

# Health Plan Comparison Chart

Effective January 1, 2009



*Alta Bates Summit  
Medical Center*  
A Sutter Health Affiliate



**SAMUEL  
MERRITT  
COLLEGE**

For Non-Union Employees  
and Union Employees  
of CNA and CHEU

# Your Medical Plan Options

PLAN OPTION	EPO OPTION	PPO OPTION		
		TIER 1	TIER 2	TIER 3 <sup>1</sup>
<b>GENERAL INFORMATION</b>				
<b>Network</b>	Sutter Health Network, Children's Hospital, Sutter Medical Groups & Aligned IPAs (i.e., ABMG), & Hill Physicians	Sutter Health Network, Children's Hospital, Sutter Medical Groups & Aligned IPAs (i.e., ABMG), & Hill Physicians	Anthem Blue Cross PPO Network	Out-of-Network
<b>Annual Deductible</b>	None	None	\$100 Individual / \$300 Family	
<b>Annual Out-of-Pocket Maximum<sup>2</sup></b>	\$750 Individual \$1,500 Family	\$500 Individual \$1,000 Family	\$1,500 Individual / \$2,500 Family	
<b>Lifetime Maximum</b>	\$3,000,000	\$3,000,000		
<b>EMERGENCY AND URGENT CARE</b>				
<b>Emergency Room</b> (Copay waived if admitted)	\$10 Copay	No Copay	Life Threatening – No Copay Non-Life Threatening – Employee pays 10%	Life Threatening – No Copay Non-Life Threatening – Employee pays 20%
<b>Urgent Care</b>	\$10 Copay	\$10 Copay	Employee pays 10%	Employee pays 20%
<b>HOSPITAL SERVICES</b>				
<b>Inpatient and Outpatient Hospitalization</b>	No Copay	No Copay	No Copay Pediatric Hospitalization – Employee pays 10%	Employee pays 50% Pediatric Hospitalization – Employee pays 20%
<b>Inpatient Physician Visits</b>	No Copay	No Copay	No Copay	No Copay
<b>Inpatient Rehabilitative Therapy</b>				
Physical and Occupational	No Copay	No Copay	Employee pays 10%	Employee pays 20%
Speech (30 visits per calendar year maximum)	No Copay	No Copay	Employee pays 20%	Employee pays 40%
<b>MENTAL HEALTH AND CHEMICAL DEPENDENCY</b> (Provided through OptumHealth Behavioral Solutions)				
<b>Inpatient</b> (35 day maximum per calendar year)	\$20 Copay	No Copay	Employee pays 20%	
<b>Outpatient</b> (40 visits per calendar year)	\$10 Copay	\$10 Copay	Employee pays 20%	
<b>OTHER MEDICAL SERVICES AND SUPPLIES</b>				
<b>Durable Medical Equipment</b>	No Copay	No Copay \$3,000 annual limit	Employee pays 10% \$3,000 annual limit	Employee pays 10% \$3,000 annual limit
<b>Home Health Care</b>	No Copay Unlimited duration, based on medical necessity	No Copay 120 visits per calendar year		
<b>Hospice</b>	No Copay	No Copay \$15,000 or 6 month lifetime maximum		
<b>Skilled Nursing Facility</b> (100 days per calendar year maximum)	No Copay	No Copay	Employee pays 10%	Employee pays 20%

<sup>1</sup> Under the PPO, any amount exceeding the reasonable and customary charge under Tier 3 is the member's responsibility and does not count toward the annual out-of-pocket maximum.

<sup>2</sup> Note: The annual out-of-pocket maximum is the most you will pay for medical expenses in a single calendar year before the plan pays 100% of the eligible charges for the rest of the calendar year.

PLAN OPTION	EPO OPTION	PPO OPTION		
		TIER 1	TIER 2	TIER 3 <sup>1</sup>
<b>PHYSICIAN AND PROFESSIONAL SERVICES</b>				
If physician/professional services are in conjunction with an office visit, the office visit copay applies.				
<b>Allergy Testing, Treatment and Injections</b> (including serum)	\$10 Copay	\$10 Copay	Employee pays 10%	Employee pays 20%
<b>Chiropractic</b>	\$10 Copay	No Copay	Employee pays 10%	Employee pays 20%
<b>Acupuncture</b>  (Combined limit of \$1,500 per calendar year)	\$10 Copay	No Copay	Employee pays 20%	Employee pays 40%
<b>Diagnostic Laboratory &amp; X-Ray</b>	No Copay	No Copay	Employee pays 10%	Employee pays 20%
<b>Dialysis</b>	\$10 Copay	No Copay	No Copay	Employee pays 50%
<b>Infertility Treatment</b> (\$10,000 lifetime maximum)	No Copay	No Copay	Employee pays 10%	Employee pays 20%
<b>Mammography</b>	No Copay	No Copay	Employee pays 10%	Employee pays 20%
<b>Maternity Care</b>	\$10 Copay	\$10 Copay	Employee pays 10%	Employee pays 20%
<b>Physician Office Visits</b>	\$10 Copay	\$10 Copay	Employee pays 10%	Employee pays 20%
<b>Rehabilitative Therapy</b>				
Physical and Occupational	\$10 Copay	No Copay	Employee pays 10%	Employee pays 20%
Speech (30 visits per calendar year maximum)	\$10 Copay	No Copay	Employee pays 20%	Employee pays 40%
<b>Routine Immunizations</b>	No Copay	No Copay	Employee pays 10%	Employee pays 20%
<b>Routine Physical Exam</b> (1 exam per calendar year)	\$10 Copay	No Copay \$400 max per individual, \$1,500 max per family	Employee pays 10% \$400 max per individual, \$1,500 max per family	Employee pays 20% \$400 max per individual, \$1,500 max per family
<b>Well-Baby/Child Care</b> (including immunizations birth to age 12)	\$10 Copay	No Copay		
<b>PRESCRIPTION DRUGS</b>				
<b>Retail (30 day supply)</b>				
Generic	\$5 Copay	\$5 Copay		
Brand Name	\$10 Copay	\$10 Copay		
Non-formulary Brand Name	\$25 Copay	\$25 Copay		
<b>Peralta Outpatient Pharmacy (60 day supply)</b>				
Generic	No Copay	No Copay		
Brand Name	\$5 Copay	\$5 Copay		
Non-formulary Brand Name	\$10 Copay	\$10 Copay		

Employees and dependents who are diabetic or pre-diabetic will receive diabetes-related medications and supplies free of all copays.

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 chiropractic visits, 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.

## Dental Plans — Delta Dental Plan Options

BENEFITS	DELTA PREMIER PLAN		DELTACARE PLAN
	IN NETWORK	OUT OF NETWORK	IN NETWORK ONLY
<b>Network</b>	Extremely broad, no need to pre-select dentist	See any dentist	Very narrow network – Must pre-select dentist
<b>Calendar Year Deductible</b>	None		None
<b>Calendar Year Maximum</b>	\$2,000 per covered person		None
<b>Preventive Care</b> such as cleanings, x-rays, fluoride applications, consultations	100% covered 2 times per year Deductible waived	Pays 100% 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 10% after deductible	You pay 10% 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 10% after deductible	You pay 10% of usual and customary charges after deductible	100% covered (implants not covered)
<b>Orthodontia</b>	You pay 40% after deductible	You pay 40% of usual and customary charges after deductible	You pay \$350 “startup” fee plus max copay: \$1,600 – child, \$1,800 – adult
<b>Orthodontia Lifetime Maximum</b>	\$2,000		No lifetime maximum

## Vision Plan — Vision Service Plan (VSP)

BENEFITS	IN NETWORK	OUT OF NETWORK
<b>Complete Eye Exam</b>	You pay \$10 Copay 1 exam every 12 months	You pay balance over \$45 1 exam every 12 months
<b>Standard Eyeglass Lenses</b>	1 pair every 12 months Covers single vision, lined bifocal, lined trifocal lenses and tints Special features such as coatings and progressive lenses are available at a discount	1 pair lenses every 12 months Employee pays balance over following amounts: Single lenses: \$55/pair Bifocal lenses: \$70/pair Trifocal lenses: \$80/pair
<b>Standard Eyeglass Frames</b>	Available every 12 months Covered up to \$120 value	Available every 12 months Employee pays balance over \$45
<b>Contact Lenses</b> (Instead of eyeglasses)	1 pair every 12 months Covered up to \$130 value	1 pair every 12 months Employee pays balance over \$130

The information contained in this comparison chart 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.