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.

### Important Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$1,000 individual / $1,000 individual family member / $2,000 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><strong>Are there services covered before you meet your deductible?</strong></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><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$6,750 individual / $6,750 individual family member / $13,500 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><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, health care this plan doesn’t cover and cost sharing for most optional benefits 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>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary Care Physician (PCP) Visit to treat an injury or illness</td>
<td>Participating Provider: $30 copay per visit Deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Specialist Visit</td>
<td>Non-Participating Provider: Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive Care / Screening / Immunization</td>
<td>No charge Deductible does not apply</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic Test (X-ray, blood work)</td>
<td>Lab: $30 copay per visit Deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$200 copay per procedure</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Tier 1 (Most generic drugs and low-cost preferred brand name drugs)</td>
<td>Participating Provider: Retail: $5 copay per prescription Mail Order: $10 copay per prescription Deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Tier 2 (Preferred brand name drugs and non-preferred generic drugs)</td>
<td>Participating Provider: Retail: $25 copay per prescription Mail Order: $50 copay per prescription Deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Tier 3 (Non-preferred brand name drugs)</td>
<td>Participating Provider: Retail: $50 copay per prescription Mail Order: $100 copay per prescription Deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Tier 4 (Specialty drugs)</td>
<td>Specialty Pharmacy: 20% coinsurance up to $250 per prescription Deductible does not apply</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility Fee (e.g., ambulatory surgery center)</td>
<td>$500 copay per visit</td>
</tr>
<tr>
<td></td>
<td>Physician / Surgeon Fee</td>
<td>$30 copay per visit</td>
</tr>
</tbody>
</table>

* 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.
<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 need immediate medical attention</td>
<td>Emergency Room Care</td>
<td>Facility: $250 copay per visit&lt;br&gt;Professional: No charge</td>
<td></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>Emergency Medical Transportation</td>
<td>$250 copay per trip</td>
<td></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>$30 copay per visit&lt;br&gt;Deductible does not apply</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility Fee (e.g., hospital room)</td>
<td>$500 copay per day up to a maximum of 5 days 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: $30 copay per visit; deductible does not apply&lt;br&gt;Group Office Visit: $15 copay per visit; deductible does not apply&lt;br&gt;Other Outpatient Services: $30 copay per visit</td>
<td>Not covered</td>
<td>You may self-refer to a USBHPC provider for Office Visits. 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>Inpatient Services</td>
<td>Facility: $500 copay per day up to a maximum of 5 days per admission&lt;br&gt;Professional: No charge</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 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><strong>If you are pregnant</strong></td>
<td>Office Visits</td>
<td>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>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth / Delivery Services</td>
<td>$500 copay per day up to a maximum of 5 days per admission</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home Health Care</td>
<td>$30 copay per visit Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation Services</td>
<td>$30 copay per visit Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation Services</td>
<td>$30 copay per visit Deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled Nursing Care</td>
<td>$225 copay per day up to a maximum of 5 days per admission</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable Medical Equipment</td>
<td>20% coinsurance</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>

* 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>
</table>
| If your child needs dental or eye care | Children's Eye Exam | Participating Provider: No charge 
Deductible does not apply | Non-Participating Provider: Not covered | Quantitative limits exist for the following children’s services: 
Eye Exam – 1 preventive exam per year. 
Glasses – 1 pair of glasses (or contact lenses in lieu of glasses) per year. 
Dental Check-up – preventive prophylaxis and diagnostic oral evaluation limited to 1 per 6 months. 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. |
| | Children’s Glasses | Participating Provider: No charge 
Deductible does not apply | Non-Participating Provider: Not covered |
| | Children’s Dental Check-up | Participating Provider: No charge 
Deductible does not apply | Non-Participating Provider: Not covered |

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.)

- 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 Evidence of Coverage (EOC) at [www.sutterhealthplus.org/about/plans-benefits](http://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.

* 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.
### 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**: $1,000
- **Specialist copayment**: $50
- **Hospital (facility) copayment**: $500
- **Other coinsurance**: 20%

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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible(s)</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$600</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or excluded services</td>
<td>$60</td>
</tr>
</tbody>
</table>

**The total Peg would pay is**: $1,660

---

### Managing Joe’s Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible**: $1,000
- **Specialist copayment**: $50
- **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**: $5,600

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible(s)</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,200</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or excluded services</td>
<td>$20</td>
</tr>
</tbody>
</table>

**The total Joe would pay is**: $1,220

---

### Mia’s Simple Fracture

(in-network emergency room visit and follow-up care)

- **The plan’s overall deductible**: $1,000
- **Specialist copayment**: $50
- **Hospital (facility) copayment**: $500
- **Other coinsurance**: 20%

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></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible(s)</td>
<td>$1,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$500</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$50</td>
</tr>
<tr>
<td><strong>What isn’t covered</strong></td>
<td></td>
</tr>
<tr>
<td>Limits or excluded services</td>
<td>$20</td>
</tr>
</tbody>
</table>

**The total Mia would pay is**: $1,550

---

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)

ملحوظة مهمة: هل أنت قادر على قراءة هذا؟ إذا لم تكن قادرًا فاعلم أن صتر هيلث بلس (Sutter Health Plus) قد يكون لديهم شخصًا يمكنه مساعدتك في قراءة هذا النص. كما يمكنك أيضًا أن تتلقى مكتوبًا بلغتك. للحصول على مساعدة مالية، ترجاء الاتصال بخدمات أعضاء صتر هيلث بلاس (Sutter Health Plus Member Services) على هاتف 1-855-315-5800 (TTY 1-855-830-3500). (Arabic)

ԿԱՐԵՎՈՐ ՏԵՂԵԿԱՏ ՎՈՒԹՅՈՒՆ. Կարո՞ղ եք կարդալ այս նույնաբարանում? Եթե ոչ, Sutter Health Plus կարող է տրամադրել մեկին, ով կօգնի Ձեզ կարդալ այն։ Դուք կարող եք նաև ստանալ այն գրված Ձեր լեզվով։ Անվճար օգնության համար խնդրում ենք զանգահարել Sutter Health Plus-ի Անդամների սպասարկման բաժին՝ 1-855-315-5800 (TTY 1-855-830-3500) հեռախոսահամարով։ (Armenian)

توخطق مہم: آیا میں اسے پڑھ سکتا/سکتی ہوں؟ اگر نہیں، تو Sutter Health Plus میں کسی سے آپکی سہاہرک کرنا توانائی ہے۔ آپ اسے اپنی بیانیہ میں یہ کسی سے آپکی سہاہرک کرنا توانائی ہے۔ اگر نہیں تو سدر هلث پلس (Sutter Health Plus) کے لئے 1-855-315-5800 (TTY 1-855-830-3500) پر سفارش کریں۔ (Hindi)

(Japanese)

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。

(Korean)


(Punjabi)

BAJHKHO: 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)
