

HEALTH PLAN BENEFITS AND COVERAGE MATRIX

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

**BENEFIT PLAN NAME: Vista HD18 HDHP HMO
 HEALTH SAVINGS ACCOUNT (HSA)-COMPATIBLE PLAN**

| Annual Deductible for Certain Medical Services (Combined Medical and Pharmacy) | |
|---|---------|
| For self-only enrollment (a Family of one Member) | \$2,500 |
| For any one Member in a Family of two or more Members | \$2,800 |
| For an entire Family of two or more Members | \$5,000 |

| Separate Annual Deductible for Prescription Drugs | |
|--|------|
| For self-only enrollment (a Family of one Member) | None |
| For any one Member in a Family of two or more Members | None |
| For an entire Family of two or more Members | None |

| Annual Out-of-Pocket Maximum (OOPM) (Combined Medical and Pharmacy) | |
|--|---------|
| You will not pay any more Cost Sharing if the amount you paid for Copayments, Coinsurance and Deductibles for Covered Services in a calendar year totals one of the following amounts: | |
| For self-only enrollment (a Family of one Member) | \$4,000 |
| For any one Member in a Family of two or more Members | \$4,000 |
| For an entire Family of two or more Members | \$8,000 |

| Lifetime Maximum | |
|--------------------------|------|
| Lifetime benefit maximum | None |

| Benefits | Member Cost Sharing |
|---|----------------------------------|
| Preventive Care Services | |
| Annual eye exam for refraction | No charge |
| Family planning counseling and services, including preconception care visits (see Endnotes) | No charge |
| Immunizations/vaccines | No charge |
| Routine preventive medical exams, procedures and screenings (e.g., hearing exams, colorectal cancer screenings, well-child exams and well-woman exams) | No charge |
| Routine preventive imaging and laboratory services | No charge |
| Preventive care drugs, supplies, equipment and supplements (refer to the Sutter Health Plus Formulary for a complete list) | No charge |
| Outpatient Services | |
| Primary Care Physician (PCP) office visit to treat an injury or illness | 20% coinsurance after deductible |
| Other practitioner office visit (see Endnotes) | 20% coinsurance after deductible |
| Acupuncture services (see Endnotes) | 20% coinsurance after deductible |
| Sutter Walk-in Care visit, where available | 20% coinsurance after deductible |
| Specialist office visit | 20% coinsurance after deductible |
| <p>Allergy services provided as part of a Specialist visit (includes testing, injections and serum)</p> <p>There is no Cost Sharing after the Deductible for serum billed separately from the Specialist office visit or for allergy injections that are provided when the Specialist is not seen and no other services are received.</p> | 20% coinsurance after deductible |
| Medically administered drugs dispensed to a Participating Provider for administration | No charge after deductible |
| Outpatient rehabilitation services | 20% coinsurance after deductible |

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| Outpatient habilitation services | Not covered |
| Outpatient surgery facility fee | 20% coinsurance after deductible |
| Outpatient surgery Professional fee | 20% coinsurance after deductible |
| Outpatient visit (non-office visit, see Endnotes) | 20% coinsurance after deductible |
| Non-preventive laboratory services | 20% coinsurance after deductible |
| Radiological and nuclear imaging (e.g., MRI, CT and PET scans) | 20% coinsurance after deductible |
| Diagnostic and therapeutic imaging and testing (e.g., X-ray, mammogram, ultrasound, EKG/ECG, cardiac stress test and cardiac monitoring) | 20% coinsurance after deductible |
| Hospitalization Services | |
| Inpatient facility fee (e.g., hospital room, medical supplies and inpatient drugs including anesthesia) | 20% coinsurance after deductible |
| Inpatient Professional fees (e.g., surgeon and anesthesiologist) | 20% coinsurance after deductible |
| Emergency and Urgent Care Services | |
| Emergency room facility fee | 20% coinsurance after deductible |
| Emergency room Professional fee | 20% coinsurance after deductible |
| This emergency room Cost Sharing does not apply if admitted directly to the hospital as an inpatient for Covered Services. If admitted directly to the hospital for an inpatient stay, the Cost Sharing for "Hospitalization Services" will apply. | |
| Urgent Care consultations, exams and treatment | 20% coinsurance after deductible |
| Ambulance Services | |
| Medical transportation (including emergency and non-emergency) | No charge after deductible |

| Prescription Drugs, Supplies, Equipment and Supplements | |
|---|--|
| Covered outpatient items obtained at a Participating Pharmacy through retail, mail order or Specialty Pharmacy services and in accordance with our drug formulary guidelines: | |
| Tier 1 - Most Generic Drugs and low-cost preferred brand name drugs | <u>Retail</u> : \$10 copay per prescription after deductible for up to a 30-day supply <u>Mail order</u> : \$20 copay per prescription after deductible for up to a 100-day supply |
| Tier 2 - Preferred brand name drugs, non-preferred Generic Drugs and drugs recommended by Sutter Health Plus's (SHP) pharmacy and therapeutics committee based on drug safety, efficacy and cost | <u>Retail</u> : \$30 copay per prescription after deductible for up to a 30-day supply <u>Mail order</u> : \$60 copay per prescription after deductible for up to a 100-day supply |
| 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 <i>(These generally have a preferred and often less costly therapeutic alternative at a lower tier)</i> | <u>Retail</u> : \$60 copay per prescription after deductible for up to a 30-day supply <u>Mail order</u> : \$120 copay per prescription after deductible for up to a 100-day supply |
| Tier 4 - Drugs that are biologics, drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply | <u>Specialty Pharmacy</u> : 20% coinsurance up to \$100 per prescription after deductible for up to a 30-day supply |
| Durable Medical Equipment | |
| Durable medical equipment | 20% coinsurance after deductible |
| Mental/Behavioral Health & Substance Use Disorder (MH/SUD) Treatment Services | |
| MH/SUD inpatient facility fee (see Endnotes) | 20% coinsurance after deductible |
| MH/SUD inpatient Professional fees (see Endnotes) | 20% coinsurance after deductible |
| MH/SUD individual outpatient office visits (e.g., evaluation and treatment services) | 20% coinsurance after deductible |

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|---|----------------------------------|
| MH/SUD group outpatient office visits (e.g., evaluation and treatment services) | 20% coinsurance after deductible |
| MH/SUD other outpatient services (see Endnotes) | 20% coinsurance after deductible |
| Home Health Services | |
| Home health care (up to 100 visits per calendar year) | No charge after deductible |
| Maternity Care | |
| Routine prenatal care visits, after confirmation of pregnancy, and the first postnatal care visit | No charge |
| Maternity care provided at office visits or other outpatient locations may include diagnostic tests and services described elsewhere in this BCM that result in Cost Sharing (e.g., see “Diagnostic and therapeutic imaging and testing” for ultrasounds and “Non-preventive laboratory services” for lab tests). | |
| Breastfeeding counseling, services and supplies (e.g., electronic or manual breast pump) | No charge |
| Labor and delivery inpatient facility fee (e.g., anesthesia and delivery services for all inpatient childbirth methods) | 20% coinsurance after deductible |
| Labor and delivery inpatient Professional fees (e.g., anesthesiologist, nurse midwife and obstetrician) | 20% coinsurance after deductible |
| Other Services | |
| Skilled Nursing Facility services (up to 100 days per benefit period) | 20% coinsurance after deductible |
| Ostomy and urological supplies; prosthetic and orthotic devices | No charge after deductible |
| Hospice care | No charge after deductible |

Endnotes:

1. Except for optional benefits, if elected, Deductibles and other Cost Sharing payments made by each Member in a Family contribute to the “entire Family of two or more Members” Deductible and Out-of-Pocket Maximum (OOPM). Each Family Member is responsible for the “one Member in a Family of two or more Members” Deductible and OOPM until the Family as a whole meets the “entire Family of two or more Members” Deductible and OOPM. Once the Family as a whole meets the “entire Family of two or more Members” OOPM, the plan pays all costs for Covered Services for all Family Members.

For HDHPs, in a Family plan, an individual Family Member's "any one member in a Family of two or more Members" Deductible, if required, must be the higher of the specified "self-only enrollment" Deductible amount or the IRS minimum of \$2,800 for plan year 2021. Once an individual Family Member's "any one member in a Family of two or more Members" Deductible is satisfied, that Member will only be responsible for the Cost Sharing listed for each service. Other Family Members will be required to continue to contribute to the "any one member in a Family of two or more Members" Deductible until the "entire Family of two or more Members" Deductible is met. In a Family plan, an individual Family Member's out-of-pocket contribution is limited to the "any one Member in a Family of two or more Members" annual OOPM amount.

2. Cost Sharing for all Essential Health Benefits, including that which accumulates toward an applicable Deductible, accumulates toward the OOPM.
3. a) Copayments apply per prescription for up to a 30-day supply of prescribed and Medically Necessary generic or brand-name drugs in accordance with formulary guidelines. All Medically Necessary prescription drug Cost Sharing contributes toward the annual Deductible and OOPM.
b) Member Cost Sharing for orally administered anticancer drugs shall not exceed \$250 per prescription for up to a 30-day supply. Members may have a Cost Sharing maximum equal to or lower than \$250 as the applicable maximum for oral anticancer drugs is determined by each plan's prescription drug benefits. Orally administered anticancer drugs follow applicable tier-based Cost Sharing. Refer to the Prescription Drugs, Supplies, Equipment and Supplements section of this matrix for Cost Sharing details. For High Deductible Health Plans (HDHPs), oral anticancer drugs on any tier are subject to the annual Deductible and the Cost Sharing maximum will not apply until after the Deductible is met.
c) FDA-approved, self-administered hormonal contraceptives that are dispensed at one time for a Member by a provider, pharmacist or other location licensed or authorized to dispense drugs or supplies, may be covered at up to a 12-month supply. Cost Sharing for a 12-month supply of contraceptives, when applicable, will be 12 times the retail cost or four times the mail order cost.
d) Except for Specialty Drugs, up to a 100-day supply is available, at twice the 30-day Copayment price, through the mail order pharmacy. Specialty Drugs are available for up to a 30-day supply through the Specialty Pharmacy.
e) Some drugs prescribed for sexual dysfunction, such as Cialis, Levitra or Viagra (or the generic equivalent, if available) are limited to 8 doses per 30-day supply.
f) Upon request from a Member or prescriber, a pharmacist may, but is not required to, dispense a partial fill of a prescription for an oral, solid dosage form of a Schedule II controlled substance in accordance with Section 4052.10 of the California Business and Professions Code. The Cost Sharing for a partial fill of a prescription will be prorated.
4. Other practitioner office visits include therapy visits and other office visits not provided by either PCPs or Specialists or visits not specified in another benefit category.


5. The family planning counseling and services benefit does not include termination of pregnancy or male sterilization procedures, which are covered under the “Outpatient Care” section of the “Your Benefits” chapter in the *Evidence of Coverage and Disclosure Form* (EOC) and included in the Cost Sharing for the outpatient surgery services listed above.
6. Acupuncture is typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain. Chiropractic services are not covered as part of the SHP medical plan.
7. The outpatient visit (non-office visit) category includes, but is not limited to, services such as outpatient chemotherapy, outpatient dialysis, outpatient radiation therapy, outpatient infusion therapy, sleep studies and similar outpatient services performed in a non-office setting. This category also includes storage of cryopreserved reproductive materials included in the fertility preservation services benefit. Storage of cryopreserved materials is not a per visit service and is typically billed on an annual basis at the outpatient visit (non-office visit) Cost Sharing.
8. Inpatient MH/SUD services include, but are not limited to: inpatient psychiatric hospitalization; inpatient chemical dependency hospitalization, including detoxification; mental health psychiatric observation; mental health residential treatment; Substance Use Disorder Transitional Residential Recovery Services in a non-medical residential recovery setting; Substance Use Disorder Treatment for Withdrawal; inpatient Behavioral Health Treatment for Pervasive Developmental Disorder (PDD) and autism.
9. MH/SUD other outpatient services include, but are not limited to: mental health psychological testing; day treatment such as partial hospitalization and intensive outpatient program; outpatient psychiatric observation for acute psychiatric crisis; outpatient Behavioral Health Treatment for Pervasive Developmental Disorder and autism delivered at home; and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
10. Cost Sharing for services with Copayments is the lesser of the Copayment amount or allowed amount.
11. In order to be covered, most services require a referral from your PCP and many also require Prior Authorization by your PCP’s medical group. Please consult the complete EOC for additional information on referral and Prior Authorization requirements.
12. The deductible will be waived for drugs and services listed in the Internal Revenue Service Notice 2019-45 for the specified diagnoses. Applicable Copayments or Coinsurance will apply. Refer to [irs.gov/pub/irs-drop/n-19-45.pdf](https://www.irs.gov/pub/irs-drop/n-19-45.pdf) for details.
13. For 2021, this benefit plan provides eligible Medicare beneficiaries with prescription drug coverage that is expected to pay on average as much as the standard Medicare Part D coverage in accordance with Centers for Medicare and Medicaid Services. The coverage is at least as good as the Medicare drug benefit and therefore considered “creditable coverage”. Refer to [Medicare.gov](https://www.Medicare.gov) for complete details.



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 Plus at 1-855-315-5800 or visit 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 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 <u>deductible</u> ? | \$2,500 individual / \$2,800 individual family member / \$5,000 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 <u>plan</u> 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> . |
| Are there services covered before you meet your <u>deductible</u> ? | Yes. Only <u>preventive care</u> is 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 www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ? | \$4,000 individual / \$4,000 individual family member / \$8,000 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. |
| What is not included in the <u>out-of-pocket limit</u> ? | <u>Premiums</u> and health care this <u>plan</u> doesn't cover. | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> . |

| | | |
|--|---|---|
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.sutterhealthplus.org/provider-search or call 1-855-315-5800 for a list of <u>network providers</u> . | 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. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ? | 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 | |
| If you visit a health care <u>provider's</u> office or clinic | <u>Primary Care Physician</u> (PCP) Visit to treat an injury or illness | 20% <u>coinsurance</u> | Not covered | Includes Other Health Professional and Sutter Walk-in Care visits. *See Definitions section in EOC for list of Other Health Professionals. |
| | <u>Specialist</u> Visit | 20% <u>coinsurance</u> | 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</u> / <u>Screening</u> / Immunization | No charge <u>Deductible</u> does not apply | Not covered | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic Test</u> (X-ray, blood work) | 20% <u>coinsurance</u> | 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) | 20% <u>coinsurance</u> | Not covered | |

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at www.sutterhealthplus.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 need drugs to treat your illness or condition For information about prescription drug coverage , including the Sutter Health Plus (SHP) Formulary , visit www.sutterhealthplus.org/pharmacy or call Express Scripts at 1-877-787-8661. | 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 Pharmacy: covers up to a 30-day supply. A participating retail pharmacy in the Smart90 Program covers up to a 90-day supply of maintenance drugs at three times the retail <u>cost sharing</u> . Mail Order/home delivery service: covers up to a 100-day supply of maintenance drugs at two times the retail <u>cost sharing</u> . |
| | Tier 2 (Preferred brand name drugs and non-preferred generic drugs) | Retail: \$30 copay per prescription Mail Order: \$60 copay per prescription | Not covered | Specialty Pharmacy: covers up to a 30-day supply of <u>specialty drugs</u> provided through Accredo. |
| | Tier 3 (Non-preferred brand name drugs) | Retail: \$60 copay per prescription Mail Order: \$120 copay per prescription | Not covered | FDA-approved, self-administered hormonal contraceptives are available for up to a 12-month supply. |
| | Tier 4 (<u>Specialty drugs</u>) | Specialty Pharmacy: 20% <u>coinsurance</u> up to \$100 per prescription | Not covered | *See SHP Formulary or the Outpatient Prescription Drugs, Supplies, Equipment and Supplement section in EOC for any SHP policy requirements such as prior authorization and step therapy, or coverage limitations and exceptions. |
| If you have outpatient surgery | Facility Fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | Not covered | Prior authorization is required. If it is not received, you may be responsible for paying all charges. |
| | Physician / Surgeon Fee | 20% <u>coinsurance</u> | Not covered | |

* For more information about limitations and exceptions, see [plan Evidence of Coverage \(EOC\)](#) at www.sutterhealthplus.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 need immediate medical attention | <u>Emergency Room Care</u> | Facility: 20% <u>coinsurance</u> Professional: 20% <u>coinsurance</u> | | If admitted to the hospital, <u>Emergency Room Care cost sharing</u> will not apply. See hospital stay information below for applicable <u>cost sharing</u> . |
| | <u>Emergency Medical Transportation</u> | No charge | | 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% <u>coinsurance</u> | | None |
| If you have a hospital stay | Facility Fee (e.g., hospital room) | 20% <u>coinsurance</u> | Not covered | Prior authorization is required. If it is not received, you may be responsible for paying all charges. |
| | Physician / Surgeon fees | 20% <u>coinsurance</u> | Not covered | |
| If you need mental health, behavioral health, or substance use disorder (MH/SUD) services For information, call U.S. Behavioral Health Plan, California (USBHPC) at 1-855-202-0984 or visit www.liveandworkwell.com (access code: "Sutter"). | Outpatient Services | Individual Office Visit: 20% <u>coinsurance</u> Group Office Visit: 20% <u>coinsurance</u> Other Outpatient Services: 20% <u>coinsurance</u> | Not covered | You may self-refer to a USBHPC <u>provider</u> for Office Visits. Prior authorization is required for Other Outpatient Services and all Inpatient Services by USBHPC. If it is not obtained when required, you may be liable for the payment of services or supplies. |
| | Inpatient Services | Facility: 20% <u>coinsurance</u> Professional: 20% <u>coinsurance</u> | Not covered | |

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at www.sutterhealthplus.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: 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 PCP Visit <u>cost sharing</u> for all subsequent postnatal office visits. Maternity care may include tests and services described elsewhere in the SBC (e.g., <u>Diagnostic Tests</u> such as ultrasounds and blood work). |
| | Childbirth / Delivery Professional Services | 20% <u>coinsurance</u> | Not covered | None |
| | Childbirth / Delivery Facility Services | 20% <u>coinsurance</u> | 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. |
| | <u>Rehabilitation Services</u> | 20% <u>coinsurance</u> | Not covered | Quantitative limits exist for the following services: |
| | <u>Habilitation Services</u> | Not covered | Not covered | <u>Home Health Care</u> – 100 visits per calendar year. |
| | <u>Skilled Nursing Care</u> | 20% <u>coinsurance</u> | Not covered | <u>Skilled Nursing Care</u> – 100 days per benefit period. *See Skilled Nursing Facility Care section in EOC for additional information. |
| | <u>Durable Medical Equipment</u> | 20% <u>coinsurance</u> | Not covered | <u>Hospice Services</u> – respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time. |
| | <u>Hospice Services</u> | No charge | Not covered | |

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at www.sutterhealthplus.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 your child needs dental or eye care For more information, contact Vision Services Plan (VSP) at 1-800-877-7195. | Children's Eye Exam | No charge <u>Deductible</u> does not apply | Up to \$45 max reimbursement | Quantitative limits exist for the following children's services: Eye Exam – 1 preventive exam per year. |
| | Children's Glasses | Not covered | Not covered | |
| | Children's Dental Check-up | Not covered | Not covered | |

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 <u>excluded services</u> .) | | |
|---|---|---|
| <ul style="list-style-type: none"> Chiropractic care Commercial weight loss programs Cosmetic surgery Dental care (Adult) | <ul style="list-style-type: none"> <u>Habilitation services</u> Hearing aids Infertility treatment Long-term care | <ul style="list-style-type: none"> 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 <u>plan</u> document.) | | |
|---|---|---|
| <ul style="list-style-type: none"> Acupuncture typically provided only for the treatment of nausea or chronic pain; embedded in medical <u>plan</u>. PCP <u>referral</u> and prior authorization are required. | <ul style="list-style-type: none"> Bariatric surgery | <ul style="list-style-type: none"> Routine eye care (Adult) limited to an annual preventive eye exam through VSP; embedded in medical <u>plan</u>. |

* For more information about limitations and exceptions, see plan Evidence of Coverage (EOC) at www.sutterhealthplus.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 Plus 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.sutterhealthplus.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 <u>plan's overall deductible</u> | \$2,500 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 20% |

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:

| <u>Cost Sharing</u> | |
|------------------------------------|----------------|
| <u>Deductible(s)</u> | \$2,500 |
| <u>Copayments</u> | \$10 |
| <u>Coinsurance</u> | \$1,400 |
| <i>What isn't covered</i> | |
| Limits or <u>excluded services</u> | \$60 |
| The total Peg would pay is | \$3,970 |

Managing Joe's Type 2 Diabetes

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

| | |
|--|---------|
| ■ The <u>plan's overall deductible</u> | \$2,500 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ 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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost Sharing</u> | |
|------------------------------------|----------------|
| <u>Deductible(s)</u> | \$2,500 |
| <u>Copayments</u> | \$600 |
| <u>Coinsurance</u> | \$50 |
| <i>What isn't covered</i> | |
| Limits or <u>excluded services</u> | \$20 |
| The total Joe would pay is | \$3,170 |

Mia's Simple Fracture

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

| | |
|--|---------|
| ■ The <u>plan's overall deductible</u> | \$2,500 |
| ■ <u>Specialist coinsurance</u> | 20% |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 20% |

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:

| <u>Cost Sharing</u> | |
|------------------------------------|----------------|
| <u>Deductible(s)</u> | \$2,500 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$50 |
| <i>What isn't covered</i> | |
| Limits or <u>excluded services</u> | \$0 |
| The total Mia would pay is | \$2,550 |

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

Notice of Language Assistance

IMPORTANT: Can you read this? If not, Sutter Health Plus can have somebody help you read it. You may also be able to get this written in your language. For no-cost help, please call Sutter Health Plus Member Services at 1-855-315-5800 (TTY 1-855-830-3500). (English)

IMPORTANTE: ¿Puede leer esto? Si no puede, Sutter Health Plus puede proporcionarle alguien que le ayude a leerlo. También puede obtenerlo por escrito en su idioma. Llame a Sutter Health Plus Member Services al 1-855-315-5800 (TTY 1-855-830-3500), sin costo alguno. (Spanish)

重要提示：您能讀懂這份文件嗎？如果不能，Sutter Health Plus 可以找人幫助您讀它。您還可
能得到用您的語言書寫的這份文件。若需要免費幫助，請致電 Sutter Health Plus 會員服務，
電話號碼 1-855-315-5800 (TTY 1-855-830-3500)。(Chinese)

ملحوظة مهمة: هل أنت قادر على قراءة هذا؟ إذا لم تكن قادرًا فاعلم أن صتّر هيلث بلاس (Sutter Health Plus) قد يكون لديهم شخصًا يمكنه مساعدتك في قراءة هذا النص. كما يمكنك أيضًا أن تتلقاه مكتوبًا بلغتك. للحصول على مساعدة مجانية، برجاء الاتصال بخدمات أعضاء صتّر هيلث بلاس (Sutter Health Plus Member Services) على هاتف 1-855-315-5800 (هاتف النص المرئي [TTY] 1-855-830-3500). (Arabic)

ԿԱՐԵՎՈՐ ՏԵՂԵԿԱՏՎՈՒԹՅՈՒՆ. Կարո՞ղ եք կարդալ սա: Եթե ոչ, Sutter Health Plus-ը կարող է տրամադրել մեկին, ով կօգնի Ձեզ կարդալ այն: Դուք կարող եք նաև ստանալ այն գրված Ձեր լեզվով: Անվճար օգնության համար խնդրում ենք զանգահարել Sutter Health Plus-ի Անդամների սպասարկման բաժին՝ 1-855-315-5800 (TTY 1-855-830-3500) հեռախոսահամարով: (Armenian)

**សារ:សំខាន់៖ តើអ្នកអាចអានសេចក្តីនេះឬទេ? បើសិនមិនអាចទេ Sutter Health Plus អាចមាន
នរណាម្នាក់ជួយអានវាជូនអ្នក ។ អ្នកក៏អាចនឹងឲ្យបានសេចក្តីនេះ សរសេរជាភាសារបស់អ្នកដែរ។ សំ
រាប់ជំនួយដោយឥតគិតថ្លៃ សូមទូរស័ព្ទទៅ ផ្នែកសេវាសមាជិក Sutter Health Plus តាមលេខ
1-855-315-5800 (TTY 1-855-830-3500)។ (Cambodian)**

نکته مهم: آیا می توانید این مطالب را بخوانید و بفهمید؟ اگر نمی توانید، Sutter Health Plus می تواند از فردی کمک بگیرد تا آنرا برایتان بخواند. همچنین امکان ترجمه این مطالب به زبان فارسی وجود دارد. برای دریافت خدمات و کمک رایگان، لطفاً با دفتر خدمات اعضای Sutter Health Plus با شماره تلفن 1-855-315-5800 (TTY 1-855-830-3500) تماس بگیرید. (Farsi)

महत्वपूर्ण: क्या आप इसे पढ़ सकते/सकती हैं? यदि नहीं, तो सट्टर हेल्थ प्लस इसे पढ़ने में किसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा में भी लिखवाने में समर्थ हो सकते/सकती हैं। निःशुल्क सहायता के लिए, कृपया 1-855-315-5800 (TTY 1-855-830-3500) पर सट्टर हेल्थ प्लस मेंबर सर्विसेस को कॉल करें। (Hindi)

LUS TSEEM CEEB: Koj nyeem puas tau tsab ntawv no? Yog koj nyeem tsis tau, Sutter Health Plus muaj neeg pab nyeem rau koj. Tsis tas li ntawd xwb, peb tuaj yeem muab sau ua hom lus koj nyeem tau rau koj tib si. Yog koj xav tau kev pab pub dawb, thov hu rau Sutter Health Plus Lub Chaw Pab Cuam Tswv Cuab ntawm tus xov tooj 1-855-315-5800 (TTY 1-855-830-3500). (Hmong)

重要なお知らせ：これを読むことができますか？読めない場合は、Sutter Health Plus が読むのをお手伝いします。あなたの言語で表示できるかもしれません。無料のご相談は、Sutter Health Plus Member Services、電話: 1-855-315-5800 (TTY 1-855-830-3500) まで。(Japanese)

중요: 귀하는 이것을 읽으실 수 있습니까? 만약 읽으실 수 없다면, Sutter Health Plus 에서 다른 사람에게 부탁하여 그것을 읽으실 수 있도록 도와드릴 수 있습니다. 또한 이것을 귀하의 사용 언어로 작성해 받으실 수도 있습니다. Sutter Health Plus 회원 서비스(1-855-315-5800 (TTY 1-855-830-3500))에 전화를 하시어 무상으로 도움을 받으십시오. (Korean)

ໝາຍເຫດ: ທ່ານອ່ານໄດ້ຈົດໝາຍສະບັບນີ້ບໍ່? ຖ້າອ່ານບໍ່ໄດ້, ທາງ Sutter Health Plus ມີ ພະນັກງານຊ່ວຍອ່ານໃຫ້ທ່ານ. ນອກຈາກນັ້ນ, ພວກເຮົາຍັງສາມາດຂຽນເປັນພາສາຂອງທ່ານໃຫ້ທ່ານອີກ ດ້ວຍ. ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໂດຍບໍ່ເສຍຄ່າບໍລິການ, ກະລຸນາຕິດຕໍ່ ໜ່ວຍບໍລິການ ຂອງ Sutter Health Plus ທີ່ໝາຍເລກໂທລະສັບ 1-855-315-5800 (TTY 1-855-830-3500). (Laotian)

ਅਹਿਮ: ਕੀ ਤੁਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ, Sutter Health Plus (ਸੱਟਰ ਹੈਲਥ ਪਲਸ) ਕਿਸੇ ਤੋਂ ਇਹ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮੱਦਦ ਕਰਵਾ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਮੁਫਤ ਮੱਦਦ ਲਈ ਕਿਰਪਾ ਕਰ ਕੇ Sutter Health Plus Member Services ਨੂੰ 1-855-315-5800 (TTY 1-855-830-3500) ਉੱਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ВАЖНО: Вы можете это прочитать? Если нет, Sutter Health Plus может предоставить Вам кого-то, кто сможет помочь Вам прочитать это. Вы также можете получить это в письменной форме на своем языке. Для бесплатной помощи позвоните в Службу поддержки членов Sutter Health Plus по телефону 1-855-315-5800 (TTY 1-855-830-3500). (Russian)

MAHALAGA: Nababasa mo ba ito? Kung hindi, maaari kang bigyan ng Sutter Health Plus ng taong babasa para sa iyo. Maaari mo ding hilingin na isulat ito sa iyong wika. Para sa walang-gastos na tulong, mangyaring tumawag sa Sutter Health Plus Member Services sa. 1-855-315-5800 (TTY 1-855-830-3500). (Tagalog)

สำคัญ: คุณอ่านออกหรือไม่ ถ้าอ่านไม่ออก Sutter Health Plus สามารถให้คนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถขอรับเนื้อหานี้เป็นภาษาของคุณได้อีกด้วย หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย กรุณาโทรหา Sutter Health Plus Member Services ที่ 1-855-315-5800 (TTY 1-855-830-3500) (Thai)

QUAN TRỌNG: Qu. vị có thể đọc thông tin này không? Nếu không, Sutter Health Plus có thể yêu cầu ai đó đọc giúp cho qu. vị. Qu. vị cũng có thể nhận được thông tin này dưới dạng văn bản bằng ngôn ngữ của qu. vị. Để được hỗ trợ miễn phí, vui lòng gọi cho ban Dịch Vụ Thành Viên của Sutter Health Plus theo số 1-855-315-5800 (TTY 1-855-830-3500). (Vietnamese)