



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](https://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](https://www.healthcare.gov/sbc-glossary) or call 1-855-315-5800 to request a copy.

| Important Questions   | Answers  | Why This Matters:  |
|---|--|--|
| <b>What is the overall deductible?</b>                              | <b>\$0</b> individual / <b>\$0</b> individual family member / <b>\$0</b> family per calendar year.   | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.   |
| <b>Are there services covered before you meet your deductible?</b>  | Yes. There is no <u>deductible</u> for covered services.   | You don't have to meet <u>deductibles</u> for covered items and services. But a <u>copayment</u> (copay) or <u>coinsurance</u> may apply. This <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <b>Are there other deductibles for specific services?</b>           | No.  | You don't have to meet <u>deductibles</u> for specific services.   |
| <b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b> | <b>\$1,500</b> individual / <b>\$1,500</b> individual family member / <b>\$3,000</b> family per calendar year.   | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.  |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>      | <u>Premiums</u> , health care this <u>plan</u> doesn't cover and <u>cost sharing</u> for optional benefits (infertility treatment and chiropractic care) elected by your employer group. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .   |

|  |   |   |
|--|---|---|
| <b>Will you pay less if you use a <u>network provider</u>?</b>   | Yes. See <a href="http://www.sutterhealthplus.org/provider-search">www.sutterhealthplus.org/provider-search</a> or call 1-855-315-5800 for a list of <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services. |
| <b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b> | Yes.  | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .  |

| Common Medical Event   | Services You May Need   | What You Will Pay   |                            | Limitations, Exceptions & Other Important Information   |
|--|---|---|----------------------------|---|
|  |   | Participating Provider  | Non-Participating Provider |   |
| <b>If you visit a health care <u>provider's office or clinic</u></b> | <u>Primary Care Physician (PCP) Visit</u> to treat an injury or illness | PCP Office Visit: \$10 copay per visit<br>Sutter Walk-in Care Visit: \$5 copay per visit<br>Telehealth Visit: \$5 copay per visit | Not covered                | Includes Other Health Professional visits. *See Definitions section in EOC for list of Other Health Professionals.  |
|  | <u>Specialist Visit</u>   | <u>Specialist Office Visit</u> : \$10 copay per visit<br>Telehealth Visit: \$5 copay per visit                                    | Not covered                | Prior authorization for some <u>referrals</u> to <u>specialists</u> is required. If it is not received, you may be responsible for paying all charges.                  |
|  | <u>Preventive Care / Screening / Immunization</u>                       | No charge   | Not covered                | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| <b>If you have a test</b>  | <u>Diagnostic Test</u> (X-ray, blood work)                              | Lab: No charge<br>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.

| Common Medical Event   | Services You May Need   | What You Will Pay  |                            | Limitations, Exceptions & Other Important Information   |
|--|---|--|----------------------------|---|
|  |   | Participating Provider   | Non-Participating Provider |   |
| <b>If you need drugs to treat your illness or condition</b><br>For information about <u>prescription drug coverage</u> , including the Sutter Health Plus (SHP) <u>formulary</u> , visit <a href="http://www.sutterhealthplus.org/p/harmacy">www.sutterhealthplus.org/p/harmacy</a> or call CVS Caremark® at 1-844-740-0635. | Tier 1 (Most generic drugs and low-cost preferred brand name drugs) | Retail: \$5 copay per prescription<br>Mail Order: \$10 copay per prescription  | Not covered                | Retail covers up to a 30-day supply through a CVS Health® National Network pharmacy and covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through the CVS Health Retail-90 Network.                    |
|  | Tier 2 (Preferred brand name drugs and non-preferred generic drugs) | Retail: \$10 copay per prescription<br>Mail Order: \$20 copay per prescription | Not covered                | Mail Order/home delivery service: covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through the CVS Caremark® Mail Service Pharmacy.   |
|  | Tier 3 (Non-preferred brand name drugs)                             | Retail: \$20 copay per prescription<br>Mail Order: \$40 copay per prescription | Not covered                | Specialty Pharmacy: covers up to a 30-day supply of <u>specialty drugs</u> through CVS Specialty®. <u>Specialty drugs</u> are not exclusive to Tier 4 and, regardless of tier placement, have the same fill requirements.               |
|  | Tier 4 ( <u>Specialty drugs</u> )                                   | Specialty Pharmacy: \$20 copay per prescription                                | Not covered                | *See SHP <u>formulary</u> or the Outpatient Prescription Drugs, Supplies, Equipment and Supplement section in EOC for any SHP policy requirements such as prior authorization and step therapy, or coverage limitations and exceptions. |
| <b>If you have outpatient surgery</b>  | Facility Fee (e.g., ambulatory surgery center)                      | \$10 copay per visit   | Not covered                | Prior authorization is required. If it is not received, you may be responsible for paying all charges.  |
|  | Physician / Surgeon Fee   | No charge  | Not covered                |   |

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| Common Medical Event                    | Services You May Need                   | What You Will Pay   |                            | Limitations, Exceptions & Other Important Information  |
|---|---|---|----------------------------|--|
|   |   | Participating Provider                                    | Non-Participating Provider |  |
| If you need immediate medical attention | <u>Emergency Room Care</u>              | Facility: \$50 copay per visit<br>Professional: No charge |                            | If admitted to the hospital, <u>Emergency Room Care cost sharing</u> will not apply. See hospital stay information below for applicable <u>cost sharing</u> .  |
|   | <u>Emergency Medical Transportation</u> | \$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.  |
|   | <u>Urgent Care</u>                      | \$10 copay per visit                                      |                            | For in-area <u>Urgent Care</u> , visit your Medical Group's contracted <u>Urgent Care</u> facility. For Out-of-Area <u>Urgent Care</u> , visit the nearest <u>Urgent Care</u> facility.<br><br><u>Medically necessary</u> treatment of a MH/SUD provided by a 988 center or mobile crisis team, or other providers of behavioral health crisis services is covered in and out-of- <u>network</u> . |
| If you have a hospital stay             | Facility Fee (e.g., hospital room)      | No charge   | Not covered                | Prior authorization may be required. If it is not received, you may be responsible for paying all charges.   |
|   | Physician / Surgeon Fees                | No charge   | Not covered                | Services that are part of a CARE agreement or plan approved by a court, or <u>medically necessary</u> treatment of a MH/SUD from a 988 center or mobile crisis team or other providers of behavioral health crisis services, are covered in or out-of- <u>network</u> and without prior authorization  |

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| Common Medical Event   | Services You May Need                       | What You Will Pay  |                            | Limitations, Exceptions & Other Important Information  |
|--|---|--|----------------------------|--|
|  |   | Participating Provider   | Non-Participating Provider |  |
| <p><b>If you need mental health, behavioral health, or substance use disorder (MH/SUD) services</b></p> <p>For information, call U.S. Behavioral Health Plan, California (USBHPC) at 1-855-202-0984 or visit <a href="http://www.liveandworkwell.com">www.liveandworkwell.com</a> (access code: "Sutter").</p> | Outpatient Services                         | Individual Office Visit: \$10 copay per visit<br>Group Office Visit: \$5 copay per visit<br>Telehealth Office Visit: \$5 copay per visit<br>Other Outpatient Services: No charge | Not covered                | <p>You may self-refer to a <u>USBHPC provider</u> for Office Visits.</p> <p>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.</p> <p>Services that are part of a CARE agreement or plan approved by a court, or <u>medically necessary</u> treatment of a MH/SUD from a 988 center or mobile crisis team or other providers of behavioral health crisis services, are covered in or out-of-<u>network</u> and without prior authorization.</p> |
|  | Inpatient Services                          | Facility: No charge<br>Professional: No charge   | Not covered                |  |
| <p><b>If you are pregnant</b></p>  | Office Visits                               | Prenatal and Postnatal Care (In-person or telehealth visit): No charge   | Not covered                | <p>Prenatal and Postnatal Care includes all prenatal office visits and the first postnatal office visit. Refer to the PCP Visit <u>cost sharing</u> for all subsequent postnatal office visits.</p> <p>Maternity care may include tests and services described elsewhere in the SBC (e.g., <u>Diagnostic Tests</u> such as ultrasounds and blood work).</p> <p style="text-align: center;">None</p>  |
|  | Childbirth / Delivery Professional Services | No charge  | Not covered                |  |
|  | Childbirth / Delivery Facility Services     | No charge  | Not covered                |  |

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| Common Medical Event   | Services You May Need            | What You Will Pay      |                              | Limitations, Exceptions & Other Important Information  |
|--|----------------------------------|------------------------|------------------------------|--|
|  |                                  | Participating Provider | Non-Participating Provider   |  |
| <b>If you need help recovering or have other special health needs</b>  | <u>Home Health Care</u>          | No charge              | Not covered                  | <p>Prior authorization is required. If it is not received, you may be responsible for paying all charges.</p> <p>Quantitative limits exist for the following services:</p> <p><u>Home Health Care</u> – 100 visits per calendar year.</p> <p><u>Skilled Nursing Care</u> – 100 days per benefit period. *See Skilled Nursing Facility Care section in EOC for additional information.</p> <p><u>Hospice Services</u> – respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time.</p> |
|  | <u>Rehabilitation Services</u>   | \$10 copay per visit   | Not covered                  |  |
|  | <u>Habilitation Services</u>     | Not covered            | Not covered                  |  |
|  | <u>Skilled Nursing Care</u>      | No charge              | Not covered                  |  |
|  | <u>Durable Medical Equipment</u> | No charge              | Not covered                  |  |
|  | <u>Hospice Services</u>          | No charge              | Not covered                  |  |
| <b>If your child needs dental or eye care</b><br>For more information, contact Vision Services Plan (VSP) at 1-800-877-7195. | Children's Eye Exam              | No charge              | Up to \$45 max reimbursement | <p>Quantitative limits exist for the following children's services:</p> <p>Eye Exam – 1 preventive exam per calendar year.</p>   |
|  | Children's Glasses               | Not covered            | Not covered                  |  |
|  | Children's Dental Check-up       | Not covered            | Not covered                  |  |

**Excluded Services & Other Covered Services:**

|  |  |   |
|--|--|---|
| <b>Services Your Plan Generally Does NOT Cover</b> (Check your <u>plan</u> Evidence of Coverage (EOC) for more information and a list of any other <u>excluded services</u> .) |  |   |
| <ul style="list-style-type: none"> <li>Commercial weight loss programs</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> </ul>                                       | <ul style="list-style-type: none"> <li><u>Habilitation services</u></li> <li>Hearing aids</li> <li>Long-term care</li> </ul> | <ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> <li>Routine foot care</li> </ul> |

\* 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.

**Other Covered Services** (Limitations may apply to these services. This isn't a complete list. Please see your plan Evidence of Coverage (EOC).)

- Abortion
- Acupuncture typically provided only for the treatment of nausea or chronic pain; embedded in medical plan. PCP referral and prior authorization are required.
- Bariatric surgery
- Chiropractic care provided as an optional benefit through ACN Group of California (ACN) for medically necessary services; separate from medical plan. Limited to 20 visits per calendar year. See the ACN Schedule of Benefits for additional information.
- 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.
- Routine eye care (Adult) limited to an annual preventive eye exam through VSP; embedded in medical plan.

**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](http://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](http://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](http://www.coveredca.com). For more information about the Marketplace, visit [healthcare.gov](http://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](http://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.*

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## 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 (copays) 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.

### Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

|  |      |
|--|------|
| ■ The <u>plan's overall deductible</u> | \$0  |
| ■ <u>Specialist copayment</u>          | \$10 |
| ■ Hospital (facility) <u>copayment</u> | \$0  |
| ■ Other <u>coinsurance</u>             | N/A  |

#### 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| <u>Cost Sharing</u>                |             |
|------------------------------------|-------------|
| <u>Deductible</u>                  | \$0         |
| <u>Copayments</u>                  | \$10        |
| <u>Coinsurance</u>                 | \$0         |
| <i>What isn't covered</i>          |             |
| Limits or <u>excluded services</u> | \$60        |
| <b>The total Peg would pay is</b>  | <b>\$70</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|  |      |
|--|------|
| ■ The <u>plan's overall deductible</u> | \$0  |
| ■ <u>Specialist copayment</u>          | \$10 |
| ■ Hospital (facility) <u>copayment</u> | \$0  |
| ■ Other <u>coinsurance</u>             | N/A  |

#### This EXAMPLE event includes services like:

Primary Care Physician Office Visits (*including disease education*)  
Diagnostic Tests (*blood work*)  
 Prescription Drugs (*including glucose meter*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| <u>Cost Sharing</u>                |              |
|------------------------------------|--------------|
| <u>Deductible</u>                  | \$0          |
| <u>Copayments</u>                  | \$500        |
| <u>Coinsurance</u>                 | \$0          |
| <i>What isn't covered</i>          |              |
| Limits or <u>excluded services</u> | \$20         |
| <b>The total Joe would pay is</b>  | <b>\$520</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow-up care)

|  |      |
|--|------|
| ■ The <u>plan's overall deductible</u> | \$0  |
| ■ <u>Specialist copayment</u>          | \$10 |
| ■ Hospital (facility) <u>copayment</u> | \$0  |
| ■ Other <u>coinsurance</u>             | N/A  |

#### This EXAMPLE event includes services like:

Emergency Room Care (*including medical supplies*)  
Diagnostic Tests (*X-ray*)  
 Durable Medical Equipment (*crutches*)  
 Rehabilitation Services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| <u>Cost Sharing</u>                |              |
|------------------------------------|--------------|
| <u>Deductible</u>                  | \$0          |
| <u>Copayments</u>                  | \$200        |
| <u>Coinsurance</u>                 | \$0          |
| <i>What isn't covered</i>          |              |
| Limits or <u>excluded services</u> | \$0          |
| <b>The total Mia would pay is</b>  | <b>\$200</b> |

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