**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at sutterhealthplus.org or by calling 1-855-315-5800.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$0** individual/**$0** individual family member/**$0** family for certain medical services per calendar year. | See the chart starting on page 2 for your costs for services this plan covers. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. **$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 during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Premiums, copayments for optional benefit riders (if elected by your employer group) and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of participating doctors and hospitals, go to sutterhealthplus.org or call 1-855-315-5800. | If you use an **in-network** doctor or other health care **provider**, this **plan** will pay some or all of the costs of covered services. Be aware, your in-network doctor may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred,** or participating for **providers** in their **network.** See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | Yes. Oral approval is required. | The **plan** will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist.** |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this **plan** doesn't cover are listed on page 4. See your plan document for additional information about **excluded services**. |

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **in-network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $15 per visit | Not covered | ---None--- |
| | Specialist visit | $15 per visit | Not covered | ---None--- |
| | Other practitioner office visit | $15 per visit | Not covered | ---None--- |
| | Preventive care/screening/immunization | No charge | Not covered | ---None--- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge | Not covered | ---None--- |
| | Imaging (CT/PET scans, MRIs) | $15 per procedure | Not covered | ---None--- |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at optumrx.com or call 1-888-574-7417 | Tier 1 | **Retail**: $10 copay<br>**Mail Order**: $20 copay | Not covered | **Retail:** 30-day supply<br>**Mail Order:** 90-day supply |
| | Tier 2 | **Retail**: $20 copay<br>**Mail Order**: $40 copay | Not covered | **Retail:** 30-day supply<br>**Mail Order:** 90-day supply |
| | Tier 3 | **Retail:** $35 copay<br>**Mail Order**: $70 copay | Not covered | **Retail:** 30-day supply<br>**Mail Order:** 90-day supply |
| | Tier 4 | **Retail:** 20% coinsurance up to $100 per prescription<br>**Mail Order**: 20% coinsurance up to $100 per prescription | Not covered | **Retail:** 30-day supply<br>**Mail Order:** 30-day supply. Sexual dysfunction medications have a 50% cost share and some are limited to 8 doses per 30-day supply. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $15 per visit | Not covered | ---None--- |
| | Physician/surgeon fees | No charge | Not covered | ---None--- |
| **If you need immediate medical attention** | Emergency room services | Facility: $35 per visit<br>Professional: No charge | Facility: $35 per visit<br>Professional: No charge | Does not apply if admitted directly to the hospital as an inpatient for covered services. |
| | Emergency medical transportation | No charge | No charge | ---None--- |
| | Urgent care | $15 per visit | $15 per visit | ---None--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | No charge | Not covered | ---None--- |
| | Physician/surgeon fee | No charge | Not covered | ---None--- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Office Visit: $15 (individual); $7 (group)<br>Other Outpatient: No charge | Not covered | ---None--- |
| | Mental/Behavioral health inpatient services | Facility and Professional: No charge | Not covered | ---None--- |
| | Substance use disorder outpatient services | Office Visit: $15 (individual); $5 (group)<br>Other Outpatient: No charge | Not covered | ---None--- |
| | Substance use disorder inpatient services | Facility and Professional: No charge | Not covered | ---None--- |
| **If you are pregnant** | Prenatal and postnatal care | Prenatal: No charge<br>Postnatal care: No charge | Not covered | ---None--- |
| | Delivery and all inpatient services | Facility and Professional: No charge | Not covered | ---None--- |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | No charge | Not covered | 100 visits per calendar year. |
| | Rehabilitation services | $15 per visit | Not covered | ---None--- |
| | Habilitation services | $15 per visit | Not covered | ---None--- |
| | Skilled nursing care | No charge | Not covered | 100 days per benefit period. |
| | Durable medical equipment | No charge | Not covered | ---None--- |
| | Hospice service | No charge | Not covered | ---None--- |
| **If your child needs dental or eye care** | Eye exam | No charge | Up to $45 max reimbursement | ---None--- |
| | Glasses | Not covered | Not covered | ---None--- |
| | Dental check-up | Not covered | Not covered | ---None--- |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture*

* Offered as rider, in addition to core medical benefit through ACN Group of California

- Bariatric surgery
- Chiropractic care**

** Offered as rider, separate from core medical benefit plan through ACN Group of California

- Infertility services***
- Routine eye exam

*** Offered as rider, separate from core medical benefit plan

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your right to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-855-315-5800. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 EXT 61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Sutter Health Plus at 1-855-315-5800 or TTY/TDD: 1-855 830 3500 or visit www.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 www.dol.gov/ebsa/healthreform, and the California Department of Insurance at 1-800-927-HELP (4357) or www.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
(888) 466-2219 or TTY/TDD: 1-877-688-9891 | http://www.healthhelp.ca.gov | helpline@dmhc.ca.gov

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## 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 page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,360
- **Patient pays** $180

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $30 |
| Coinsurance | $0 |
| Limits or exclusions | $150 |
| **Total** | **$180** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,770
- **Patient pays** $630

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Copays | $550 |
| Coinsurance | $0 |
| Limits or exclusions | $80 |
| **Total** | **$630** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.