2017

Sutter Health Plus
Your Health Plan

SMALL GROUP ENDNOTES

1. Family deductibles and out-of-pocket maximum (OOPM) values are equal to two times the individual values. Except for high-deductible health plans (HDHPs), an individual in a family plan is only responsible for the single deductible amount and the single OOPM amount. Except for optional benefits, if elected, deductibles and other cost-sharing payments made by each individual in a family contribute to the family deductible and OOPM. Each individual family member is responsible for the amounts listed for any one member in a family of two or more members until the family as a whole meets the family deductible or OOPM. Once the family as a whole meets the family OOPM, the plan pays all costs for covered services for all family members.

   For HDHPs, in family coverage, an individual family member's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual (self only) coverage or $2,600 for the 2017 benefit year. Once an individual family member's deductible is satisfied, that individual will only be responsible for the cost sharing listed for each service. Other family members will be required to continue to contribute to the deductible until the family deductible is met. In family coverage, an individual family member's out-of-pocket contribution is limited to the individual (self only) annual OOPM amount.

2. Cost-sharing amounts for all covered essential health benefits, including those applied to a deductible, accumulate toward the OOPM.

3. Prenatal and postnatal care includes all scheduled prenatal visits and the first postpartum visit.

4. The non-specialist practitioner office visits category includes therapy visits, other office visits not provided by either primary care or specialty physicians or not specified in another benefit category. Applicable member cost sharing will be charged as a separate copay from a preventive service during an office visit.

5. Member cost sharing for oral anti-cancer drugs shall not exceed $200 per prescription per 30-day supply. For HDHPs, this applies after the deductible is met. 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. A 100-day supply is available, at twice the 30-day copay price, through the mail order pharmacy. Specialty medications are only available for a 30-day supply. FDA-approved, self-administered hormonal contraceptives that are dispensed at one time for a member by a provider, pharmacist, or location licensed or authorized to dispense drugs or supplies may be covered at up to a 12-month supply. Prescription drug deductibles and copays contribute toward the calendar year medical OOPM. Please consult specific plan documents for any applicable maximum amounts for prescription cost sharing (may not apply to all plan designs).

6. Sexual dysfunction medications are subject to prior authorization, have a 50% cost share, and some are limited to eight doses per 30-day supply.

7. Mental and behavioral health services include substance use disorder treatment services.

8. Mental health, behavioral health, substance use disorder and 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; developmental disorder and autism.

9. Inpatient mental health, behavioral health and substance use disorder treatment 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 and autism.

10. Pediatric eye exam and glasses or contact lenses are provided annually for members 19 and under (until at least the end of the month in which the member turns 19 years of age) as part of the essential health benefit for pediatric vision.

SMALL GROUP MEDICAL PLANS (1-100)

Plan Name Plan ID	SG $25 Platinum: MS38	SG Platinum Copay Platinum: MS40	SG $30 – $1500 Gold: MS37
Plan Part D Creditability	**Creditable**	**Creditable**	**Creditable**
Annual Out-of-Pocket Maximum (embedded)			
Single/individual family member	**$3,500**	**$4,000**	**$2,500**
Family	**$7,000**	**$8,000**	**$5,000**
Deductible (embedded)			
Single/individual family member	**$0**	**$0**	**$1,500**
Family	**$0**	**$0**	**$3,000**
Deductible for Prescription Drugs (embedded)			
Single/individual family member	**$0**	**$0**	**$0**
Family	**$0**	**$0**	**$0**
Professional Services			
Primary care office visit or other non-specialist practitioner visit to treat an injury or illness	$25 per visit	$15 per visit	$30 per visit after deductible
Specialist office visit	$25 per visit	$40 per visit	$30 per visit after deductible
Preventive care, routine maintenance exams, immunizations, preventive imaging	No charge	No charge	No charge
Pediatric vision eye exam	No charge	No charge	No charge
Pediatric dental services (diagnostic and preventive services such as exams, cleanings, X-rays and sealants)	No charge	No charge	No charge
Outpatient rehabilitation and habilitation services	$25 per visit	$15 per visit	$30 per visit after deductible
Outpatient Services			
Outpatient surgery facility fee	10% coinsurance	$250 per visit	20% coinsurance after deductible
Outpatient surgery physician/surgeon fee	10% coinsurance	$40 per visit	20% coinsurance after deductible
Non-preventive lab tests	$25 per visit	$20 per visit	$30 per visit after deductible
Imaging (CT/PET scans, MRIs)	$150 per procedure	$150 per procedure	$50 per procedure after deductible
Non-preventive diagnostic and therapeutic X-rays and imaging	$25 per procedure	$40 per procedure	$30 per procedure after deductible
Hospitalization Services			
Hospitalization facility fee	$250 per day up to 5 days	$250 per day up to 5 days	20% coinsurance after deductible
Hospitalization physician/surgeon fees	No charge	$40 per admission	20% coinsurance after deductible
Emergency and Urgent Care Services			
Emergency room services (waived if admitted)	$100 per visit	$150 per visit	$150 per visit after deductible
Emergency medical transportation (ambulance)	$100 per trip	$150 per trip	$150 per trip after deductible
Urgent care	$25 per visit	$15 per visit	$30 per visit after deductible
Prescription Drugs			
Tier 1 (most generic medications and low-cost preferred brands)	$5 copay	$5 copay	$5 copay
Tier 2 (preferred brand-name and non-preferred generic medications)	$15 copay	$15 copay	$15 copay
Tier 3 (non-preferred brand-name medications)	$25 copay	$25 copay	$25 copay
Tier 4 (specialty medications, self-administered medications that require training or clinical monitoring, and bioengineered medications)	10% coinsurance up to $250 per prescription	10% coinsurance up to $250 per prescription	20% coinsurance up to $250 per prescription
Durable Medical Equipment			
Durable medical equipment	10% coinsurance	10% coinsurance	20% coinsurance after deductible
Mental/Behavioral Health/Substance Use Disorder (SUD)			
Mental/behavioral health/SUD outpatient office visits - individual	$25 per visit	$15 per visit	$30 per visit after deductible
Mental/behavioral health/SUD inpatient facility (includes residential treatment)	$250 per day up to 5 days	$250 per day up to 5 days	20% coinsurance after deductible

Amounts are per visit/per trip/per service unless otherwise stated. This is only a summary. In the event of any discrepancies in information, the SHP Evidence of Coverage (EOC) and incorporated Benefits and Coverage Matrix (BCM) determine coverage and costs. SHP offers plans with embedded Infertility and Special Footwear benefits that mirror these plans—please consult with your SHP Account Executive if you have any questions.

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SMALL GROUP MEDICAL PLANS (1-100)

Plan Name Plan ID	SG Gold Copay Gold: MS33	SG Silver Copay Silver: MS34	SG Silver Copay Silver: MS35	SG Silver HDHP $35 (HSA Compatible) Silver: SD07/SD57
Plan Part D Creditability	**Creditable**	**Creditable**	**Creditable**	**Creditable**
Annual Out-of-Pocket Maximum (embedded)				
Single/individual family member	**$6,750**	**$6,800**	**$6,800**	**$5,400**
Family	**$13,500**	**$13,600**	**$13,600**	**$10,800**
Deductible (embedded)				
Single/individual family member	**$0**	**$2,000**	**$3,000**	**$2,000/2,600 integrated**
Family	**$0**	**$4,000**	**$6,000**	
Deductible for Prescription Drugs (embedded)				**$4,000 integrated**
Single/individual family member	**$0**	**$250**	**$250**	
Family	**$0**	**$500**	**$500**	**$0**
Professional Services				
Primary care office visit or other non-specialist practitioner visit to treat an injury or illness	$30 per visit	$45 per visit	$50 per visit	$35 per visit after deductible
Specialist office visit	$55 per visit	$75 per visit	$80 per visit	$35 per visit after deductible
Preventive care, routine maintenance exams, immunizations, preventive imaging	No charge	No charge	No charge	No charge
Pediatric vision eye exam	No charge	No charge	No charge	No charge
Pediatric dental services (diagnostic and preventive services such as exams, cleanings, X-rays and sealants)	No charge $30 per visit	No charge $45 per visit	No charge $50 per visit	No charge $35 per visit after deductible
Outpatient rehabilitation and habilitation services				
Outpatient Services	$600 per visit	20% coinsurance	30% coinsurance	20% coinsurance after deductible
Outpatient surgery facility fee	$55 per visit	20% coinsurance	30% coinsurance	20% coinsurance after deductible
Outpatient surgery physician/surgeon fee	$35 per visit	$40 per visit	$45 per visit	$35 per visit after deductible
Non-preventive lab tests	$275 per procedure	$300 per procedure	$300 per procedure	$50 per procedure after deductible
Imaging (CT/PET scans, MRIs)	$55 per procedure	$70 per procedure	$80 per procedure	$15 per procedure after deductible
Non-preventive diagnostic and therapeutic X-rays and imaging				
Hospitalization Services	$600 per day up to 5 days	20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible
Hospitalization facility fee	$55 per admission	20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible
Hospitalization physician/surgeon fees				
Emergency and Urgent Care Services	$325 per visit	$350 per visit	30% coinsurance after deductible	20% coinsurance after deductible
Emergency room services (waived if admitted)	$250 per trip	$250 per trip after deductible	30% coinsurance after deductible	20% coinsurance after deductible
Emergency medical transportation (ambulance)	$30 per visit	$45 per visit	$50 per visit	$35 per visit after deductible
Urgent care				
Prescription Drugs	$15 copay	$15 copay	$15 copay	$10 copay after deductible
Tier 1 (most generic medications and low-cost preferred brands)	$55 copay $75 copay	$55 copay after pharmacy deductible $85 copay after pharmacy deductible	$55 copay after pharmacy deductible $85 copay after pharmacy deductible	$20 copay after deductible $40 copay after deductible
Tier 2 (preferred brand-name and non-preferred generic medications)				
Tier 3 (non-preferred brand-name medications)	20% coinsurance up to $250 per prescription	20% coinsurance up to $250 per prescription after pharmacy deductible	30% coinsurance up to $250 per prescription after pharmacy deductible	20% coinsurance up to $250 per prescription after deductible
Tier 4 (specialty medications, self-administered medications that require training or clinical monitoring, and bioengineered medications)				
Durable Medical Equipment	20% coinsurance	20% coinsurance	30% coinsurance	20% coinsurance after deductible
Durable medical equipment				
Mental/Behavioral Health/Substance Use Disorder (SUD)	$30 per visit	$45 per visit	$50 per visit	$35 per visit after deductible
Mental/behavioral health/SUD outpatient office visits - individual	$600 per day up to 5 days	20% coinsurance after deductible	30% coinsurance after deductible	20% coinsurance after deductible
Mental/behavioral health/SUD inpatient facility (includes residential treatment)				

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SMALL GROUP MEDICAL PLANS (1-100)

Plan Name Plan ID	SG Bronze Bronze: MS36	SG Bronze HDHP 40% (HSA Compatible) Bronze: SE08/SE58
Plan Part D Creditability	**Not Creditable**	**Not Creditable**
Annual Out-of-Pocket Maximum (embedded)		
Single/individual family member	**$6,800**	**$6,550**
Family	**$13,600**	**$13,100**
Deductible (embedded)		
Single/individual family member	**$6,300**	**$4,800 integrated**
Family	**$12,600**	**$9,600 integrated**
Deductible for Prescription Drugs (embedded)		
Single/individual family member	**$500**	**$0**
Family	**$1,000**	**$0**
Professional Services		
Primary care office visit or other non-specialist practitioner visit to treat an injury or illness	$75 per visit after deductible, deductible waived for first 3 non-preventive visits	40% coinsurance after deductible
Specialist office visit	$105 per visit after deductible, deductible waived for first 3 non-preventive visits	40% coinsurance after deductible
Preventive care, routine maintenance exams, immunizations, preventive imaging	No charge	No charge
Pediatric vision eye exam	No charge	No charge
Pediatric dental services (diagnostic and preventive services such as exams, cleanings, X-rays and sealants)	No charge	No charge
Outpatient rehabilitation and habilitation services	$75 per visit	40% coinsurance after deductible
Outpatient Services		
Outpatient surgery facility fee	100% coinsurance after deductible	40% coinsurance after deductible
Outpatient surgery physician/surgeon fee	100% coinsurance after deductible	40% coinsurance after deductible
Non-preventive lab tests	$40 per visit	40% coinsurance after deductible
Imaging (CT/PET scans, MRIs)	100% coinsurance after deductible	40% coinsurance after deductible
Non-preventive diagnostic and therapeutic X-rays and imaging	100% coinsurance after deductible	40% coinsurance after deductible
Hospitalization Services		
Hospitalization facility fee	100% coinsurance after deductible	40% coinsurance after deductible
Hospitalization physician/surgeon fees	100% coinsurance after deductible	40% coinsurance after deductible
Emergency and Urgent Care Services		
Emergency room services (waived if admitted)	100% coinsurance after deductible	40% coinsurance after deductible
Emergency medical transportation (ambulance)	100% coinsurance after deductible	40% coinsurance after deductible
Urgent care	$75 per visit after deductible, deductible waived after first 3 non-preventive visits	40% coinsurance after deductible
Prescription Drugs		
Tier 1 (most generic medications and low-cost preferred brands)	100% up to $500 per prescription after pharmacy deductible	40% coinsurance up to $500 per perscription after deductible
Tier 2 (preferred brand-name and non-preferred generic medications)	100% up to $500 per prescription after pharmacy deductible	40% coinsurance up to $500 per perscription after deductible
Tier 3 (non-preferred brand-name medications)	100% up to $500 per prescription after pharmacy deductible	40% coinsurance up to $500 per perscription after deductible
Tier 4 (specialty medications, self-administered medications that require training or clinical monitoring, and bioengineered medications)	100% up to $500 per prescription after pharmacy deductible	40% coinsurance up to $500 per perscription after deductible
Durable Medical Equipment		
Durable medical equipment	100% coinsurance after deductible	40% coinsurance after deductible
Mental/Behavioral Health/Substance Use Disorder (SUD)		
Mental/behavioral health/SUD outpatient office visits - individual	$75 per visit after deductible, deductible waived for first 3 non-preventive visits	40% coinsurance after deductible
Mental/behavioral health/SUD inpatient facility (includes residential treatment)	100% coinsurance after deductible	40% coinsurance after deductible

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