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, visit sutterhealthplus.org or call 1-855-315-5800. 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?	$1,500 individual / $3,000 individual family member / $3,000 family for certain medical services per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Only preventive care is covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,000 individual / $3,000 individual family member / $6,000 family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, health care this plan doesn't cover, and cost sharing for optional benefits if elected by your employer group.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.sutterhealthplus.org/provider- search or call 1-855-315-5800 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment 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: Participating Provider	What You Will Pay: Non-Participating Provider	Limitations, Exceptions & Other Important Information
	Primary Care (PCP) Visit to treat an injury or illness	PCP Office Visit: No charge Sutter Walk-in Care: No charge Telehealth Visit: No charge		

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

Common Medical Event	Services You May Need	What You Will Pay

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

* For more information about limitations and exceptions, see

Common Medical Events	Services You May Need	What You Will Pay		Limitations, Exceptions & Information
		Participating Provider	Non-Participating Provider	

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

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, 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
look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information
or grievance for any reason to your plan. For more information about your rights, this notice, or assistance, c 1-855-315-5800 (
855-830-3500) California Department of Managed Health Care 1-888-466-2219 (TTY 1-877-688-9891) 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 policie
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 c

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.

* For more information about limitations and exceptions, see the plan or policy document (EOC) at www.sutterhealthplus.org/about/plans-b