INDIVIDUAL MEDICAL PLANS

Sutter Health Plus

Enrollment Assistance: 1 (408) 641-8950

MEDICAL PLAN FOOTNOTES

[1]Family deductibles and out-of-pocket maximums are equal to two times the individual values. Cost sharing payments (deductibles, copayments, and coinsurance, but not premiums) for essential health benefits made by each individual apply to the deductible and out-of-pocket maximum. However, cost sharing payments made for non-emergent out-of-network services that are not plan-authorized exceptions do not apply to the family deductible or out-of-pocket maximum. The family deductible amount may be satisfied by any combination of individual deductible payments, after which member copays or coinsurance apply until the family out-of-pocket maximum is reached. Once the family out-of-pocket maximum is reached, the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends. Medical or prescription services are subject to a deductible as indicated within each benefit plan's services listing. The member must pay for these services when services are rendered until the deductible or coinsurance is met in that plan year. Charges for services subject to a deductible are based on SHP's contracted rate with the provider of service. [2]Cost sharing amounts for all in-network services, including those applied to a deductible, accumulate toward the out-of-pocket maximum. [3]Including, but not limited to: routine physical examinations, hearing exams, immunizations (adult and pediatric), maternity care (after initial diagnosis and pre- and post-natal visits), well baby care, breast, cervical, prostate and colorectal cancer screenings and preventive imaging. Preventive care services are available at no cost. For a complete list of preventive services please refer to the Combined Disclosure Form and Evidence of Coverage. [4]Copays apply per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand-name medications in accordance with formulary guidelines. A 100-day supply is available, at twice the 30-day copay price, through the mail-order form. Specialty medications are only available for a 30-day supply. Prescription medication deductibles or copays contribute toward the annual deductible (as applicable) and out-of-pocket maximum. Member cost sharing for oral anti-cancer drugs shall not exceed $200 per prescription per 30-day supply. For HDHP plans, this applies after the deductible has been met. [5]Subject to prior authorization. Sexual dysfunction medications have a 50% cost share, and are limited to 8 doses per 30-day supply. [6]Mental and behavioral health services include substance use disorder treatment services. [7]Up to 100 days per year for home health care and up to 100 days per benefit period for skilled nursing care. [8]Eye exam and one pair of lenses and frames annually under age 19 as part of essential health benefit for pediatric vision. [9]Under age 19. Please refer to the Benefits and Cost Sharing Matrix and/or Evidence of Coverage for specific cost sharing amounts for major services, orthodontia and other pediatric dental services not noted here. [10]Non-specialist Practitioner office visits includes Therapy Visits, other office visits not provided by ether Primary Care or Specialty Physicians or not specified in another benefit category. Member cost-sharing will be charged as a separate copay from a preventive service during an office visit. [11]This category of 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 "outpatient surgeries and certain other outpatient procedures."

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Plan Name	Platinum Individual	Gold Individual	Silver Individual	Bronze Individual
Part D Creditability	Creditable	Creditable	Creditable	Not Creditable
Plan ID	Platinum: MI01	Gold: MI02	Silver: MI03	Bronze: MI04
Overall Deductible				
Single	$0	$0	$0	$5,000
Family	$0	$0	$0	$10,000
Deductible for Certain Medical Services[1]				
Single	$0	$0	$2,000	$0
Family	$0	$0	$4,000	$0
Deductible for Prescription Drugs[1]				
Brand (Preferred and Non-Preferred)	$0	$0	$250	$0
Annual Out-of-Pocket Maximum[2]				
Single	$4,000	$6,250	$6,250	$6,250
Family	$8,000	$12,500	$12,500	$12,500
Professional and Outpatient Services				
Preventive Care[3]	No Charge	No Charge	No Charge	No Charge
Primary Care or Non-specialist Practitioner Office Visit[10]	$20 per visit	$30 per visit	$45 per visit	$60 per visit after deductible*
Specialist Office Visit	$40 per visit	$50 per visit	$65 per visit	$70 per visit after deductible
Family Planning Counseling & Services[11]	No Charge	No Charge	No Charge	No Charge
Pediatric Vision[8]	No Charge	No Charge	No Charge	No Charge
Pediatric Diagnostic and Preventive Dental Services[9]	No Charge	No Charge	No Charge	No Charge
Urgent Care	$40 per visit	$60 per visit	$90 per visit	$120 per visit*
Outpatient Rehabilitation and Habilitation Services	$20 per visit	$30 per visit	$45 per visit	$60 after deductible
Outpatient Surgery Facility Fee	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance after deductible
Outpatient Surgery Physician/Surgeon Fees	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance after deductible
Non-Preventive Lab Tests	$20 per visit	$30 per visit	$45 per visit	30% coinsurance after deductible
Imaging (CT/PET Scans, MRIs)	10% coinsurance	20% coinsurance	20% coinsurance after deductible	30% coinsurance after deductible
Non-Preventive Diagnostic and Therapeutic X-Rays and Imaging	$40 per visit	$50 per visit	$65 per visit	30% coinsurance after deductible
Hospitalization Services				
Hospitalization Facility and Physician/Surgeon Fees	10% coinsurance	20% coinsurance	20% coinsurance after deductible	30% coinsurance after deductible
Emergency and Urgent Care Services				
Emergency Room Services (Waived if Admitted)	$150 per visit	$250 per visit	$250 per visit after deductible	$300 per visit after deductible
Emergency Medical Transportation	$150 per trip	$250 per trip	$250 per trip after deductible	$300 per trip after deductible
Prescription Drugs[4]				
Generic Drugs	$5 copay	$15 copay	$15 copay	$15 copay after deductible
Preferred Brand Name Drugs[5]	$15 copay	$50 copay	$50 copay after deductible	$50 copay after deductible
Non-Preferred Brand Name Drugs[5]	$25 copay	$70 copay	$70 copay after deductible	$75 copay after deductible
Specialty Drugs[5]	10% coinsurance	20% coinsurance	20% coinsurance after deductible	30% coinsurance after deductible
Durable Medical Equipment				
Durable Medical Equipment	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance after deductible
Mental / Behavioral Health[6]				
Individual Outpatient Mental Behavioral Health/SUD Services	$20 per visit	$30 per visit	$45 per visit	$60 per visit*
Inpatient Mental/Behavorial Health/SUD Services	10% coinsurance	20% coinsurance	20% coinsurance after deductible	30% coinsurance after deductible
Other Services				
Home Health Care[7]	10% coinsurance	20% coinsurance	20% coinsurance	30% coinsurance after deductible
Skilled Nursing Care[7]	10% coinsurance	20% coinsurance	20% coinsurance after deductible	30% coinsurance after deductible
Hospice Services	No Charge	No Charge	No Charge	No charge after deductible

*Deductible waived for 1st 3 non-preventive visits

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Your Health Plan