PENDING REGULATORY APPROVAL

Sutter Health Plus
Your Health Plan

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Sutter Health Plus: Summit ML84 HMO

Coverage Period: 01/01/2024 – 12/31/2024
Coverage for: Large Group | Plan Type: 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 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 deductible?	**$0** individual / **$0** individual family member / **$0** family per calendar year.	See the Common Medical Events chart below for your costs for services this plan covers.
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 (copay) or coinsurance may apply. This plan covers certain preventive services without cost sharing. 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?	**$1,500** individual / **$1,500** individual family member / **$3,000** family per calendar year.	The out-of-pocket limit is the most you could pay 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 most 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.

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 provider's office or clinic	Primary Care Physician (PCP) Visit to treat an injury or illness	PCP Office Visit: $15 copay per visit Sutter Walk-in Care Visit: $5 copay per visit Telehealth Visit: $5 copay per visit	Not covered	Includes Other Health Professional visits. *See Definitions section in EOC for list of Other Health Professionals.
	Specialist Visit	Specialist Office Visit: $15 copay per visit Telehealth Visit: $5 copay per visit	Not covered	Prior authorization for some referrals to specialists is required. If it is not received, you may be responsible for paying all charges.
	Preventive Care / Screening / Immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic Test (X-ray, blood work)	Lab: No charge X-ray: No charge	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)	$15 copay per procedure	Not covered	
If you need drugs to treat your illness or condition For information about prescription drug coverage,	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® National Network pharmacy and covers up to a 100-day supply of maintenance drugs, at two times the retail copay, through a CVS retail pharmacy that participates in the Retail-90 Network.

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 Plus (SHP) formulary, visit www.sutterhealthplus.org/pharmacy or call CVS Caremark® at 1-844-740-0635.	Tier 2 (Preferred brand name drugs and non-preferred generic drugs)	Retail: $20 copay per prescription Mail Order: $40 copay per prescription	Not covered	Mail Order/home delivery service: covers up to a 100-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 specialty drugs through CVS Specialty®. Specialty drugs are not exclusive to Tier 4 and, regardless of tier placement, have the same fill requirements. *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.
	Tier 3 (Non-preferred brand name drugs)	Retail: $35 copay per prescription Mail Order: $70 copay per prescription	Not covered	
	Tier 4 (Specialty drugs)	Specialty Pharmacy: 20% coinsurance up to $100 per prescription	Not covered	
If you have outpatient surgery	Facility Fee (e.g., ambulatory surgery center)	$15 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	Emergency Room Care	Facility: $35 copay per visit Professional: No charge		If admitted to the hospital, Emergency Room Care cost sharing will not apply. See hospital stay information below for applicable cost sharing.
	Emergency Medical Transportation	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.
	Urgent Care	$15 copay per visit		Refer to the Your Benefits section of the EOC for additional information.

* 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 have a hospital stay	Facility Fee (e.g., hospital room)	No charge	Not covered	Prior authorization is required. If it is not received, you may be responsible for paying all charges.
	Physician / Surgeon Fees	No charge	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: $15 copay per visit MH Group Office Visit: $7 copay per visit SUD Group Office Visit: $5 copay per visit Telehealth Office Visit: $5 copay per visit Other Outpatient Services: No charge	Not covered	You may self-refer to a USBHPC provider 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: No charge Professional: No charge	Not covered	
If you are pregnant	Office Visits	Prenatal and Postnatal Care (In-person or telehealth visit): No charge	Not covered	Prenatal and Postnatal Care includes all prenatal office visits and the first postnatal office visit. Refer to the PCP Visit cost sharing for all subsequent postnatal office visits. Maternity care may include tests and services described elsewhere in the SBC (e.g., Diagnostic Tests such as ultrasounds and blood work).
	Childbirth / Delivery Professional Services	No charge	Not covered	None
	Childbirth / Delivery Facility Services	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 you need help recovering or have other special health needs	Home Health Care	No charge	Not covered	Prior authorization is required. If it is not received, you may be responsible for paying all charges. Quantitative limits exist for the following services: Home Health Care – 100 visits per calendar year. Skilled Nursing Care – 100 days per benefit period. *See Skilled Nursing Facility Care section in EOC for additional information. Hospice Services – respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time.
	Rehabilitation Services	$15 copay per visit	Not covered	
	Habilitation Services	$15 copay per visit	Not covered	
	Skilled Nursing Care	No charge	Not covered	
	Durable Medical Equipment	No charge	Not covered	
	Hospice Services	No charge	Not covered	
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	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	
	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.)

- Commercial weight loss programs
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

* 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.

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

- Abortion
- Acupuncture provided as an optional benefit through ACN Group of California (ACN) for medically necessary services. See the ACN Schedule of Benefits for additional information. This optional benefit is in addition to acupuncture embedded in the medical plan that is typically provided only for the treatment of nausea or chronic pain where a PCP referral and prior authorization are 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 or OB/GYN referral and prior authorization by your medical group or SHP are required for medically necessary services. See the Infertility Services Benefit Rider for cost sharing and additional information.
- Routine eye care (Adult) limited to an annual preventive eye exam through VSP; embedded in medical plan.

* 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 plan's overall deductible	$0
Specialist copayment	$15
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 *(anesthesia)*
Diagnostic Tests (*ultrasounds and blood work)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductible	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or excluded services	$60
The total Peg would pay is	**$70**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist copayment	$15
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 meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductible	$0
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or excluded services	$20
The total Joe would pay is	**$920**

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

The plan's overall deductible	$0
Specialist copayment	$15
Hospital (facility) copayment	$0
Other coinsurance	N/A

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:

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

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

Sutter Health Plus
Your Health Plan

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 صَتر هيلث بلاس (Sutter Health Plus) قد يكون لديهم شخصًا يمكنه مساعدتك في قراءة هذا النص. كما يمكنك أيضًا أن تتلقاه مكتوبًا بلُغتك. للحصول على مساعدة مجانية، برجاء الاتصال بخدمات أعضاء صَتر 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)

សារៈសំខាន់ៈ តើអ្នកអាចអានសេចក្តីនេះឬទេ? បើសិនមិនអាចទេ Sutter Health Plus **អាចមាននរណាម្នាក់ជួយអានវាជូនអ្នក ។ អ្នកក៏អាចនឹងឲ្យបានសេចក្តីនេះ សរសេរជាភាសារបស់អ្នកដែរ។ សំរាប់ជំនួយដោយឥតអស់ថ្លៃ 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، لطفا 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 मे 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？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**? **ຖ້າ**ທ່ານອ່ານບໍ່ໄດ້, **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। ਮੁਫ਼ਤ ਮੱਦਦ ਲਈ ਕਿਰਪਾ ਕਰ ਕੇ Sutter Health Plus Member Services ਨੂੰ 1-855-315-5800 (TTY 1-855-830-3500) ਉਤੇ 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)

Sutter Health Plus
Your Health Plan

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 PLUS (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: Summit ML84 HMO

Annual Deductible for Certain Medical Services	
For self-only enrollment (Subscriber-only)	None
For any one Member in a Family	None
For an entire Family	None
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)	$1,500
For any one Member in a Family	$1,500
For an entire Family	$3,000

Lifetime Maximum	
Lifetime benefit maximum	None

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 visit to treat an injury or illness	Office visit: $15 copay per visit Telehealth visit: $5 copay per visit
Other practitioner office visit (see Endnotes)	Office visit: $15 copay per visit Telehealth visit: $5 copay per visit
Acupuncture services (see Endnotes)	$15 copay per visit
Chiropractic services	Not covered
Sutter Walk-in Care visit, where available	Office/telehealth visit: $5 copay per visit
Specialist office visit	Office visit: $15 copay per visit Telehealth visit: $5 copay per visit
Allergy services provided as part of a Specialist visit (includes testing, injections and serum)	$15 copay per visit

There is no Cost Sharing 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	No charge
Outpatient rehabilitation services	$15 copay per visit
Outpatient habilitation services	$15 copay per visit
Outpatient surgery facility fee	$15 copay per visit
Outpatient surgery Professional fee	No charge
Outpatient non-office visit (see Endnotes)	$15 copay per visit
Non-preventive laboratory services	No charge
Radiological and nuclear imaging (e.g., MRI, CT and PET scans)	$15 copay per procedure
Diagnostic and therapeutic imaging and testing (e.g., X-ray, mammogram, ultrasound, EKG/ECG, cardiac stress test and cardiac monitoring)	No charge
Male sterilization/vasectomy services and procedures	No charge
Hospitalization Services	
Inpatient facility fee (e.g., hospital room, medical supplies and inpatient drugs including anesthesia)	No charge
Inpatient Professional fees (e.g., surgeon and anesthesiologist)	No charge
Emergency and Urgent Care Services	
Emergency room facility fee	$35 copay per visit
Emergency room Professional fee	No charge
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	$15 copay per visit
Ambulance Services	
Medical transportation (including emergency and non-emergency)	No charge
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	Retail-30: $10 copay per prescription for up to a 30-day supply Retail-90/Mail order: $20 copay per prescription for up to a 100-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	Retail-30: $20 copay per prescription for up to a 30-day supply Retail-90/Mail order: $40 copay per prescription 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 *(These generally have a preferred and often less costly therapeutic alternative at a lower tier)*	Retail-30: $35 copay per prescription for up to a 30-day supply Retail-90/Mail order: $70 copay per prescription 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	Specialty Pharmacy: 20% coinsurance up to $100 per prescription for up to a 30-day supply
Durable Medical Equipment, Prosthetics, Orthotics and Supplies	
Durable medical equipment for home use	No charge
Ostomy and urological supplies; prosthetic and orthotic devices	No charge
Mental Health & Substance Use Disorder (MH/SUD) Services	
MH/SUD inpatient facility fee (see Endnotes)	No charge
MH/SUD inpatient Professional fees (see Endnotes)	No charge
MH/SUD individual outpatient office visit (e.g., evaluation and treatment services)	Office visit: $15 copay per visit Telehealth visit: $5 copay per visit
MH/SUD group outpatient office visit (e.g., evaluation and treatment services)	Office visit: MH: $7 copay per visit SUD: $5 copay per visit Telehealth visit: $5 copay per visit

MH/SUD other outpatient services (see Endnotes)	No charge
Maternity Care	
Routine prenatal care visits, after confirmation of pregnancy, and the first postnatal care visit	Office/telehealth 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., 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)	No charge
Labor and delivery inpatient Professional fees (e.g., anesthesiologist, nurse midwife and obstetrician)	No charge
Abortion Services	
Abortion (e.g., medication or procedural abortions) Abortion-related services, including pre-abortion and follow-up services	No charge
Other Services for Special Health Needs	
Skilled Nursing Facility services (up to 100 days per benefit period)	No charge
Home health care (up to 100 visits per calendar year)	No charge
Hospice care	No charge

Endnotes:

1. Family Deductibles (when applicable) and Out-of-Pocket Maximums (OOPM) are equal to two times the "self-only" values. In a Family plan, a Member is only responsible for the "one Member in a Family" Deductible and OOPM. Deductibles and other Cost Sharing payments made by each Member in a Family contribute to the "entire Family" Deductible and OOPM. Once the "entire Family" Deductible amount is satisfied by any combination of Member Deductible payments, plan Copayment or Coinsurance amounts apply until the "entire Family" OOPM is reached, after which the plan pays all costs for Covered Services for all Family Members.
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 100-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.

4. The "Other practitioner office 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.
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. The "Outpatient non-office 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 non-office setting. This benefit 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 non-office visit" Cost Sharing.
8. 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.
9. "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 an acute psychiatric crisis; 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.
10. Cost Sharing for services with Copayments is the lesser of the Copayment amount or allowed amount.
11. 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.

12. COVID-19 diagnostic and screening testing; therapeutics; and preventive services are covered at no cost share when provided by an in-network provider.
13. 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* for complete details.

Sutter Health Plus
Your Health Plan

SUTTER HEALTH PLUS
INFERTILITY SERVICES BENEFIT RIDER

This is an Addendum to your Large Group *Combined Evidence of Coverage and Disclosure Form* (*EOC*), describing your coverage for Infertility services. Please keep this Addendum with your *EOC* for future reference. This Addendum is effective January 1, 2024.

COVERED INFERTILITY SERVICES

Your Infertility services benefit includes: services, supplies and drugs for the diagnosis and treatment of Infertility, including consultations, examinations, diagnostic tests, procedures, and drug therapy, subject to the Exclusions and Limitations described below.

DEFINITIONS

***Infertility means*:**

- For Members under the age of 35 years: inability to conceive a pregnancy or carry a pregnancy to a live birth after one year (12 months) of regular intercourse without contraception.
- For Members over the age of 35 years or with a history of oligo/amenorrhea; or with known or suspected uterine/tubal disease or endometriosis: inability to conceive a pregnancy or carry a pregnancy to a live birth after 6 months of regular intercourse without contraception
- For Members: inability to conceive a pregnancy or carry a pregnancy to a live birth after six (6) cycles of artificial donor insemination under medical supervision.
- For Members with other health conditions known to cause Infertility, as recognized by licensed physicians.

COST SHARE

Your Cost Share is: 50% Coinsurance.

Your Cost Share for Infertility services does NOT apply to your annual Out of Pocket Maximum.

All services Medically Necessary and clinically appropriate to diagnose and treat involuntary Infertility, as defined above, including the diagnostic work-up and testing, procedures and services and all drugs are covered at 50% of SHP's contracted prices when referred by your PCP or OB/GYN doctor and authorized by your medical group. Drugs prescribed for the treatment of Infertility are covered at 50% of the contracted prescription cost. You should contact your SHP network Infertility provider directly to obtain your estimated Cost Share for a particular procedure. You may call CVS Caremark® at 1-844-740-0635 to determine your Cost Share for prescription drugs, and SHP Member Services at 1-855-315-5800 (TYY 1-855-830-3500) for other benefit questions.

LIMITATIONS

1. Intrauterine Insemination (IUI) is limited to three (3) cycles per Member's lifetime, as defined in Limitation 3 below.
2. In-Vitro Fertilization (IVF) is limited to one (1) per Member's lifetime, as defined in Limitation 3 below.
3. For purposes of this Infertility benefit, lifetime means the lifetime of the Member who is the recipient of Infertility services, and includes all treatments provided to the Member under any health care coverage plan in which the Member participated.

EXCLUSIONS

1. Services and supplies to reverse voluntary Infertility, including but not limited to reversals of vasectomy and tubal ligation, or other surgically induced Infertility, or to treat Infertility following reversal procedures.
2. Services and supplies related to donor sperm or sperm preservation for artificial insemination are excluded.
3. Surrogacy or gestational carriers if the prenatal and postpartum care is covered by the intended parent(s).
4. Frozen embryo transfers, and Zygote Intra-Fallopian Transfers (ZIFT).
5. ICSI, Intracytoplasmic Sperm Injection.
6. Ova Sticks (a self-test for Infertility).
7. Ovum Transfer/Transplants or Uterine Lavage as part of Infertility diagnosis or treatment.
8. Sperm Donor, including the actual collection and storage of the sperm.
9. Donor sperm in lieu of a partner is not covered.
10. Treatment of female sterility in which a donor ovum would be necessary (e.g., post-menopausal syndrome).
11. Experimental and/or investigational diagnostic studies, procedures or drugs used to treat or determine the cause of Infertility.
12. Laboratory medical procedures involving the freezing or storing of sperm, ovum and/or pre-embryos.
13. Inoculation of women with partner's white cells (considered experimental).

Chiropractic and Acupuncture Schedule of Benefits Offered by ACN Group of California, Inc.

BENEFIT PLAN:

$20 Copayment per visit

20 visits combined Annual Benefit Maximum for Acupuncture and/or Chiropractic Services

CLAIMS DETERMINATION PERIOD:

Calendar Year

Your Group makes available to you and your eligible dependents a complementary health benefits program for chiropractic and acupuncture. This program is provided through an arrangement with the ACN Group of California, Inc. dba *OptumHealth Physical Health of California* (OptumHealth). OptumHealth monitors the quality of the care provided by participating OptumHealth providers.

How to Use the Program

With OptumHealth, you have direct access to more than 3,500 credentialed Chiropractors and over 950 credentialed Acupuncturists servicing California. You are not required to predesignate an OptumHealth provider or to obtain a medical referral from your primary care physician prior to seeking Chiropractic or Acupuncture Services. Additionally, you may change participating Chiropractors or Acupuncturists at any time.

Our program is designed for your convenience. You simply pay your Copayment at each visit. There are no deductibles or claim forms to fill out. Your OptumHealth provider coordinates all services and billing directly with OptumHealth

Annual Benefits

Benefits include Chiropractic Services and Acupuncture Services that are Medically Necessary services rendered by an OptumHealth Participating Provider. In the case of Acupuncture Services, the services must be for Medically Necessary diagnosis and treatment to correct body imbalances and conditions such as low back pain, sprains and strains (such as tennis elbow or sprained ankle), nausea, headaches, menstrual cramps, carpal tunnel syndrome, and other conditions. In the case of Chiropractic Services, the services must be for Medically Necessary diagnosis and treatment to reduce pain and improve functioning of the neuromusculoskeletal system.

Calculation of Annual Benefit Maximum Limits

Each visit to an OptumHealth Participating Provider, as described below, requires a Copayment by the Member. A maximum number of visits to either an OptumHealth participating Chiropractor or participating Acupuncturist, or any combination of both, per Claims Determination Period will apply to each Member.

Chiropractic Services: Adjunctive therapy is allowed at each office visit. If adjunctive therapy is provided without a chiropractic adjustment, the adjunctive therapy will count as an office visit toward the maximum benefit. If an examination or re-examination is supplied without an adjustment, the examination or re-examination will count as an office visit toward the maximum benefit.

Acupuncture Services: Adjunctive therapy is allowed at each office visit. If adjunctive therapy is provided without acupuncture treatment, the adjunctive therapy will count as an office visit toward the maximum benefit. If an examination or re-examination is supplied without acupuncture treatment, the examination or re-examination will count as an office visit toward the maximum benefit.

Provider Eligibility

OptumHealth only contracts with duly licensed California Chiropractors and Acupuncturists. Members must use OptumHealth Participating Providers to receive their maximum benefit.

Types of Covered Services

Chiropractic Services:

1. An initial examination is performed by the OptumHealth participating Chiropractor to determine the nature of the Member's problem, and to provide, or commence, in the initial examination, Medically Necessary services that are Covered Services, to the extent consistent with professionally recognized standards of practice, and to prepare a treatment plan of services to be furnished. An initial examination will be provided to a Member if the Member seeks services from an OptumHealth participating Chiropractor for any injury, illness, disease, functional disorder or condition with regard to which the Member is not, at the time, receiving services from the OptumHealth participating Chiropractor. A Copayment will be

required for such examination.

2. Subsequent office visits, as set forth in a treatment plan, may involve a chiropractic adjustment, a brief re-examination and other services, in various combinations. A Copayment will be required for each visit to the office.
3. Adjunctive therapy, as set forth in a treatment plan, may involve therapies such as ultrasound, electrical muscle stimulation and other therapies.
4. A re-examination may be performed by the OptumHealth participating Chiropractor to assess the need to continue, extend or change a treatment plan. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a Copayment will be required.
5. X-rays and laboratory tests are a covered benefit to examine any aspect of the Member's condition.
6. Chiropractic appliances are payable up to a maximum of $50 per year when prescribed by an OptumHealth participating Chiropractor.

Acupuncture Services:

1. An initial examination is performed by the OptumHealth participating Acupuncturist to determine the nature of the Member's problem and to provide or commence, in the initial examination, Medically Necessary services that are Covered Services, to the extent consistent with professionally recognized standards of practice, and to prepare a treatment plan of services to be furnished. An initial examination will be provided to a Member if the Member seeks services from an OptumHealth participating Acupuncturist for any injury, illness, disease, functional disorder or condition with regard to which the Member is not, at that time, receiving services from an OptumHealth participating Acupuncturist. A Copayment will be required for such examination.
2. Subsequent office visits, as set forth in a treatment plan, may involve acupuncture treatment, a brief re-examination and other services, in various combinations. A Copayment will be required for each visit to the office.
3. A re-examination may be performed by the OptumHealth participating Acupuncturist to assess the need to continue, extend or change a treatment plan. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a Copayment will be required.

Important OptumHealth Addresses:

Member Correspondence

OptumHealth of California, Inc.
P.O. Box 880009
San Diego, CA 92168-0009

Grievances and Complaints

Attn.: Grievance Coordinator
OptumHealth of California, Inc.
P.O. Box 880009
San Diego, CA 92168-0009

Exclusions and Limitations

Benefits do not include services that are not described under the Covered Services or contained elsewhere in the *Evidence Of Coverage* (EOC) provided to a Member. The following accommodations, services, supplies, and other items are specifically excluded from coverage as referenced in the EOC:

1. Any accommodation, service, supply or other item determined by Health Plan not to be Medically Necessary;
2. Any accommodation, service, supply or other item not provided in compliance with the Managed Care Program;
3. Services provided for employment, licensing, insurance, school, camp, sports, adoption, or other non-Medically Necessary purposes, and related expenses for reports, including report presentation and preparation;
4. Examination or treatment ordered by a court or in connection with legal proceedings unless such examinations or treatment otherwise qualify as Covered Services under this document;
5. Experimental or investigative services unless required by an external, independent review panel as described in Section 16.5 of the EOC;
6. Services provided at a hospital or other facility outside of a Participating Provider's facility;
7. Holistic or homeopathic care including drugs and ecological or environmental medicine;
8. Services involving the use of herbs and herbal remedies;
9. Treatment for asthma or addiction (including but not limited to smoking cessation);
10. Any services or treatments caused by or arising out of the course of employment and are covered under Workers' Compensation;
11. Transportation to and from a provider;
12. Drugs or medicines;

13. Intravenous injections or solutions;
14. Charges for services provided by a provider to his or her family member(s);
15. Charges for care or services provided before the effective date of the Member's coverage under the Group Enrollment Agreement, or after the termination of the Member's coverage under the Group Enrollment Agreement, except as otherwise provided in the Group Enrollment Agreement;
16. Special nutritional formulas, food supplements such as vitamins and minerals, or special diets;
17. Sensitivity training, electrohypnosis, electronarcosis, educational training therapy, psychoanalysis, treatment for personal growth and development, and treatment for an educational requirement;
18. Claims by providers who or which are not Participating Providers, except for claims for out-of-network Emergency Services or Urgent Services, or other services authorized by Health Plan;
19. Ambulance services;
20. Surgical services;
21. Services relating to Member education (including occupational or educational therapy) for a problem not associated with a Chiropractic Disorder or Acupuncture Disorder, unless supplied by the provider at no additional charge to the Member or to Health Plan; and
22. Non-Urgent Services performed by a provider who is a relative of Member by birth or marriage, including spouse or Domestic Partner, brother, sister, parent or child;