Sutter Health Plus
Your Health Plan

2018 **Optional Benefits**

2018 **Vision Plans** offered and contracted through vision service plan (VSP)

Plan Name	VSP Plan A (Voluntary)	VSP Plan B (Voluntary)	VSP Plan C (Voluntary)	Exam Plus** Core (LG Only)	Pediatric Vision Core (IFP and SG Only)
Plan ID	**VA01**	**VA02**	**VA03**	**VA09**	**VA10**
Copay	$20	$20	$20	N/A	N/A
Frequency					
Eye examination	Every 12 months	Every 12 months	Every 12 months	Every 12 Months	Every 12 months
Lenses	Every 24 months	Every 12 months	Every 12 months	N/A	Every 12 months
Frames	Every 24 months	Every 24 months	Every 12 months	N/A	Every 12 months
In-Network Benefits					
Vision Care Services					
Vision examination	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Vision Care Materials					
Lenses: single vision	Covered in full*	Covered in full*	Covered in full*	N/A	Covered in full
Lenses: bifocal	Covered in full*	Covered in full*	Covered in full*	N/A	Covered in full
Lenses: trifocal	Covered in full*	Covered in full*	Covered in full*	N/A	Covered in full
Lenses: lenticular	Covered in full*	Covered in full*	Covered in full*	N/A	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*	N/A	From collection
Contact Lenses					
Necessary professional fees and materials	Covered in full	Covered in full	Covered in full	N/A	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	N/A	Professional fees covered in full, limited materials
Out-of-Network Benefits					
Vision Care Services					
Vision Examination	Up to $45	Up to $45	Up to $45	Up to $45	N/A
Vision Care Materials					
Lenses: single vision	Up to $30*	Up to $30*	Up to $30*	N/A	N/A
Lenses: bifocal	Up to $50*	Up to $50*	Up to $50*	N/A	N/A
Lenses: trifocal	Up to $65*	Up to $65*	Up to $65*	N/A	N/A
Lenses: lenticular	Up to $100*	Up to $100*	Up to $100*	N/A	N/A
Frames	Up to $70*	Up to $70*	Up to $70*	N/A	N/A
Contact Lenses					
Necessary professional fees and materials	Up to $210	Up to $210	Up to $210	N/A	N/A
Elective professional fees and materials	Up to $105	Up to $105	Up to $105	N/A	N/A
Value-Added Discounts					
Glasses	20% off the amount over allowance				N/A
Lens options	20–25% average savings on all non-covered lens options				N/A
Sunglasses	20% discount				N/A
Contacts	15% discount off fitting and evaluation				N/A
TruHearing	25% average discount				N/A
Frames	15% average discount				N/A

*Indicates subject to copayment

**This benefit applies to large employer groups (101+ employees effective 1/1/2017) ONLY. Each covered person shall be entitled to receive a discount of twenty percent (20%) toward the purchase of non-covered materials from any VSP member doctor when a complete pair of glasses is dispensed. Also, covered persons shall be entitled to receive a discount of fifteen percent (15%) off of contact lens examination services from any VSP member doctor.

Note: VSP Plan A, Plan B and Plan C are available for all members of large group plans and adults only (age 19 and up) for members of small group plans.

2018 **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	DeltaCare USA Pediatric Dental Plan (Embedded)
Plan ID	DL03	DL02	DL01	DS01	N/A
Dignostic Services					
Periodic oral examinations	No charge	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	No charge
Preventive Services					
Teeth cleaning (prophylaxis)	No charge	No charge	No charge	No charge	No charge
Topical fluoride - child (adult at different cost share)	No charge	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	$45
Crown: porcelain fused to predominantly base metal	$140	$280	$410	$410	$300
Oral Surgery Services					
Extraction of erupted tooth or exposed root	$5	$8	$70	$18	$65
Surgical removal of erupted tooth	$25	$50	$115	$30	$165
Removal of impacted tooth: full bony	$90	$110	$160	$80	$160
Endontic Services					
Root canal: anterior	$55	$110	$300	$110	$195
Root canal: bicuspid	$120	$200	$365	$195	$235
Root canal: molar	$250	$350	$470	$245	$300
Periodontic Services					
Gingivectomy: one to three teeth per quadrant	$80	$85	$50	$50	$50
Gingivectomy-four (+) contiguous teeth per quadrant	$130	$145	$175	$165	$150
Scaling/root planing: one to three teeth per quadrant	$20	$45	$60	$40	$30
Prosthodontic Services					
Complete denture	$145	$335	$600	$510	$300
Partial denture - resin base	$120	$295	$440	$535	$300
Orthodontic Services (medically necessary)					
Comprehensive Treatment - Child (ages 13-18)	$1,700	$1,900	$2,100	N/A	$1,000
Comprehensive Treatment - Adult (age 19+)	$1,900	$2,100	$2,250	$2,900	N/A
Other Services					
Office visit: after hours	$25	$35	$45	$35	$45
Local anesthesia	No charge	No charge	No charge	No charge	$15

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.

2018 **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

2018 **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.