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, visit sutterhealthplus.org or call 1-855-315-5800. 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 sutterhealthplus.org or call 1-855-315-5800 to request a copy.

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 medical 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/.
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?	**$1,500** individual/ **$1,500** individual family member/ **$3,000** 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 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider	Non-participating Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	Not covered	None
	Specialist visit	$20 copay per visit	Not covered	Prior authorization for some referrals to specialists is required. If it is not received, you may be responsible for paying all charges.
	Preventive care/screening/ immunization	No charge	Not covered	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.
If you have a test	Diagnostic test (X-ray, blood work)	Lab: $20 copay per visit X-ray: $20 copay per procedure	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	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider	Non-participating Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage, including the Sutter Health Plus Formulary, is available at mp.medimpact.com/STH or call 1-844-282-5330.	Tier 1 (most generic drugs and low-cost preferred brands)	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. FDA-approved, self-administered hormonal contraceptives are available for up to a 12-month supply. Sexual dysfunction drugs have 50% cost sharing and some are limited to 8 doses per 30-day supply. Some drugs have process requirements, such as prior authorization, or limitations for coverage, such as a quantity limit. Please refer to the Sutter Health Plus Formulary for details.
	Tier 2 (preferred brand name and non-preferred generic drugs)	Retail: $30 copay per prescription Mail Order: $60 copay per prescription	Not covered	
	Tier 3 (non-preferred brand drugs)	Retail: $60 copay per prescription Mail Order: $120 copay per prescription	Not covered	
	Tier 4 (specialty drugs, some self-administered or bioengineered drugs)	Specialty Pharmacy: 20% coinsurance up to $100 per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	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	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider	Non-participating Provider	
If you need immediate medical attention	Emergency room care	Facility: $50 copay per visit Professional: No charge		Does not apply if admitted for hospitalization for covered services.
	Emergency medical transportation	$50 copay per trip		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.
	Urgent care	$20 copay per visit		None
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	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 services (MH/SUD) More information about US Behavioral Health Plan, California is available at liveandworkwell.com or call 1-855-202-0984.	Outpatient services	Individual office visit: $20 copay per visit Group office visit: $10 copay per visit Other outpatient services: No charge	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 and Professional: No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider	Non-participating Provider	
If you are pregnant	Office visits	Prenatal and postnatal care: No charge	Not covered	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.
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	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. Hospice services – respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time.
	Rehabilitation services	$20 copay per visit	Not covered	
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	$100 copay per day up to 5 days	Not covered	
	Durable medical equipment	20% coinsurance	Not covered	
	Hospice services	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider	Non-participating Provider	
If your child needs dental or eye care Provided through the end of the month in which the member turns 19 years of age.	Children's eye exam	No charge	Up to $45 max reimbursement	1 preventive exam per year. Offered through Vision Service Plan (VSP).
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

- Commercial weight loss programs
- Cosmetic surgery
- Dental care (Adult)
- Dental care (Child)
- 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 provided as an optional benefit through ACN Group of California for medically necessary services. This optional benefit is in addition to acupuncture embedded in the medical plan that is typically provided only for the treatment of nausea or chronic pain where a primary care physician referral is required.
- Bariatric surgery
- Chiropractic care provided as an optional benefit through ACN Group of California for medically necessary services.
- 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 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:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-315-5800.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-315-5800.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-855-315-5800.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-315-5800.

——————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 (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	**$20**
Hospital (facility) copayment	**$0**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services*(anesthesia)*
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductible	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or excluded services	$60
The total Peg would pay is	**$460**

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	**$20**
Hospital (facility) copayment	**$0**
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:

Cost Sharing	
Deductible	$0
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or excluded services	$60
The total Joe would pay is	**$1,560**

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

The plan's overall deductible	**$0**
Specialist copayment	**$20**
Hospital (facility) copayment	**$0**
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:

Cost Sharing	
Deductible	$0
Copayments	$500
Coinsurance	$10
What isn't covered	
Limits or excluded services	$0
The total Mia would pay is	**$510**

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