

# 2024 Plan Comparisons

Small Group  
Medical Plans (1-100)



# SMALL GROUP MEDICAL PLANS | PLATINUM

PLAN NAME	MS78 HMO	MS90 HMO
<b>Part D Creditability</b>	<b>Creditable</b>	<b>Creditable</b>
<b>HSA Compatible</b>	<b>No</b>	<b>No</b>
<b>Annual Out-of-Pocket Maximum</b>		
<b>Single/individual family member</b>	<b>\$3,500</b>	<b>\$4,500</b>
<b>Family</b>	<b>\$7,000</b>	<b>\$9,000</b>
<b>Deductible</b>		
<b>Single/individual family member</b>	<b>\$0</b>	<b>\$0</b>
<b>Family</b>	<b>\$0</b>	<b>\$0</b>
<b>Separate Deductible for Prescription Drugs</b>		
<b>Single/individual family member</b>	<b>\$0</b>	<b>\$0</b>
<b>Family</b>	<b>\$0</b>	<b>\$0</b>
<b>Professional Services</b>		
<b>Primary care provider (PCP) or other practitioner office visit to treat an injury or illness</b>	\$15 copay per visit	\$20 copay per visit
<b>Sutter Walk-In Care visit</b>	\$15 copay per visit	\$20 copay per visit
<b>PCP or other practitioner telehealth visit</b> (including telephone and video visits)	\$15 copay per visit	\$20 copay per visit
<b>Specialist office visit</b>	\$30 copay per visit	\$30 copay per visit
<b>Specialist telehealth visit</b> (including telephone and video visits)	\$30 copay per visit	\$30 copay per visit
<b>Preventive care</b>	No charge	No charge
<b>Outpatient rehabilitation visit</b>	\$15 copay per visit	\$20 copay per visit
<b>Outpatient Services</b>		
<b>Outpatient surgery facility fee</b>	\$100 copay per visit	\$100 copay per visit
<b>Outpatient surgery physician/surgeon fee</b>	\$25 copay per visit	\$25 copay per visit
<b>Non-preventive lab tests</b>	\$15 copay per visit	\$20 copay per visit
<b>Radiological/nuclear imaging</b> (CT/PET scans, MRIs)	\$150 copay per procedure	\$100 copay per procedure
<b>Diagnostic and therapeutic imaging and testing</b> (X-ray, ultrasound, EKG)	\$25 copay per procedure	\$30 copay per procedure
<b>Hospitalization Services</b>		
<b>Hospitalization facility fee</b>	\$250 copay per day up to a maximum of 5 days per admission	\$250 copay per day up to a maximum of 5 days per admission
<b>Hospitalization physician/surgeon fee</b>	No charge	No charge
<b>Emergency and Urgent Care Services</b>		
<b>Emergency room services</b> (waived if admitted)	\$100 copay per visit	\$150 copay per visit
<b>Medical transportation</b> (including emergency and non-emergency)	\$100 copay per trip	\$150 copay per trip
<b>Urgent care</b>	\$15 copay per visit	\$20 copay per visit
<b>Prescription Drugs</b>		
<b>Tier 1 - retail pharmacy</b>	\$5 copay per prescription	\$5 copay per prescription
<b>Tier 2 - retail pharmacy</b>	\$15 copay per prescription	\$20 copay per prescription
<b>Tier 3 - retail pharmacy</b>	\$30 copay per prescription	\$30 copay per prescription
<b>Tier 4 - specialty pharmacy</b>	10% coinsurance up to \$250 per prescription	10% coinsurance up to \$250 per prescription
<b>Mental Health and Substance Use Disorder (MH/SUD) Treatment Services</b>		
<b>MH/SUD outpatient office visits - individual</b>	\$15 copay per visit	\$20 copay per visit
<b>MH/SUD telehealth office visits - individual</b> (including telephone and video visits)	\$15 copay per visit	\$20 copay per visit
<b>MH/SUD inpatient facility fee</b> (includes residential treatment)	\$250 copay per day up to a maximum of 5 days per admission	\$250 copay per day up to a maximum of 5 days per admission

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# SMALL GROUP MEDICAL PLANS | GOLD

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

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# SMALL GROUP MEDICAL PLANS | GOLD

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

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

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# SMALL GROUP MEDICAL PLANS | BRONZE

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