<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>$2,500 individual/ $2,500 individual family member/ $5,000 family for certain medical services per calendar year.</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 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>$5,000 individual/ $5,000 individual family member/ $10,000 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>
</tbody>
</table>
**What is not included in the out-of-pocket limit?**

Premiums, health care this plan doesn’t cover and cost sharing for optional benefit 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>Participating Provider</th>
<th>Non-Participating Provider</th>
<th>Limitations, Exceptions and Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copay per visit <strong>Deductible does not apply</strong></td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 copay per visit <strong>Deductible does not apply</strong></td>
<td>Not covered</td>
<td>Prior authorization for some referrals to specialists is required. If it is not received, you may be responsible for paying all charges.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge <strong>Deductible does not apply</strong></td>
<td>Not covered</td>
<td>You may have to pay for services that aren’t preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.</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>
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</tr>
</thead>
</table>
| If you have a test   | **Diagnostic test** (X-ray, blood work) | Lab: $20 copay per visit  
X-ray: $10 copay per procedure  
Deductible does not apply | 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) | $50 copay per procedure  
Deductible does not apply | | |
| If you need drugs to treat your illness or condition | Tier 1 | Retail: $10 copay per prescription  
Mail-Order: $20 copay per prescription  
Deductible does not apply | 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  
Deductible does not apply | 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  
Deductible does not apply | 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  
Deductible does not apply | Not covered | |

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<table>
<thead>
<tr>
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<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><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>Facility and Professional: 20% coinsurance</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$20 copay per visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance use disorder services (MH/SUD)</strong></td>
<td>Outpatient services</td>
<td>Individual office visit: $20 copay per visit; deductible does not apply</td>
<td>Individual office visit: $20 copay per visit; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group office visit: $10 copay per visit; deductible does not apply</td>
<td>Group office visit: $10 copay per visit; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Other outpatient services: 20% coinsurance</td>
<td>Other outpatient services: 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>Facility and Professional: 20% coinsurance</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Common Medical Event</th>
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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 you are pregnant</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office visits</td>
<td>Prenatal and postnatal care:</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>No charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deductible does not apply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery professional</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<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>Deductible does not apply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$20 copay per visit</td>
<td>Not covered</td>
<td>Quantitative limits exist for the following services:</td>
</tr>
<tr>
<td></td>
<td>Deductible does not apply</td>
<td></td>
<td>Home health care – 100 visits per calendar year.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Skilled nursing care – 100 days per benefit period.</td>
</tr>
<tr>
<td>Skilled nursing care</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>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Deductible does not apply</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
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<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 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>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>Not covered</td>
<td>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
- Routine eye care (Adult) limited to an annual preventive eye exam through VSP; embedded in medical plan.

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

* 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; 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.

* 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.

<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</td>
<td>$2,500</td>
<td>$2,500</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>$20</td>
<td>$20</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>This EXAMPLE event includes services like:</td>
<td>This EXAMPLE event includes services like:</td>
<td>This EXAMPLE event includes services like:</td>
</tr>
<tr>
<td>Specialist office visits (prenatal care)</td>
<td>Primary care physician office visits (including disease education)</td>
<td>Emergency room care (including X-ray)</td>
</tr>
<tr>
<td>Childbirth/Delivery Professional Services</td>
<td>Diagnostic tests (blood work)</td>
<td>Durable medical equipment (crutches)</td>
</tr>
<tr>
<td>Childbirth/Delivery Facility Services (anesthesia)</td>
<td>Prescription drugs (including glucose meter)</td>
<td>Rehabilitation services (physical therapy)</td>
</tr>
<tr>
<td>Diagnostic tests (ultrasounds and blood work)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Example Cost</td>
<td>$12,800</td>
<td>$7,400</td>
</tr>
</tbody>
</table>

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>In this example, Joe would pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td>Copayments</td>
<td>Copayments</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Coinsurance</td>
</tr>
<tr>
<td></td>
<td>What isn’t covered</td>
</tr>
<tr>
<td>Limits or excluded services</td>
<td>Limits or excluded services</td>
</tr>
<tr>
<td></td>
<td>The total Joe would pay is $2,260</td>
</tr>
<tr>
<td>The total Peg would pay is $4,760</td>
<td>$60</td>
</tr>
</tbody>
</table>

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>What isn’t covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td>$2,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or excluded services</td>
<td>$60</td>
</tr>
<tr>
<td>The total Joe would pay is $2,260</td>
<td></td>
</tr>
</tbody>
</table>

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>What isn’t covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td></td>
</tr>
<tr>
<td>Copayments</td>
<td>$2,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or excluded services</td>
<td>$60</td>
</tr>
</tbody>
</table>

What isn’t covered:

- $60 Limits or excluded services

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）

 важно: هل أنت قادر على قراءة هذا؟ إذا لم يكن قادرًا فاعمل أن صندل هيلث بلس (Sutter Health Plus) قد يكون لديهم شخصًا يمكنهم مساعدتك في قراءة هذا النص. كما يمكنك أيضًا أن تتلقى مكتوبًا بإلخ. للحصول على مساعدة مجانية، رجاء الاتصال بخدمات أعضاء صندل هيلث بلس (Sutter Health Plus Member Services) على هاتف 1-855-315-5800 (TTY 1-855-830-3500). (Arabic)

 نکته مهم: ایا می توانید این مطالب را بخوانید و بفهمید؟ اگر نیست، Sutter Health Plus می تواند به عنوان کمک بگیرد. تا انتها پردازی بخوانید. همچنین امکان ترجمه این مطالب به زبان فارسی وجود دارد. برای دریافت خدمات و کمک رایگان، لطفاً با 1-855-315-5800 (TTY 1-855-830-3500) ساتر هالانس ممبر سری سیس که اصلی کارهای تلفن، دفتر خدمات اعضای Sutter Health Plus (Farsi).

 महत्वपूर्ण: क्या आप इसे पढ़ सकते/सकती हैं? यदि नहीं, तो सहूल 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। निश्चित सहायता के लिए, कृपया 1-855-315-5800 (TTY 1-855-830-3500) पर सहूल हेल्थ प्लस मेंबर सर्विस को कॉल करें। (Hindi)

 중요: 귀하의 이것을 읽을 수 있습니까? 만약 읽을 수 없다면, Sutter Health Plus에서 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 무상으로 도움을 받으십시오. (Korean)
