SUTTER BAY OPERATING UNIT SELF-FUNDED HEALTH PLAN

Coverage Period: 01-01-2017 to 12-31-2017

Summary of Benefits and Coverage: What this **Plan** Covers & What it Costs **Coverage for:** Individual + Family | **Plan Type:** EPO Plus

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or **plan** document at http://sutterselect.tpa.com or by calling 1-866-868-1320.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$250** individual / **$500** family.	See the chart starting on page 2 for your costs for services this **plan** covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this **plan** covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$750** individual / **$1,500** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Penalties, **premiums**, **balance-billed** charges, and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the **plan** will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **providers**, see http://sutterselect.tpa.com or call 1-866-868-1320.	If you use an **in-network** doctor or other health care **provider**, this **plan** will pay some or all of the costs of covered services. Be aware, your **in-network** doctor or hospital may use an **out-of-network provider** for some services. **Plans** use the terms **in-network**, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this **plan** pays different kinds of **providers**.
Do I need a referral to see a specialist?	No.	You can see the **specialist** you choose without permission from this **plan**.
Are there services this plan doesn't cover?	Yes.	Some of the services this **plan** doesn't cover are listed on page 5. See your policy or **plan** document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the **plan's allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the **plan** pays for covered services is based on the **allowed amount**. If an **out-of-network provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an **out-of-network** hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This **plan** may encourage you to use **in-network providers** by charging you lower **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20/visit (**Deductible** waived)	Not covered	none
	Specialist visit	$20/visit (**Deductible** waived)	Not covered	none
	Other practitioner office visit	$20/visit (**Deductible** waived)	Not covered	20 visit combined maximum per calendar year for Chiropractic and Acupuncture services. Visits greater than six (6) per incident require prior certification.
	Preventive care/screening/immunization	No charge	Not covered	none
If you have a test	Diagnostic test (x-ray, blood work)	No charge (inpatient) 10% **coinsurance** (outpatient)	Not covered	none
	Imaging (CT/PET scans, MRIs)	No charge (inpatient) 10% **coinsurance** (outpatient)	Not covered	Failure to receive prior certification may result in a $250 penalty per incident.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at https://mp.medimpact.com/SSP	Tier 1 Lowest cost share level; mostly **Generic** drugs and some low cost **Preferred** brands	$2.50/prescription (Peralta/ABSOP) $5/prescription (retail) $10/prescription (mail order)	Not covered	Covers up to a 30 day supply (retail and in-house prescription); up to a 90 day supply (mail order prescription). 50% **coinsurance** for oral and injectable infertility drugs. If You use a brand drug instead of its generic equivalent, You will pay the brand copay plus the difference between the brand and generic drug cost. Prior certification is required for selected drugs. ABSOP – Alta Bates Summit Outpatient Pharmacy
	Tier 2 Moderate cost share level; mostly **Preferred** brands and some non-**Preferred** **Generics**	$10/prescription (Peralta/ABSOP) $20/prescription (retail) $40/prescription (mail order)		
	Tier 3 High cost share level; mostly specialty, non-**Preferred** brands, high cost **Generics** and brands and bioengineered medications drugs	$25/prescription (Peralta/ABSOP) $40/prescription (retail) $80/prescription (mail order)		
	Specialty drugs	$50 copay with $150 max/month		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Failure to receive prior certification may result in a $250 penalty per incident.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room services	$50/visit (**Deductible** waived)		Emergency room copay waived if admitted as inpatient within 24 hours.
	Emergency medical transportation	No charge		——————none——————
	Urgent care	$30/visit (**Deductible** waived)		——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge (Sutter) $150/day for the first 3 days (Non-Sutter) (**Deductible** waived)	Not covered	Failure to receive prior certification may result in a $250 penalty per incident.
	Physician/surgeon fee	No charge	Not covered	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20/visit	Not covered	Failure to receive prior certification may result in a $250 penalty per incident.
	Mental/Behavioral health inpatient services	No charge (Sutter) $150/day for the first 3 days (Non-Sutter) (**Deductible** waived)	Not covered	
	Substance use disorder outpatient services	$20/visit	Not covered	
	Substance use disorder inpatient services	No charge (Sutter) $150/day for the first 3 days (Non-Sutter) (**Deductible** waived)	Not covered	
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	——————none——————
	Delivery and all inpatient services	No charge	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Failure to receive prior certification may result in a $250 penalty per incident.
	Rehabilitation services	$20/visit (**Deductible** waived)	Not covered	Pediatric visits prior to onset of therapy and adult visits greater than eight (8) per incident require prior certification. Failure to receive prior certification may result in a $250 penalty per incident.
	Habilitation services	$20/visit (**Deductible** waived)	Not covered	Failure to receive prior certification may result in a $250 penalty per incident.
	Skilled nursing care	No charge	Not covered	Limited to 100 days per calendar year. Failure to receive prior certification may result in a $250 penalty per incident.
	Durable medical equipment	No charge (inpatient) 10% **coinsurance** (outpatient)	Not covered	Failure to receive prior certification may result in a $250 penalty for equipment in excess of $500/month rental or $1,500/purchase.
	Hospice service	No charge	Not covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No charge	Not covered	none
	Glasses	Not covered		Coverage may be available separately.
	Dental check-up	Not covered		

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Services not deemed **medically necessary**

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (limited to 20 **in-network** visits per calendar year, combined with chiropractic care)
- Bariatric surgery
- Chiropractic Care (limited to 20 **in-network** visits per calendar year, combined with acupuncture)
- Hearing Aids (limited to 1 hearing aid, per ear, every 36 months)
- Infertility treatment
- Routine eye care (adult)
- Weight loss programs (must be physician-supervised)

Your Rights to Continue Coverage:

If you lose coverage under the **plan**, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the **plan**. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the **plan** at 1-877-292-6272. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your **plan**, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: your human resource department or the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program may help you file your **appeal**. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/prgrams/consumer/capgrants/index.html.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health **plan**. The minimum value standard is 60% (actuarial value). **This plan does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-826-9781.

This is only a summary. It in no way modifies your benefits as described in your **plan** documents. Please refer to your **plan** documents provided by your employer for complete terms of this **plan**.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next page.*

About these Coverage Examples:

These examples show how this **plan** might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different **plans**.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this **plan**. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,700
- **Patient pays** $840

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Copays	$40
Coinsurance	$500
Limits or exclusions	$0
Total	**$840**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,480
- **Patient pays** $920

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Copays	$600
Coinsurance	$20
Limits or exclusions	$0
Total	**$920**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Costs are based on individual coverage benefit levels.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health **plan**.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this **plan**.
- **Out-of-pocket** expenses are based only on treating the condition in the example.
- The patient received all care from **in-network providers**. If the patient had received care from **out-of-network providers**, costs would have been higher.
- **Prescription drug** costs (Prescriptions) shown in the Coverage Examples reflect information provided by the **Plan's** Prescription Benefits Manager.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different, based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only.

Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health **plan** allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other **plans**, you'll find the same Coverage Examples. When you compare **plans**, check the "Patient Pays" box in each example. The smaller that number, the more coverage the **plan** provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in **out-of-pocket costs**, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay **out-of-pocket** expenses.