### Important Questions | Answers | Why This Matters:
---|---|---
**What is the overall deductible?** | $0 individual/ $0 individual family member/ $0 family per calendar year. | See the Common Medical Events chart below for your costs for services this plan covers.

**Are there services covered before you meet your deductible?** | Yes. There is no deductible for covered services. | 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/](https://healthcare.gov/coverage/preventive-care-benefits/).

**Are there other deductibles for specific services?** | No. | You don’t have to meet deductibles for specific services.

**What is the out-of-pocket limit for this plan?** | $2,000 individual/ $2,000 individual family member/ $4,000 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, health care this plan doesn’t cover and cost sharing for optional benefits and riders if elected by your employer group. | 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.

<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>$30 copay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30 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&lt;br&gt;X-ray: $10 copay per procedure</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$50 copay per procedure</td>
<td>Not covered</td>
</tr>
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</table>

* For more information about limitations and exceptions, see the plan or policy document at sutterhealthplus.org or call 1-855-315-5800.
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| If you need drugs to treat your illness or condition | Tier 1 | Retail: $10 copay per prescription  
Mail-Order: $20 copay per prescription | Not covered | Retail: up to a 30-day supply.  
Mail-Order: up to a 100-day supply.  
Specialty Pharmacy: up to a 30-day supply. |
| | Tier 2 | Retail: $30 copay per prescription  
Mail-Order: $60 copay per prescription | Not covered | FDA-approved, self-administered hormonal contraceptives are available for up to a 12-month supply. |
| | Tier 3 | Retail: $60 copay per prescription  
Mail-Order: $120 copay per prescription | Not covered | 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. |
| | Tier 4 | Specialty Pharmacy: 20% coinsurance up to $100 per prescription | Not covered | 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. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | $100 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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| **If you need immediate medical attention** | Emergency room care | Facility: $150 copay per visit  
Professional: No charge | Cost sharing does not apply if admitted for hospitalization for covered services. |
| | Emergency medical transportation | $100 copay per trip | |
| | Urgent care | $40 copay per visit | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $500 copay per admission | Not covered  
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: $30 copay per visit  
Group office visit: $15 copay per visit  
Other outpatient services: $60 copay per visit | 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: $500 copay per admission  
Professional: No charge | Not covered |
<table>
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</thead>
<tbody>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Prenatal and postnatal care: No charge</td>
<td>Not covered</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$500 copay per admission</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>No charge</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>Rehabilitation services</td>
<td>$30 copay per visit</td>
<td>Not covered</td>
<td>Quantitative limits exist for the following services:</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Home health care – 100 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>Not covered</td>
<td>Skilled nursing care – 100 days per benefit period.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>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>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
</tbody>
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<th>What You Will Pay 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</td>
<td>Up to $45 max reimbursement</td>
<td>1 preventive exam per year. Offered through Vision Service Plan (VSP).</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</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.)

- Acupuncture 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.)

- 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 (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 overall deductible $0
- Specialist copayment $30
- Hospital (facility) copayment $500
- 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>Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$600</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Peg would pay is $660

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

- The plan’s overall deductible $0
- Specialist copayment $30
- Hospital (facility) copayment $500
- 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>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Joe would pay is $1,760

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

- The plan’s overall deductible $0
- Specialist copayment $30
- Hospital (facility) copayment $500
- 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>Deductible</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
<tr>
<td>What isn’t covered</td>
<td>$60</td>
</tr>
</tbody>
</table>

The total Mia would pay is $410

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)
(Hmong)

(Japanese)

(Korean)

(Russian)

(Tagalog)

(Vietnamese)

(Thai)

(Vietnamese)