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 Plan at 1-855-315-5800 or visit sutterhealthplan.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	Answers	Why This Matters:
What is the overall deductible?	**$2,500** individual / **$3,500** individual family member / **$5,000** family for certain medical and pharmacy services per calendar year.	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.
Are there services covered before you meet your deductible?	Yes. Only preventive care is covered before you meet your deductible.	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 www.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?	**$4,000** individual / **$4,000** individual family member / **$8,000** 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 most optional benefits 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. See www.sutterhealthplan.org/provider-search or call 1-855-315-5800 for a list of network providers.	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.

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	
If you visit a health care provider's office or clinic	Primary Care Physician (PCP) Visit to treat an injury or illness	PCP Office Visit: $40 copay per visit Sutter Walk-in Care Visit: $20 copay per visit Telehealth Visit: $20 copay per visit	Not covered	Includes Other Health Professional visits. *See Definitions section in EOC for list of Other Health Professionals.
	Specialist Visit	Specialist Office Visit: $80 copay per visit Telehealth Visit: $40 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 Deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic Test (X-ray, blood work)	Lab: $40 copay per visit X-ray: $15 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	
If you need drugs to treat your illness or condition For information about prescription drug coverage,	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	Retail: covers up to a 30-day supply through a CVS Caremark contracted retail network pharmacy and covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through SHP's CVS Health Retail-90 Network.

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at www.sutterhealthplan.org/about/plans-benefits 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	
including the Sutter Health Plan (SHP) formulary, visit www.sutterhealthplan.org/pharmacy or call CVS Caremark at 1-844-740-0635.	Tier 2 (Preferred brand name drugs and non-preferred generic drugs)	Retail: $30 copay per prescription Mail Order: $60 copay per prescription	Not covered	Mail Order/home delivery service: covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through the CVS Caremark Mail Service Pharmacy. Most specialty drugs are covered up to a 30-day supply through a CVS Caremark contracted specialty pharmacy. Specialty drugs are not exclusive to Tier 4 and, regardless of tier placement, have the same fill requirements. *See SHP formulary or the Outpatient Prescription Drugs, Supplies, Equipment and Supplement section and Exclusions and Limitations section in EOC for any SHP policy requirements such as prior authorization and step therapy, or coverage limitations and exceptions.
	Tier 3 (Non-preferred brand name drugs)	Retail: $75 copay per prescription Mail Order: $150 copay per prescription	Not covered	
	Tier 4 (Specialty drugs, drugs that require special handling, or drugs that cost SHP more than $600 net of rebates)	20% coinsurance up to $250 per prescription	Not covered	
If you have outpatient surgery	Facility Fee (e.g., ambulatory surgery center)	$250 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	
If you need immediate medical attention	Emergency Room Care	Facility: $200 copay per visit Professional: No charge		If admitted to the hospital, Emergency Room Care cost sharing will not apply. See hospital stay information below for applicable cost sharing.
	Emergency Medical Transportation	$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.

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at www.sutterhealthplan.org/about/plans-benefits 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	
	Urgent Care	$80 copay per visit		For in-area Urgent Care, visit your Medical Group's contracted Urgent Care facility. For Out-of-Area Urgent Care, visit the nearest Urgent Care facility. Behavioral health crisis services provided by a 988 center or mobile crisis team, or other providers of behavioral health crisis services is covered in and out-of-network.
If you have a hospital stay	Facility Fee (e.g., hospital room)	$500 copay per day up to a maximum of 5 days per admission	Not covered	Prior authorization may be required. If it is not received, you may be responsible for paying all charges. Services that are part of a CARE agreement or plan approved by a court, or behavioral health crisis services from a 988 center or mobile crisis team or other providers of behavioral health crisis services, are covered in or out-of-network and without prior authorization.
	Physician / Surgeon Fees	No charge	Not covered	
If you need mental health, behavioral health, or substance use disorder (MH/SUD) services For information, call Carelon Behavioral Health of California, Inc (Carelon) at 844-398-0314 or visit carelonbh.com/sutterhealthplan.	Outpatient Services	Individual Office Visit: $40 copay per visit Group Office Visit: $20 copay per visit Telehealth Office Visit: $20 copay per visit Other Outpatient Services: $250 copay per visit	Not covered	You may self-refer to a Carelon provider for Office Visits. Prior authorization is required for Other Outpatient Services and all Inpatient Services by Carelon. If it is not obtained when required, you may be liable for the payment of services or supplies. Services that are part of a CARE agreement or plan approved by a court, or behavioral health crisis services from a 988 center or mobile crisis team or other providers of behavioral health crisis services, are covered in or out-of-network and without prior authorization.
	Inpatient Services	Facility: $500 copay per day up to a maximum of 5 days per admission Professional: No charge	Not covered	

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at www.sutterhealthplan.org/about/plans-benefits 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	
If you are pregnant	Office Visits	Prenatal and Postnatal Care (In-person or telehealth visit): No charge Deductible does not apply	Not covered	Prenatal and Postnatal Care includes all prenatal office visits and the first postnatal office visit. Refer to the PCP Visit cost sharing for all subsequent postnatal office visits. Maternity care may include tests and services described elsewhere in the SBC (e.g., Diagnostic Tests such as ultrasounds and blood work).
	Childbirth / Delivery Professional Services	No charge	Not covered	None
	Childbirth / Delivery Facility Services	$500 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	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. *See Skilled Nursing Facility Care section in EOC for additional information. Hospice Services – respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time.
	Rehabilitation Services	$40 copay per visit	Not covered	
	Habilitation Services	Not covered	Not covered	
	Skilled Nursing Care	$250 copay per day up to a maximum of 5 days per admission	Not covered	
	Durable Medical Equipment	50% coinsurance	Not covered	
	Hospice Services	No charge	Not covered	
If your child needs dental or eye care For more information, contact Vision Services	Children's Eye Exam	No charge Deductible does not apply	Up to $45 max reimbursement	Quantitative limits exist for the following children's services: Eye Exam – 1 preventive exam per calendar year.
	Children's Glasses	Not covered	Not covered	

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at www.sutterhealthplan.org/about/plans-benefits 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	
Plan (VSP) at 1-800-877-7195.	Children's Dental Check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan Evidence of Coverage (EOC) 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
- 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 Evidence of Coverage (EOC).)

- Abortion
- 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
- Infertility treatment (coverage for the diagnosis and treatment of infertility and fertility services) embedded in medical plan. A PCP or OB/GYN referral and prior authorization by your medical group or SHP are required for medically necessary services. *See the Infertility and Fertility Services section of the Your Benefits chapter in your EOC for additional information.
- 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 plan Evidence of Coverage (EOC) at www.sutterhealthplan.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 Plan 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? 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 plan Evidence of Coverage (EOC) at www.sutterhealthplan.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	**$2,500**
Specialist copayment	**$80**
Hospital (facility) copayment	**$500**
Other coinsurance	**50%**

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:

Cost Sharing	
Deductible	$2,500
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or excluded services	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	**$2,500**
Specialist copayment	**$80**
Hospital (facility) copayment	**$500**
Other coinsurance	**50%**

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:

Cost Sharing	
Deductible	$2,500
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or excluded services	$20
The total Joe would pay is	**$3,220**

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

The plan's overall deductible	**$2,500**
Specialist copayment	**$80**
Hospital (facility) copayment	**$500**
Other coinsurance	**50%**

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:

Cost Sharing	
Deductible	$2,500
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or excluded services	$0
The total Mia would pay is	**$2,590**

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

Sutter Health Plan

Notice of Language Assistance

ATTENTION: Sutter Health Plan provides timely, no-cost language assistance. You can ask for interpreter services or materials translated into your language. For help, call Customer Service at 855-315-5800 (TTY 855-830-3500). (English)

ATENCIÓN: Sutter Health Plan ofrece asistencia de idiomas oportuna y gratuita. Puede solicitar los servicios de un intérprete o materiales traducidos al idioma de su preferencia. Si necesita ayuda, llame a los Servicios al Cliente al 855-315-5800 (TTY 855-830-3500). (Spanish)

注意：Sutter Health Plan 會及時提供免費語言協助。您可以要求提供口譯員服務或翻譯成您的語言的資料。如需幫助，撥打客戶服務部電話 855-315-5800 (TTY 855-830-3500)。 (Chinese)

تنبيه: تُقدِّم خطة Sutter Health Plan مُساعدة لغويّة مجانيّة مُلائمة التوقيت. يُمكنكم طلب خدمات ترجمة شفهيّة أو مواد مُترجمة إلى لغتكم. للحصول على مُساعدة، يُرجى الاتصال بخدمة العُملاء على هاتف 855-315-5800 (أو الهاتف النصي للصُمّ [TTY] 855-830-3500). (Arabic)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Sutter Health Plan-ը ժամանակին տրամադրում է անվճար լեզվական աջակցություն: Դուք կարող եք խնդրել բանավոր թարգմանչի ծառայություններ կամ Ձեր լեզվով թարգմանված նյութեր: Օգնության համար դիմեք Հաճախորդների սպասարկման բաժին՝ 855-315-5800 (TTY 855-830-3500) հեռախոսահամարով: (Armenian)

សម្គាល់៖ គម្រោងសុខភាព Sutter Health Plan មានផ្តល់ជូនជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ និងទាន់ពេលវេលា។ លោកអ្នកអាចស្នើសុំសេវាអ្នកបកប្រែភាសាផ្ទាល់មាត់ ឬឯកសារដែលបានបកប្រែជាភាសារបស់លោកអ្នក។ សម្រាប់ជំនួយ សូមទូរសព្ទទៅកាន់ផ្នែកសេវាកម្មអតិថិជន តាមរយៈលេខ 855-315-5800 (TTY 855-830-3500)។ (Khmer)

توجه: طرح سلامت Sutter Health Plan خدمات کمک زبانی را به‌موقع و به‌صورت رایگان ارائه می‌دهد. شما می‌توانید درخواست استفاده از خدمات مترجم شفاهی یا دریافت مطالب ترجمه‌شده به زبان خود را داشته باشید. برای دریافت کمک، با بخش خدمات مشتریان به شماره 855-315-5800 (TTY 855-830-3500) تماس بگیرید. (Farsi)

ध्यान दें: स्टटर हेल्थ प्लान (Sutter Health Plan) के अंतर्गत समय पर, और बिना किसी लागत के भाषा संबंधी सहायता प्रदान की जाती है। आप दुभाषिया सेवाओं या अपनी भाषा में अनुवादित सामग्री के लिए निवेदन कर सकते/सकती हैं। सहायता हेतु, 855-315-5800 (TTY 855-830-3500) पर ग्राहक सेवा को कॉल करें। (Hindi)

LUS CEEB TOOM: Sutter Health Plan muab kev pab txhais txhais lus raws sij hawm thiab tsis tau them nqi. Koj tuaj yeem thov kev pab txhais lus los sis cov ntaub ntawv txhais ua koj hom lus. Yog xav tau kev pab, hu rau Lub Chaw Pab Cuam Qhua ntawm 855-315-5800 (TTY 855-830-3500). (Hmong)

お知らせ：サター・ヘルス・プラン（Sutter Health Plan）では、無料の言語サポートをすぐにご利用いただけます。通訳サービスを依頼したり、資料をご希望の言語に翻訳してもらったりすることができます。お困りのときは、カスタマーサービス 855-315-5800（TTY 855-830-3500）までお電話ください。(Japanese)

알려드립니다: Sutter Health Plan은 신속한 언어 지원 서비스를 무료 제공합니다. 귀하는 통역 서비스나 본인의 언어로 번역된 자료를 요청하실 수 있습니다. 도움이 필요하시면 고객 서비스 센터(855-315-5800, TTY 855-830-3500)로 전화 연락을 바랍니다. (Korean)

ກະລຸນາຮັບຊາບ: Sutter Health Plan ໃຫ້ການຊ່ວຍເຫຼືອດ້ານພາສາທີ່ທັນເວລາ ແລະ ບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍໃດໆ. ທ່ານສາມາດຂໍບໍລິການລ່າມພາສາ ຫຼື ເອກະສານທີ່ແປເປັນພາສາຂອງທ່ານໄດ້. ສຳລັບ ຄວາມຊ່ວຍເຫຼືອ, ກະລຸນາໂທຫາບໍລິການລູກຄ້າທີ່ເບີ 855-315-5800 (TTY 855-830-3500). (Lao)

ਧਿਆਨ ਦਿਓ: ਸੱਟਰ ਹੈਲਥ ਪਲਾਨ ਸਮੇਂ ਸਿਰ, ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਮੁਹੱਈਆ ਕਰਦਾ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਜਾਂ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕੀਤੀ ਸਮੱਗਰੀ ਦੀ ਮੰਗ ਕਰ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ, ਗਾਹਕ ਸੇਵਾ ਨੂੰ 855-315-5800 (TTY 855-830-3500) 'ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ВНИМАНИЕ! Sutter Health Plan предоставляет своевременную бесплатную языковую помощь. Вы можете запросить услуги переводчика или материалы, переведённые на ваш язык. Чтобы получить помощь, позвоните в отдел обслуживания клиентов по телефону 855-315-5800 (TTY 855-830-3500). (Russian)

MAHALAGANG PAALALA: Ang Sutter Health Plan ay nagbibigay ng maagap at walang bayad na tulong sa wika. Maaari kang humiling ng serbisyo ng interpreter o mga materyales na isinalin sa iyong wika. Para humingi ng tulong, tawagan ang Customer Service sa 855-315-5800 (TTY 855-830-3500). (Tagalog)

โปรดทราบ: Sutter Health Plan ให้ความช่วยเหลือด้านภาษาโดยไม่มีค่าใช้จ่ายและไม่ต้องรอนาน คุณสามารถขอรับบริการล่ามหรือขอให้แปลเนื้อหาเป็นภาษาของคุณได้ โดยติดต่อฝ่ายบริการลูกค้าที่ 855-315-5800 (TTY 855-830-3500) เพื่อขอรับความช่วยเหลือ (Thai)

LƯU Ý: Sutter Health Plan cung cấp dịch vụ hỗ trợ ngôn ngữ kịp thời và miễn phí. Quý vị có thể yêu cầu thông dịch viên hoặc tài liệu được dịch sang ngôn ngữ của mình. Để được trợ giúp, vui lòng gọi Dịch Vụ Khách Hàng theo số 855-315-5800 (TTY 855-830-3500). (Vietnamese)