The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact Sutter Health Plus at 1-855-315-5800 or visit sutterhealthplus.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment (copay), deductible, provider, or other underlined terms, see the Glossary of Health Coverage and Medical Terms. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-855-315-5800 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0 individual / $0 individual family member / $0 family per plan year.</td>
<td>See the Common Medical Events chart below for your costs for services this plan covers.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. There is no deductible for covered services.</td>
<td>You don’t have to meet deductibles for covered items and services. But a copayment (copay) or coinsurance may apply. This plan covers certain preventive services without cost sharing. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$1,500 individual / $1,500 individual family member / $3,000 family per plan year.</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, health care this plan doesn’t cover and cost sharing for optional benefits (acupuncture, chiropractic care and infertility treatment) elected by your employer group.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
</tbody>
</table>
**Will you pay less if you use a network provider?**
Yes. See [www.sutterhealthplus.org/provider-search](http://www.sutterhealthplus.org/provider-search) or call 1-855-315-5800 for a list of network providers.

This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

**Do you need a referral to see a specialist?**
Yes.

This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
</table>
| **If you visit a health care provider’s office or clinic** | Primary Care Physician (PCP) Visit to treat an injury or illness | Participating Provider: PCP Office Visit: $20 copay per visit  
Sutter Walk-in Care Visit: $10 copay per visit  
Telehealth Visit: $10 copay per visit | Non-Participating Provider: Not covered | Includes Other Health Professional visits. *See Definitions section in EOC for list of Other Health Professionals. |
| | Specialist Visit | Specialist Office Visit: $20 copay per visit  
Telehealth Visit: $10 copay per visit | Not covered | Prior authorization for some referrals to specialists is required. If it is not received, you may be responsible for paying all charges. |
| | Preventive Care / Screening / Immunization | No charge | Not covered | You may have to pay for services that aren’t preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic Test (X-ray, blood work) | Lab: $20 copay per visit  
X-ray: No charge | Not covered | Prior authorization for some diagnostic services is required. If it is not received, you may be responsible for paying all charges. |
| | Imaging (CT/PET scans, MRIs) | No charge | Not covered | |

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at [www.sutterhealthplus.org/about/plans-benefits](http://www.sutterhealthplus.org/about/plans-benefits) or call 1-855-315-5800.
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</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1 (Most generic drugs and low-cost preferred brand name drugs)</td>
<td>Participating Provider: Retail: $10 copay per prescription Mail Order: $20 copay per prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Preferred brand name drugs and non-preferred generic drugs)</td>
<td>Participating Provider: Retail: $30 copay per prescription Mail Order: $60 copay per prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3 (Non-preferred brand name drugs)</td>
<td>Participating Provider: Retail: $60 copay per prescription Mail Order: $120 copay per prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 4 (Specialty drugs)</td>
<td>Specialty Pharmacy: 20% coinsurance up to $250 per prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility Fee (e.g., ambulatory surgery center)</td>
<td>Participating Provider: $100 copay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician / Surgeon Fee</td>
<td>Participating Provider: $20 copay per visit</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at [www.sutterhealthplus.org/about/plans-benefits](http://www.sutterhealthplus.org/about/plans-benefits) or call 1-855-315-5800.
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</tr>
</thead>
</table>
| If you need immediate medical attention | Emergency Room Care | Facility: $100 copay per visit  
Professional: No charge | If admitted to the hospital, Emergency Room Care cost sharing will not apply.  
See hospital stay information below for applicable cost sharing. |
| Emergency Medical Transportation | $50 copay per trip | Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance or psychiatric transport van) is not covered. |
| Urgent Care | $20 copay per visit | None |
| If you have a hospital stay | Facility Fee (e.g., hospital room) | $250 copay per admission | Prior authorization is required. If it is not received, you may be responsible for paying all charges. |
| Physician / Surgeon Fees | No charge | Not covered |
| If you need mental health, behavioral health, or substance use disorder (MH/SUD) services | Outpatient Services | Individual Office Visit: $20 copay per visit  
Group Office Visit: $10 copay per visit  
Telehealth Office Visit: $10 copay per visit  
Other Outpatient Services: $100 copay per visit | You may self-refer to a USBHPC provider for Office Visits.  
Prior authorization is required for Other Outpatient Services and all Inpatient Services by USBHPC. If it is not obtained when required, you may be liable for the payment of services or supplies. |
| Inpatient Services | Facility: $250 copay per admission  
Professional: No charge | Not covered |
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you are pregnant</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits</td>
<td></td>
<td>Participating Provider: Prenatal and Postnatal Care (In-person or telehealth visit): No charge</td>
<td>Non-Participating Provider: Not covered</td>
</tr>
<tr>
<td>Childbirth / Delivery Professional Services</td>
<td></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Childbirth / Delivery Facility Services</td>
<td></td>
<td>$250 copay per admission</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>Rehabilitation Services</td>
<td></td>
<td>$20 copay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>Habilitation Services</td>
<td></td>
<td>$20 copay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>Skilled Nursing Care</td>
<td></td>
<td>$200 copay per admission</td>
<td>Not covered</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td></td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hospice Services</td>
<td></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at [www.sutterhealthplus.org/about/plans-benefits](http://www.sutterhealthplus.org/about/plans-benefits) or call 1-855-315-5800.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s Eye Exam</td>
<td>No charge</td>
<td>Up to $45 max reimbursement</td>
</tr>
<tr>
<td></td>
<td>Children’s Glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s Dental Check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Quantitative limits exist for the following children’s services:

Eye Exam – 1 preventive exam per calendar year.

Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover</th>
<th>Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial weight loss programs</td>
<td>Abortion</td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td>Bariatric surgery</td>
</tr>
<tr>
<td>Dental care (Adult)</td>
<td>Infertility treatment offered as an optional benefit through SHP. A PCP or OB/GYN referral and prior authorization by your medical group or SHP are required for medically necessary services. See the Infertility Services Benefit Rider for cost sharing and additional information.</td>
</tr>
<tr>
<td></td>
<td>Routine eye care (Adult) limited to an annual preventive eye exam through VSP; embedded in medical plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan Evidence of Coverage (EOC).)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private-duty nursing</td>
</tr>
<tr>
<td>Routine foot care</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at [www.sutterhealthplus.org/about/plans-benefits](http://www.sutterhealthplus.org/about/plans-benefits) or call 1-855-315-5800.
Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: The Department of Managed Health Care at 1-888-466-2219 or www.dmhc.ca.gov, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through California’s Health Insurance Marketplace, Covered California, at 1-800-300-1506 or www.coveredca.com. For more information about the Marketplace, visit healthcare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance (*See If You Have A Concern Or Dispute With SHP section in EOC for information about grievances) or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Sutter Health Plus at 1-855-315-5800 (TTY: 1-855-830-3500) or California Department of Managed Health Care at 1-888-466-2219 (TTY: 1-877-688-9891) or www.dmhc.ca.gov.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn’t meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Please see Notice of Language Assistance addendum.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at www.sutterhealthplus.org/about/plans-benefits or call 1-855-315-5800.
About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s Type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network prenatal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow-up care)</td>
</tr>
<tr>
<td>The plan’s overall deductible</td>
<td>$0</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$20</td>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital (facility) copayment</td>
<td>$250</td>
<td>Hospital (facility) copayment</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>20%</td>
<td>Other coinsurance</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:
Office Visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services (anesthesia)
Diagnostic Tests (ultrasounds and blood work)

This EXAMPLE event includes services like:
Primary Care Physician Office Visits (including disease education)
Diagnostic Tests (blood work)
Prescription Drugs (including glucose meter)

This EXAMPLE event includes services like:
Emergency Room Care (including medical supplies)
Diagnostic Tests (X-ray)
Durable Medical Equipment (crutches)
Rehabilitation Services (physical therapy)

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$12,700</th>
<th>Total Example Cost</th>
<th>$5,600</th>
<th>Total Example Cost</th>
<th>$2,800</th>
</tr>
</thead>
</table>

In this example, Peg would pay:
<table>
<thead>
<tr>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
</tr>
<tr>
<td>Copayments</td>
</tr>
<tr>
<td>Coinsurance</td>
</tr>
</tbody>
</table>

What isn’t covered:
Limits or excluded services | $60 |

The total Peg would pay is | $360 |

In this example, Joe would pay:
<table>
<thead>
<tr>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
</tr>
<tr>
<td>Copayments</td>
</tr>
<tr>
<td>Coinsurance</td>
</tr>
</tbody>
</table>

What isn’t covered:
Limits or excluded services | $20 |

The total Joe would pay is | $1,220 |

In this example, Mia would pay:
<table>
<thead>
<tr>
<th>Cost Sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
</tr>
<tr>
<td>Copayments</td>
</tr>
<tr>
<td>Coinsurance</td>
</tr>
</tbody>
</table>

What isn’t covered:
Limits or excluded services | $0 |

The total Mia would pay is | $350 |

The plan would be responsible for the other costs of these EXAMPLE covered services.
Notice of Language Assistance

IMPORTANT: Can you read this? If not, Sutter Health Plus can have somebody help you read it. You may also be able to get this written in your language. For no-cost help, please call Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500). (English)

IMPORTANTE: ¿Puede leer esto? Si no puede, Sutter Health Plus puede proporcionarle alguien que le ayude a leerlo. También puede obtenerlo por escrito en su idioma. Llame a Sutter Health Plus Member Services al 1-855-315-5800 (TTY 1-855-830-3500), sin costo alguno. (Spanish)

重要提示：您能讀懂這份文件嗎？如果不能，Sutter Health Plus 可以找人幫助您讀它。您還可能得到用您的語言書寫的這份文件。若需要免費幫助，請致電 Sutter Health Plus 會員服務，電話號碼 1-855-315-5800 (TTY 1-855-830-3500)。(Chinese)

ملحوظة مهمة: هل أنت قادر على قراءة هذا؟ إذا لم تكون قادرًا فاعلم أن صنر هيلث بلس (Sutter Health Plus) قد يكون لديهم شخصًا يمكنهم مساعدتك في قراءة هذا النص. كما يمكن أن تتلقى مكتوبًا بلغتك. للحصول على مساعدة مجانية، بحث اختصاصي صنر هيلث بلس (Sutter Health Plus Member Services) على هاتف 1-855-315-5800 (TTY 1-855-830-3500). (Arabic)


noticedefi: Sutter Health Plus ផ្តល់សំណុំជំនួយការសួរសុខាភិបាល: ប្រសិនបើអ្នកមិនអាចច្រើនបានធ្វើឱ្យយើងឃើញសុខាភិបាលមានការសួរសុខាភិបាលសំខាន់ ក៏អាចមានកូនមនុស្សមើលលេខទី 1-855-315-5800 (TTY 1-855-830-3500) ហាងឈ្នះនេះ។ (Cambodian)

نکته مهم: آیا می توانید این مطالب را بخوانید و بفهمید؟ اگر نیست، Sutter Health Plus می تواند از فرصتی کمک بگیرد. Outcome: این مطالب به زبان فارسی وجود دارد. برای دریافت خدمات و کمک رایگان، لطفاً با Sutter Health Plus دریافت خدمات اعضای به شماره تلفن (3500) 1-855-315-5800 (TTY 1-855-830-3500) کناره گیرید. (Farsi)

महत्वपूर्ण: क्या आप इसे पढ़ सकते/सकती हैं? यदि नहीं, तो सदिक हेल्थ प्लस इसे पढ़ने के किसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा में भी लिखवाने में समर्थ हो सकते/सकती हैं। निष्क्रिय सहायता के लिए, कृपया 1-855-315-5800 (TTY 1-855-830-3500) पर सदिक हेल्थ प्लस मेंबर सर्विस को कॉल करें। (Hindi)

 중요なお知らせ:これを読むことができます？読めない場合は、Sutter Health Plusが読むのをお手伝いします。あなたの言語で表示できるかもしれません。無料のご相談は、Sutter Health Plus membr service(1-855-315-5800 (TTY 1-855-830-3500))まで。（Japanese）

중요:귀하는 이것을 읽으실 수 있습니까?만약 읽을 수 없다면, Sutter Health Plus에서 다른 사람에게 부탁하여 그것을 읽으실 수 있도록 도와드릴 수 있습니다. 또한 이것은 귀하의 사용 언어로 작성해 받으실 수도 있습니다. Sutter Health Plus mem service(1-855-315-5800 (TTY 1-855-830-3500))에 전화를 하시어 무상으로 도움을 받으십시오. (Korean)

ВАЖНО: Вы можете это прочитать? Если нет, Sutter Health Plus может предоставить Вам кого-то, кто сможет помочь Вам прочитать это. Вы также можете получить это в письменной форме на своем языке. Для бесплатной помощи позвоните Sutter Health Plus mem service по телефону 1-855-315-5800 (TTY 1-855-830-3500). (Russian)
