**Summary of Benefits and Coverage**: What this Plan Covers and What You Pay For Covered Services

**Sutter Health Plus: Summit ML26 HMO**

<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 calendar 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>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/.</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 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, health care this plan doesn’t cover and cost sharing for optional benefits and riders if 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. For a list of participating providers, go to sutterhealthplus.org or call 1-855-315-5800.

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 and Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Participating Provider</td>
<td>Non-Participating Provider</td>
</tr>
<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>$10 copay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$10 copay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (X-ray, blood work)</td>
<td>Lab: $10 copay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>X-ray: $10 copay per procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$50 copay per procedure</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

* 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>What You Will Pay Participating Provider</th>
<th>Non-Participating Provider</th>
<th>Limitations, Exceptions and Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Tier 1</td>
<td>Retail: $10 copay per prescription Mail-Order: $20 copay per prescription</td>
<td>Not covered</td>
<td>Retail: up to a 30-day supply. Mail-Order: up to a 100-day supply. Specialty Pharmacy: up to a 30-day supply.</td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>Retail: $30 copay per prescription Mail-Order: $60 copay per prescription</td>
<td>Not covered</td>
<td>FDA-approved, self-administered hormonal contraceptives are available for up to a 12-month supply.</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>Retail: $60 copay per prescription Mail-Order: $120 copay per prescription</td>
<td>Not covered</td>
<td>Some drugs have process requirements, such as prior authorization, or limitations for coverage, such as a quantity limit. Please refer to the SHP Formulary for details.</td>
</tr>
<tr>
<td></td>
<td>Tier 4</td>
<td>Specialty Pharmacy: 20% coinsurance up to $250 per prescription</td>
<td>Not covered</td>
<td>The difference in cost for obtaining a brand drug, when a FDA-approved generic equivalent is available, is not a covered expense and will not accrue towards your out-of-pocket limit unless prior authorized for medical necessity.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$10 copay per visit</td>
<td>Not covered</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>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
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<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Facility: $100 copay per visit Professional: No charge</td>
<td>Cost sharing does not apply if admitted for hospitalization for covered services.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$100 copay per trip</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$10 copay per visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$250 copay per admission</td>
<td>Not covered</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>No charge</td>
<td>Not covered</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: $10 copay per visit Group office visit: $5 copay per visit Other outpatient services: $10 copay per visit</td>
<td>Not covered</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Facility: $250 copay per admission Professional: No charge</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
</table>

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<tr>
<td></td>
<td></td>
<td>Participating Provider</td>
<td>Non- Participating Provider</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td><strong>Office visits</strong></td>
<td>Prenatal and postnatal care: No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Childbirth/delivery professional services</strong></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Childbirth/delivery facility services</strong></td>
<td>$250 copay per admission</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td><strong>Home health care</strong></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>$10 copay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>$100 copay per admission</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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### Common Medical Event

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<th>What You Will Pay</th>
<th>Limitations, Exceptions and Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>Participating Provider: No charge</td>
<td>Non-Participating Provider: Up to $45 max reimbursement</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Participating Provider: Not covered</td>
<td>Non-Participating Provider: Not covered</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>Participating Provider: Not covered</td>
<td>Non-Participating Provider: Not covered</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)
- Habilitation services
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

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

- 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
- Routine eye care (Adult) limited to an annual preventive eye exam through VSP; embedded in medical plan.

* 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.
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 dmhc.ca.gov; The U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or dol.gov/ebsa; or the U.S. Department of Health and Human Services at 1-877-267-2323 - option 4 - ext. 61565 or cciio.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 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.

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, and the California Department of Insurance at 1-800-927-HELP (4357) or 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 | 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.

* For more information about limitations and exceptions, see the plan or policy document at sutterhealthplus.org 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 $0</td>
<td>- The plan’s overall deductible $0</td>
<td>- The plan’s overall deductible $0</td>
</tr>
<tr>
<td>- Specialist copayment $10</td>
<td>- Specialist copayment $10</td>
<td>- Specialist copayment $10</td>
</tr>
<tr>
<td>- Hospital (facility) copayment $250</td>
<td>- Hospital (facility) copayment $250</td>
<td>- Hospital (facility) copayment $250</td>
</tr>
<tr>
<td>- Other coinsurance 20%</td>
<td>- Other coinsurance 20%</td>
<td>- Other coinsurance 20%</td>
</tr>
</tbody>
</table>

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>Deductible</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>$0</td>
<td>$400</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or excluded services</td>
<td>$60</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The total Peg would pay is</strong></td>
<td>$460</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$7,400</th>
</tr>
</thead>
</table>

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductible</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>$0</td>
<td>$1,500</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or excluded services</td>
<td>$60</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The total Joe would pay is</strong></td>
<td>$1,560</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Example Cost</th>
<th>$1,900</th>
</tr>
</thead>
</table>

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductible</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What isn’t covered</strong></td>
<td>$0</td>
<td>$300</td>
<td>$10</td>
</tr>
<tr>
<td>Limits or excluded services</td>
<td>$60</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The total Mia would pay is</strong></td>
<td>$310</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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)

IMPORTANTANTE: ¿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）

notifications of language assistance in your preferred language: 1-855-315-5800 (TTY 1-855-830-3500) (Arabic)

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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 읽으실 수 있습니까? 만약 읽으실 수 없다면, Sutter Health Plus에서 다른 사람에게 부탁하여 그것을 읽으실 수 있도록 도와드릴 수 있습니다. 또한 이것을 귀하의 사용 언어로 작성해 받으실 수도 있습니다. Sutter Health Plus Member Services (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 в Службу поддержки членов Sutter Health Plus по телефону 1-855-315-5800 (TTY 1-855-830-3500). (Russian)
