**Important Questions** | **Answers** | **Why This Matters:**
--- | --- | ---
What is the overall deductible? | $4,000 individual/ $4,000 individual family member/ $8,000 family for certain medical services per calendar year. | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.

Are there services covered before you meet your deductible? | Yes. Preventive care and other services as indicated in the chart starting on page 2 are covered before you meet your deductible. | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment (copay) or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at [healthcare.gov/coverage/preventive-care-benefits/](http://healthcare.gov/coverage/preventive-care-benefits/).

Are there other deductibles for specific services? | Yes. Pharmacy deductible: $300 individual/ $300 individual family member/ $600 family for prescription drug coverage per calendar year. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.

What is the out-of-pocket limit for this plan? | $7,800 individual/ $7,800 individual family member/ $15,600 family per calendar year. | 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.
### What is not included in the out-of-pocket limit?

- Premiums and health care this plan doesn’t cover.

Even though you pay these expenses, they don’t count toward the out-of-pocket limit.

### Will you pay less if you use a network provider?

- Yes. For a list of participating providers, go to sutterhealthplus.org or call 1-855-315-5800.

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.

---

All **copayment** (copay) and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions and Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>Participating Provider: $40 copay per visit; Deductible does not apply</td>
<td>Non-Participating Provider: Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>Participating Provider: $80 copay per visit; Deductible does not apply</td>
<td>Non-Participating Provider: Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>Participating Provider: No charge; Deductible does not apply</td>
<td>Non-Participating Provider: Not covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (X-ray, blood work)</td>
<td>Participating Provider: Lab: $40 copay per visit; X-ray: $85 copay per procedure; Deductible does not apply</td>
<td>Non-Participating Provider: Not covered</td>
</tr>
</tbody>
</table>

* For more information about limitations and exceptions, see the plan or policy document at [sutterhealthplus.org](http://sutterhealthplus.org) or call 1-855-315-5800.
<table>
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<tr>
<th>Common Medical Event</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Participating Provider</td>
<td>Non-Participating Provider</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$325 copay per procedure Deductible does not apply</td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>Tier 1</td>
<td>Retail: $16 copay per prescription after pharmacy deductible Mail-Order: $32 copay per prescription after pharmacy deductible</td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>Tier 2</td>
<td>Retail: $60 copay per prescription after pharmacy deductible Mail-Order: $120 copay per prescription after pharmacy deductible</td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>Tier 3</td>
<td>Retail: $90 copay per prescription after pharmacy deductible Mail-Order: $180 copay per prescription after pharmacy deductible</td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>Tier 4</td>
<td>Specialty Pharmacy: 20% coinsurance up to $250 per prescription after pharmacy deductible</td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>More information about prescription drug coverage, including the Sutter Health Plus (SHP) Formulary, is available at express-scripts.com or call 1-877-787-8661.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance Deductible does not apply</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
</table>
| If you need immediate medical attention     | Emergency room care   | Facility: $400 copay per visit  
Professional: No charge  
Deductible does not apply | Cost sharing does not apply if admitted for hospitalization for covered services. |
|                                             | Emergency medical transportation | $250 copay per trip  
Deductible does not apply | 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           | $40 copay per visit  
Deductible does not apply | None |
| If you have a hospital stay                 | Facility fee (e.g., hospital room) | 20% coinsurance | Not covered  
Prior authorization is required. If it is not received, you may be responsible for paying all charges. |
|                                             | Physician/surgeon fees | 20% coinsurance  
Deductible does not apply | Not covered |
| If you need mental health, behavioral health, or substance use disorder (MH/SUD) services | Outpatient services | Individual office visit: $40 copay per visit  
Group office visit: $20 copay per visit  
Other outpatient services: 20% coinsurance (maximum $40 per visit)  
Deductible does not apply | Not covered  
Prior authorization is required for Other outpatient services and all Inpatient services by US Behavioral Health Plan, California. If it is not obtained when required, you may be liable for the payment of services or supplies. |
|                                             | Inpatient services    | Facility: 20% coinsurance  
Professional: 20% coinsurance; deductible does not apply | Not covered |

* For more information about limitations and exceptions, see the plan or policy document at [sutterhealthplus.org](http://sutterhealthplus.org) or call 1-855-315-5800.
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<th>Services You May Need</th>
<th>What You Will Pay</th>
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</tr>
</thead>
<tbody>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Participating Provider: Prenatal and postnatal care: No charge Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>20% coinsurance Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>$45 copay per visit Deductible does not apply</td>
<td>Prior authorization is required. If it is not received, you may be responsible for paying all charges.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$40 copay per visit Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$40 copay per visit Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge Deductible does not apply</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Prenatal and postnatal care includes all prenatal office visits and the first postnatal office visit. Refer to the primary care visit cost sharing for all subsequent postnatal office visits.

Prior authorization is required. If it is not received, you may be responsible for paying all charges.

Quantitative limits exist for the following services:
- Home health care – 100 visits per calendar year.
- Skilled nursing care – 100 days per benefit period.
- Hospice services – respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time.

* For more information about limitations and exceptions, see the plan or policy document at sutterhealthplus.org or call 1-855-315-5800.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Participating Provider</th>
<th>Non-Participating Provider</th>
<th>Limitations, Exceptions and 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 Deductible does not apply</td>
<td>Not covered</td>
<td>1 preventive exam per year. Offered through Vision Service Plan (VSP).</td>
</tr>
<tr>
<td>Embedded pediatric benefits that are provided through the end of the month in which the member turns 19 years of age.</td>
<td>Children’s glasses</td>
<td>No charge Deductible does not apply</td>
<td>Not covered</td>
<td>1 pair of glasses (or contact lenses in lieu of glasses) per year. Offered through (VSP).</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge Deductible does not apply</td>
<td>Not covered</td>
<td>Preventive prophylaxis and diagnostic oral evaluation limited to 1 per 6 months. Offered through Delta Dental.</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover**
(Check your policy or plan document for more information and a list of any other excluded services.)

- Chiropractic care
- Commercial weight loss programs
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

**Other Covered Services**
(Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Abortion
- Acupuncture services typically provided only for the treatment of nausea or chronic pain; embedded in medical plan. A primary care physician referral and prior authorization are required.
- Bariatric surgery

* For more information about limitations and exceptions, see the plan or policy document at sutterhealthplus.org 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: Sutter Health Plus at 1-855-315-5800; The Department of Managed Health Care at 1-888-466-2219 or [dmc.ca.gov](http://dmc.ca.gov); The U.S. Department of Labor, Employee benefits Security Administration at 1-866-444-3272 or [dol.gov/ebsa](http://dol.gov/ebsa); or the U.S. Department of Health and Human Services at 1-877-267-2323 - option 4 - ext. 61565 or [ccio.cms.gov](http://ccio.cms.gov). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. 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 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or for assistance, contact: Sutter Health Plus at 1-855-315-5800 (TTY: 1-855-830-3500) or visit [sutterhealthplus.org](http://sutterhealthplus.org).

If this coverage is subject to ERISA, you may contact Sutter Health Plus at 1-855-315-5800 or the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform), and the California Department of Insurance at 1-800-927-HELP (4357) or [insurance.ca.gov](http://insurance.ca.gov).

Additionally, a consumer assistance program can help you file your appeal:
Contact Department of Managed Health Care Help Center, 980 9th Street, Suite 500, Sacramento, CA 95814
1-888-466-2219 (TTY: 1-877-688-9891) | [healthhelp.ca.gov](http://healthhelp.ca.gov) | [helpline@dmhc.ca.gov](mailto:helpline@dmhc.ca.gov)

**Does this plan provide Minimum Essential Coverage?** Yes.
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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.
### 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 plan’s medical deductible**: $4,000
- **Specialist copayment**: $80
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 20%

This EXAMPLE event includes services like:
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services (anesthesia)
- Diagnostic tests (ultrasounds and blood work)

**Total Example Cost**: $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$4,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,800</td>
</tr>
</tbody>
</table>

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

**The total Peg would pay is**: $6,160

#### Managing Joe’s Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan’s medical deductible**: $4,000
- **Specialist copayment**: $80
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 20%

This EXAMPLE event includes services like:
- Primary care physician office visits (including disease education)
- Diagnostic tests (blood work)
- Prescription drugs (including glucose meter)

**Total Example Cost**: $7,400

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$2,800</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

**The total Joe would pay is**: $3,160

#### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan’s medical deductible**: $4,000
- **Specialist copayment**: $80
- **Hospital (facility) coinsurance**: 20%
- **Other coinsurance**: 20%

This EXAMPLE event includes services like:
- Emergency room care (including X-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost**: $1,900

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
</tbody>
</table>

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

**The total Mia would pay is**: $1,010

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）

(Arabic) ملاحظة مهمة: هل أنت قادر على قراءة هذا؟ إذا لم تكون قادرًا فاعمل أن صنتر هيلث بلس (Sutter Health Plus) قد يكون لديهم شخصًا يمكنه مساعدتك في قراءة هذا النص. كما يمكنك أيضًا أن تتلقي مكتوبًا لأجله. للحصول على مساعدة مجانية، برامج الاتصال بخدمات أعضاء صنتر هيلث بلس (Sutter Health Plus Member Services) على هاتفي 1-855-315-5800 (TTY 1-855-830-3500).

(Chinese) 當你無法閱讀時，Sutter Health Plus 可以協助你。你可以電話 1-855-315-5800 (TTY 1-855-830-3500) 得到你的文字報告。（Chinese）

(Spanish) Si no puede leer esto, Sutter Health Plus puede proporcionarle a 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)

(Arabic) إذا لم تستطع قراءة هذا النص، يمكن أن يقدم Sutter Health Plus شخصاً يمكنه مساعدتك في قراءته. كما يمكنك أيضًا أن تطلب النص مكتوباً. للحصول على مساعدة مجانية، اتصل بخدمة أعضاء صنتر هيلث بلس (Sutter Health Plus Member Services) على هاتفي 1-855-315-5800 (TTY 1-855-830-3500).

(Hindi) नक्ते महम्: आप इसे पढ़ सकते/सकती हैं? यदि नहीं, तो सह्य लैंथ प्लेस इसे पढ़ने में किसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा में भी लिखवाने में समर्थ हो सकते/सकती हैं। निष्कृत सहायता के लिए, कृपया 1-855-315-5800 (TTY 1-855-830-3500) पर सह्य लैंथ प्लेस मंडर सर्विसिस को कॉल करें। (Hindi)

重要なお知らせ：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 Member Services、電話：1-855-315-5800 (TTY 1-855-830-3500) まで。(Japanese)

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

ในภาษา: เธอสามารถอ่านคุณได้มั้ย? หากเธอไม่สามารถอ่านได้ เธอสามารถขอให้ Sutter Health Plus ให้ช่วยอ่านให้เธอได้ หรือเธอสามารถขอให้ Sutter Health Plus ส่งเอกสารนี้เป็นภาษาของเธอไปให้เธอได้ หรือเธอสามารถขอให้ Sutter Health Plus ส่งเอกสารนี้เป็นเอกสารที่เธอต้องการให้ Sutter Health Plus ช่วยให้เธอได้ 1-855-315-5800 (TTY 1-855-830-3500) (Laotian)


MAHALAGA: Nababasa mo ba ito? Kung hindi, Sutter Health Plus dapat magbigay ng tulong, mangyaring tumawag sa Sutter Health Plus Member Services sa 1-855-315-5800 (TTY 1-855-830-3500). (Tagalog)

QUAN TRỌNG: Qu. vī có thể đọc thông tin này không? Nếu không, Sutter Health Plus có thể yêu cầu ai đó đọc giúp cho qu. vī. Qu. vī cũng có thể nhận được thông tin này được đặng vần bản bằng ngôn ngữ của qu. vī. Để được hỗ trợ miễn phí, vui lòng gọi cho ban Dịch Vụ Thành Viên của Sutter Health Plus theo số 1-855-315-5800 (TTY 1-855-830-3500). (Vietnamese)