Sutter Health Plus
Your Health Plan

2025 Optional Benefits

2025 **Vision Plans**

offered and contracted through Vision Service Plan (VSP)

PLAN NAME **Plan ID**	**VSP Plan A** (Voluntary) **VA01**	**VSP Plan B** (Voluntary) **VA02**	**VSP Plan C** (Voluntary) **VA03**
Prescription Glasses Copayment	$20	$20	$20
Benefits Frequency			
Eye examination	Every calendar year[1]	Every calendar year[1]	Every calendar year[1]
Lenses	Every other calendar year[1]	Every calendar year[1]	Every calendar year[1]
Frames	Every other calendar year[1]	Every other calendar year[1]	Every calendar year[1]
Contact Lenses (in lieu of glasses)	Every other calendar year[1]	Every calendar year[1]	Every calendar year[1]
In-Network Benefits			
Vision Care Services			
WellVision Examination	Covered in full	Covered in full	Covered in full
Prescription Glasses			
Lenses: single vision	Covered in full[2]	Covered in full[2]	Covered in full[2]
Lenses: bifocal	Covered in full[2]	Covered in full[2]	Covered in full[2]
Lenses: trifocal	Covered in full[2]	Covered in full[2]	Covered in full[2]
Lenses: lenticular	Covered in full[2]	Covered in full[2]	Covered in full[2]
Frames	Covered up to plan allowance of $120[2]	Covered up to plan allowance of $120[2]	Covered up to plan allowance of $120[2]
Contact Lenses (in lieu of glasses)			
Professional fees and materials	Covered up to plan allowance of $120	Covered up to plan allowance of $120	Covered up to plan allowance of $120
Out-of-Network Benefits			
Vision Care Services			
WellVision Examination	Reimbursed up to $45	Reimbursed up to $45	Reimbursed up to $45
Prescription Glasses			
Lenses: single vision	Reimbursed up to $30[2]	Reimbursed up to $30[2]	Reimbursed up to $30[2]
Lenses: bifocal	Reimbursed up to $50[2]	Reimbursed up to $50[2]	Reimbursed up to $50[2]
Lenses: trifocal	Reimbursed up to $65[2]	Reimbursed up to $65[2]	Reimbursed up to $65[2]
Lenses: lenticular	Reimbursed up to $100[2]	Reimbursed up to $100[2]	Reimbursed up to $100[2]
Frames	Reimbursed up to $70[2]	Reimbursed up to $70[2]	Reimbursed up to $70[2]
Contact Lenses (in lieu of glasses)			
Professional fees and materials	Reimbursed up to $105	Reimbursed up to $105	Reimbursed up to $105
Value-Added Discounts (apply only to In-Network Benefits)			
Frames	20% off the amount over allowance		
Lens Enhancements	30% average savings on some lens enhancement options		
Sunglasses	20% discount		
Contact Lens Exam Services	15% discount off fitting and evaluation		
TruHearing Hearing Aids	Savings up to 60% on brand-name hearing aids		
Laser Vision Correction	15% average discount off the regular price or 5% off the promotional price for laser vision correction provided by VSP contracted facilities		

[1] Calendar year begins January 1

[2] Indicates subject to prescription glasses copayment

This is only a summary. For a complete list of vision services cost sharing or in the event of any discrepancies in information, please review the applicable benefit documents to determine coverage and costs.

2025 **Dental Plan**

offered and contracted through Delta Dental

PLAN NAME Plan ID	Small Group (Adult) Dental DS01
Dignostic Services	
Periodic oral examinations	No charge
X-rays	No charge
Preventive Services	
Teeth cleaning (prophylaxis)	No charge
Topical fluoride - child (adult at different cost share)	No charge
Restorative Services: Filling - Permanent	
Amalgam-four (+) surfaces: primary or permanent	No charge
Crown: porcelain fused to predominantly base metal	$410
Oral Surgery Services	
Simple extraction of erupted tooth or exposed root	$18
Surgical extraction of erupted tooth	$30
Removal of impacted tooth: full bony	$80
Endontic Services	
Root canal: anterior	$110
Root canal: bicuspid/premolar	$195
Root canal: molar	$245
Periodontic Services	
Gingivectomy: one to three teeth per quadrant	$50
Gingivectomy-four (+) contiguous teeth per quadrant	$165
Scaling/root planing: one to three teeth per quadrant	$40
Prosthodontic Services	
Complete denture	$510
Partial denture - resin base	$535
Orthodontic Services (medically necessary)	
Comprehensive Treatment - Child (ages 13-18)	N/A
Comprehensive Treatment - Adult (age 19+)	$2,900
Other Services	
Office visit: after hours	$35
Local anesthesia	No charge

This is only a summary. For a complete list of dental services cost sharing or in the event of any discrepancies in information, please review the applicable benefit documents to determine coverage and costs.

2025 **Chiropractic and Acupuncture Plans**[1]

offered and contracted through ACN Group of California, Inc.

Chiropractic Only						
Plan ID	**CA01**	**CA02**	**CA05**	**CA06**	**CA09**	**CA10**
Max visits per year	20	30	20	30	20	30
Copayment per visit	$20	$20	$15	$15	$10	$10

Acupuncture Only						
Plan ID	**AA01**	**AA02**	**AA05**	**AA06**	**AA09**	**AA10**
Max visits per year	20	30	20	30	20	30
Copayment per visit	$20	$20	$15	$15	$10	$10

Chiropractic and Acupuncture									
Plan ID	**XA01**	**XA02**	**XA04**	**XA05**	**XA06**	**XA08**	**XA09**	**XA10**	**XA12**
Max visits per year	20	30	Unlimited	20	30	Unlimited	20	30	Unlimited
Copayment per visit	$20	$20	$20	$15	$15	$15	$10	$10	$10

2025 **Infertility Plan**[2]

Plan ID	**IF50**
Copayment per treatment and services	50%

2025 **Special Footwear and Orthotics Plans**[2]

Plan ID	**OP20**[3]	**OH20**[4]
Copayment per treatment and services	20%	20% after deductible

[1] Available for small and large group plans only. Not available for election with high-deductible health plans (HDHPs).

[2] Available for large group offerings only.

[3] Not available with large group HDHPs.

[4] Only available with large group HDHPs.

This is only a summary. For a complete list of chiropractic, acupuncture, infertility or special footwear and orthotics services cost sharing or in the event of any discrepancies in information, please review the applicable benefit documents to determine coverage and costs.

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