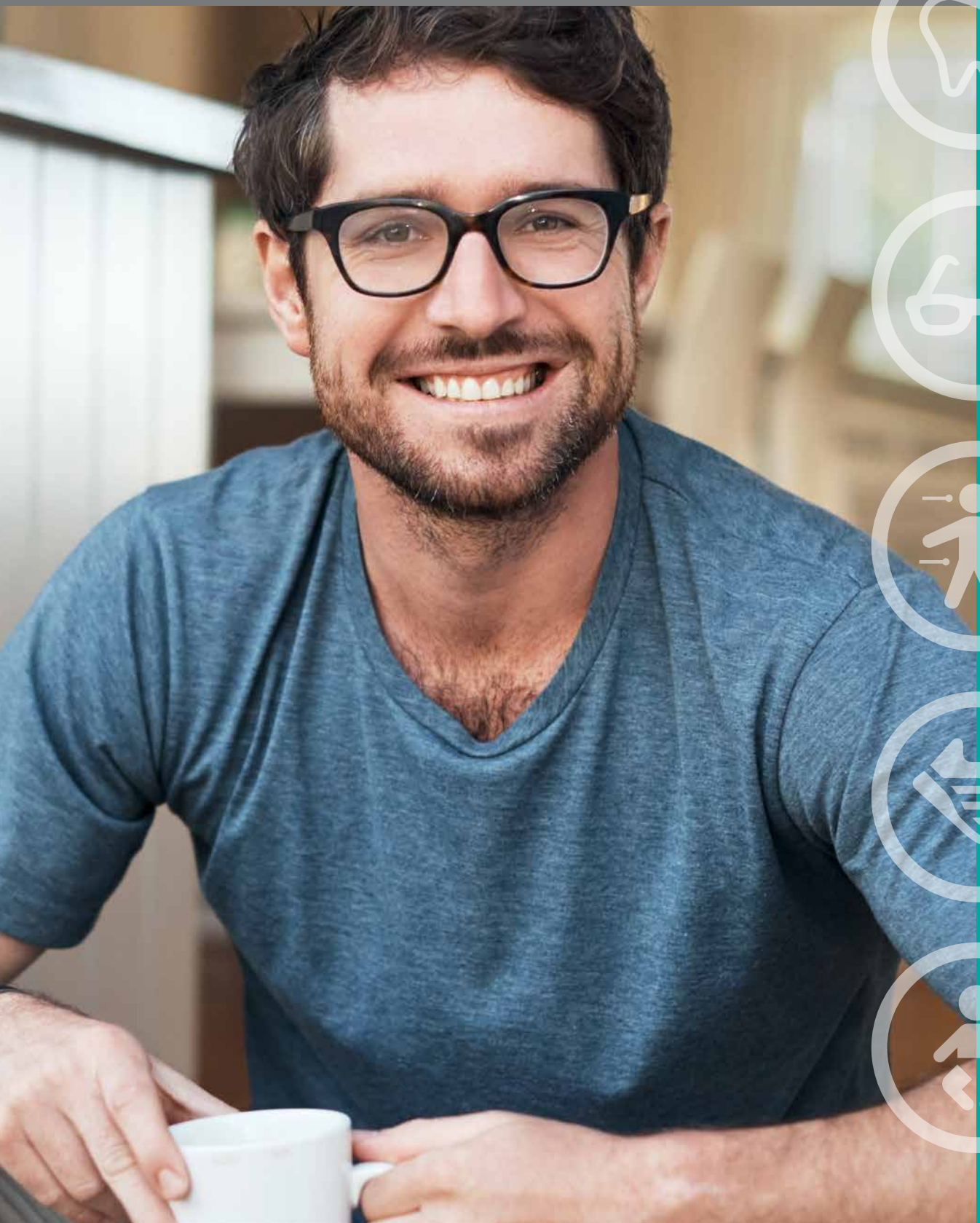
Sutter Health Plus
Your Health Plan

2020 **Optional Benefits**



2020 **Vision Plans** offered and contracted through Vision Service Plan (VSP)

Plan Name	VSP Plan A (Voluntary)	VSP Plan B (Voluntary)	VSP Plan C (Voluntary)
Plan ID	VA01	VA02	VA03
Copay	$20	$20	$20
Frequency			
Eye examination	Every 12 months	Every 12 months	Every 12 months
Lenses	Every 24 months	Every 12 months	Every 12 months
Frames	Every 24 months	Every 24 months	Every 12 months
In-Network Benefits			
Vision Care Services			
Vision examination	Covered in full	Covered in full	Covered in full
Vision Care Materials			
Lenses: single vision	Covered in full*	Covered in full*	Covered in full*
Lenses: bifocal	Covered in full*	Covered in full*	Covered in full*
Lenses: trifocal	Covered in full*	Covered in full*	Covered in full*
Lenses: lenticular	Covered in full*	Covered in full*	Covered in full*
Frames	Covered up to plan allowance of $120*	Covered up to plan allowance of $120*	Covered up to plan allowance of $120*
Contact Lenses			
Necessary professional fees and materials	Covered in full	Covered in full	Covered in full
Elective professional fees and materials	Up to $120 15% professional fees discount applies to member doctor's usual and customary professional fees for contact lens evaluation and fitting	Up to $120 15% professional fees discount applies to member doctor's usual and customary professional fees for contact lens evaluation and fitting	Up to $120 15% professional fees discount applies to member doctor's usual and customary professional fees for contact lens evaluation and fitting
Out of Network Benefits			
Vision Care Services			
Vision Examination	Up to $45	Up to $45	Up to $45
Vision Care Materials			
Lenses: single vision	Up to $30*	Up to $30*	Up to $30*
Lenses: bifocal	Up to $50*	Up to $50*	Up to $50*
Lenses: trifocal	Up to $65*	Up to $65*	Up to $65*
Lenses: lenticular	Up to $100*	Up to $100*	Up to $100*
Frames	Up to $70*	Up to $70*	Up to $70*
Contact Lenses			
Necessary professional fees and materials	Up to $210	Up to $210	Up to $210
Elective professional fees and materials	Up to $105	Up to $105	Up to $105
Value-Added Discounts			
Glasses	20% off the amount over allowance		
Lens options	20–25% average savings on all non-covered lens options		
Sunglasses	20% discount		
Contacts	15% discount off fitting and evaluation		
TruHearing	25% average discount		
Frames	15% average discount		

*Indicates subject to copayment

2020 **Dental Plans** offered and contracted through Delta Dental

Plan Name	Large Group Dental High	Large Group Dental Mid	Large Group Dental Low	Small Group (Adult) Dental
Plan ID	DL03	DL02	DL01	DS01
Dignostic Services				
Periodic oral examinations	No charge	No charge	No charge	No charge
X-rays	No charge (up to four)	No charge (up to four)	No charge (up to three)	No charge
Preventive Services				
Teeth cleaning (prophylaxis)	No charge	No charge	No charge	No charge
Topical fluoride - child (adult at different cost share)	No charge	No charge	No charge	No charge
Restorative Services: Filling - Permanent				
Amalgam-four (+) surfaces: primary or permanent	No charge	No charge	$68	No charge
Crown: porcelain fused to predominantly base metal	$140	$280	$410	$410
Oral Surgery Services				
Extraction of erupted tooth or exposed root	$5	$8	$70	$18
Surgical removal of erupted tooth	$25	$50	$115	$30
Removal of impacted tooth: full bony	$90	$110	$160	$80
Endontic Services				
Root canal: anterior	$55	$110	$300	$110
Root canal: bicuspid	$120	$200	$365	$195
Root canal: molar	$250	$350	$470	$245
Periodontic Services				
Gingivectomy: one to three teeth per quadrant	$80	$85	$50	$50
Gingivectomy-four (+) contiguous teeth per quadrant	$130	$145	$175	$165
Scaling/root planing: one to three teeth per quadrant	$20	$45	$60	$40
Prosthodontic Services				
Complete denture	$145	$335	$600	$510
Partial denture - resin base	$120	$295	$440	$535
Orthodontic Services (medically necessary)				
Comprehensive Treatment - Child (ages 13-18)	$1,700	$1,900	$2,100	N/A
Comprehensive Treatment - Adult (age 19+)	$1,900	$2,100	$2,250	$2,900
Other Services				
Office visit: after hours	$25	$35	$45	$35
Local anesthesia	No charge	No charge	No charge	No charge

This is only a summary. For a complete list of dental services copayments or in the event of any discrepancies in information, please review the applicable benefit documents to determine coverage and costs.

2020 **Chiropractic and Acupuncture**[1] **Plans**

offered and contracted through ACN Group of California, Inc.

Chiropractic Only						
Plan ID	CA01	CA02	CA05	CA06	CA09	CA10
Max visits per year	20	30	20	30	20	30
Copayment per visit	$20	$20	$15	$15	$10	$10

Acupuncture Only						
Plan ID	AA01	AA02	AA05	AA06	AA09	AA10
Max visits per year	20	30	20	30	20	30
Copayment per visit	$20	$20	$15	$15	$10	$10

Chiropractic and Acupuncture									
Plan ID	XA01	XA02	XA04	XA05	XA06	XA08	XA09	XA10	XA12
Max visits per year	20	30	Unlimited	20	30	Unlimited	20	30	Unlimited
Copayment per visit	$20	$20	$20	$15	$15	$15	$10	$10	$10

2020 **Infertility**[2]**/Orthotics and Special Footwear**[2] **Plans**

Infertility	
Plan ID	IF50
Copayment per treatment and services	50%

Orthotics and Special Footwear		
Plan ID	OP20	OH20[3]
Copayment per treatment and services	20%	20% after deductible

[1]Available for small and large group plans only. Not available for election with HDHPs.
[2]Available for large group offerings only.
[3]Only available with large group high-deductible health plans.