

# 2024 Plan Comparisons



## Individual and Family Medical Plans

# INDIVIDUAL AND FAMILY MEDICAL PLANS

	PLATINUM	GOLD
Plan Name	(2024) MI01 HMO*	(2024) MI02 HMO*
<b>Part D Creditability</b>	<b>Creditable</b>	<b>Creditable</b>
<b>Annual Out-of-Pocket Maximum</b>		
Single/individual family member	\$4,500	\$8,700
Family	\$9,000	\$17,400
<b>Deductible</b>		
Single/individual family member	\$0	\$0
Family	\$0	\$0
<b>Separate Deductible for Prescription Drugs</b>		
Single/individual family member	\$0	\$0
Family	\$0	\$0
<b>Professional Services</b>		
Primary care provider (PCP) or other practitioner office visit to treat an injury or illness	\$15 copay per visit	\$35 copay per visit
Sutter Walk-In Care visit	\$15 copay per visit	\$35 copay per visit
PCP or other practitioner telehealth visit (including telephone and video visits)	\$15 copay per visit	\$35 copay per visit
Specialist office visit	\$30 copay per visit	\$65 copay per visit
Specialist telehealth visit (including telephone and video visits)	\$30 copay per visit	\$65 copay per visit
Preventive care	No charge	No charge
Outpatient rehabilitation visit	\$15 copay per visit	\$35 copay per visit
<b>Outpatient Services</b>		
Outpatient surgery facility fee	10% coinsurance	30% coinsurance
Outpatient surgery physician/surgeon fee	10% coinsurance	30% coinsurance
Non-preventive lab tests	\$15 copay per visit	\$40 copay per visit
Radiological/nuclear imaging (CT/PET scans, MRIs)	10% coinsurance	25% coinsurance
Diagnostic and therapeutic imaging and testing (X-ray, ultrasound, EKG)	\$30 copay per procedure	\$75 copay per procedure
<b>Hospitalization Services</b>		
Hospitalization facility fee	10% coinsurance	30% coinsurance
Hospitalization physician/surgeon fee	10% coinsurance	30% coinsurance
<b>Emergency and Urgent Care Services</b>		
Emergency room services (waived if admitted)	\$150 copay per visit	\$350 copay per visit
Medical transportation (including emergency and non-emergency)	\$150 copay per trip	\$250 copay per trip
Urgent care	\$15 copay per visit	\$35 copay per visit
<b>Prescription Drugs</b>		
Tier 1 - retail pharmacy	\$7 copay per prescription	\$15 copay per prescription
Tier 2 - retail pharmacy	\$16 copay per prescription	\$60 copay per prescription
Tier 3 - retail pharmacy	\$25 copay per prescription	\$85 copay per prescription
Tier 4 - specialty pharmacy	10% coinsurance up to \$250 per prescription	20% coinsurance up to \$250 per prescription
<b>Mental Health and Substance Use Disorder (MH/SUD) Services</b>		
MH/SUD outpatient office visits - individual	\$15 copay per visit	\$35 copay per visit
MH/SUD telehealth office visits - individual (including telephone and video visits)	\$15 copay per visit	\$35 copay per visit
MH/SUD inpatient facility fee (includes residential treatment)	10% coinsurance	30% coinsurance

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\* Pending regulatory approval

# INDIVIDUAL AND FAMILY MEDICAL PLANS

	SILVER
<b>Plan Name</b>	<b>(2024) MI03 HMO*</b>
<b>Part D Creditability</b>	<b>Creditable</b>
<b>Annual Out-of-Pocket Maximum</b>	
<b>Single/individual family member</b>	<b>\$9,100</b>
<b>Family</b>	<b>\$18,200</b>
<b>Deductible</b>	
<b>Single/individual family member</b>	<b>\$5,400</b>
<b>Family</b>	<b>\$10,800</b>
<b>Separate Deductible for Prescription Drugs</b>	
<b>Single/individual family member</b>	<b>\$150</b>
<b>Family</b>	<b>\$300</b>
<b>Professional Services</b>	
<b>Primary care provider (PCP) or other practitioner office visit to treat an injury or illness</b>	\$50 copay per visit
<b>Sutter Walk-In Care visit</b>	\$50 copay per visit
<b>PCP or other practitioner telehealth visit (including telephone and video visits)</b>	\$50 copay per visit
<b>Specialist office visit</b>	\$90 copay per visit
<b>Specialist telehealth visit (including telephone and video visits)</b>	\$90 copay per visit
<b>Preventive care</b>	No charge
<b>Outpatient rehabilitation visit</b>	\$50 copay per visit
<b>Outpatient Services</b>	
<b>Outpatient surgery facility fee</b>	30% coinsurance
<b>Outpatient surgery physician/surgeon fee</b>	30% coinsurance
<b>Non-preventive lab tests</b>	\$50 copay per visit
<b>Radiological/nuclear imaging (CT/PET scans, MRIs)</b>	\$325 copay per procedure
<b>Diagnostic and therapeutic imaging and testing (X-ray, ultrasound, EKG)</b>	\$95 copay per procedure
<b>Hospitalization Services</b>	
<b>Hospitalization facility fee</b>	30% coinsurance after deductible
<b>Hospitalization physician/surgeon fee</b>	30% coinsurance
<b>Emergency and Urgent Care Services</b>	
<b>Emergency room services (waived if admitted)</b>	\$450 copay per visit
<b>Medical transportation (including emergency and non-emergency)</b>	\$250 copay per trip
<b>Urgent care</b>	\$50 copay per visit
<b>Prescription Drugs</b>	
<b>Tier 1 - retail pharmacy</b>	\$19 copay per prescription
<b>Tier 2 - retail pharmacy</b>	\$60 copay per prescription after pharmacy deductible
<b>Tier 3 - retail pharmacy</b>	\$90 copay per prescription after pharmacy deductible
<b>Tier 4 - specialty pharmacy</b>	20% coinsurance up to \$250 per prescription after pharmacy deductible
<b>Mental Health and Substance Use Disorder (MH/SUD) Services</b>	
<b>MH/SUD outpatient office visits - individual</b>	\$50 copay per visit
<b>MH/SUD telehealth office visits - individual (including telephone and video visits)</b>	\$50 copay per visit
<b>MH/SUD inpatient facility fee (includes residential treatment)</b>	30% coinsurance after deductible

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# INDIVIDUAL AND FAMILY MEDICAL PLANS

	BRONZE
<b>Plan Name</b>	<b>(2024) MI04 HMO*</b>
<b>Part D Creditability</b>	<b>Creditable</b>
<b>Annual Out-of-Pocket Maximum</b>	
<b>Single/individual family member</b>	<b>\$9,100</b>
<b>Family</b>	<b>\$18,200</b>
<b>Deductible</b>	
<b>Single/individual family member</b>	<b>\$6,300</b>
<b>Family</b>	<b>\$12,600</b>
<b>Separate Deductible for Prescription Drugs</b>	
<b>Single/individual family member</b>	<b>\$500</b>
<b>Family</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>	\$60 copay per visit after deductible, deductible waived for 1st 3 non-preventive visits
<b>Sutter Walk-In Care visit</b>	\$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>	\$60 copay per visit after deductible, deductible waived for 1st 3 non-preventive visits
<b>Specialist office visit</b>	\$95 copay per visit after deductible, deductible waived for 1st 3 non-preventive visits
<b>Specialist telehealth visit (including telephone and video visits)</b>	\$95 copay per visit after deductible, deductible waived for 1st 3 non-preventive visits
<b>Preventive care</b>	No charge
<b>Outpatient rehabilitation visit</b>	\$60 copay per visit
<b>Outpatient Services</b>	
<b>Outpatient surgery facility fee</b>	40% coinsurance after deductible
<b>Outpatient surgery physician/surgeon fee</b>	40% coinsurance after deductible
<b>Non-preventive lab tests</b>	\$40 copay per visit
<b>Radiological/nuclear imaging (CT/PET scans, MRIs)</b>	40% coinsurance after deductible
<b>Diagnostic and therapeutic imaging and testing (X-ray, ultrasound, EKG)</b>	40% coinsurance after deductible
<b>Hospitalization Services</b>	
<b>Hospitalization facility fee</b>	40% coinsurance after deductible
<b>Hospitalization physician/surgeon fee</b>	40% coinsurance after deductible
<b>Emergency and Urgent Care Services</b>	
<b>Emergency room services (waived if admitted)</b>	40% coinsurance after deductible
<b>Medical transportation (including emergency and non-emergency)</b>	40% coinsurance after deductible
<b>Urgent care</b>	\$60 copay per visit after deductible, deductible waived for 1st 3 non-preventive visits
<b>Prescription Drugs</b>	
<b>Tier 1 - retail pharmacy</b>	\$17 copay per prescription after pharmacy deductible
<b>Tier 2 - retail pharmacy</b>	40% coinsurance up to \$500 per prescription after pharmacy deductible
<b>Tier 3 - retail pharmacy</b>	40% coinsurance up to \$500 per prescription after pharmacy deductible
<b>Tier 4 - specialty pharmacy</b>	40% coinsurance up to \$500 per prescription after pharmacy deductible
<b>Mental Health and Substance Use Disorder (MH/SUD) Services</b>	
<b>MH/SUD outpatient office visits - individual</b>	\$60 copay per visit
<b>MH/SUD telehealth office visits - individual (including telephone and video visits)</b>	\$60 copay per visit
<b>MH/SUD inpatient facility fee (includes residential treatment)</b>	40% coinsurance after deductible

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## 2024 Individual and Family Plan 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. 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.
2. Cost sharing amounts for all essential health benefits, including those which accumulate toward an applicable deductible, accumulate toward the 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.