



The Summary of Benefits and Coverage (SBC) does not cover all services. Please read the SBC carefully to understand what is covered and what you pay for. This is only a general definition of Health Coverage and Medical Terms. You may want to request a copy of the complete SBC at 1-855-315-5800 or visit [www.healthcare.gov/sbc](http://www.healthcare.gov/sbc).

### Important Questions

### Why This Matters:

<p>What is the <u>deductible</u> for individual or family coverage?</p>	<p>See the Common Medical Events chart for details.</p>
<p>Are there <u>services</u> covered before you reach your deductible?</p>	<p>You do not have to pay for services covered before you reach your deductible. See the <a href="http://www.sutterhealthcare.gov/coverage/preferred">preferred services list</a> for more information.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>You do not have to pay for specific services.</p>
<p>What is the <u>out-of-pocket</u> limit for this plan?</p>	<p>\$1,000 for individual and \$2,000 for family members. See the <a href="http://www.sutterhealthcare.gov/coverage/preferred">preferred services list</a> for more information.</p>

What is not included in the

Common Medical Services You	What You Will Pay	Limitations, Exceptions & Participating Information
You May Need	Participating Provider	Non-Participating Provider
<p><u>Primary Care (PCP) Visit to injury or illness</u></p>	<p>PCP Office Visit: \$10</p>	

\* For more information about limiations and exceptions, see

Common Medications You May Need	Physician / Services Fees	What You Will Pay		Limitations, Exceptions & Participating Information
		Participating Provider	Non-Participating Provider	
	Physician / Services Fees	Uncharge	Not covered	paying all charges.
If you need mental health, behavioral or substance use disorder (MH/SU) services	Outpatient Services	Individual Office visit per visit Group Office visit per visit Telehealth Office visit per visit Other Outpatient Service charge	Not covered	You may self-refer to SBH Office Visits. Prior authorization is required for Inpatient Services and all Inpatient Services it is not obtained when required for the payment of services.
	Behavioral Health Plan, California (USBHPC) at 1-855-202-0984 <a href="http://www.liveandworkwell.com">www.liveandworkwell.com</a> (access code: Sutter).	Facility charges	Not covered	Prenatal and Postnatal Care office visits and the first postnatal office visit subsequent to the PG Visit. Maternity care may include tests such as ultrasounds and bloodwork.
If you are pregnant	Office Visits	Prenatal and Postnatal (In-person or telephone charge)	Not covered	Prenatal and Postnatal Care office visits and the first postnatal office visit subsequent to the PG Visit. Maternity care may include tests such as ultrasounds and bloodwork.
	Childbirth / Delivery Professional Services	Delivery Charge	Not covered	
	Childbirth / Delivery Facility Services	Charge	Not covered	
	Home Health	Charge	Not covered	Prior authorization is required. You may be responsible for payment.
	Rehabilitation	Charge	Not covered	Quantitative limits exist for Home Health visits per calendar month.

Common Medical Services You May Need	What You Will Pay		Limitations, Exceptions & Participating Information
	Participating Provider	Non-Participating Provider	
If you need help recovering or have other special health	<u>Habilitation Services</u>	Not covered	Skilled Nursing Care days per benefit period. * See Skilled Nursing in EOC for additional information
	<u>Skilled Nursing Charge</u>	Not covered	Hospice Services care is covered for short-term inpatient care limited to five consecutive days at a time
	<u>Durable Medical Equipment</u>	Not covered	
	<u>Hospice Services Charge</u>	Not covered	
If your child needs dental or eye care	<u>Children's Eye Exam Charge</u>	No	2052b27 m 10elS 0g 0 G 3220ET 0 G 4Q27 Tj 4 w 668

Other Covered Services may apply to these services. [Please visit the ecom page.](#) (E003)

- Abortion
- Chiropractor provided as an optional benefit
- Acupuncture typically provided through California (ACN) for of nausea or chronic pain; separate from; separate from PCP See the ACN Schedule of Benefits for additional information.
- Bariatric surgery
- Infertility See the ACN Schedule of Benefits for through SHP. A See the ACN Schedule of Benefits for authorization by your medical group or SHP are required See the ACN Schedule of Benefits for Infertility Services Benefit Rider for

**Your Rights to Continue Coverage** agencies that can help if you want to continue your coverage agencies is: The Department of Health and Human Services, U.S. Department of Health and Human Services, 2025-Medicaid-Coverage, 267-2323 x101565, [coverage@hhs.gov](mailto:coverage@hhs.gov). Coverage options may be available to you, too, including but not limited to the following information: <https://www.hhs.gov/health-care/medicaid-coverage>. For more information, call 1-800-318-2596.

**You Grievance Appeal** There are agencies that can help if you have a grievance or appeal. See [Grievance and Appeal](#) for more information. For more information, see the [Grievance and Appeal](#) page.

To see example [sample](#) costs for a sample medical situation, see the [sample](#) page.







