

2024 Plan Comparisons



Small Group

Medical Plans 1-100

SMALL GROUP MEDICAL PLANS

GOLD

Plan Name	MS87 HMO*	SD12 HDHP HMO*
Part D Creditability	Creditable	Creditable
HSA Compatible	No	Yes
Annual Out-of-Pocket Maximum		
Single/individual family member	\$5,000	\$6,000
Family	\$10,000	\$12,000
Deductible		
Single/individual family member	\$1,500	\$1,600/\$3,200
Family	\$3,000	\$3,200
Separate Deductible for Prescription Drugs		
Single/individual family member	\$0	N/A
Family	\$0	N/A
Professional Services		
Primary care provider (PCP) or other practitioner office visit to treat an injury or illness	\$30 copay per visit after deductible	20% coinsurance after deductible
Sutter Walk-In Care visit	\$30 copay per visit after deductible	20% coinsurance after deductible
PCP or other practitioner telehealth visit (including telephone and video visits)	\$30 copay per visit after deductible	20% coinsurance after deductible
Specialist office visit	\$50 copay per visit after deductible	20% coinsurance after deductible
Specialist telehealth visit (including telephone and video visits)	\$50 copay per visit after deductible	20% coinsurance after deductible
Preventive care	No charge	No charge
Outpatient rehabilitation visit	\$30 copay per visit after deductible	20% coinsurance after deductible
Outpatient Services		
Outpatient surgery facility fee	20% coinsurance after deductible	20% coinsurance after deductible
Outpatient surgery physician/surgeon fee	20% coinsurance after deductible	20% coinsurance after deductible
Non-preventive lab tests	\$30 copay per visit after deductible	20% coinsurance after deductible
Radiological/nuclear imaging (CT/PET scans, MRIs)	\$175 copay per procedure after deductible	20% coinsurance after deductible
Diagnostic and therapeutic imaging and testing (X-ray, ultrasound, EKG)	\$50 copay per procedure after deductible	20% coinsurance after deductible
Hospitalization Services		
Hospitalization facility fee	20% coinsurance after deductible	20% coinsurance after deductible
Hospitalization physician/surgeon fee	20% coinsurance after deductible	20% coinsurance after deductible
Emergency and Urgent Care Services		
Emergency room services (waived if admitted)	\$200 copay per visit after deductible	20% coinsurance after deductible
Medical transportation (including emergency and non-emergency)	\$200 copay per trip after deductible	20% coinsurance after deductible
Urgent care	\$30 copay per visit after deductible	20% coinsurance after deductible
Prescription Drugs		
Tier 1 - retail pharmacy	\$15 copay per prescription	\$15 copay per prescription after deductible
Tier 2 - retail pharmacy	\$30 copay per prescription	\$50 copay per prescription after deductible
Tier 3 - retail pharmacy	\$50 copay per prescription	\$80 copay per prescription after deductible
Tier 4 - specialty pharmacy	20% coinsurance up to \$250 per prescription	20% coinsurance up to \$250 per prescription after deductible
Mental Health and Substance Use Disorder (MH/SUD) Treatment Services		
MH/SUD outpatient office visits - individual	\$30 copay per visit after deductible	20% coinsurance after deductible
MH/SUD telehealth office visits - individual (including telephone and video visits)	\$30 copay per visit after deductible	20% coinsurance after deductible
MH/SUD inpatient facility fee (includes residential treatment)	20% coinsurance after deductible	20% coinsurance after deductible

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**Pending regulatory approval.*

SMALL GROUP MEDICAL PLANS

GOLD

Plan Name	MS72 HMO*	MS93 HMO*
Part D Creditability	Creditable	Creditable
HSA Compatible	No	No
Annual Out-of-Pocket Maximum		
Single/individual family member	\$7,500	\$7,800
Family	\$15,000	\$15,600
Deductible		
Single/individual family member	\$500	\$250
Family	\$1,000	\$500
Separate Deductible for Prescription Drugs		
Single/individual family member	\$0	\$0
Family	\$0	\$0
Professional Services		
Primary care provider (PCP) or other practitioner office visit to treat an injury or illness	\$30 copay per visit	\$35 copay per visit
Sutter Walk-In Care visit	\$30 copay per visit	\$35 copay per visit
PCP or other practitioner telehealth visit (including telephone and video visits)	\$30 copay per visit	\$35 copay per visit
Specialist office visit	\$50 copay per visit	\$55 copay per visit
Specialist telehealth visit (including telephone and video visits)	\$50 copay per visit	\$55 copay per visit
Preventive care	No charge	No charge
Outpatient rehabilitation visit	\$30 copay per visit	\$35 copay per visit
Outpatient Services		
Outpatient surgery facility fee	\$500 copay per visit after deductible	\$300 copay per visit after deductible
Outpatient surgery physician/surgeon fee	\$30 copay per visit after deductible	\$35 copay per visit
Non-preventive lab tests	\$30 copay per visit	\$35 copay per visit
Radiological/nuclear imaging (CT/PET scans, MRIs)	\$200 copay per procedure after deductible	\$250 copay per procedure after deductible
Diagnostic and therapeutic imaging and testing (X-ray, ultrasound, EKG)	\$30 copay per procedure	\$55 copay per procedure
Hospitalization Services		
Hospitalization facility fee	\$500 copay per day up to a maximum of 5 days per admission after deductible	\$600 copay per day up to a maximum of 5 days per admission after deductible
Hospitalization physician/surgeon fee	No charge after deductible	No charge
Emergency and Urgent Care Services		
Emergency room services (waived if admitted)	\$250 copay per visit after deductible	\$250 copay per visit after deductible
Medical transportation (including emergency and non-emergency)	\$250 copay per trip after deductible	\$250 copay per trip after deductible
Urgent care	\$30 copay per visit	\$35 copay per visit
Prescription Drugs		
Tier 1 - retail pharmacy	\$5 copay per prescription	\$15 copay per prescription
Tier 2 - retail pharmacy	\$25 copay per prescription	\$40 copay per prescription
Tier 3 - retail pharmacy	\$50 copay per prescription	\$70 copay per prescription
Tier 4 - specialty pharmacy	20% coinsurance up to \$250 per prescription	20% coinsurance up to \$250 per prescription
Mental Health and Substance Use Disorder (MH/SUD) Treatment Services		
MH/SUD outpatient office visits - individual	\$30 copay per visit	\$35 copay per visit
MH/SUD telehealth office visits - individual (including telephone and video visits)	\$30 copay per visit	\$35 copay per visit
MH/SUD inpatient facility fee (includes residential treatment)	\$500 copay per day up to a maximum of 5 days per admission after deductible	\$600 copay per day up to a maximum of 5 days per admission after deductible

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**Pending regulatory approval.*

SMALL GROUP MEDICAL PLANS

	SILVER	
Plan Name	SD11 HDHP HMO*	MS94 HMO*
Part D Creditability	Creditable	Creditable
HSA Compatible	Yes	No
Annual Out-of-Pocket Maximum		
Single/individual family member	\$7,200	\$8,750
Family	\$14,400	\$17,500
Deductible		
Single/individual family member	\$2,800/\$3,200	\$2,500
Family	\$5,600	\$5,000
Separate Deductible for Prescription Drugs		
Single/individual family member	N/A	\$300
Family	N/A	\$600
Professional Services		
Primary care provider (PCP) or other practitioner office visit to treat an injury or illness	\$35 copay per visit after deductible	\$55 copay per visit
Sutter Walk-In Care visit	\$35 copay per visit after deductible	\$55 copay per visit
PCP or other practitioner telehealth visit (including telephone and video visits)	\$35 copay per visit after deductible	\$55 copay per visit
Specialist office visit	\$50 copay per visit after deductible	\$90 copay per visit
Specialist telehealth visit (including telephone and video visits)	\$50 copay per visit after deductible	\$90 copay per visit
Preventive care	No charge	No charge
Outpatient rehabilitation visit	\$35 copay per visit after deductible	\$55 copay per visit
Outpatient Services		
Outpatient surgery facility fee	25% coinsurance after deductible	35% coinsurance after deductible
Outpatient surgery physician/surgeon fee	25% coinsurance after deductible	35% coinsurance
Non-preventive lab tests	\$35 copay per visit after deductible	\$55 copay per visit
Radiological/nuclear imaging (CT/PET scans, MRIs)	\$50 copay per procedure after deductible	\$300 copay per procedure after deductible
Diagnostic and therapeutic imaging and testing (X-ray, ultrasound, EKG)	\$15 copay per procedure after deductible	\$90 copay per procedure
Hospitalization Services		
Hospitalization facility fee	25% coinsurance after deductible	35% coinsurance after deductible
Hospitalization physician/surgeon fee	25% coinsurance after deductible	35% coinsurance
Emergency and Urgent Care Services		
Emergency room services (waived if admitted)	25% coinsurance after deductible	35% coinsurance after deductible
Medical transportation (including emergency and non-emergency)	25% coinsurance after deductible	35% coinsurance after deductible
Urgent care	\$35 copay per visit after deductible	\$55 copay per visit
Prescription Drugs		
Tier 1 - retail pharmacy	\$20 copay per prescription after deductible	\$19 copay per prescription
Tier 2 - retail pharmacy	\$40 copay per prescription after deductible	\$85 copay per prescription after pharmacy deductible
Tier 3 - retail pharmacy	\$60 copay per prescription after deductible	\$110 copay per prescription after pharmacy deductible
Tier 4 - specialty pharmacy	25% coinsurance up to \$250 per prescription after deductible	30% coinsurance up to \$250 per prescription after pharmacy deductible
Mental Health and Substance Use Disorder (MH/SUD) Treatment Services		
MH/SUD outpatient office visits - individual	\$35 copay per visit after deductible	\$55 copay per visit
MH/SUD telehealth office visits - individual (including telephone and video visits)	\$35 copay per visit after deductible	\$55 copay per visit
MH/SUD inpatient facility fee (includes residential treatment)	25% coinsurance after deductible	35% coinsurance after deductible

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SMALL GROUP MEDICAL PLANS

BRONZE

Plan Name	SD03 HDHP HMO*	MS96 HMO*
Part D Creditability	Creditable	Creditable
HSA Compatible	Yes	No
Annual Out-of-Pocket Maximum		
Single/individual family member	\$7,050	\$9,100
Family	\$14,100	\$18,200
Deductible		
Single/individual family member	\$7,050	\$6,300
Family	\$14,100	\$12,600
Separate Deductible for Prescription Drugs		
Single/individual family member	N/A	\$500
Family	N/A	\$1,000
Professional Services		
Primary care provider (PCP) or other practitioner office visit to treat an injury or illness	No charge after deductible	\$60 copay per visit after deductible, deductible waived for 1st 3 non-preventive visits
Sutter Walk-In Care visit	No charge after deductible	\$60 copay per visit after deductible, deductible waived for 1st 3 non-preventive visits
PCP or other practitioner telehealth visit (including telephone and video visits)	No charge after deductible	\$60 copay per visit after deductible, deductible waived for 1st 3 non-preventive visits
Specialist office visit	No charge after deductible	\$95 copay per visit after deductible, deductible waived for 1st 3 non-preventive visits
Specialist telehealth visit (including telephone and video visits)	No charge after deductible	\$95 copay per visit after deductible, deductible waived for 1st 3 non-preventive visits
Preventive care	No charge	No charge
Outpatient rehabilitation visit	No charge after deductible	\$60 copay per visit
Outpatient Services		
Outpatient surgery facility fee	No charge after deductible	40% coinsurance after deductible
Outpatient surgery physician/surgeon fee	No charge after deductible	40% coinsurance after deductible
Non-preventive lab tests	No charge after deductible	\$40 copay per visit
Radiological/nuclear imaging (CT/PET scans, MRIs)	No charge after deductible	40% coinsurance after deductible
Diagnostic and therapeutic imaging and testing (X-ray, ultrasound, EKG)	No charge after deductible	40% coinsurance after deductible
Hospitalization Services		
Hospitalization facility fee	No charge after deductible	40% coinsurance after deductible
Hospitalization physician/surgeon fee	No charge after deductible	40% coinsurance after deductible
Emergency and Urgent Care Services		
Emergency room services (waived if admitted)	No charge after deductible	40% coinsurance after deductible
Medical transportation (including emergency and non-emergency)	No charge after deductible	40% coinsurance after deductible
Urgent care	No charge after deductible	\$60 copay per visit after deductible, deductible waived for 1st 3 non-preventive visits
Prescription Drugs		
Tier 1 - retail pharmacy	No charge after deductible	\$17 copay per prescription after pharmacy deductible
Tier 2 - retail pharmacy	No charge after deductible	40% coinsurance up to \$500 per prescription after pharmacy deductible
Tier 3 - retail pharmacy	No charge after deductible	40% coinsurance up to \$500 per prescription after pharmacy deductible
Tier 4 - specialty pharmacy	No charge after deductible	40% coinsurance up to \$500 per prescription after pharmacy deductible
Mental Health and Substance Use Disorder (MH/SUD) Treatment Services		
MH/SUD outpatient office visits - individual	No charge after deductible	\$60 copay per visit
MH/SUD telehealth office visits - individual (including telephone and video visits)	No charge after deductible	\$60 copay per visit
MH/SUD inpatient facility fee (includes residential treatment)	No charge after deductible	40% coinsurance after deductible

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2024 Small Group Endnotes

1. Family deductibles (when applicable) and out-of-pocket maximums (OOPM) are “embedded.” This means that an individual in a family plan is responsible for no more than the “individual family member” deductible and OOPM [please see exceptions below regarding high-deductible health plans (HDHPs)]. Once an individual family member has met their deductible, that family member will only be responsible for the specified copayment or coinsurance until that individual meets the individual family member OOPM or the family as a whole meets the family OOPM, whichever comes first. Deductibles and other cost sharing payments made by each individual in a family accrue to both the “family” deductible and “family” OOPM. Once the family deductible has been met, individual family members who have not yet met the individual family member OOPM amount will continue to be responsible for the specified copayment or coinsurance until they meet the individual family member OOPM or until the family as a whole meets the “family” OOPM, at which point, Sutter Health Plus pays all costs for covered services for all family members.

For HDHPs, in a family plan, an individual family member’s deductible must be the higher of the specified “single” deductible amount or the IRS minimum of \$3,200 for 2024 plans.

2. Cost sharing amounts for all essential health benefits, including those which accumulate toward an applicable deductible, accumulate toward the OOPM.

Cost sharing for non-essential health benefits such as infertility included only in Plus plans or optional benefits elected by a group does not accrue to the deductible or OOPM.

3. Other practitioner office visits include therapy visits, other office visits not provided by either primary care physicians or specialists, or office visits not specified in another benefit category.

4. For prescription drugs, cost sharing applies per prescription for up to a 30-day supply of prescribed and medically necessary generic or brand name drugs in accordance with formulary guidelines. Maintenance drugs are available for up to a 100-day supply at twice the 30-day retail copay price, through the CVS Health Retail-90 Network or the CVS Caremark Mail Service Pharmacy. Specialty drugs are only available for up to a 30-day supply through CVS Specialty®. 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 for up to a 12-month supply. Cost sharing for a 12-month supply of contraceptives will be up to four times the retail cost share.

All medically necessary prescription drug cost sharing contributes toward the annual OOPM. Please consult specific plan designs for any applicable maximum amounts for prescription cost sharing (may not apply to all plan designs).

5. MH/SUD inpatient facility fee services 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. There may be separate cost sharing for inpatient professional fees.