

HEALTH PLAN BENEFITS AND COVERAGE MATRIX

THIS BENEFITS AND COVERAGE MATRIX (BCM) IS INTENDED TO HELP YOU COMPARE COVERAGE AND BENEFITS AND IS A SUMMARY ONLY. THIS BCM SHOWS THE AMOUNT YOU WILL PAY FOR COVERED SERVICES. FOR A DETAILED DESCRIPTION OF COVERAGE, BENEFITS AND LIMITATIONS, THE EVIDENCE OF COVERAGE AND DISCLOSURE FORM (EOC) SHOULD BE CONSULTED. PLEASE CONTACT SUTTER HEALTH PLAN (SHP) FOR ADDITIONAL INFORMATION.

(Important disclaimer regarding optional benefits: Cost Sharing and benefit information for optional benefits that may be elected by your employer group are not reflected on this Benefits and Coverage Matrix. Most optional benefits do not accrue to your Deductible, if applicable, and to your Out-of-Pocket Maximum. Please refer to the separate plan documents for elected optional benefits to determine Cost Sharing, Covered Services and any limitations or exclusions.)

BENEFIT PLAN NAME: City of Sacramento HDHP HMO (HSA-Compatible HDHP)

HEALTH SAVINGS ACCOUNT (HSA)-COMPATIBLE PLAN

Annual Deductible for Certain Medical Services (Combined Medical and Pharmacy)

For self-only enrollment (Subscriber-only)	\$2,000
For any one Member in a Family	\$3,400
For an entire Family	\$4,000

Separate Annual Deductible for Prescription Drugs

For self-only enrollment (Subscriber-only)	None
For any one Member in a Family	None
For an entire Family	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 (Subscriber-only)	\$3,400
For any one Member in a Family	\$3,400
For an entire Family	\$6,800

Lifetime Maximum

Lifetime benefit maximum	None
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Benefits	Member Cost Sharing
Preventive Care Services If you receive a non-Preventive Care Service during a preventive care visit, then you may be responsible for the Cost Sharing of the additional non-Preventive Care Service. In addition, if abnormalities are found during a preventive care exam or screening, such as a mammogram for breast cancer screening or a colonoscopy for colorectal cancer screening, then follow-up testing or procedures may be considered non-Preventive Care Services and Cost Sharing may apply. Please refer to the EOC for more information on Preventive Care Services.	
Annual eye exam for refraction	No charge
Family planning counseling, services and procedures, including preconception care visits (see Endnotes)	No charge
Routine preventive immunizations/vaccines	No charge
Routine preventive visits (e.g., well-child and well-woman visits), inclusive of routine preventive counseling, physical exams, procedures and screenings (e.g., screenings for diabetes and cervical cancer)	No charge
Routine preventive imaging and laboratory services	No charge
Preventive care drugs, supplies, equipment and supplements (refer to the SHP formulary for a complete list)	No charge
Outpatient Services	
Primary Care Physician (PCP) office/video visit to treat an injury or illness	<u>Office visit</u> : \$30 copay per visit after deductible <u>Telehealth visit</u> : \$15 copay per visit after deductible
Other practitioner office/video visit (see Endnotes)	<u>Office visit</u> : \$30 copay per visit after deductible <u>Telehealth visit</u> : \$15 copay per visit after deductible
Acupuncture services (see Endnotes)	\$30 copay per visit after deductible
Chiropractic services	Not covered
Sutter Walk-In Care office/video visit, where available	<u>Office/telehealth visit</u> : \$15 copay per visit after deductible
Specialist office/video visit	<u>Office visit</u> : \$30 copay per visit after deductible <u>Telehealth visit</u> : \$15 copay per visit after deductible
Allergy services provided as part of a Specialist visit (includes testing, injections and serum)	\$5 copay per visit after deductible

PENDING REGULATORY APPROVAL

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.

Medically administered drugs dispensed to a Participating Provider for administration (see Endnotes)	No charge after deductible
Outpatient rehabilitation services	\$30 copay per visit after deductible
Outpatient habilitation services	Not covered
Outpatient surgery facility fee	\$150 copay per visit after deductible
Outpatient surgery Professional fee	No charge after deductible
Outpatient visit (nonoffice visit, see Endnotes)	No charge after deductible
Non-preventive laboratory services	\$10 copay per visit after deductible
Radiological and nuclear imaging (e.g., MRI, CT and PET scans)	\$50 copay per procedure after deductible
Diagnostic and therapeutic imaging and testing (e.g., X-ray, mammogram, ultrasound, EKG/ECG, cardiac stress test and cardiac monitoring)	\$10 copay per procedure after deductible
Male sterilization/vasectomy services and procedures	No charge after deductible
Hospitalization Services	
Inpatient facility fee (e.g., hospital room, medical supplies and inpatient drugs including anesthesia)	\$250 copay per admission after deductible
Inpatient Professional fees (e.g., surgeon and anesthesiologist)	No charge after deductible
Emergency and Urgent Care Services	
Emergency room facility fee	\$100 copay per visit after deductible
Emergency room Professional fee	No charge 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 visit	\$30 copay per visit after deductible
Ambulance Services	
Medical transportation (including emergency and nonemergency)	\$100 copay per trip after deductible

Outpatient Prescription Drugs, Supplies, Equipment and Supplements

Covered Outpatient Prescription Drugs obtained at a Participating Pharmacy through retail, mail order or Specialty Pharmacy services and in accordance with SHP's drug formulary guidelines:

Tier 1 - Most Generic Drugs and low-cost preferred brand name drugs	<u>Retail-30</u> : \$10 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$20 copay per prescription after deductible for up to a 90-day supply
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	<u>Retail-30</u> : \$30 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$60 copay per prescription after deductible for up to a 90-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-30</u> : \$50 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$100 copay per prescription after deductible for up to a 90-day supply
Tier 4 - 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 copay per prescription after deductible for up to a 30-day supply

Durable Medical Equipment, Prosthetics, Orthotics and Supplies

Durable medical equipment for home use	20% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge after deductible

Mental Health & Substance Use Disorder (MH/SUD) Services

MH/SUD inpatient facility fee (see Endnotes)	\$250 copay per admission after deductible
MH/SUD inpatient Professional fees (see Endnotes)	No charge after deductible
MH/SUD individual outpatient office/video visit (e.g., evaluation and treatment services)	<u>Office visit</u> : \$30 copay per visit after deductible <u>Telehealth visit</u> : \$15 copay per visit after deductible

MH/SUD group outpatient office/video visit (e.g., evaluation and treatment services)	<u>Office visit</u> : \$15 copay per visit after deductible <u>Telehealth visit</u> : \$15 copay per visit after deductible
MH/SUD other outpatient services (see Endnotes)	No charge after deductible
Children and Youth Behavioral Health Initiative (CYBHI) school site behavioral health services	No charge after deductible
Maternity Care	
Routine prenatal care visits, after confirmation of pregnancy, and the first postnatal care visit 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).	<u>Office/telehealth visit</u> : No charge
Breastfeeding counseling, services and supplies (e.g., double electric or manual breast pump)	No charge
Labor and delivery inpatient facility fee (e.g., anesthesia and delivery services for all inpatient childbirth methods)	\$250 copay per admission after deductible
Labor and delivery inpatient Professional fees (e.g., anesthesiologist, nurse midwife and obstetrician)	No charge after deductible
Abortion Services	
Abortion (e.g., medication or procedural abortions) Abortion-related services, including pre-abortion and follow-up services	No charge after deductible
Other Services for Special Health Needs	
Skilled Nursing Facility services (up to 100 days per benefit period)	\$200 copay per admission after deductible
Home health care (up to 100 visits per calendar year)	No charge after deductible
Hospice care	No charge after deductible
Infertility and fertility services as described in the EOC (see Endnotes)	See applicable category of Covered Services

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" Deductible and Out-of-Pocket Maximum (OOPM). Each Family Member is responsible for the "one Member in a Family" Deductible and OOPM until the Family as a whole meets the "entire Family" Deductible and OOPM. Once the Family as a whole meets the "entire Family" 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" Deductible, if required, must be the higher of the specified "self-only enrollment" Deductible amount or the IRS minimum of \$3,400 for plan year 2026. Once an individual Family Member's "any one Member in a Family" Deductible is satisfied, that Member will only be responsible for the listed Copayment or Coinsurance amount. Other Family Members will be required to continue to contribute to the "any one Member in a Family" Deductible until the "entire Family" 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" annual OOPM amount.

2. Cost Sharing for all Essential Health Benefits, including that which accumulates toward an applicable Deductible, accumulates toward the OOPM.
3. Outpatient Prescription Drugs, when prescribed, are Medically Necessary generic or brand-name drugs in accordance with SHP's formulary guidelines. All Medically Necessary prescription drug Cost Sharing, paid by the Member, contributes toward your Deductible, if applicable, and OOPM.

Outpatient Prescription Drugs are available for up to a 30-day supply through a retail Participating Pharmacy. Maintenance Drugs are available for up to a 90-day supply through the CVS Health Retail-90 Network or through the CVS Caremark Mail Service Pharmacy. Specialty Drugs are only available for up to a 30-day supply through CVS Specialty. Specialty Drugs are not exclusive to Tier 4 and, regardless of tier placement, have the same fill requirements.

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. For a 12-month supply of contraceptives, applicable Cost Sharing will be up to four times the retail Cost Share.

Outpatient Prescription Drugs dispensed by non-participating pharmacies are not covered except for emergency or urgent situations, including drugs prescribed for treatment of a mental health and substance use disorder, or when dispensed as part of a Community Assistance, Recovery, and Empowerment (CARE) agreement or CARE plan approved by a court.

4. The "Other practitioner office/video visit" benefit includes therapy visits and other office visits not provided by either PCPs or Specialists or visits not specified in another benefit.
5. The "Family planning counseling, services and procedures" benefit does not include male sterilization services and procedures which are covered under the "Male sterilization/vasectomy services and procedures" benefit listed above. This benefit also does not include termination of pregnancy or abortion-related services which are covered under the "Abortion Services" benefit category listed above. "Male sterilization/vasectomy services and

procedures" are covered at no cost share after the minimum deductible of \$1,700 for self-only coverage or \$3,400 for family coverage is met for plan year 2026.

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.
7. Certain medically administered drugs requires Prior Authorization from CVS Caremark and must be obtained from a Participating Pharmacy.
8. The "Outpatient visit (nonoffice visit)" benefit 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 nonoffice setting.

The "Outpatient visit (nonoffice visit)" benefit also includes storage of cryopreserved reproductive materials included in the fertility preservation and infertility and fertility services benefits. Storage of cryopreserved materials is not a per visit service and is typically billed on an annual basis at the "Outpatient visit (nonoffice visit)" Cost Sharing.

When performed in an office setting, these services are covered under the PCP office visit, other practitioner office visit or specialist office visit benefit depending on which provider administers the service.

9. The "MH/SUD inpatient" benefits include, but are not limited to: inpatient psychiatric hospitalization, including inpatient psychiatric observation; inpatient Behavioral Health Treatment for autism spectrum disorder; treatment in a Residential Treatment Center; inpatient chemical dependency hospitalization, including medical detoxification and treatment for withdrawal symptoms; and prescription drugs prescribed in an inpatient setting, excluding a Residential Treatment Center. Refer to the Outpatient Prescription Drug benefit for coverage details for prescription drugs prescribed in a Residential Treatment Center.
10. "MH/SUD other outpatient services" include, but are not limited to: psychological testing; multidisciplinary intensive day treatment programs such as partial hospitalization and intensive outpatient programs; outpatient psychiatric observation for Behavioral Health Crisis Services; outpatient Behavioral Health Treatment for autism spectrum disorder delivered in any outpatient setting, including the home; and other outpatient intermediate services that fall between inpatient care and outpatient office visits.
11. Behavioral Health Crisis Services provided to a Member by a 988 center, mobile crisis team or other provider of Behavioral Health Crisis Services is covered regardless of whether the treatment is provided by a Participating Provider or an out-of-network provider. Prior Authorization is not required for this treatment and Cost Sharing will be based on the setting where the Member receives treatment.
12. "Children and Youth Behavioral Health Initiative (CYBHI) school site behavioral health services" include, outpatient non-specialty mental health and substance use disorder services (e.g., psychoeducation, screening and assessments, therapy, case management) provided to Members 25 years of age or younger at a school site, including on-campus, off-campus and mobile clinic locations, when the services are provided or arranged by a local educational agency (LEA) or public institution of higher education (IHE) that participate in the CYBHI Fee Schedule Program. The scope of services can be found in the CYBHI Fee Schedule available on the DHCS website at <https://www.dhcs.ca.gov/CYBHI/Pages/Fee-Schedule.aspx>.

PENDING REGULATORY APPROVAL

13. Cost Sharing for services with Copayments is the lesser of the Copayment amount or allowed amount.
14. In order to be covered, most non-preventive care medical services require a referral from your PCP. Many of these services also require Prior Authorization by your PCP 's medical group or SHP. Please consult the EOC for complete details on referral and Prior Authorization requirements for all Covered Services.
15. COVID-19 diagnostic and screening tests are covered at no Cost Share, after the annual deductible has been met, when provided by a Participating Provider and at the standard benefit Cost Sharing for the place of service when provided by a non-Participating Provider. COVID-19 vaccines and other preventive services are covered at no Cost Share when provided by a Participating or non-Participating Provider or Pharmacy. COVID-19 therapeutics are covered at no Cost Share, after the annual deductible has been met, when provided by a Participating or non-Participating Provider or Pharmacy.

COVID-19 over-the-counter (OTC) tests with a prescription are covered at no Cost Share, after the annual deductible has been met, when obtained from a Participating or non-Participating Pharmacy. If a member purchases COVID-19 OTC tests from a Participating Pharmacy without a prescription, SHP will reimburse the Member for the cost of the tests, up to 8 tests per month. If a Member purchases COVID-19 OTC tests without a prescription from a non-Participating Pharmacy, reimbursement is limited to a quantity of 8 tests per month and up to \$12 per test. SHP will reimburse the cost of the OTC tests after the annual deductible has been met.
16. 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 for details.
17. For covered infertility and fertility services, you will pay the Cost Sharing you would pay for the applicable category of Covered Services.
18. For this Benefit Year, 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.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2026 – 12/31/2026

Sutter Health Plan: City of Sacramento HDHP HMO (HSA-Compatible HDHP)

Coverage for: Large Group | Plan Type: HDHP HMO



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?	\$2,000 individual / \$3,400 individual family member / \$4,000 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 deductible?	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 deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	\$3,400 individual / \$3,400 individual family member / \$6,800 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 out-of-pocket limit?	<u>Premiums</u> , health care this <u>plan</u> doesn't cover and <u>cost sharing</u> for most optional benefits if elected by your employer group.	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 network provider?	Yes. See www.sutterhealthplan.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> .
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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	PCP Office Visit: \$30 copay per visit Sutter Walk-in Care Visit: \$15 copay per visit Telehealth Visit: \$15 copay per visit	Not covered	Includes Other Health Professional visits. *See Definitions section in EOC for list of Other Health Professionals.
	<u>Specialist</u> Visit	<u>Specialist</u> Office Visit: \$30 copay per visit Telehealth Visit: \$15 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</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)	Lab: \$10 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	
If you need drugs to treat your illness or condition For information about <u>prescription drug coverage</u> ,	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 Health® contracted retail network pharmacy and covers up to a 90-day supply of maintenance drugs, at two times the retail copay, through the 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) <u>formulary</u> , visit www.sutterhealthplan.org/p/harmacy 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 90-day supply of maintenance drugs, at two times the retail copay, through the CVS Caremark® Mail Service Pharmacy. Specialty Pharmacy: covers up to a 30-day supply of <u>specialty drugs</u> through CVS Specialty®. <u>Specialty drugs</u> are not exclusive to Tier 4 and, regardless of tier placement, have the same fill requirements.
	Tier 3 (Non-preferred brand name drugs)	Retail: \$50 copay per prescription Mail Order: \$100 copay per prescription	Not covered	*See SHP <u>formulary</u> or the Outpatient <u>Prescription Drugs</u> , Supplies, Equipment and Supplement section in EOC for any SHP policy requirements such as prior authorization and step therapy, or coverage limitations and exceptions.
	Tier 4 (<u>Specialty drugs</u>)	Specialty Pharmacy: \$20 copay per prescription	Not covered	
If you have outpatient surgery	Facility Fee (e.g., ambulatory surgery center)	\$150 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	<u>Emergency Room Care</u>	Facility: \$100 copay per visit Professional: No charge		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>	\$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	
	<u>Urgent Care</u>	\$30 copay per visit		For in-area <u>Urgent Care</u> , visit your Medical Group's contracted <u>Urgent Care</u> facility. For Out-of-Area <u>Urgent Care</u> , visit the nearest <u>Urgent Care</u> 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- <u>network</u> .
If you have a hospital stay	Facility Fee (e.g., hospital room)	\$250 copay per admission	Not covered	Prior authorization may be required. If it is not received, you may be responsible for paying all charges.
	Physician / Surgeon Fees	No charge	Not covered	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- <u>network</u> and without prior authorization.
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: \$30 copay per visit Group Office Visit: \$15 copay per visit Telehealth Office Visit: \$15 copay per visit Other Outpatient Services: No charge	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: \$250 copay per admission Professional: No charge	Not covered	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- <u>network</u> and without prior authorization.

* 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 <u>Deductible</u> does not apply Postnatal Care, Subsequent Visits: \$30 copay per visit	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	No charge	Not covered	None
	Childbirth / Delivery Facility Services	\$250 copay 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.
	<u>Rehabilitation Services</u>	Inpatient: \$250 copay per admission Outpatient: \$30 copay per visit	Not covered	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. *See Skilled Nursing Facility Care section in EOC for additional information. <u>Hospice Services</u> – respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time.
	<u>Habilitation Services</u>	Not covered	Not covered	
	<u>Skilled Nursing Care</u>	\$200 copay per admission	Not covered	
	<u>Durable Medical Equipment</u>	20% <u>coinsurance</u>	Not covered	
	<u>Hospice Services</u>	No charge	Not covered	
If your child needs dental or eye care For more information, contact Vision Services	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 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.)

- | | | |
|--|---|---|
| <ul style="list-style-type: none"> • Chiropractic care • Commercial weight loss programs • Cosmetic surgery | <ul style="list-style-type: none"> • Dental care (Adult) • <u>Habilitation services</u> • Hearing aids • 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 plan Evidence of Coverage (EOC).)

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> • Abortion • 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. • Bariatric surgery | <ul style="list-style-type: none"> • Infertility treatment embedded in medical <u>plan</u>. A PCP or OB/GYN <u>referral</u> and prior authorization by your medical group or SHP are required for <u>medically necessary</u> services. *See the Infertility and Fertility Services section of the Your Benefits chapter in your EOC for additional information. | <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.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.dmhca.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.dmhca.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 <u>plan's overall deductible</u>	\$2,000
■ <u>Specialist copayment</u>	\$30
■ <u>Hospital (facility) copayment</u>	\$250
■ <u>Other 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
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductible</u>	\$2,000
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or <u>excluded services</u>	\$60
The total Peg would pay is	\$2,360

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>	\$2,000
■ <u>Specialist copayment</u>	\$30
■ <u>Hospital (facility) copayment</u>	\$250
■ <u>Other 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
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductible</u>	\$2,000
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or <u>excluded services</u>	\$20
The total Joe would pay is	\$2,820

Mia's Simple Fracture

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

■ The <u>plan's overall deductible</u>	\$2,000
■ <u>Specialist copayment</u>	\$30
■ <u>Hospital (facility) copayment</u>	\$250
■ <u>Other 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
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductible</u>	\$2,000
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or <u>excluded services</u>	\$0
The total Mia would pay is	\$2,200

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 Plan 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 Plan Customer Service at 855-315-5800 (TTY 855-830-3500). (English)

IMPORTANTE: ¿Puede leer esto? Si no puede, Sutter Health Plan puede proporcionarle a alguien que lo ayude a leerlo. También puede obtener este documento en su idioma. Llame al Servicio de Atención al Cliente de Sutter Health Plan al 855-315-5800 (TTY 855-830-3500). (Spanish)

重要事項：您能閱讀這些內容嗎？如果不能閱讀，Sutter Health Plan 可以安排人員幫助您閱讀。您還可能可以獲得以您的語言編寫的這些內容。如需免費幫助，請致電 Sutter Health Plan 客戶服務部，電話號碼：855-315-5800 (TTY 855-830-3500)。(Chinese)

ملاحظة مهمة: هل يمكنك قراءة هذا؟ إذا لم تتمكن من القراءة، Sutter Health Plan يمكن أن يساعدك في قراءة هذا. يمكنك أيضًا الحصول على هذا المستند بلغة أخرى. للحصول على مساعدة مجانية، يرجى الاتصال بخدمات Sutter Health Plan على 855-315-5800 (TTY 855-830-3500). (Arabic)

ԿԱՐԵՎՈՐ Է: Կարո՞ղ եք սա կարդալ: Եթե ոչ, Sutter Health Plan-ը կարող է տրամադրել մեկին, ով կօգնի Ձեզ կարդալ այն: Դուք կկարողանաք նաև ստանալ այն գրված Ձեր լեզվով: Անվճար օգնության համար զանգահարեք Sutter Health Plan-ի Հանախորդների սպասարկման բաժին՝ 855-315-5800 (TTY 855-830-3500) հեռախոսահամարով: (Armenian)

សំខាន់៖ តើអ្នកអាចអានដាច់ទេ? បើអានមិនដាច់ទេ Sutter Health Plan អាចឱ្យគេជួយអ្នកអានបាន។ អ្នកក៏ប្រហែលជាអាចទទួលបានឯកសារនេះសរសេរជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទៅកាន់ផ្នែកសេវាអតិថិជន Sutter Health Plan តាមលេខ 855-315-5800 (TTY 855-830-3500)។ (Cambodian)

نکته مهم: آیا می‌توانید این مطلب را بخوانید؟ اگر نمی‌توانید، Sutter Health Plan می‌تواند از فردی کمک بگیرد تا آن را برایتان بخواند. همچنین امکان دریافت این مطالب به زبان شما وجود دارد. برای دریافت کمک به صورت رایگان، لطفاً با خدمات مشتریان Sutter Health Plan از طریق شماره تلفن 855-315-5800 (TTY 855-830-3500) تماس بگیرید. (Farsi)

महत्वपूर्ण: क्या आप इसे पढ़ सकते/ती हैं? यदि नहीं, तो सट्टर हेल्थ प्लान (Sutter Health Plan) इसे पढ़ने में किसी से आपकी सहायता करवा सकता है। आप इसे अपनी भाषा में भी लिखवा सकते/ती हैं। निःशुल्क सहायता के लिए, कृपया Sutter Health Plan ग्राहक सेवा को 855-315-5800 (TTY 855-830-3500) पर कॉल करें। (Hindi)

TSEEM CEEB: Koj puas tuaj yeem nyeem qhov no tau? Yog tias tsis tau, Sutter Health Plan tuaj yeem kom ib tus neeg pab koj nyeem nws. Tsis tas li ntawd, tej zaum koj kuj tseem tuaj yeem tau txais qhov no sau ua koj hom lus thiab. Yog xav tau kev pab dawb, thov hu rau Sutter Health Plan Lub Chaw Pab Cuam Qhua ntawm 855-315-5800 (TTY 855-830-3500). (Hmong)

重要: こちらの文書が読めますか? 読むのが難しいときは、サッター ヘルス プランが読むのをお手伝いするスタッフを手配します。また、これを日本語で書いてもらうこともできます。無料でのサポートをご利用いただくには、電話 855-315-5800 (TTY 855-830-3500)、サッター ヘルス プラン カスタマー サービスにご連絡ください。(Japanese)

중요 사항: 이것을 읽으실 수 있습니까? 만약 읽으실 수 없는 경우, Sutter Health Plan 은 귀하가 읽으실 수 있도록 다른 사람을 시켜 도와 드릴 수 있습니다. 또한 이 내용을 자신이 사용하는 언어로 작성하도록 하실 수도 있습니다. 비용 부담 없이 도움을 받으시려면 Sutter Health Plan 고객 서비스에 전화를 하십시오. 전화: 855-315-5800 (TTY 855-830-3500). (Korean)

ສຳຄັນ: ທ່ານສາມາດອ່ານຂໍ້ຄວາມນີ້ໄດ້ບໍ່? ຖ້າບໍ່ໄດ້, Sutter Health Plan ສາມາດໃຫ້ຄົນຊ່ວຍທ່ານອ່ານຂໍ້ຄວາມນີ້. ນອກຈາກນີ້, ທ່ານຍັງອາດຈະສາມາດຂໍໃຫ້ຂຽນເປັນພາສາຂອງທ່ານໄດ້. ຫາກຕ້ອງການການຊ່ວຍເຫຼືອໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ, ກະລຸນາໂທຫາຝ່າຍບໍລິການລູກຄ້າຂອງ Sutter Health Plan ທີ່ເບີ 855-315-5800 (TTY 855-830-3500). (Laotian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ, ਤਾਂ ਸੱਟਰ ਹੈਲਥ ਪਲਾਨ (Sutter Health Plan) ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਤੁਹਾਡੀ ਮਦਦ ਕਰ ਸਕਦਾ ਹੈ। ਤੁਸੀਂ ਇਸ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਵੀ ਲਿਖਵਾ ਸਕਦੇ ਹੋ। ਬਿਨਾਂ ਲਾਗਤ ਦੇ ਮਦਦ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਸੱਟਰ ਹੈਲਥ ਪਲਾਨ ਦੀ ਗਾਹਕ ਸੇਵਾ ਨੂੰ 855-315-5800 (TTY 855-830-3500) 'ਤੇ ਕਾਲ ਕਰੋ। (Punjabi)

ВАЖНО. Вы можете это прочитать? Если нет, Sutter Health Plan может предоставить вам того, кто сможет помочь вам прочитать это. Вы также можете получить этот документ в письменной форме на своём языке. Для бесплатной помощи позвоните в отдел обслуживания клиентов Sutter Health Plan по телефону 855-315-5800 (TTY 855-830-3500). (Russian)

MAHALAGA: Nababasa mo ba ito? Kung hindi, maaari kang bigyan ng Sutter Health Plan ng taong makakatulong sa iyo na basahin ito. Maaari mo ring hilingin na ipasulat ito sa iyong wika. Para sa walang bayad na tulong, mangyaring tumawag sa Sutter Health Plan Customer Service sa 855-315-5800 (TTY 855-830-3500). (Tagalog)

หมายเหตุ: คุณอ่านข้อความนี้ออกหรือไม่ ถ้าหากคุณอ่านไม่ออก Sutter Health Plan สามารถให้คนมาช่วยคุณอ่านได้ นอกจากนี้ คุณยังสามารถขอรับเนื้อหานี้เป็นภาษาของคุณได้อีกด้วย หากคุณต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย กรุณาติดต่อ Sutter Health Plan Customer Service ได้ที่ 855-315-5800 (TTY 855-830-3500) (Thai)

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