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.

BENEFIT PLAN NAME: Platinum Coinsurance 2016 *PENDING REGULATORY APPROVAL*

Annual Out-of Pocket Maximum[1,2]

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 total the following amounts:

For self-only enrollment (a Family of one Member)..... $4,000
For any one Member in a Family of two or more Members[1]..... $4,000
For an entire Family of two or more Members.....$8,000

Lifetime Maximum	**Unlimited**

Annual Deductible for Certain Services

For self-only enrollment (a Family of one Member)..... $0
For any one Member in a Family of two or more Members[1]..... $0
For an entire Family of two or more Members.....$0

Deductible for Prescription Medications[1]

For self-only enrollment (a Family of one Member)..... $0
For any one Member in a Family of two or more Members[1]..... $0
For an entire Family of two or more Members..... $0

Professional Services (Plan Provider office visits)	**You Pay**
Primary care visit or non-specialist practitioner visit to treat an injury or illness[4]	$20 per visit
Specilist visit[5]	$40 per visit
Preventive and routine physical maintenance exams (including routine screening tests)	No Charge
Well-child preventive care exams	No Charge
Family planning counseling and services[6]	No Charge
Pediatric Vision Eye Exam[7]	No Charge
1 pair of glasses per year (or contact lenses in lieu of glasses)[7]	No Charge
Pediatric dental services under age 19 (Diagnostic and preventive services such as exams, cleanings, X-rays and sealants)	No Charge
Basic pediatric dental services under age 19:Amalgam fillings – 1 surface)	$25
Major pediatric dental services under age 19: Root canal – molar	$300
Gingivectomy per Quad	$150
Extraction - single tooth exposed root or erupted	$65

Extraction – complete bony	$160
Crown – Porcelain with metal	$300
Pediatric dental services under age 19 - Medically necessary orthodontics	$1,000
Hearing exams	No Charge
Urgent care consultations, exams, and treatment	$40 per visit
Outpatient Rehabilitation and Habilitation Services	$20 per visit

Outpatient Services	**You Pay**
Outpatient surgery (facility fee)	10% coinsurance
Outpatient surgery (physician/surgeon fees)	10% coinsurance
Outpatient Visit (non-office visit)	10% coinsurance
Immunizations (including vaccines)	No Charge
Laboratory Tests (non-preventive)	$20
Preventive X-rays, screenings, and laboratory tests as described in the "Your Benefits" section	No Charge
Imaging (MRI, CT, and PET scans)	10% coinsurance
Diagnostic and therapeutic X-rays and imaging	$40

Hospitalization Services	**You Pay**
Facility Fee (e.g. hospital room)	10% coinsurance
Physician/Surgeon Fee	10% coinsurance

Emergency Health Services	**You Pay**
Emergency Room Facility Fee	$150 per visit
Emergency Room Physician Fee	No Charge

This 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.

Ambulance Services	**You Pay**
Ambulance Services	$150 per trip

Prescription Drug[3]	**You Pay**

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	
Tier 1	$5 for up to a 30-day supply
Tier 2	$15 for up to a 30-day supply
Tier 3	$25 for up to a 30-day supply
Tier 4	10% coinsurance for up to a 30-day supply (up to $250 per prescription) (except for sexual dysfunction medications, which are 50% of cost, 8 doses per 30-day supply
For Drugs Filled Through Mail-Order Service	
Tier 1	$10 for up to a 100-day supply
Tier 2	$30 for up to a 100-day supply
Tier 3	$50 for up to a 100-day supply
Tier 4	10% coinsurance (up to $250 per

prescription) for up to a 30-day supply (except for sexual dysfunction medications, which are 50% of cost, 8 doses per 30-day supply).

Durable Medical Equipment	You Pay
The durable medical equipment for home use listed in the "Your Benefits" section in accord with our durable medical equipment formulary guidelines....	10% coinsurance

Mental/Behavioral Health/SUD Services	You Pay
Mental/Behavioral Health/SUD Inpatient Facility[8]	10% coinsurance
Mental/Behavioral Health/SUD Inpatient Physician/Surgeon Fee.....	10% coinsurance
Mental/Behavioral Health/SUD Outpatient Office Visits - Individual (Individual Outpatient MH/SUD evaluation and treatment services)..	$20 per visit
Mental/Behavioral Health/SUD Outpatient Office Visits - Group (Group Outpatient MH/SUD evaluation and treatment services).....	$10 per visit
Mental/Behavioral Health/SUD Other Outpatient Services[9]	10% coinsurance (maximum $20)

Pregnancy Services	You Pay
Prenatal care and preconception visits.....	No Charge
Delivery and all inpatient services (Hospital).....	10% coinsurance
Delivery and all inpatient services (Professional).....	10% coinsurance

Home Health Services	You Pay
Home health care (up to 100 visits per year).....	10% coinsurance

Other	You Pay
Skilled nursing care.....	10% coinsurance
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the "Your Benefits" section.....	No Charge
Hospice Care.....	No Charge

Footnotes:

1. Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out-of-pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out-of-pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out-of-pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans linked to HSAs, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or $2,600 for plan year 2016. In other than self-only coverage, an individual's out of pocket contribution is limited to the individual's out of pocket maximum.
2. Cost sharing amounts for all in-network services accumulate toward the deductible, if deductible applies to that service, and the out-of-pocket maximum.
3. Member cost sharing for oral anti-cancer drugs shall not exceed $200 per prescription per 30-day supply. Copays 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 copay price, through the mail-order pharmacy. Prescription drug deductibles and copays contribute toward the plan year medical out-of-pocket maximum.
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 copay from a preventive service provided during an office visit.
6. This category of 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. Eye exam, complete pair of glasses (lenses and frame) or contact lenses. Annually under age 19.
8. 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.
9. 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.

General Note: Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).