after deductible
Outpatient surgery Professional fee	$30 copay per visit after deductible

Outpatient visit (non-office visit, see Endnotes)	$30 copay per visit after deductible
Non-preventive laboratory services	$30 copay per visit
Imaging (radiological and nuclear, e.g. MRI, CT and PET scans)	$200 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)	$30 copay per procedure
Hospitalization Services	
Inpatient facility fee (e.g. hospital room, inpatient drugs including anesthesia, medical supplies, and labor and delivery)	$500 copay per day up to a maximum of 5 days per admission after deductible
Inpatient Professional fees	No charge after deductible
Emergency and Urgent Care Services	
Emergency room facility fee	$250 copay per visit 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 consultations, exams and treatment	$30 copay per visit
Ambulance Services	
Medical transportation (including emergency and non-emergency)	$250 copay per trip 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: $5 copay per prescription for up to a 30-day supply Mail-Order: $10 copay per prescription 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: $25 copay per prescription for up to a 30-day supply Mail-Order: $50 copay per prescription 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: $50 copay per prescription for up to a 30-day supply Mail-Order: $100 copay per prescription for up to a 100-day supply
Tier 4 - Drugs that are biologics, drugs that the 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: 20% coinsurance for up to a 30-day supply Member cost share will not exceed $250 per prescription 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 (see Endnotes)	$500 copay per day up to a maximum of 5 days per admission after deductible
MH/SUD inpatient Professional fees (see Endnotes)	No charge after deductible

MH/SUD individual outpatient office visits (e.g.evaluation and treatment services)	$30 copay per visit
MH/SUD group outpatient office visits (e.g. evaluation and treatment services)	$15 copay per visit
MH/SUD other outpatient services (see Endnotes)	$30 copay per visit after deductible
Home Health Services	
Home health care (up to 100 visits per calendar year)	$30 copay per visit
Other Services	
Skilled Nursing Facility services (up to 100 days per benefit period)	$225 copay per day up to a maximum of 5 days per admission after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	20% coinsurance after deductible
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. exams, cleanings, X-rays, sealants and fluoride)	No charge
Basic Pediatric Dental Services (e.g. restorative procedures and periodontal maintenance)	See the 2019 Dental Copay Schedule in EOC
Major Pediatric Dental Services (e.g. crowns and casts, endodontics, other periodontics, prosthodontics and oral surgery)	See the 2019 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. 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) For plans with a Deductible that applies to prescription drugs, the annual Deductible does not apply to oral anti-cancer drugs. Member Cost Sharing for oral anti-cancer drugs shall not exceed $200 per prescription for up to a 30-day supply.

   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. Family planning counseling and services include all Food and Drug Administration approved contraceptive methods (drugs and devices), 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. 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.

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. 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.

12. For 2019, 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.