

**Travis Unified School District  
Sutter Health Plus Plan Benefit Comparisons**

Effective: January 1, 2024

Carrier Name	Sutter Health Plus HMO - \$10 Copay <b>Closed to New Enrollment</b>	Sutter Health Plus HMO - \$20 Copay	Sutter Health Plus HSA \$2,500
Plan Name			
<b>General Plan Information</b>			
Annual Deductible/Individual	\$0	\$500	\$2,500
Annual Deductible/Two-Party/Family	\$0	\$500/\$1,000	\$2,800/\$5,000
Office Visit/Exam/ Outpatient Specialist Visit	\$10 copay	\$20 copay no deductible	20% after deductible
Telehealth Visits - PCP, Specialist, MH/SUD	\$5 copay	\$10 copay no deductible	\$10 copay no deductible
Annual Out-of-Pocket Limit/Individual	\$1,500	\$3,000	\$4,000
Annual Out-of-Pocket Limit/Two-Party/Family	\$1,500/\$3,000	\$3,000/\$6,000	\$4,000/\$8,000
<b>Outpatient Services</b>			
Well-Child Care	\$0 copay	\$0 copay no deductible	\$0 copay no deductible
Immunizations	\$0 copay	\$0 copay no deductible	\$0 copay no deductible
Well Woman Exams/ Mammograms	\$0 copay	\$0 copay no deductible	\$0 copay no deductible
Adult Periodic Exams with Preventive Tests	\$0 copay	\$0 copay no deductible	\$0 copay no deductible
Diagnostic X-Ray and Lab Tests	\$10 copay	\$20 copay no deductible	20% after deductible
Pregnancy and Maternity Care (Pre-Natal Care)	\$0 copay	\$0 copay no deductible	\$0 copay no deductible
<b>Inpatient/Outpatient Hospital Services</b>			
Inpatient Hospitalization	\$250 copay per admission	10% after deductible	20% after deductible
Outpatient Facility Charge	\$10 copay	10% after deductible	20% after deductible
<b>Emergency Services/Urgent Care</b>			
Emergency Room	\$100 copay waived if admitted	10% after deductible, waived if admitted	20% after deductible
Urgent Care Facility	\$10 copay	\$20 copay no deductible	20% after deductible
<b>Prescription Drug Benefits</b>			
<b>Retail Prescriptions</b>			
Generic	\$10 copay no deductible	\$10 copay no deductible	\$10 copay after deductible
Brand (Formulary/Preferred)	\$30 copay no deductible	\$30 copay no deductible	\$30 copay after deductible
Brand (Non-Formulary/Non-preferred)	\$60 copay no deductible	\$60 copay no deductible	\$60 copay after deductible
Number of Days Supply	30 days	30 days	30 days
<b>Mail Order Prescriptions</b>			
Generic	\$20 copay no deductible	\$20 copay no deductible	\$20 copay after deductible
Brand (Formulary/Preferred)	\$60 copay no deductible	\$60 copay no deductible	\$60 copay after deductible
Brand (Non-Formulary/Non-preferred)	\$120 copay no deductible	\$120 copay no deductible	\$120 copay after deductible
Number of Days Supply for Mail Order	up to 100 days	up to 100 days	100 days
	20% not to exceed \$100/Rx no deductible (30 day supply)	10% not to exceed \$100/Rx no deductible (30 day supply)	20% after deductible not to exceed \$100/RX (30 day supply)
<b>Specialty Prescriptions</b>			
<b>Employee Premium - Less \$625 Employer Contribution</b>			
<b>SINGLE</b>			
12 Months	\$529.70	\$353.60	\$230.10
11 Months	\$577.85	\$385.75	\$251.02
10 Months	\$635.64	\$424.32	\$276.12
<b>TWO-PARTY</b>			
12 Months	\$1,730.70	\$1,371.30	\$1,119.40
11 Months	\$1,888.04	\$1,495.96	\$1,221.16
10 Months	\$2,076.84	\$1,645.56	\$1,343.28
<b>FAMILY</b>			
12 Months	\$1,915.30	\$1,527.90	\$1,256.30
11 Months	\$2,089.42	\$1,666.80	\$1,370.51
10 Months	\$2,298.36	\$1,833.48	\$1,507.56

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