



SutterSelect

*Sutter Health  
East Bay Region*



## Health Plan Comparison Chart

Effective January 1, 2012

Alta Bates Summit Medical Center  
*Non-Union Employees*  
Alta Bates Summit Perinatal Center  
Samuel Merritt University  
Sutter Delta Medical Center  
*Non-Union Employees*  
Sutter East Bay Medical Foundation  
Thunder Road Adolescent Treatment  
Centers, Inc.

# Your SutterSelect Medical Plan Options

Plan Option	EPO Plus Option	PPO Option		
		TIER 1	TIER 2	TIER 3
<b>GENERAL INFORMATION</b>				
<b>Network</b>	Sutter Network and some non-Sutter providers	Sutter Network and some non-Sutter providers	Interplan Health Group Network	Out-of-Network
<b>Annual Deductible</b>	None	None	\$300 Individual \$600 Family	
<b>Annual Out-of-Pocket Maximum<sup>1</sup></b>	\$750 Individual \$1,500 Family	\$750 Individual \$1,500 Family	\$2,000 Individual \$4,000 Family	\$4,000 Individual \$8,000 Family
<b>Lifetime Maximum</b>	None	None		
<b>EMERGENCY AND URGENT CARE</b>				
<b>Emergency Room</b> (Copay waived if admitted)	\$30 Copay	\$30 Copay	\$30 Copay*	\$30 Copay*
<b>Urgent Care</b>	\$15 Copay	\$15 Copay	\$30 Copay*	\$30 Copay*
<b>HOSPITAL SERVICES</b>				
<b>Inpatient and Outpatient Services</b>	No Copay	No Copay	Employee pays 20%	Employee pays 30%
<b>Inpatient Physician Visits</b>	No Copay	No Copay	Employee pays 20%	Employee pays 30%
<b>Inpatient Rehabilitative Therapy</b> (physical, occupational, speech)	No Copay	No Copay	Employee pays 20%	Employee pays 30%
<b>OTHER MEDICAL SERVICES AND SUPPLIES</b>				
<b>Durable Medical Equipment, Corrective Appliances, Prosthetic Devices</b>	No Copay	No Copay	No Copay	Employee pays 30%
<b>Hearing Aids</b> (once every 36 months)	No Copay	No Copay	No Copay	Not Covered
<b>Home Health Care</b>	No Copay Unlimited duration	No Copay Unlimited duration	\$20 Copay* 100 visits per calendar year	Employee pays 30% 100 visits per calendar year
<b>Hospice</b>	No Copay	No Copay	Employee pays 20%	Employee pays 30%
<b>Skilled Nursing Facility</b>	No Copay 100 days per calendar year maximum	No Copay	Employee pays 20%	Employee pays 30% 60 days per calendar year maximum
<b>MENTAL HEALTH &amp; CHEMICAL DEPENDENCY</b> (Provided through United Behavioral Health)				
<b>Inpatient</b>	No Copay	No Copay		Employee pays 30%
<b>Outpatient</b>	\$10 Copay	\$10 Copay		Employee pays 30%

\*Copay only. Not subject to annual deductible.

<sup>1</sup>Note: The annual out-of-pocket maximum is the most you will pay for eligible medical expenses in a single calendar year before the plan pays 100% of the eligible charges for the rest of the calendar year.

All copays for office visits, approved medical services and diabetic supplies dispensed through a participating pharmacy count toward the out-of-pocket maximum, except: copays for acupuncture or chiropractic visits, infertility treatment, copays for prescription drugs, services or supplies received that are not covered by the plan and any amount incurred as a penalty for receiving non-certified services or expenses.

In addition, the following PPO expenses do not count toward the out-of-pocket maximum: deductibles, any amount exceeding the customary and reasonable charge under Tier 3 and covered expenses for which your coinsurance is 50%.

**Chart Indicates Patient Financial Responsibility**

Plan Option	EPO Plus Option	PPO Option		
		TIER 1	TIER 2	TIER 3

**PHYSICIAN AND PROFESSIONAL SERVICES**

*If physician/professional services are in conjunction with an office visit, the office visit copay applies.*

<b>Allergy Testing and Injections</b> (including serum)	No Copay	No Copay	No Copay	Employee pays 30%
<b>Chiropractic &amp; Acupuncture</b> (20 visit combined maximum per calendar year)	\$10 Copay	\$10 Copay	\$10 Copay*	Not Covered
<b>Diagnostic Laboratory &amp; X-Ray</b>	No Copay	No Copay	Employee pays 20%	Employee pays 30%
<b>Dialysis</b>	No Copay	No Copay	Employee pays 20%	Employee pays 30%
<b>Immunizations, Routine</b>	No Copay	No Copay	No Copay	Employee pays 30%
<b>Infertility Treatment</b> (limited benefit)	50% Copay	50% Copay	50% Copay	Not Covered
<b>Mammography</b>	No Copay	No Copay	No Copay	Not Covered
<b>Physical Exam, Routine</b> (age 2 & up)	No Copay	No Copay	No Copay	Not Covered
<b>Physician Office Visits</b>	\$10 Copay	\$10 Copay	\$20 Copay*	Employee pays 30%
<b>Prenatal and Postnatal Care</b>	No Copay after 1st visit	No Copay after 1st visit	Employee pays 20%	Employee pays 30%
<b>Rehabilitative Therapy</b> (physical, occupational and speech)	\$10 Copay	\$10 Copay	\$20 Copay*	Employee pays 30%
<b>Well-Baby/Child Care</b> (including immunizations birth to age 2)	No Copay	No Copay	No Copay	Employee pays 30%

**PRESCRIPTION DRUGS**

**Retail (30-day supply)**

Generic	\$5 Copay	\$5 Copay
Preferred Brand Name	\$20 Copay	\$20 Copay
Non-Preferred Brand Name	\$40 Copay	\$40 Copay

**Peralta and Milvia Outpatient Pharmacies<sup>2</sup> (60-day supply)**

Generic	\$2.50 Copay	\$2.50 Copay
Preferred Brand Name	\$10 Copay	\$10 Copay
Non-Preferred Brand Name	\$25 Copay	\$25 Copay

**Mail Order (90-day supply)**

Generic	\$10 Copay	\$10 Copay
Preferred Brand Name	\$40 Copay	\$40 Copay
Non-Preferred Brand Name	\$80 Copay	\$80 Copay

For drugs used to treat high blood pressure, high cholesterol and diabetes, copays will be waived for generic medications and generic drug copays will apply for preferred brand name drugs. Non-preferred brand name drugs will be subject to the regular copays. This applies to medications for these three high-risk chronic conditions only.

\*Copay only. Not subject to annual deductible.

<sup>2</sup>Note: Contact the pharmacy for prescription information. Peralta Outpatient Pharmacy, 3300 Webster St, Oakland, CA 94609, (510) 869-8835 or Milvia Outpatient Pharmacy, 2500 Milvia St., Berkeley, CA 94704, (510) 204-6550.

## Dental Plans – Delta Dental Plan Options

**Chart Indicates Patient Financial Responsibility**

Benefits	Delta Premier Plan		Delta Preferred Plan		DeltaCare Plan
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK	IN NETWORK ONLY
<b>Network</b>	Extremely broad, no need to pre-select dentist	See any dentist	Narrower network; no need to pre-select dentist	Can select any dentist	Very narrow network—Must pre-select dentist
<b>Calendar Year Deductible</b>	\$25 per covered person (3 max)		\$25 per covered person (3 max)		None
<b>Calendar Year Maximum</b>	\$1,500 per covered person		\$1,500 per covered person		None
<b>Preventive Care</b> such as cleanings, x-rays, fluoride applications, consultations	100% covered 2 times per year Deductible waived	100% covered for usual and customary charges 2 times per year Deductible waived	100% covered 2 times per year Deductible waived	You pay 10% of usual and customary charges 2 times per year, Deductible waived	100% covered
<b>Basic Care</b> such as fillings, crowns, oral surgery, endodontics, periodontics	You pay 20% after deductible	You pay 20% of usual and customary charges after deductible	You pay 20% of discounted charges after deductible	You pay 30% of usual and customary charges after deductible	100% covered
<b>Major Care</b> such as bridges, partial dentures and implants (subject to certain limitations)	You pay 50% after deductible	You pay 50% of usual and customary charges after deductible	You pay 50% of discounted charges after deductible	You pay 60% of usual and customary charges after deductible	100% covered (implants not covered)
<b>Orthodontia</b>	Not Covered	Not Covered	You pay 50% of adult or child charges		You pay \$350 “start-up” fee plus max copay: \$1,600—child, \$1,800—adult
<b>Orthodontia Lifetime Maximum</b>	Not Covered	Not Covered	\$1,500 per covered person		No lifetime maximum

## Vision Plans – Vision Service Plan (VSP)

Benefits	VSP – In Network	VSP Plus – In Network	VSP & VSP Plus – Out of Network
<b>Complete Eye Exam</b>	You pay \$10 copay 1 exam every 12 months	You pay \$20 copay 1 exam every 12 months	You pay balance over \$40 1 exam every 12 months
<b>Standard Eyeglass Lenses</b>	Included with exam: 1 pair lenses every 24 months or after 12 months with specified prescription change Covers single vision, lined bifocal, and lined trifocal lenses  Special features such as progressive lenses are available at a discount	Included with exam: 1 pair lenses every 12 months Covers single vision, lined bifocal, lined trifocal and progressive lenses	VSP—1 pair lenses every 24 months VSP Plus—1 pair lenses every 12 months Employee pays balance over following amounts: • Single lenses: \$40/pair • Bifocal lenses: \$60/pair • Trifocal lenses: \$80/pair • Lenticular Lens: \$125/pair
<b>Standard Eyeglass Frames</b>	Available every 24 months Included with exam (value worth \$115 retail + 20% discount off out-of-pocket costs)	Available every 12 months Included with exam (value worth \$150 retail + 20% discount off out-of-pocket costs)	Every 24 months—VSP Every 12 months—VSP Plus Employee pays balance over \$45
<b>Contact Lenses instead of eyeglasses</b>	Available every 24 months Employee pays balance over following amounts: • Elective contacts: \$120 • Medically necessary contacts: no charge	Available every 12 months Employee pays balance over following amounts: • Elective contacts: \$150 • Medically necessary contacts: no charge	VSP—Available every 24 months VSP Plus—Available every 12 months Employee pays balance over following amounts: • Elective contact lenses: \$105 • Medically necessary contact lenses: \$210

The enclosed information provides highlights of the health plans. Complete details are contained in the official plan documents. If there are differences between the information contained herein and the official plan documents, the plan documents will govern.