Sutter Health Plan

2027 Plan Comparisons

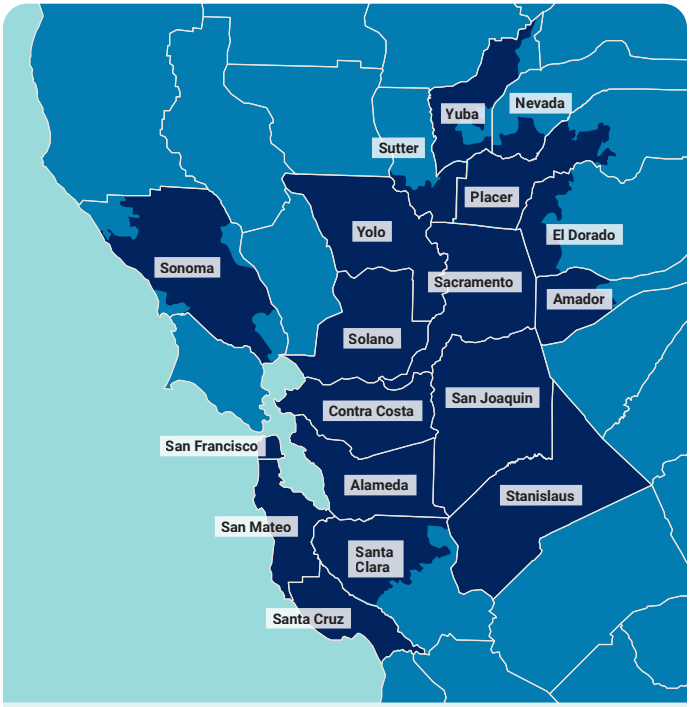
Point-of-Service Plans

Plans are subject to regulatory approval.

Sutter Health Plan offers a portfolio of point-of-service (POS) plans with copay and deductible options for large group clients.

Designed to give employers flexibility for employees or covered dependents who live outside the service area, POS plans use a simple, location-based tier structure. This structure helps manage costs through use of the Sutter Health Plan HMO Network, with additional tiers for coverage outside the defined service area within California and outside the state.

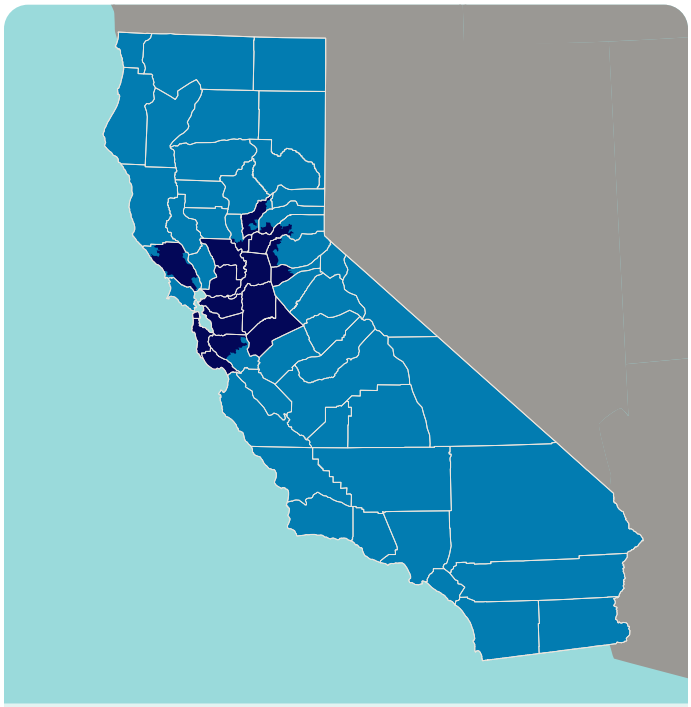
POS plans are available only when paired with a Sutter Health Plan traditional HMO plan and require that no more than 20% of eligible employees live outside the service area.



Tier 1

Sutter Health Plan HMO Network

Provides coverage within the Sutter Health Plan service area with the lowest out-of-pocket costs. Members access Sutter Health Plan HMO Network providers, including all Sutter Health facilities throughout California, and receive coordinated care through a primary care physician (PCP). Referrals and prior authorization are required for many services.



Tier 2

Prudent Buyer Plan® Network

Provides coverage within California, outside the Sutter Health Plan service area, with higher out-of-pocket costs than Tier 1. Members have access to providers through the Prudent Buyer Plan® Network* and can receive care without a PCP referral. Certain services may require precertification or prior authorization from Sutter Health Plan.

* The Prudent Buyer Plan® Network is Anthem's Prudent Buyer PPO CA Network.

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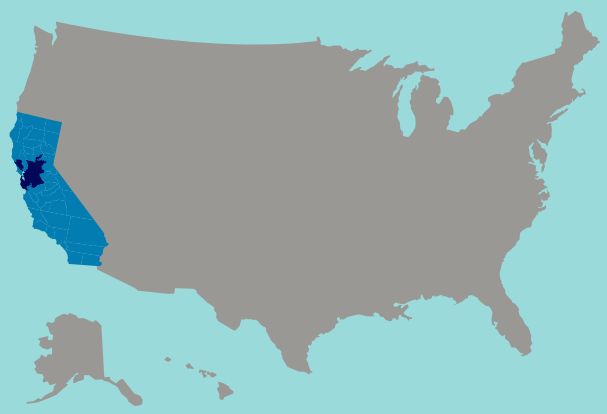

Tier 3

Out-of-Network Coverage (available with select plans)

Provides coverage outside California, with the highest out-of-pocket costs. Members may receive covered services without a PCP referral. Certain services may require precertification or prior authorization from Sutter Health Plan. Coverage is limited to 10 covered outpatient services per year. An enhanced out-of-network plan option is available, which includes expanded Tier 3 benefits and a separate deductible and out-of-pocket maximum.

Connect with our Large Group Account Executive to discuss plan options and request a quote:

Tammy Mendez
916-305-2765
Tamara.Mendez@sutterhealth.org

For renewals, contact our Account Management Manager for more information:

Bonnie Jones
916-502-5449
Bonnie.Jones@sutterhealth.org

Plans are subject to regulatory approval.

$0/$20 Copay POS

PLAN ID: LP01	TIER 1 Sutter Health Plan HMO Network	TIER 2 Prudent Buyer Plan® Network
Part D Creditability	**Creditable**	**Creditable**
HSA Compatible	**No**	**No**
Annual Out-of-Pocket Maximum		
Single/individual family member	**$1,500**	**$3,000**
Family	**$3,000**	**$6,000**
Deductible		
Single/individual family member	**$0**	**$0**
Family	**$0**	**$0**
Separate Deductible for Prescription Drugs		
Single/individual family member	**$0**	**n/a**
Family	**$0**	**n/a**
Outpatient Services		
Infertility services	Standard cost sharing*	Standard cost sharing*
Primary care physician (PCP) or other practitioner office visit	$20 copay per visit (Copay waived on 1st PCP visit)	$40 copay per visit
PCP or other practitioner telehealth visit	$10 copay per visit (Copay waived on 1st PCP visit)	$40 copay per visit
Specialist office visit	$40 copay per visit	$60 copay per visit
Specialist telehealth visit	$20 copay per visit	$60 copay per visit
Sutter Walk-In Care visit	$20 copay per visit	n/a
Preventive care	No charge	No charge
Outpatient rehabilitation visit	$20 copay per visit	$40 copay per visit
Outpatient surgery facility fee	$100 copay per visit	$150 per visit
Outpatient surgery physician/surgeon fee	No charge	No charge
Non-preventive lab tests	$10 per visit	$30 copay per visit
Radiological/nuclear imaging (CT/PET scans, MRIs)	$75 per procedure	$125 per procedure
Diagnostic and therapeutic imaging and testing (X-ray, ultrasound, EKG)	$10 per procedure	$30 copay per procedure
Hospitalization Services		
Hospitalization facility fee	$250 per day up to a maximum of 5 days per admission	$300 per day up to a maximum of 5 days per admission
Hospitalization physician/surgeon fee	No charge	No charge
Emergency and Urgent Care Services		
Emergency room services (waived if admitted)	$200 copay per visit	Covered as Tier 1
Medical transportation (including emergency and non-emergency)	$100 copay per trip	Covered as Tier 1
Urgent care	$60 copay per visit	Covered as Tier 1
Prescription Drugs	**SHP Pharmacy Network**	
Formulary Tier 1, retail (Generics)	$10 copay per prescription	
Formulary Tier 2, retail (Preferred brand)	$30 copay per prescription	
Formulary Tier 3, retail (Non-preferred brand)	$75 copay per prescription	
Formulary Tier 4 (Specialty drugs)	10% coinsurance up to $250 per prescription	
Mental Health and Substance Use Disorder (MH/SUD) Services	**Carelon Behavioral Health of California Network**	
MH/SUD outpatient office visits - individual	$20 copay per visit	
MH/SUD telehealth office visits - individual (including telephone and video visits)	$10 copay per visit	
MH/SUD inpatient facility fee (includes residential treatment)	$250 per day up to a maximum of 5 days per admission	

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* For covered services, the standard cost share applies to the type of service (e.g., office visit, outpatient lab, etc.).

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$750/$20 Low-Deductible POS

PLAN ID: LP02	TIER 1 Sutter Health Plan HMO Network	TIER 2 Prudent Buyer Plan® Network
Part D Creditability	**Creditable**	**Creditable**
HSA Compatible	**No**	**No**
Annual Out-of-Pocket Maximum		
Single/individual family member	**$1,500**	**$3,000**
Family	**$3,000**	**$6,000**
Deductible		
Single/individual family member	**$750**	**$1,500**
Family	**$1,500**	**$3,000**
Separate Deductible for Prescription Drugs		
Single/individual family member	**$100**	**n/a**
Family	**$200**	**n/a**
Outpatient Services		
Infertility services	Standard cost sharing*	Standard cost sharing*
Primary care physician (PCP) or other practitioner office visit	$20 copay per visit (Copay waived on 1st PCP visit)	$40 copay per visit
PCP or other practitioner telehealth visit	$10 copay per visit (Copay waived on 1st PCP visit)	$40 copay per visit
Specialist office visit	$40 copay per visit	$60 copay per visit
Specialist telehealth visit	$20 copay per visit	$60 copay per visit
Sutter Walk-In Care visit	$20 copay per visit	n/a
Preventive care	No charge	No charge
Outpatient rehabilitation visit	$20 copay per visit	$40 copay per visit
Outpatient surgery facility fee	10% coinsurance after deductible	20% coinsurance after deductible
Outpatient surgery physician/surgeon fee	10% coinsurance after deductible	20% coinsurance after deductible
Non-preventive lab tests	$10 copay per visit	$30 copay per visit
Radiological/nuclear imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	20% coinsurance after deductible
Diagnostic and therapeutic imaging and testing (X-ray, ultrasound, EKG)	$10 copay per procedure	$30 copay per procedure
Hospitalization Services		
Hospitalization facility fee	10% coinsurance after deductible	20% coinsurance after deductible
Hospitalization physician/surgeon fee	10% coinsurance after deductible	20% coinsurance after deductible
Emergency and Urgent Care Services		
Emergency room services (waived if admitted)	10% coinsurance after deductible	Covered as Tier 1
Medical transportation (including emergency and non-emergency)	10% coinsurance after deductible	Covered as Tier 1
Urgent care	$60 copay per visit	Covered as Tier 1
Prescription Drugs	**SHP Pharmacy Network**	
Formulary Tier 1, retail (Generics)	$10 copay per prescription	
Formulary Tier 2, retail (Preferred brand)	$30 copay per prescription after pharmacy deductible	
Formulary Tier 3, retail (Non-preferred brand)	$75 copay per prescription after pharmacy deductible	
Formulary Tier 4 (Specialty drugs)	10% coinsurance up to $250 per prescription after pharmacy deductible	
Mental Health and Substance Use Disorder (MH/SUD) Services	**Carelon Behavioral Health of California Network**	
MH/SUD outpatient office visits - individual	$20 copay per visit	
MH/SUD telehealth office visits - individual (including telephone and video visits)	$10 copay per visit	
MH/SUD inpatient facility fee (includes residential treatment)	10% coinsurance after deductible	

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* For covered services, the standard cost share applies to the type of service (e.g., office visit, outpatient lab, etc.).

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$1,500/$20 Deductible POS

PLAN ID: LP03	TIER 1 Sutter Health Plan HMO Network	TIER 2 Prudent Buyer Plan® Network
Part D Creditability	**Creditable**	**Creditable**
HSA Compatible	**No**	**No**
Annual Out-of-Pocket Maximum		
Single/individual family member	**$3,000**	**$6,000**
Family	**$6,000**	**$12,000**
Deductible		
Single/individual family member	**$1,500**	**$3,000**
Family	**$3,000**	**$6,000**
Separate Deductible for Prescription Drugs		
Single/individual family member	**$300**	**n/a**
Family	**$600**	**n/a**
Outpatient Services		
Infertility services	Standard cost sharing*	Standard cost sharing*
Primary care physician (PCP) or other practitioner office visit	$20 copay per visit	$80 copay per visit
PCP or other practitioner telehealth visit	$10 copay per visit	$80 copay per visit
Specialist office visit	$40 copay per visit	$100 copay per visit
Specialist telehealth visit	$20 copay per visit	$100 copay per visit
Sutter Walk-In Care visit	$20 copay per visit	n/a
Preventive care	No charge	No charge
Outpatient rehabilitation visit	$20 copay per visit	30% coinsurance after deductible
Outpatient surgery facility fee	10% coinsurance after deductible	30% coinsurance after deductible
Outpatient surgery physician/surgeon fee	10% coinsurance after deductible	30% coinsurance after deductible
Non-preventive lab tests	$10 copay per visit	$50 copay per visit
Radiological/nuclear imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	30% coinsurance after deductible
Diagnostic and therapeutic imaging and testing (X-ray, ultrasound, EKG)	$10 copay per procedure	$50 copay per procedure
Hospitalization Services		
Hospitalization facility fee	10% coinsurance after deductible	30% coinsurance after deductible
Hospitalization physician/surgeon fee	10% coinsurance after deductible	30% coinsurance after deductible
Emergency and Urgent Care Services		
Emergency room services (waived if admitted)	10% coinsurance after deductible	Covered as Tier 1
Medical transportation (including emergency and non-emergency)	10% coinsurance after deductible	Covered as Tier 1
Urgent care	$60 copay per visit	Covered as Tier 1
Prescription Drugs	**SHP Pharmacy Network**	
Formulary Tier 1, retail (Generics)	$10 copay per prescription	
Formulary Tier 2, retail (Preferred brand)	$30 copay per prescription after pharmacy deductible	
Formulary Tier 3, retail (Non-preferred brand)	$75 copay per prescription after pharmacy deductible	
Formulary Tier 4 (Specialty drugs)	10% coinsurance up to $250 per prescription after pharmacy deductible	
Mental Health and Substance Use Disorder (MH/SUD) Services	**Carelon Behavioral Health of California Network**	
MH/SUD outpatient office visits - individual	$20 copay per visit	
MH/SUD telehealth office visits - individual (including telephone and video visits)	$10 copay per visit	
MH/SUD inpatient facility fee (includes residential treatment)	10% coinsurance after deductible	

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* For covered services, the standard cost share applies to the type of service (e.g., office visit, outpatient lab, etc.).

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$0/$20 Copay POS + Out-of-Network

PLAN ID: LP04	TIER 1 Sutter Health Plan HMO Network	TIER 2 Prudent Buyer Plan® Network	TIER 3 Out-of-Network (Outside CA) Limited to 10 covered services per year
Part D Creditability	**Creditable**	**Creditable**	**Creditable**
HSA Compatible	**No**	**No**	**No**
Annual Out-of-Pocket Maximum			
Single/individual family member	**$1,500**	**$3,000**	**n/a**
Family	**$3,000**	**$6,000**	**n/a**
Deductible			
Single/individual family member	**$0**	**$0**	**n/a**
Family	**$0**	**$0**	**n/a**
Separate Deductible for Prescription Drugs			
Single/individual family member	**$0**	**n/a**	**n/a**
Family	**$0**	**n/a**	**n/a**
Outpatient Services			
Infertility services	Standard cost sharing*	Standard cost sharing*	Not covered
Primary care physician (PCP) or other practitioner office visit	$20 copay per visit (Copay waived on 1st PCP visit)	$40 copay per visit	$60 copay per visit
PCP or other practitioner telehealth visit	$10 copay per visit (Copay waived on 1st PCP visit)	$40 copay per visit	$60 copay per visit
Specialist office visit	$40 copay per visit	$60 copay per visit	$80 copay per visit
Specialist telehealth visit	$20 copay per visit	$60 copay per visit	$80 copay per visit
Sutter Walk-In Care visit	$20 copay per visit	n/a	n/a
Preventive care	No charge	No charge	No charge
Outpatient rehabilitation visit	$20 copay per visit	$40 copay per visit	$60 copay per visit
Outpatient surgery facility fee	$100 copay per visit	$150 copay per visit	Not covered
Outpatient surgery physician/surgeon fee	No charge	No charge	Not covered
Non-preventive lab tests	$10 copay per visit	$30 copay per visit	$50 copay per visit
Radiological/nuclear imaging (CT/PET scans, MRIs)	$75 copay per procedure	$125 copay per procedure	Not covered
Diagnostic and therapeutic imaging and testing (X-ray, ultrasound, EKG)	$10 copay per procedure	$30 copay per procedure	$50 copay per procedure
Hospitalization Services			
Hospitalization facility fee	$250 per day up to a maximum of 5 days per admission	$300 per day up to a maximum of 5 days per admission	Not covered
Hospitalization physician/surgeon fee	No charge	No charge	Not covered
Emergency and Urgent Care Services			
Emergency room services (waived if admitted)	$200 copay per visit	Covered as Tier 1	Covered as Tier 1
Medical transportation (including emergency and non-emergency)	$100 copay per trip	Covered as Tier 1	Covered as Tier 1
Urgent care	$60 copay per visit	Covered as Tier 1	Covered as Tier 1
Prescription Drugs	**SHP Pharmacy Network**		
Formulary Tier 1, retail (Generics)	$10 copay per prescription		
Formulary Tier 2, retail (Preferred brand)	$30 copay per prescription		
Formulary Tier 3, retail (Non-preferred brand)	$75 copay per prescription		
Formulary Tier 4 (Specialty drugs)	10% coinsurance up to $250 per prescription		
Mental Health and Substance Use Disorder (MH/SUD) Services	**Carelon Behavioral Health of California Network**		**Out-of-Network**
MH/SUD outpatient office visits - individual	$20 copay per visit		$60 copay per visit
MH/SUD telehealth office visits - individual (including telephone and video visits)	$10 copay per visit		$60 copay per visit
MH/SUD inpatient facility fee (includes residential treatment)	$250 per day up to a maximum of 5 days per admission		Not covered

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* For covered services, the standard cost share applies to the type of service (e.g., office visit, outpatient lab, etc.).

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$750/$20 Low-Deductible POS + Out-of-Network

PLAN ID: LP05	TIER 1 Sutter Health Plan HMO Network	TIER 2 Prudent Buyer Plan® Network	TIER 3 Out-of-Network (Outside CA) Limited to 10 covered services per year
Part D Creditability	**Creditable**	**Creditable**	**Creditable**
HSA Compatible	**No**	**No**	**No**
Annual Out-of-Pocket Maximum			
Single/individual family member	**$1,500**	**$3,000**	**n/a**
Family	**$3,000**	**$6,000**	**n/a**
Deductible			
Single/individual family member	**$750**	**$1,500**	**n/a**
Family	**$1,500**	**$3,000**	**n/a**
Separate Deductible for Prescription Drugs			
Single/individual family member	**$100**	**n/a**	**n/a**
Family	**$200**	**n/a**	**n/a**
Outpatient Services			
Infertility services	Standard cost sharing*	Standard cost sharing*	Not covered
Primary care physician (PCP) or other practitioner office visit	$20 copay per visit (Copay waived on 1st PCP visit)	$40 copay per visit	$60 copay per visit
PCP or other practitioner telehealth visit	$10 copay per visit (Copay waived on 1st PCP visit)	$40 copay per visit	$60 copay per visit
Specialist office visit	$40 copay per visit	$60 copay per visit	$80 copay per visit
Specialist telehealth visit	$20 copay per visit	$60 copay per visit	$80 copay per visit
Sutter Walk-In Care visit	$20 copay per visit	n/a	n/a
Preventive care	No charge	No charge	No charge
Outpatient rehabilitation visit	$20 copay per visit	$40 copay per visit	$60 copay per visit
Outpatient surgery facility fee	10% coinsurance after deductible	20% coinsurance after deductible	Not covered
Outpatient surgery physician/surgeon fee	10% coinsurance after deductible	20% coinsurance after deductible	Not covered
Non-preventive lab tests	$10 copay per visit	$30 copay per visit	$50 copay per visit
Radiological/nuclear imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	20% coinsurance after deductible	Not covered
Diagnostic and therapeutic imaging and testing (X-ray, ultrasound, EKG)	$10 copay per procedure	$30 copay per procedure	$50 copay per procedure
Hospitalization Services			
Hospitalization facility fee	10% coinsurance after deductible	20% coinsurance after deductible	Not covered
Hospitalization physician/surgeon fee	10% coinsurance after deductible	20% coinsurance after deductible	Not covered
Emergency and Urgent Care Services			
Emergency room services (waived if admitted)	10% coinsurance after deductible	Covered as Tier 1	Covered as Tier 1
Medical transportation (including emergency and non-emergency)	10% coinsurance after deductible	Covered as Tier 1	Covered as Tier 1
Urgent care	$60 copay per visit	Covered as Tier 1	Covered as Tier 1
Prescription Drugs	**SHP Pharmacy Network**		
Formulary Tier 1, retail (Generics)	$10 copay per prescription		
Formulary Tier 2, retail (Preferred brand)	$30 copay per prescription after pharmacy deductible		
Formulary Tier 3, retail (Non-preferred brand)	$75 copay per prescription after pharmacy deductible		
Formulary Tier 4 (Specialty drugs)	10% coinsurance up to $250 per prescription after pharmacy deductible		
Mental Health and Substance Use Disorder (MH/SUD) Services	**Carelon Behavioral Health of California Network**		**Out-of-Network**
MH/SUD outpatient office visits - individual	$20 copay per visit		$60 copay per visit
MH/SUD telehealth office visits - individual (including telephone and video visits)	$10 copay per visit		$60 copay per visit
MH/SUD inpatient facility fee (includes residential treatment)	10% coinsurance after deductible		Not covered

Plans are subject to regulatory approval.

* For covered services, the standard cost share applies to the type of service (e.g., office visit, outpatient lab, etc.).

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$1,500/$20 Deductible POS + Out-of-Network

PLAN ID: LP06	TIER 1 Sutter Health Plan HMO Network	TIER 2 Prudent Buyer Plan® Network	TIER 3 Out-of-Network (Outside CA) Limited to 10 covered services per year
Part D Creditability	**Creditable**	**Creditable**	**Creditable**
HSA Compatible	**No**	**No**	**No**
Annual Out-of-Pocket Maximum			
Single/individual family member	**$3,000**	**$6,000**	**n/a**
Family	**$6,000**	**$12,000**	**n/a**
Deductible			
Single/individual family member	**$1,500**	**$3,000**	**n/a**
Family	**$3,000**	**$6,000**	**n/a**
Separate Deductible for Prescription Drugs			
Single/individual family member	**$300**	**n/a**	**n/a**
Family	**$600**	**n/a**	**n/a**
Outpatient Services			
Infertility services	Standard cost sharing*	Standard cost sharing*	Not covered
Primary care physician (PCP) or other practitioner office visit	$20 copay per visit	$80 copay per visit	$100 copay per visit
PCP or other practitioner telehealth visit	$10 copay per visit	$80 copay per visit	$100 copay per visit
Specialist office visit	$40 copay per visit	$100 copay per visit	$120 copay per visit
Specialist telehealth visit	$20 copay per visit	$100 copay per visit	$120 copay per visit
Sutter Walk-In Care visit	$20 copay per visit	n/a	n/a
Preventive care	No charge	No charge	No charge
Outpatient rehabilitation visit	$20 copay per visit	30% coinsurance after deductible	$100 copay per visit
Outpatient surgery facility fee	10% coinsurance after deductible	30% coinsurance after deductible	Not covered
Outpatient surgery physician/surgeon fee	10% coinsurance after deductible	30% coinsurance after deductible	Not covered
Non-preventive lab tests	$10 copay per visit	$50 copay per visit	$70 copay per visit
Radiological/nuclear imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	30% coinsurance after deductible	Not covered
Diagnostic and therapeutic imaging and testing (X-ray, ultrasound, EKG)	$10 copay per procedure	$50 copay per procedure	$70 copay per procedure
Hospitalization Services			
Hospitalization facility fee	10% coinsurance after deductible	30% coinsurance after deductible	Not covered
Hospitalization physician/surgeon fee	10% coinsurance after deductible	30% coinsurance after deductible	Not covered
Emergency and Urgent Care Services			
Emergency room services (waived if admitted)	10% coinsurance after deductible	Covered as Tier 1	Covered as Tier 1
Medical transportation (including emergency and non-emergency)	10% coinsurance after deductible	Covered as Tier 1	Covered as Tier 1
Urgent care	$60 copay per visit	Covered as Tier 1	Covered as Tier 1
Prescription Drugs	**SHP Pharmacy Network**		
Formulary Tier 1, retail (Generics)	$10 copay per prescription		
Formulary Tier 2, retail (Preferred brand)	$30 copay per prescription after pharmacy deductible		
Formulary Tier 3, retail (Non-preferred brand)	$75 copay per prescription after pharmacy deductible		
Formulary Tier 4 (Specialty drugs)	10% coinsurance up to $250 per prescription after pharmacy deductible		
Mental Health and Substance Use Disorder (MH/SUD) Services	**Carelon Behavioral Health of California Network**		**Out-of-Network**
MH/SUD outpatient office visits - individual	$20 copay per visit		$100 copay per visit
MH/SUD telehealth office visits - individual (including telephone and video visits)	$10 copay per visit		$100 copay per visit
MH/SUD inpatient facility fee (includes residential treatment)	10% coinsurance after deductible		Not covered

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* For covered services, the standard cost share applies to the type of service (e.g., office visit, outpatient lab, etc.).

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$750/$20 Low-Deductible POS + Enhanced Out-of-Network

PLAN ID: LP07	TIER 1 Sutter Health Plan HMO Network	TIER 2 Prudent Buyer Plan® Network	TIER 3 Out-of-Network (Outside CA)
Part D Creditability	**Creditable**	**Creditable**	**Creditable**
HSA Compatible	**No**	**No**	**No**
Annual Out-of-Pocket Maximum[2]			
Single/individual family member	**$1,500**	**$3,000**	**$16,000**
Family	**$3,000**	**$6,000**	**$32,000**
Deductible[2]			
Single/individual family member	**$750**	**$1,500**	**$8,000**
Family	**$1,500**	**$3,000**	**$16,000**
Separate Deductible for Prescription Drugs			
Single/individual family member	**$100**	**n/a**	**n/a**
Family	**$200**	**n/a**	**n/a**
Outpatient Services			
Infertility services	Standard cost sharing*	Standard cost sharing*	Standard cost sharing*
Primary care physician (PCP) or other practitioner office visit	$20 copay per visit (Copay waived on 1st PCP visit)	$40 copay per visit	50% coinsurance
PCP or other practitioner telehealth visit	$10 copay per visit (Copay waived on 1st PCP visit)	$40 copay per visit	50% coinsurance
Specialist office visit	$40 copay per visit	$60 copay per visit	50% coinsurance
Specialist telehealth visit	$20 copay per visit	$60 copay per visit	50% coinsurance
Sutter Walk-In Care visit	$20 copay per visit	n/a	n/a
Preventive care	No charge	No charge	50% coinsurance
Outpatient rehabilitation visit	$20 copay per visit	$40 copay per visit	50% coinsurance
Outpatient surgery facility fee	10% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient surgery physician/surgeon fee	10% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Non-preventive lab tests	$10 copay per visit	$30 copay per visit	50% coinsurance
Radiological/nuclear imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Diagnostic and therapeutic imaging and testing (X-ray, ultrasound, EKG)	$10 copay per procedure	$30 copay per procedure	50% coinsurance
Hospitalization Services			
Hospitalization facility fee	10% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Hospitalization physician/surgeon fee	10% coinsurance after deductible	20% coinsurance after deductible	50% coinsurance after deductible
Emergency and Urgent Care Services			
Emergency room services (waived if admitted)	10% coinsurance after deductible	Covered as Tier 1	Covered as Tier 1
Medical transportation (including emergency and non-emergency)	10% coinsurance after deductible	Covered as Tier 1	Covered as Tier 1
Urgent care	$60 copay per visit	Covered as Tier 1	Covered as Tier 1
Prescription Drugs	**SHP Pharmacy Network**		
Formulary Tier 1, retail (Generics)	$10 copay per prescription		
Formulary Tier 2, retail (Preferred brand)	$30 copay per prescription after pharmacy deductible		
Formulary Tier 3, retail (Non-preferred brand)	$75 copay per prescription after pharmacy deductible		
Formulary Tier 4 (Specialty drugs)	10% coinsurance up to $250 per prescription after pharmacy deductible		
Mental Health and Substance Use Disorder (MH/SUD) Services	**Carelon Behavioral Health of California Network**		**Out-of-Network**
MH/SUD outpatient office visits - individual	$20 copay per visit		50% coinsurance
MH/SUD telehealth office visits - individual (including telephone and video visits)	$10 copay per visit		50% coinsurance
MH/SUD inpatient facility fee (includes residential treatment)	10% coinsurance after deductible		50% coinsurance after deductible

Plans are subject to regulatory approval.

* For covered services, the standard cost share applies to the type of service (e.g., office visit, outpatient lab, etc.).

This is only a summary. In the event of any discrepancies in information, the Sutter Health Plan Evidence of Coverage and Disclosure Form (EOC) and incorporated Benefits and Coverage Matrix (BCM) determine coverage and costs.

2027 POS 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 benefits for all family members. Deductibles and OOPMs do not cross-accumulate between network tiers.
2. Cost sharing for all essential health benefits, including that which accumulates toward an applicable deductible, accumulates toward the OOPM. Deductibles and OOPMs do not cross-accumulate between network tiers.
3. Outpatient prescription drugs, when prescribed, are medically necessary generic or brand-name drugs in accordance with Sutter Health Plan's formulary guidelines. All medically necessary prescription drug cost sharing, paid by the member, contributes toward your deductible, if applicable, and OOPM.

   Outpatient prescription drug coverage is available through CVS Caremark's national pharmacy network. You must obtain covered outpatient prescription drugs through a CVS Caremark participating pharmacy, unless otherwise stated within the EOC. Outpatient prescription drug cost sharing will apply to your Tier 1: Sutter Health Plan HMO Network deductible for prescription drugs, if applicable, and OOPM, regardless of the prescribing provider's network tier.

   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 Sutter Health Plan's CVS Health Retail-90 Network or through the CVS Caremark Mail Service Pharmacy. Most Specialty Drugs are only available for up to a 30-day supply through a CVS Caremark contracted Specialty Pharmacy. Specialty Drugs are not exclusive to formulary tier 4 and, regardless of formulary 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/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 "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.
6. Cost sharing for MH/SUD services provided by a Carelon Behavioral Health of California participating provider applies to your Tier 1: Sutter Health Plan HMO Network deductible, if applicable, and OOPM.
7. Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
8. For covered infertility and fertility services, you will pay the cost sharing you would pay for the applicable category of covered benefits.
9. The Tier 1 network is the Sutter Health Plan HMO Network. 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 Sutter Health Plan. Please consult the Seeing a Doctor and Other Providers chapter in the EOC for complete details on referral and prior authorization requirements for all covered benefits.

   The Tier 2 network is the Prudent Buyer Plan® Network, which is Anthem's Prudent Buyer PPO CA Network. Tier 2 provides coverage for services received outside of the Tier 1 service area, but within California through the Prudent Buyer Plan® Network. No referral from a PCP is required for you to access care from a Tier 2 provider, but some services do require precertification, as specified within the EOC.

   For three-tier products, Tier 3 provides limited out-of-network coverage for services received outside of California. No referral from a PCP is required for you to access care from a Tier 3 provider, but some services do require precertification, as specified within the EOC. For certain plans, Tier 3 coverage is limited to 10 out-of-network visits and certain outpatient medical services, per year, combined and cost sharing does not accumulate toward any deductible, if applicable, or OOPM.
10. Deductibles and OOPMs do not cross-accumulate between network tiers.

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