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.

(Important disclaimer regarding optional benefits: Cost Sharing and benefit information for optional benefits that may be elected by your employer group are not reflected on this Benefits and Coverage Matrix. Most optional benefits do not accrue to your Deductible or to your Out-of-Pocket Maximum. Please refer to the separate plan documents for elected optional benefits to determine Cost Sharing, Covered Services and any limitations or exclusions.)

BENEFIT PLAN NAME: Peak ML20 HMO

Annual Deductible For Certain Medical Services	
For self-only enrollment (a Family of one Member)	$500
For any one Member in a Family of two or more Members	$500
For an entire Family of two or more Members	$1,000

Separate Annual Deductible for Prescription Drugs	
For self-only enrollment (a Family of one Member)	None
For any one Member in a Family of two or more Members	None
For an entire Family of two or more Members	None

Annual Out-of-Pocket Maximum (OOPM) (Combined Medical and Pharmacy)	
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 totals one of the following amounts:	
For self-only enrollment (a Family of one Member)	$3,000
For any one Member in a Family of two or more Members	$3,000
For an entire Family of two or more Members	$6,000

Lifetime Maximum	
Lifetime maximum	None

Covered Services	Cost to Member
Preventive Care Services	
Eye exams for refraction	No charge
Family planning counseling and services	No charge
Hearing exams	No charge
Immunizations (including vaccines)	No charge
Prenatal care and preconception visits	No charge
Preventive and routine physical maintenance exams (including routine screening tests)	No charge
Preventive X-rays, screenings and laboratory tests as described in the "Your Benefits" chapter of the Evidence of Coverage and Disclosure Form (EOC)	No charge
Well-child preventive care exams	No charge
Professional Services	
Primary Care Physician (PCP) visit or non-specialist practitioner visit to treat an injury or illness	$20 copay per visit
Specialist visit	$20 copay per visit
Acupuncture	$20 copay per visit
Outpatient rehabilitation services	$20 copay per visit
Outpatient habilitation services	Not covered
Outpatient Services	
Outpatient surgery (facility fee)	10% coinsurance after deductible
Outpatient surgery (physician/surgeon fee)	10% coinsurance after deductible
Outpatient visit (non-office visit)	10% coinsurance after deductible
Laboratory tests	$20 copay per visit
Imaging (e.g. MRI, CT and PET scans)	$50 copay per procedure

Diagnostic and therapeutic X-rays and imaging	$10 copay per procedure
Hospitalization Services	
Facility fee (e.g. hospital room)	10% coinsurance after deductible
Physician/surgeon fees	10% coinsurance after deductible
Emergency and Urgent Care Services	
Emergency room facility fee	10% coinsurance after deductible
Emergency room physician fee	10% coinsurance after deductible
This emergency room Cost Sharing does not apply if admitted directly to the hospital as an inpatient for Covered Services. If admitted directly to the hospital for an inpatient stay, the Cost Sharing for "Hospitalization Services" will apply.	
Urgent Care consultations, exams and treatment	$20 copay per visit
Ambulance Services	
Ambulance services	No charge after deductible
Prescription Drugs	
Covered outpatient items in accord with our drug formulary guidelines at network retail pharmacies or through mail-order service:	
Tier 1 - Most Generic Drugs and low-cost preferred brand name drugs	Retail: $10 copay per prescription for up to a 30-day supply Mail-Order: $20 copay per prescription for up to a 100-day supply
Tier 2 - Preferred brand name drugs, non-preferred Generic Drugs and drugs recommended by Sutter Health Plus's (SHP) pharmacy and therapeutics committee based on drug safety, efficacy and cost	Retail: $30 copay per prescription for up to a 30-day supply Mail-Order: $60 copay per prescription for up to a 100-day supply

Tier 3 - Non-preferred brand name drugs or drugs that are recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost *(These generally have a preferred and often less costly therapeutic alternative at a lower tier)*	Retail: $60 copay per prescription for up to a 30-day supply Mail-Order: $120 copay per prescription for up to a 100-day supply
Tier 4 - Specialty Drugs, self-administered drugs that require training or clinical monitoring, drugs that cost SHP more than $600 net of rebates for a one-month supply or bioengineered drugs	Specialty Pharmacy: 10% coinsurance for up to a 30-day supply Member cost share will not exceed $100 per prescription per 30-day supply.
Durable Medical Equipment	
Durable medical equipment	20% coinsurance after deductible
Mental/Behavioral Health & Substance Use Disorder Treatment Services (MH/SUD)	
MH/SUD inpatient facility fee (e.g. hospital room)	10% coinsurance after deductible
MH/SUD inpatient physician/surgeon fees	10% coinsurance after deductible
MH/SUD outpatient office visits – individual *(Individual outpatient MH/SUD evaluation and treatment services)*	$20 copay per visit
MH/SUD outpatient office visits – group *(Group outpatient MH/SUD evaluation and treatment services)*	$10 copay per visit
MH/SUD other outpatient services	10% coinsurance after deductible
Home Health Services	
Home health care (up to 100 visits per calendar year)	No charge
Pregnancy Services	
Delivery and all hospital inpatient services	10% coinsurance after deductible
Delivery and all professional inpatient services	10% coinsurance after deductible

Other Services	
Skilled Nursing Facility services (up to 100 days per benefit period)	10% coinsurance after deductible
The external prosthetic devices, orthotic devices and ostomy and urological supplies listed in the “Your Benefits” chapter of the EOC	No charge
Hospice care	No charge

Endnotes:

1. Family Deductibles (when applicable) and Out-of-Pocket Maximums (OOPM) are equal to two times the “self-only” values. In a Family plan, a Member is only responsible for the “one Member in a Family” Deductible and OOPM. Deductibles and other Cost Sharing payments made by each Member in a Family contribute to the “entire Family of two or more” Deductible and OOPM. Once the “entire Family of two or more” Deductible amount is satisfied by any combination of Member Deductible payments, plan Copayment or Coinsurance amounts apply until the “entire Family of two or more” OOPM is reached, after which the plan pays all costs for Covered Services for all Family Members.

2. Cost Sharing for all Essential Health Benefits, including that which accumulates toward an applicable Deductible, accumulates toward the OOPM.

3. a) Copayments 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. All Medically Necessary prescription drug Cost Sharing contributes toward the annual OOPM.

   b) For plans with a Deductible that applies to prescription drugs, the annual Deductible does not apply to oral anti-cancer drugs. Member Cost Sharing for oral anti-cancer drugs shall not exceed $200 per prescription for up to a 30-day supply.

   c) FDA-approved, self-administered hormonal contraceptives that are dispensed at one time for a member by a provider, pharmacist or other location licensed or authorized to dispense drugs or supplies, may be covered at up to a 12-month supply. Cost Sharing for a 12-month supply of contraceptives, when applicable, will be 12 times the retail cost or four times the mail-order cost.

   d) Except for Specialty Drugs, up to a 100-day supply is available, at twice the 30-day Copayment price, through the mail-order pharmacy. Specialty Drugs are available for up to a 30-day supply through the Specialty Pharmacy.

   e) Drugs prescribed for sexual dysfunction have a 50% share of cost. For plans with a Deductible that applies to prescription drugs, the share of cost is applied after the Deductible is met. Some sexual dysfunction drugs, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.

4. Non-specialist practitioner office visits include therapy visits, other office visits not provided by either PCPs or Specialists or visits not specified in another benefit category.

5. Family planning counseling and 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 the Outpatient Care section of the "Your Benefits" chapter in the EOC and included in the Cost Sharing for the outpatient surgery services listed above.
6. Acupuncture is typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain.
7. The outpatient visit (non-office visit) category includes, but is not limited to, services such as outpatient chemotherapy, outpatient dialysis, outpatient radiation therapy, outpatient infusion therapy, sleep studies and similar outpatient services performed in a non-office setting.
8. Inpatient MH/SUD services include, but are not limited to: 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. MH/SUD other outpatient services include, but are not limited to: 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 delivered at home; and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
10. Cost Sharing for services with Copayments is the lesser of the Copayment amount or allowed amount.
11. In order to be covered, most services require a referral from your PCP and many also require Prior Authorization by your PCP's medical group. Please consult the complete EOC for additional information on referral and Prior Authorization requirements.