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.

<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>$6,300 individual / $6,300 individual family member / $12,600 family</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care and other services as indicated in the chart starting on page 2 are covered before you meet your deductible.</td>
<td>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 <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>Yes. Pharmacy deductible: $500 individual / $500 individual family member / $1,000 family for prescription drug coverage per calendar year. There are no other specific deductibles.</td>
<td>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.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$8,200 individual / $8,200 individual family member / $16,400 family per calendar 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 and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
</tbody>
</table>

Sutter Health Plus: (2021) Bronze MI04 HMO

Coverage Period: Beginning on or after 01/01/2021
Coverage for: Individual and Family Plan | Plan Type: HMO
| 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. |

⚠️ 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 &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Participating Provider</td>
<td>Non-Participating Provider</td>
</tr>
<tr>
<td></td>
<td>Primary Care Physician (PCP) Visit to treat an injury or illness</td>
<td>$65 copay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist Visit</td>
<td>$95 copay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive Care / Screening / Immunization</td>
<td>No charge</td>
<td>Deductible does not apply</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>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic Test (X-ray, blood work)</td>
<td><strong>Participating Provider</strong>&lt;br&gt;Lab: $40 copay per visit; deductible does not apply&lt;br&gt;X-ray: 40% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>40% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

| **If you need drugs to treat your illness or condition**<br>For information about prescription drug coverage, including the Sutter Health Plus (SHP) Formulary, visit [www.sutterhealthplus.org/pharmacy](http://www.sutterhealthplus.org/pharmacy) or call Express Scripts at 1-877-787-8661. | Tier 1 (Most generic drugs and low-cost preferred brand name drugs) | Retail: $18 copay per prescription after pharmacy deductible<br>Mail Order: $36 copay per prescription after pharmacy deductible | Not covered | Retail Pharmacy: covers up to a 30-day supply. A participating retail pharmacy in the Smart90 Program covers up to a 90-day supply of maintenance drugs at three times the retail cost sharing. |
| Tier 2 (Preferred brand name drugs and non-preferred generic drugs) | Retail: 40% coinsurance up to $500 per prescription after pharmacy deductible<br>Mail Order: 40% coinsurance up to $1,000 per prescription after pharmacy deductible | Not covered | Mail Order/home delivery service: covers up to a 100-day supply of maintenance drugs at two times the retail cost sharing.<br>Specialty Pharmacy: covers up to a 30-day supply of specialty drugs provided through Accredo. |
| Tier 3 (Non-preferred brand name drugs) | Retail: 40% coinsurance up to $500 per prescription after pharmacy deductible<br>Mail Order: 40% coinsurance up to $1,000 per prescription after pharmacy deductible | Not covered | FDA-approved, self-administered hormonal contraceptives are available for up to a 12-month supply. |
| Tier 4 (Specialty drugs) | Specialty Pharmacy: 40% coinsurance up to $500 per prescription after pharmacy deductible | Not covered | *See SHP Formulary 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.* |

* 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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<th>What You Will Pay</th>
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</tr>
</thead>
<tbody>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility Fee (e.g., ambulatory surgery center)</td>
<td>40% coinsurance</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>Physician / Surgeon Fee</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency Room Care</td>
<td>Facility: 40% coinsurance</td>
<td>If admitted to the hospital, Emergency Room Care cost sharing will not apply. See hospital stay information below for applicable cost sharing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Professional: No charge; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency Medical Transportation</td>
<td>40% coinsurance</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Urgent Care</td>
<td>$65 copay per visit</td>
<td>Deductible waived for 1st 3 non-preventive visits</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility Fee (e.g., hospital room)</td>
<td>40% coinsurance</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>Physician / Surgeon Fees</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance use disorder (MH/SUD) services</td>
<td>Outpatient Services</td>
<td>Individual Office Visit: $65 copay per visit</td>
<td>You may self-refer to a USBHPC provider for Office Visits.</td>
</tr>
<tr>
<td></td>
<td>Group Office Visit</td>
<td>$32.50 copay per visit</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Other Outpatient Services: 40% coinsurance (maximum $65 per visit)</td>
<td></td>
<td>MH/SUD Office Visit: deductible waived for 1st 3 non-preventive visits.</td>
</tr>
<tr>
<td></td>
<td>Inpatient Services</td>
<td>Facility: 40% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Professional: 40% coinsurance</td>
<td></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>Participating Provider</th>
<th>Non-Participating Provider</th>
<th>Limitations, Exceptions &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you are pregnant</td>
<td>Office Visits</td>
<td>Prenatal and Postnatal Care: No charge Deductible does not apply</td>
<td>Not covered</td>
<td>Prenatal and Postnatal Care includes all prenatal office visits and the first postnatal office visit. Refer to the PCP Visit cost sharing for all subsequent postnatal office visits. Maternity care may include tests and services described elsewhere in the SBC (e.g., Diagnostic Tests such as ultrasounds and blood work).</td>
</tr>
<tr>
<td></td>
<td>Childbirth / Delivery Professional Services</td>
<td>40% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth / Delivery Facility Services</td>
<td>40% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home Health Care</td>
<td>40% coinsurance</td>
<td>Not covered</td>
<td>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. *See Skilled Nursing Facility Care section in EOC for additional information. Hospice Services – respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation Services</td>
<td>$65 copay per visit Deductible does not apply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation Services</td>
<td>$65 copay per visit Deductible does not apply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled Nursing Care</td>
<td>40% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable Medical Equipment</td>
<td>40% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice Services</td>
<td>No charge Deductible does not apply</td>
<td>Not covered</td>
<td></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>Not covered</td>
</tr>
<tr>
<td>For more information, contact Vision Services Plan (VSP) at 1-800-877-7195 or Delta Dental at 1-800-422-4234.</td>
<td></td>
<td>Deductible does not apply</td>
<td>Quantitative limits exist for the following children’s services:</td>
</tr>
<tr>
<td></td>
<td>Children’s Glasses</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply</td>
<td>Eye Exam – 1 preventive exam per year.</td>
</tr>
<tr>
<td></td>
<td>Children’s Dental Check-up</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply</td>
<td>Glasses – 1 pair of glasses (or contact lenses in lieu of glasses) per year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Dental Check-up – preventive prophylaxis and diagnostic oral evaluation limited to 1 per 6 months.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>These are embedded pediatric vision and dental benefits that are provided through the end of the month in which you turn 19 years of age.</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 typically provided only for the treatment of nausea or chronic pain; embedded in medical plan. PCP referral and prior authorization are required.
- Bariatric surgery

* 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.
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? Not Applicable.
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, 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 overall deductible**: $6,300
- **Specialist copayment**: $95
- **Hospital (facility) coinsurance**: 40%
- **Other coinsurance**: 40%

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)

**Total Example Cost**: $12,700

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Deductible(s)</em></td>
<td>$6,300</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$900</td>
</tr>
</tbody>
</table>

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

**The total Peg would pay is**: $7,460

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

- **The plan’s overall deductible**: $6,300
- **Specialist copayment**: $95
- **Hospital (facility) coinsurance**: 40%
- **Other coinsurance**: 40%

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**: $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Deductible(s)</em></td>
<td>$900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,500</td>
</tr>
</tbody>
</table>

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

**The total Joe would pay is**: $2,820

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

- **The plan’s overall deductible**: $6,300
- **Specialist copayment**: $95
- **Hospital (facility) coinsurance**: 40%
- **Other coinsurance**: 40%

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

**Total Example Cost**: $2,800

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Deductible(s)</em></td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

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

**The total Mia would pay is**: $2,200

---

*Note: This plan has other deductibles for specific services included in this coverage example. See “Are there other deductibles for specific services?” row above.*

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：您能读懂这份文件吗？如果不能，Sutter Health Plus 可以找人帮助您读它。您也可能得到用您语言书写的这份文件。若需要免费帮助，请致电 Sutter Health Plus 会员服务，电话号码 1-855-315-5800 (TTY 1-855-830-3500)。 (Chinese)

.hasOwnProperty() Error: هل أنت قادر على قراءة هذا؟ إذا لم تكن قادرًا فاعلم أن صنر هيلث ب拉斯 (Sutter Health Plus) قد يكون لديهم شخصًا يمكنه مساعدتك في قراءة هذا النص. كما يمكن أيضًا أن تتلقى مكتوبًا بلغتك. للحصول على مساعدة مجانية، يرجى الاتصال بخدمات أعضاء صنر هيلث ب拉斯 (Sutter Health Plus Members Services) على هاتف 1-855-315-5800 (Sutter Health Plus Member Services) (1-855-830-3500[TTY]). (Arabic)

نکته مهم: آیا می توانید این مطالب را بخوانید و بهفهمید؟ اگر نیمی توانید، تا اینجا برایتان بخواند. همچنین امکان ترجمه این مطالب به زبان فارسی وجود دارد. برای دریافت خدمات و کمک رایگان، لطفاً با Sutter Health Plus (1-855-315-5800 (TTY 1-855-830-3500) تماس بگیرید. (Farsi)

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

(Japanese)

Health Plus Member Services โทร 1-855-315-5800 (TTY 1-855-830-3500)

(Korean)

Sutter Health Plus Member Services โทร 1-855-315-5800 (TTY 1-855-830-3500)

(Punjabi)

Sutter Health Plus Member Services โทร 1-855-315-5800 (TTY 1-855-830-3500)

(Thai)

Sutter Health Plus Member Services โทร 1-855-315-5800 (TTY 1-855-830-3500)

(Vietnamese)