

<month> <date>, <yyyy>

<Subscriber First Name> <Subscriber Last Name>

<Subscriber Street Address>

<Subscriber City>, <Subscriber State> <Subscriber ZIP>

Important: Take action by December 15, 2016, or you'll be automatically re-enrolled in similar coverage.

Thank you for choosing Sutter Health Plus for your health care needs.

Why am I getting this letter?

Your health insurance coverage is still being offered in 2017, but some details may have changed. Read this letter carefully and decide if you want to keep this plan or choose another one. Unless you take action by December 15, 2016, you'll be automatically enrolled in this plan for 2017.

Important: This isn't a Covered California plan. This means you won't get any financial help lowering your monthly premium or out-of-pocket costs if you remain enrolled in this plan. To get these savings if you qualify, you must go to Covered California and enroll in another plan. To see if you qualify, visit coveredca.com.

Changes you'll see to your plan in 2017

Your new premium

- Your 2016 monthly premium is \$[Dollar amount].
- **Starting in January, your estimated monthly premium will be \$[Dollar amount]. Important:** This is only an estimate. You'll see your new monthly payment amount when you get your January bill.

Other changes

- See the enclosed *Notice of Health Plan Changes* for more information about the changes affecting your Individual and Family health plan premium and benefits.
- You can review more details about your plan at sutterhealthplus.org and in your 2017 Summary of Benefits and Coverage.

What you need to do

Decide if you want to enroll in this plan or choose another one.

I want to enroll in this plan.

Pay the new monthly premium and you'll be automatically enrolled.

I want to pick a different plan.

You can choose a new plan between November 1, 2016 and January 31, 2017.
Enroll by December 15, 2016 for coverage to start January 1, 2017.

Here are some ways to look at other plans and enroll:

- Check with Sutter Health Plus to see what other plans may be available. Remember, you won't get financial help unless you qualify and enroll through Covered California.
- Visit coveredca.com to see Covered California plans. Consumers who shop can save hundreds of dollars per year and can find a plan that best meets their needs and budget.

We're here to help

- Call Sutter Health Plus at 1-855-315-5800 or visit sutterhealthplus.org.
- Visit coveredca.com, or call 1-800-300-1506 to learn more about Covered California and to see if you qualify for lower costs.
- Find in-person help from an assister, agent, or broker in your community at LocalHelp.HealthCare.gov.
- Call 1-855-315-5800 to request a reasonable accommodation at no cost to you if you have a disability.

Getting help in other languages

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)

Sincerely,



Rob Carnafoli
Vice President, Sales

Changes to the **BRONZE PLAN**

[Date]

[Subscriber First] [Subscriber Last]
Member Identification [Member ID Number]

The following premium and benefit changes apply to Individual and Family Plans effective Jan. 1, 2017. The changes outlined in Sections II and III are pending regulatory approval from the Department of Managed Health Care. Sutter Health Plus will notify you if additional, significant changes not identified in this notice are required.

SECTION I. HEALTH PLAN PREMIUM CHANGES

Sutter Health Plus strives to provide affordable health plan coverage to meet your needs and budget. **Health plan premium rates are based on many factors such as new medical technologies, utilization trends, and new laws and regulations, such as health care reform. Premium rates may also change each year based on your age and the age of your covered family members.**

- Your premium is changing. Your new premium starts in January. Your monthly premium will be [XX]. This is a [*XX in 12 point italicized font*] or [*XX in 12 point italicized font*] percent change from last year
- This premium amount is based on the information we have as of Sept. 8, 2016 and may change if you move to a new address or if the number of family members covered by your health plan changes

SECTION II. UPDATE TO COST SHARING

California law requires Sutter Health Plus to mirror the Standard Benefit Plan Design issued by Covered California. The following cost sharing changes to your health plan reflect changes made by Covered California for 2017.

Service	Current Cost Sharing	Cost Sharing as of Jan. 1, 2017
Annual Out-of-Pocket Maximum	\$6,500 self-only enrollment / \$6,500 any one member in a family of two or more members / \$13,000 an entire family of two or more members	\$6,800 self-only enrollment / \$6,800 any one member in a family of two or more members / \$13,600 an entire family of two or more members
Deductible for Certain Medical Services	\$6,000 self-only enrollment / \$6,000 any one member in a family of two or more members / \$12,000 an entire family of two or more members	\$6,300 self-only enrollment / \$6,300 any one member in a family of two or more members / \$12,600 an entire family of two or more members

Service	Current Cost Sharing	Cost Sharing as of Jan. 1, 2017
Primary Care Visit or other Non-Specialist Practitioner Visit to Treat an Injury or Illness	\$70 per visit after deductible, deductible waived for first three non-preventive visits	\$75 per visit after deductible, deductible waived for first three non-preventive visits
Specialist Visit	\$90 per visit after deductible, deductible waived for first three non-preventive visits	\$105 per visit after deductible, deductible waived for first three non-preventive visits
Outpatient Rehabilitation and Habilitation Services	\$70 per visit	\$75 per visit
Emergency Room Physician Fee	100% coinsurance after deductible	No charge
Urgent Care Consultations, Examinations and Treatment	\$120 per visit, deductible waived for first three non-preventive visits	\$75 per visit, deductible waived for first three non-preventive visits
Mental Health/Behavioral Health/Substance Use Disorder (MH/BH/SUD) Outpatient Office Visits – Individual	\$70 per visit, deductible waived for first three non-preventive visits	\$75 per visit, deductible waived for first three non-preventive visits
MH/BH/SUD Outpatient Office Visits – Group	\$35 per visit, deductible waived for first three non-preventive visits	\$37.50 per visit, deductible waived for first three non-preventive visits
MH/BH/SUD Other Outpatient Services	100% coinsurance after deductible (maximum \$70)	100% coinsurance after deductible (maximum \$75)

SECTION III. 2017 EVIDENCE OF COVERAGE AND DISCLOSURE FORM CHANGES

The following explains changes and identifies updates to the benefits described in the *Evidence of Coverage and Disclosure Form (EOC)* for your health benefit plan.

Changes to Prior Authorization Requirements

Sutter Health Plus expanded the list on page 11 in the *EOC* to clarify additional covered services that require prior authorization.

Changes to Pharmacy Benefits

Sutter Health Plus revised:

- Page 47 to clarify that member cost sharing applies for preventive medications offered on the *Sutter Health Plus Formulary* at Tiers 2, 3 and 4 when a Tier 1 generic equivalent is available
- Page 47 to include the following examples of Preventive Medications and Supplies: Bowel preparation medications for colonoscopy screening for members of a certain age
- Pages 48 and 49 to include information on requesting brand name medications when generic medications are available. If a member or prescribing provider requests a brand name medication when a generic medication is available, the member will pay the generic copay and the difference between the pharmacy-contracted costs for the brand name and generic medication. The cost that a member pays for medications that exceeds the allowed prescription drug amount does not apply to a member's deductible or out-of-pocket maximum. There is an exception process for a member to

obtain a brand name medication at the standard brand default tier when the prescribing provider attests that it is medically necessary

- Page 70 to include information for what a member should do if the member pays the full price for a prescription

Changes to the *EOC* Definition Section

Sutter Health Plus added the following terms to the *EOC* Definition section:

- Clinically Stable
- Life-threatening
- Specialist

Changes and Clarification of *EOC* Language for other Benefits:

Sutter Health Plus revised:

- The Bariatric Surgery section on page 29 to clarify that if the member's surgeon requires a specific liquid dietary product following bariatric surgery, the product will not be a covered service
- The Health Education section on page 34 to clarify the benefits covered under the health education benefit and provide information on when a member may have cost sharing for specific medically necessary services that fall under a separate benefit
- The Home Health Care section on page 36 to clarify that shift nursing or private duty nursing are excluded from coverage under the Home Health Care benefit
- Page 44 to detail covered services for preventive care or diagnostic or therapeutic purposes when medically necessary. Sutter Health Plus added the following services to the list for preventive care or diagnostic or therapeutic purposes when medically necessary:
 - Electrocardiograms
 - Therapeutic or diagnostic injections
 - Therapeutic or diagnostic radiation services
- Page 51 to remove ultraviolet light treatments from the list of Therapeutic Procedures
- The Clinical Trials section on page 57 to list travel, hospital and meals associated with participation in a clinical trial as excluded services

Changes to the **SILVER INDIVIDUAL PLAN**

[Date]

[Subscriber First] [Subscriber Last]
Member Identification [Member ID Number]

The following premium and benefit changes apply to Individual and Family Plans effective Jan. 1, 2017. The changes outlined in Sections II and III are pending regulatory approval from the Department of Managed Health Care. Sutter Health Plus will notify you if additional, significant changes not identified in this notice are required.

SECTION I. HEALTH PLAN PREMIUM CHANGES

Sutter Health Plus strives to provide affordable health plan coverage to meet your needs and budget. **Health plan premium rates are based on many factors such as new medical technologies, utilization trends, and new laws and regulations, such as health care reform. Premium rates may also change each year based on your age and the age of your covered family members.**

- Your premium is changing. Your new premium starts in January. Your monthly premium will be [XX]. This is a [*XX in 12 point italicized font*] or [*XX in 12 point italicized font*] percent change from last year
- This premium amount is based on the information we have as of Sept. 8, 2016 and may change if you move to a new address or if the number of family members covered by your health plan changes

SECTION II. UPDATE TO COST-SHARING

California law requires Sutter Health Plus to mirror the Standard Benefit Plan Design issued by Covered California. The following cost sharing changes to your health plan reflect changes made by Covered California for 2017.

Service	Current Cost Sharing	Cost Sharing as of Jan. 1, 2017
Annual Out-of-Pocket Maximum	\$6,250 for self-only enrollment / \$6,250 for any one member in a family of two or more members / \$12,500 for an entire family or two or more members	\$6,800 for self-only enrollment / \$6,800 for any one member in a family of two or more members / \$13,600 for an entire family or two or more members
Deductible for Certain Medical Services	\$2,250 for self-only enrollment / \$2,250 for any one member in a family of two or more members / \$4,500 for an entire family or two or more members	\$2,500 for self-only enrollment / \$2,500 for any one member in a family of two or more members / \$5,000 for an entire family or two or more members

Service	Current Cost Sharing	Cost Sharing as of Jan. 1, 2017
Primary Care Visit or Non-Specialist Practitioner Visit to Treat an Injury or Illness	\$45 per visit	\$35 per visit
Outpatient Rehabilitation and Habilitation Services	\$45 per visit	\$35 per visit
Imaging (MRI, CR and PET scans)	\$250 per procedure	\$300 per procedure
Diagnostic and Therapeutic X-Rays and Imaging	\$65 per procedure	\$70 per procedure
Emergency Room Facility Fee	\$250 per visit after deductible	\$350 per visit
Emergency Room Physician Fee	\$50 after deductible	No charge
Urgent Care Consultations, Exams and Treatment	\$90 per visit	\$35 per visit
Prescription Drugs Filled at Outpatient Retail Pharmacies – Tier 2	\$50 copay after pharmacy deductible	\$55 copay after pharmacy deductible
Prescription Drugs Filled at Outpatient Retail Pharmacies – Tier 3	\$70 copay after pharmacy deductible	\$80 copay after pharmacy deductible
Mental Health/Behavioral Health/Substance Use Disorder (MH/BH/SUD) Outpatient Office Visits – Individual	\$45 per visit	\$35 per visit
MH/BH/SUD Outpatient Office Visits – Group	\$22.50 per visit	\$17.50 per visit
MH/BH/SUD Other Outpatient Services	20% coinsurance after deductible (maximum \$45)	20% coinsurance after deductible (maximum \$35)
External prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the Your Benefits section of the <i>Evidence of Coverage and Disclosure Form</i>	No charge	20% coinsurance

SECTION III. 2017 EVIDENCE OF COVERAGE AND DISCLOSURE FORM CHANGES

The following explains changes and identifies updates to the benefits described in the *Evidence of Coverage and Disclosure Form (EOC)* for your health benefit plan.

Changes to Prior Authorization Requirements

Sutter Health Plus expanded the list on page 11 in the *EOC* to clarify additional covered services that require prior authorization.

Changes to Pharmacy Benefits

Sutter Health Plus revised:

- Page 47 to clarify that member cost sharing applies for preventive medications offered on the *Sutter Health Plus Formulary* at Tiers 2, 3 and 4 when a Tier 1 generic equivalent is available

- Page 47 to include the following examples of Preventive Medications and Supplies: Bowel preparation medications for colonoscopy screening for members of a certain age
- Pages 48 and 49 to include information on requesting brand name medications when generic medications are available. If a member or prescribing provider requests a brand name medication when a generic medication is available, the member will pay the generic copay and the difference between the pharmacy-contracted costs for the brand name and generic medication. The cost that a member pays for medications that exceeds the allowed prescription drug amount does not apply to a member's deductible or out-of-pocket maximum. There is an exception process for a member to obtain a brand name medication at the standard brand default tier when the prescribing provider attests that it is medically necessary
- Page 70 to include information for what a member should do if the member pays the full price for a prescription

Changes to the *EOC* Definition Section

Sutter Health Plus added the following terms to the *EOC* Definition section:

- Clinically Stable
- Life-threatening
- Specialist

Changes and Clarification of *EOC* Language for other Benefits:

Sutter Health Plus revised:

- The Bariatric Surgery section on page 29 to clarify that if the member's surgeon requires a specific liquid dietary product following bariatric surgery, the product will not be a covered service
- The Health Education section on page 34 to clarify the benefits covered under the health education benefit and provide information on when a member may have cost sharing for specific medically necessary services that fall under a separate benefit
- The Home Health Care section on page 36 to clarify that shift nursing or private duty nursing are excluded from coverage under the Home Health Care benefit
- Page 44 to detail covered services for preventive care or diagnostic or therapeutic purposes when medically necessary. Sutter Health Plus added the following services to the list for preventive care or diagnostic or therapeutic purposes when medically necessary:
 - Electrocardiograms
 - Therapeutic or diagnostic injections
 - Therapeutic or diagnostic radiation services
- Page 51 to remove ultraviolet light treatments from the list of Therapeutic Procedures
- The Clinical Trials section on page 57 to list travel, hospital and meals associated with participation in a clinical trial as excluded services

Changes to the **GOLD COINSURANCE PLAN**

[Date]

[Subscriber First] [Subscriber Last]
Member Identification [Member ID Number]

The following premium and benefit changes apply to Individual and Family Plans effective Jan. 1, 2017. The changes outlined in Sections II and III are pending regulatory approval from the Department of Managed Health Care. Sutter Health Plus will notify you if additional, significant changes not identified in this notice are required.

SECTION I. HEALTH PLAN PREMIUM CHANGES

Sutter Health Plus strives to provide affordable health plan coverage to meet your needs and budget. **Health plan premium rates are based on many factors such as new medical technologies, utilization trends, and new laws and regulations, such as health care reform. Premium rates may also change each year based on your age and the age of your covered family members.**

- Your premium is changing. Your new premium starts in January. Your monthly premium will be [XX]. This is a [*XX in 12 point italicized font*] or [*XX in 12 point italicized font*] percent change from last year
- This premium amount is based on the information we have as of Sept. 8, 2016 and may change if you move to a new address or if the number of family members covered by your health plan changes

SECTION II. UPDATE TO COST SHARING

California law requires Sutter Health Plus to mirror the Standard Benefit Plan Design issued by Covered California. The following cost sharing changes to your health plan reflect changes made by Covered California for 2017.

Service	Current Cost Sharing	Cost Sharing as of Jan. 1, 2017
Annual Out-of-Pocket Maximum	\$6,200 self-only enrollment / \$6,200 any one member in a family of two or more members / \$12,400 an entire family of two or more members	\$6,750 self-only enrollment / \$6,750 any one member in a family of two or more members / \$13,500 an entire family of two or more members
Primary Care Visit or Non-Specialist Practitioner Visit to Treat an Injury or Illness	\$35 per visit	\$30 per visit
Outpatient Rehabilitation and Habilitation Services	\$35 per visit	\$30 per visit
Diagnostic and Therapeutic X-rays and Imaging	\$50 per procedure	\$55 per procedure

Service	Current Cost Sharing	Cost Sharing as of Jan. 1, 2017
Emergency Room Facility Fee	\$250 per visit	\$325 per visit
Urgent Care Consultations, Exams and Treatment	\$60 per visit	\$30 per visit
Prescription Drugs Filled at Outpatient Retail Pharmacies – Tier 2	\$50 copay	\$55 copay
Prescription Drugs Filled at Outpatient Retail Pharmacies – Tier 3	\$70 copay	\$75 copay
Mental Health/Behavioral Health/Substance Use Disorder (MH/BH/SUD) Outpatient Office Visits – Individual	\$35 per visit	\$30 per visit
MH/BH/SUD Outpatient Office Visits - Group	\$17.50 per visit	\$15 per visit
MH/BH/SUD Other Outpatient Services (includes day treatment such as partial hospitalization and intensive outpatient services)	20% coinsurance (maximum \$35)	20% coinsurance (maximum \$30)
External prosthetic devices, orthotic devices and ostomy and urological supplies listed in the Your Benefits section of the <i>Evidence of Coverage and Disclosure Form</i>	No charge	20% coinsurance

SECTION III. 2017 EVIDENCE OF COVERAGE AND DISCLOSURE FORM CHANGES

The following explains changes and identifies updates to the benefits described in the *Evidence of Coverage and Disclosure Form (EOC)* for your health benefit plan.

Changes to Prior Authorization Requirements

Sutter Health Plus expanded the list on page 11 in the *EOC* to clarify additional covered services that require prior authorization.

Changes to Pharmacy Benefits

Sutter Health Plus revised:

- Page 47 to clarify that member cost sharing applies for preventive medications offered on the *Sutter Health Plus Formulary* at Tiers 2, 3 and 4 when a Tier 1 generic equivalent is available
- Page 47 to include the following examples of Preventive Medications and Supplies: Bowel preparation medications for colonoscopy screening for members of a certain age
- Pages 48 and 49 to include information on requesting brand name medications when generic medications are available. If a member or prescribing provider requests a brand name medication when a generic medication is available, the member will pay the generic copay and the difference between the pharmacy-contracted costs for the

brand name and generic medication. The cost that a member pays for medications that exceeds the allowed prescription drug amount does not apply to a member's deductible or out-of-pocket maximum. There is an exception process for a member to obtain a brand name medication at the standard brand default tier when the prescribing provider attests that it is medically necessary

- Page 70 to include information for what a member should do if the member pays the full price for a prescription

Changes to the *EOC* Definition Section

Sutter Health Plus added the following terms to the *EOC* Definition section:

- Clinically Stable
- Life-threatening
- Specialist

Changes and Clarification of *EOC* Language for other Benefits:

Sutter Health Plus revised:

- The Bariatric Surgery section on page 29 to clarify that if the member's surgeon requires a specific liquid dietary product following bariatric surgery, the product will not be a covered service
- The Health Education section on page 34 to clarify the benefits covered under the health education benefit and provide information on when a member may have cost sharing for specific medically necessary services that fall under a separate benefit
- The Home Health Care section on page 36 to clarify that shift nursing or private duty nursing are excluded from coverage under the Home Health Care benefit
- Page 44 to detail covered services for preventive care or diagnostic or therapeutic purposes when medically necessary. Sutter Health Plus added the following services to the list for preventive care or diagnostic or therapeutic purposes when medically necessary:
 - Electrocardiograms
 - Therapeutic or diagnostic injections
 - Therapeutic or diagnostic radiation services
- Page 51 to remove ultraviolet light treatments from the list of Therapeutic Procedures
- The Clinical Trials section on page 57 to list travel, hospital and meals associated with participation in a clinical trial as excluded services

Changes to the **PLATINUM COINSURANCE PLAN**

[Date]

[Subscriber First] [Subscriber Last]
Member Identification [Member ID Number]

The following premium and benefit changes apply to Individual and Family Plans effective Jan. 1, 2017. The changes outlined in Sections II and III are pending regulatory approval from the Department of Managed Health Care. Sutter Health Plus will notify you if additional, significant changes not identified in this notice are required.

SECTION I. HEALTH PLAN PREMIUM CHANGES

Sutter Health Plus strives to provide affordable health plan coverage to meet your needs and budget. **Health plan premium rates are based on many factors such as new medical technologies, utilization trends, and new laws and regulations, such as health care reform. Premium rates may also change each year based on your age and the age of your covered family members.**

- Your premium is changing. Your new premium starts in January. Your monthly premium will be [XX]. This is a [*XX in 12 point italicized font*] or [*XX in 12 point italicized font*] percent change from last year
- This premium amount is based on the information we have as of Sept. 8, 2016 and may change if you move to a new address or if the number of family members covered by your health plan changes

SECTION II. UPDATE TO COST SHARING

California law requires Sutter Health Plus to mirror the Standard Benefit Plan Design issued by Covered California. The following cost sharing changes to your health plan reflect changes made by Covered California for 2017.

Service	Current Cost Sharing	Cost Sharing as of Jan. 1, 2017
Primary Care Office Visit or Non-Specialist Practitioner Visit to Treat an Injury or Illness	\$20 per visit	\$15 per visit
Outpatient Rehabilitation and Habilitation Services	\$20 per visit	\$15 per visit
Urgent Care Consultations, Exams and Treatment	\$40 per visit	\$15 per visit
Mental Health/Behavioral Health/Substance Use Disorder (MH/BH/SUD) Outpatient Office Visits – Individual	\$20 per visit	\$15 per visit

Service	Current Cost Sharing	Cost Sharing as of Jan. 1, 2017
Mental Health/Behavioral Health/Substance Use Disorder (MH/BH/SUD) Outpatient Office Visits – Group	\$10 per visit	\$7.50 per visit
Mental Health/Behavioral Health/Substance Use Disorder (MH/BH/SUD) Other Outpatient Services	10% coinsurance (maximum \$20)	10% coinsurance (maximum \$15)
External prosthetic devices, orthotic devices and ostomy and urological supplies listed in the Your Benefits section of the <i>Evidence of Coverage and Disclosure Form</i>	No Charge	10% coinsurance

SECTION III. 2017 EVIDENCE OF COVERAGE AND DISCLOSURE FORM CHANGES

The following explains changes and identifies updates to the benefits described in the *Evidence of Coverage and Disclosure Form (EOC)* for your health benefit plan.

Changes to Prior Authorization Requirements

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- Page 47 to clarify that member cost sharing applies for preventive medications offered on the *Sutter Health Plus Formulary* at Tiers 2, 3 and 4 when a Tier 1 generic equivalent is available
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- Pages 48 and 49 to include information on requesting brand name medications when generic medications are available. If a member or prescribing provider requests a brand name medication when a generic medication is available, the member will pay the generic copay and the difference between the pharmacy-contracted costs for the brand name and generic medication. The cost that a member pays for medications that exceeds the allowed prescription drug amount does not apply to a member's deductible or out-of-pocket maximum. There is an exception process for a member to obtain a brand name medication at the standard brand default tier when the prescribing provider attests that it is medically necessary
- Page 70 to include information for what a member should do if the member pays the full price for a prescription

Changes to the *EOC* Definition Section

Sutter Health Plus added the following terms to the *EOC* Definition section:

- Clinically Stable
- Life-threatening

- Specialist

Changes and Clarification of EOC Language for other Benefits:

Sutter Health Plus revised:

- The Bariatric Surgery section on page 29 to clarify that if the member's surgeon requires a specific liquid dietary product following bariatric surgery, the product will not be a covered service
- The Health Education section on page 34 to clarify the benefits covered under the health education benefit and provide information on when a member may have cost sharing for specific medically necessary services that fall under a separate benefit
- The Home Health Care section on page 36 to clarify that shift nursing or private duty nursing are excluded from coverage under the Home Health Care benefit
- Page 44 to detail covered services for preventive care or diagnostic or therapeutic purposes when medically necessary. Sutter Health Plus added the following services to the list for preventive care or diagnostic or therapeutic purposes when medically necessary:
 - Electrocardiograms
 - Therapeutic or diagnostic injections
 - Therapeutic or diagnostic radiation services
- Page 51 to remove ultraviolet light treatments from the list of Therapeutic Procedures
- The Clinical Trials section on page 57 to list travel, hospital and meals associated with participation in a clinical trial as excluded services