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 com
at 1-855-315-5800 or 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
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?	$0 individual / $0 individual family member $0 family per calendar year.	See the Common Medical Events chart below for your
Are there services covered before you meet your deductible?	Yes. There is no deductible for covered services.	You don't have to meet deductibles for covered items and services. But a copayment or coinsurance may apply. This plan covers some preventive services without cost-sharing. See a list of covered preventive services at www.healthcare.gov/coverage/pre
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?	$1,000 individual / $1,000 individual family member $2,000 family per calendar year.	The out-of-pocket limit is the most you could pay in a year for c family members in a family plan have to meet their own out-of-pocket limits until the ove family out-of-pocket limit has been met.

What is not included in the

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Information
		Participating Provider	Non-Participating Provider	
	Primary Care (PCP) Visit to injury or illne	PCP Office Visit: $10		

* For more information about limitations and exceptions, see the plan or policy document at www.healthplus.org/about/p-1855-3

* For more information about limitations and exceptions, see

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
	Physician / Surgeon Fees	No charge	Not cove	paying all charges.
If you need me health, behavi or substance u disorder (MH/S services For informatio Behavioral Health Plan, California (USBHPC) at 1-855-202-0984 or visit www.liveandworkwell.com (access code: Sutter).	Outpatient Se	Individual Office copay per visit Group Office Visit copay per visit Telehealth Office copay per visit Other Outpatient S charge	Not cove	You may self-refer to a USBH provider for Office Visits. Prior authorization is require Services and all Inpatient Se it is not obtained when requir liable for the payment of serv
	Inpatient Services	Facility charge No Professional charge No	Not cove	
If you are preg	Office Visits	Prenatal and Postn (In-person or tele No charge	Not cove	Prenatal and Postnatal Care i office visits and the first pos to the PCP Visit. CS for all subsequ postnatal office visits. Maternity care may include te described elsewhere. The SB Diagnostic Tests such as ultrasounds and b
	Childbirth / Delivery Professional Services	No charge	Not cove	None
	Childbirth / D Facility Servi	No charge	Not cove	
	Home Health Care	No charge	Not covered	Prior authorization is require you may be responsible for pa Quantitative limits exist for t Home Health Care 100 visits per cal
	Rehabilitatio	No charge	Not covered	

* For more information about limitations and exceptions, see the plan or policy document at www.suttersealthplus.org/about/plans-3 or call 1-855-3

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health needs	Habilitation Services	Not covered	Not covered	
	Skilled Nursing Care	No charge	Not covered	Skilled Nursing Care: 100 days per benefit period. *See Skilled Nursing in EOC for additional information.
	Durable Medical Equipment	No charge	Not covered	Hospice Services: respite care is occasional short-term inpatient care limited to five consecutive days at a time.
	Hospice Services	No charge	Not covered	
If your child needs dental or eye care	Children's Eye Exam	No charge	No 2052b27 m 10el S 0 g 0 G 3220ET 0 G 4Q27 Tj 4 w 668	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Check your plan Evidence of Coverage (EOC).)

- Abortion
- Acupuncture typically provided only for the treatment of nausea or chronic pain; limited, medically necessary; PCP referral and prior authorization required.
- Bariatric surgery
- Chiropractic care provided as an optional benefit through ACN Group of California (ACN) for medically necessary services; separate from medical plan. See the ACN Schedule of Benefits for additional information.
- Infertility treatment offered as an optional benefit through SHP. A PCP referral or OB/GYN and prior authorization by your medical group or SHP are required for medically necessary services. See the Infertility Services Benefit Rider for

* For more information about limitations and exceptions, see the plan Evidence of Coverage (EOC) at www.sutterhealthplus.org/about/plans or call 1-855-3

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your covera
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
267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including bu
Health Insurance Marketplace, or Covered California, at www.coveredca.com or 1-800-300-1506. For more information about the Marketplace, visit www.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
grievance (*See If You Have A Concern Or Dispute With SHP section in EOC for information abo appeal. For more information abo

To see examples of how this plan might cover costs for a sample medical situation, see th

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 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-onl

Peg is Having a B
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible $0
- Specialist copayment $10
- Hospital (facility) copayment $0
- Other coinsurance N/A

This EXAMPLE event includes services like:
Office Visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic Tests (ultrasounds and blood work)

Total Example Cost	$12,7

In this example, Peg would pay:

Cost Sharing	
Deductible	$0
Copayments	$50
Coinsurance	$0
What isn't covered	
Limits or exclusions services	$60
The total Peg would	$11

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

- The plan's overall deductible $0
- Specialist copayment $10
- Hospital (facility) copayment $0
- Other coinsurance N/A

This EXAMPLE event includes services like:
Primary Care Physician office visits (including disease education)
Diagnostic Tests (blood work)
Prescription Drugs (including glucose

Total Example Cost	$5,6

In this example, Joe would pay:

Cost Sharing	
Deductible	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions services	$20
The total Joe would	$92

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

- The plan's overall deductible $0
- Specialist copayment $10
- Hospital (facility) copayment $0
- Other coinsurance N/A

This EXAMPLE event includes services like:
Emergency Room Care (including medical supplies)
Diagnostic Test (X-rays)
Durable Medical Equipment (crutches)
Rehabilitation Services (physical therapy)

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductible	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions services	$0
The total Mia would	$100

The plan