




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](http://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](http://sutterhealthplus.org) or call 1-855-315-5800 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	<b>\$1,500</b> individual/ <b>\$2,700</b> individual family member/ <b>\$3,000</b> family for certain medical and pharmacy services per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Only <u>preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> (copay) or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	<b>\$3,000</b> individual/ <b>\$3,000</b> individual family member/ <b>\$6,000</b> family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , health care this <u>plan</u> 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 <u>out-of-pocket limit</u> .

<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. For a list of participating <u>providers</u> , go to <a href="http://sutterhealthplus.org">sutterhealthplus.org</a> or call 1-855-315-5800.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 All **copayment** (copay) and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider	Non-participating Provider	
<b>If you visit a health care <u>provider's</u> office or clinic</b>	Primary care visit to treat an injury or illness	\$20 copay per visit	Not covered	None
	<u>Specialist</u> visit	\$20 copay per visit	Not covered	Prior authorization for some <u>referrals</u> to <u>specialists</u> is required. If it is not received, you may be responsible for paying all charges.
	<u>Preventive care/screening/immunization</u>	No charge <u>Deductible</u> does not apply	Not covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (X-ray, blood work)	Lab: \$20 copay per visit X-ray: \$10 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	

\* 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider	Non-participating Provider	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a>, including the Sutter Health Plus (SHP) Formulary, is available at <a href="http://mp.medimpact.com/STH">mp.medimpact.com/STH</a> or call 1-844-282-5330.</p>	Tier 1 (most generic drugs and low-cost preferred brand name drugs)	Retail: \$10 copay per prescription Mail-Order: \$20 copay per prescription	Not covered	<p>Retail: up to a 30-day supply. Mail-Order: up to a 100-day supply. Specialty Pharmacy: up to a 30-day supply.</p> <p>FDA-approved, self-administered hormonal contraceptives are available for up to a 12-month supply.</p> <p>Sexual dysfunction drugs have 50% <u>cost sharing</u> and some are limited to 8 doses per 30-day supply.</p> <p>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.</p>
	Tier 2 (preferred brand name drugs, non-preferred generic drugs and drugs recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost)	Retail: \$30 copay per prescription Mail-Order: \$60 copay per prescription	Not covered	
	Tier 3 (non-preferred brand name drugs or drugs that are recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost)	Retail: \$60 copay per prescription Mail-Order: \$120 copay per prescription	Not covered	
	Tier 4 ( <u>specialty drugs</u> , self-administered drugs that require training or clinical monitoring, drugs that cost SHP more than \$600 net of rebates for a one-month supply or bioengineered drugs)	Specialty Pharmacy: 20% <u>coinsurance</u> up to \$100 per prescription	Not covered	
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	\$20 copay per visit	Not covered	<p>Prior authorization is required. If it is not received, you may be responsible for paying all charges.</p>
	Physician/surgeon fee	No charge	Not covered	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider	Non-participating Provider	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	Facility: \$100 copay per visit Professional: No charge		Does not apply if admitted for <u>hospitalization</u> for covered services.
	<u>Emergency medical transportation</u>	\$100 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.
	<u>Urgent care</u>	\$20 copay per visit		None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$250 copay per day up to a maximum of 5 days 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	
<b>If you need mental health, behavioral health, or substance use disorder services (MH/SUD)</b> More information about US Behavioral Health Plan, California is available at <a href="http://liveandworkwell.com">liveandworkwell.com</a> 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: \$20 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: \$250 copay per day up to a maximum of 5 days per admission Professional: No charge	Not covered	

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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 <u>Deductible</u> does not apply	Not covered	Prenatal and postnatal care includes all prenatal office visits and the first postnatal office visit. Refer to the primary care visit <u>cost sharing</u> for all subsequent postnatal office visits.  None
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	\$250 copay per day up to a maximum of 5 days per admission	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	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: <u>Home health care</u> – 100 visits per calendar year. <u>Skilled nursing care</u> – 100 days per benefit period. <u>Hospice services</u> – respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time.
	<u>Rehabilitation services</u>	\$20 copay per visit	Not covered	
	<u>Habilitation services</u>	Not covered	Not covered	
	<u>Skilled nursing care</u>	\$100 copay per day up to a maximum of 5 days per admission	Not covered	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	
	<u>Hospice services</u>	No charge	Not covered	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider	Non-participating Provider	
<b>If your child needs dental or eye care</b> Provided through the end of the month in which the member turns 19 years of age.	Children's eye exam	No charge <u>Deductible</u> does not apply	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:

<b>Services Your <u>Plan</u> Generally Does NOT Cover</b> (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Commercial weight loss programs</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Dental care (Child)</li> <li>• <u>Habilitation services</u></li> <li>• Hearing aids</li> <li>• Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Private-duty nursing</li> <li>• Routine foot care</li> </ul>

<b>Other Covered Services</b> (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture services typically provided only for the treatment of nausea or chronic pain; embedded in medical plan. A <u>primary care physician</u> referral and prior authorization are required.</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult) limited to an annual preventive eye exam through VSP; embedded in medical plan.</li> </ul>

\* 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](http://dmhc.ca.gov); The U.S. Department of Labor, Employee benefits Security Administration at 1-866-444-3272 or [dol.gov/ebsa](http://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](http://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](http://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](http://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](http://dol.gov/ebsa/healthreform), and the California Department of Insurance at 1-800-927-HELP (4357) or [insurance.ca.gov](http://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](http://healthhelp.ca.gov) | [helpline@dmhc.ca.gov](mailto: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, kwijigo 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 <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductible</u>	\$1,500
<u>Copayments</u>	\$80
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or <u>excluded services</u>	\$60
<b>The total Peg would pay is</b>	<b>\$1,640</b>

### Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs (*including glucose meter*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductible</u>	\$1,500
<u>Copayments</u>	\$1,500
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or <u>excluded services</u>	\$60
<b>The total Joe would pay is</b>	<b>\$3,060</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1,500
■ <u>Specialist copayment</u>	\$20
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (*including X-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductible</u>	\$1,500
<u>Copayments</u>	\$110
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or <u>excluded services</u>	\$0
<b>The total Mia would pay is</b>	<b>\$1,610</b>

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