2026 Notice of Health Plan Changes
Small Group

The following benefit and cost sharing changes apply to small group health plans effective on or after January 1, 2026.

SECTION I — Benefit Plan Design Changes

Although Sutter Health Plan (SHP) does not participate in the Covered California Health Benefit Exchange, California law requires Sutter Health Plan to offer plan designs that mirror the Patient-Centered Benefit Plan Designs issued by Covered California. Cost sharing changes to a mirrored health plan reflect changes made to the Patient-Centered Benefit Plan Designs for 2026. Please refer to the following table for changes made to the plan name and cost sharing. Sutter Health Plan also updated the Benefits and Coverage Matrix (BCM) and Summary of Benefits and Coverage (SBC) to reflect these changes. Please refer to the 2026 BCM and SBC for details.

- The cost sharing amounts for certain services, plan names and plan identifications (IDs) have changed; these changes are summarized in the 2026 Small Group Health Plan Changes Grid.

SECTION II — 2026 Evidence of Coverage and Disclosure Form (EOC) Changes

Sutter Health Plan made the following changes to the EOC to comply with recently updated regulatory requirements and to clarify existing processes. The following is not meant to be a complete list of all changes.

Chapter(s)	Section(s)	Summary of Change
WHAT YOU PAY	Deductible	Updated the IRS minimum deductible amount for High Deductible Health Plans (HDHPs) to $3,400 for plan year 2026.
SEEING A DOCTOR AND OTHER PROVIDERS	Prior Authorization	Added standard fertility preservation services to the list of services that may require prior authorization.
EMERGENCY SERVICES AND URGENT CARE	Follow-Up Care After an Emergency	Added emergency room medical care and follow-up healthcare treatment for a member who is treated following a rape or sexual assault as a covered service. Added information about what follow-up healthcare treatment includes, and that it is covered if provided by a non-Participating Provider if arranged by SHP and a provider within SHP's network is not available. Coverage is not dependent on the enrollee filing a police report, pressing charges against the assailant or securing a conviction. For non-HDHPs, members will not pay a deductible or any other cost sharing for these services for the first nine months after treatment is initiated. For HDHPs, after a member meets their deductible, they will not pay any other cost sharing for these services for the first nine months after treatment is initiated.
YOUR BENEFITS	Preventive Care Services	Added medically necessary pasteurized donor human milk obtained from a licensed tissue bank as an item covered under maternity and newborn care.

Chapter(s)	Section(s)	Summary of Change
YOUR BENEFITS	Ambulance Services, Emergency	Added the following programs as services that are emergency ambulance services when developed by a local emergency medical services agency and approved by the emergency medical services authority: • Community paramedicine program • Mobile integrated health program • Triage to alternate destination program Added language to clarify that if covered services are received from a noncontracting ground or air ambulance provider, including a noncontracting community paramedicine program, triaged to alternate destination program, or mobile integrated health program, the cost sharing will be the same as when covered services are received from a contracting ground or air ambulance provider, including a contracting community paramedicine program, triaged to alternate destination program, or mobile integrated health program.
YOUR BENEFITS	Hospital Inpatient Care	Added services for the prophylaxis, diagnosis and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) to the list of covered services under hospital inpatient care.
YOUR BENEFITS	Medically Administered Drugs	Clarified that certain medically administered drugs may require prior authorization from CVS Caremark and must be obtained from a participating pharmacy. Added drugs for the medically necessary treatment of a mental health or substance use disorder, including but not limited to injectable antipsychotic drugs, to the list of drugs that are medically administered.
YOUR BENEFITS	Mental Health and Substance Use Disorder Services	Added behavioral therapies to manage neuropsychiatric symptoms for the treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) to the list of covered mental health disorder outpatient services. Removed the requirement that outpatient prescription drugs are only covered when prescribed by a USBHPC participating practitioner or SHP participating provider. Removed the limiting language for injectable drugs for both mental health and substance use disorders.
YOUR BENEFITS	Outpatient Care	Added outpatient services for the prophylaxis, diagnosis and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) to the list of covered services.
YOUR BENEFITS	Outpatient Prescription Drugs, Supplies, Equipment and Supplements	Revised language to clarify that outpatient prescription drugs for MH/SUD services are covered when prescribed by non-participating providers.
YOUR BENEFITS	Prior Authorization for Outpatient Prescription Drugs	Added a medication-assisted treatment section to provide coverage details about the benefit.

Chapter(s)	Section(s)	Summary of Change
YOUR BENEFITS	Special Footwear and Orthotic Coverage	Renamed the section to apply to all plans, not only Plus plans. Revised the section to clarify that all plans include special footwear, inserts, services and supplies that are medically necessary to accommodate foot disfigurement caused by motor impairment, paralysis or bone deformity. Added a list of items that are covered when prescribed by a participating provider and authorized by the enrollee's medical group and medically necessary.
YOUR BENEFITS	Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS)	Added a new benefit section to provide coverage information or PANDAS and PANS, including coverage limitations, coverage requirements and cost sharing information. Specified that SHP will provide a required authorization for PANDAS and PANS prophylaxis, diagnosis, or treatment in a timely manner that is appropriate for the severity of an enrollee's condition.
YOUR BENEFITS	Outpatient Care	Added outpatient services for the prophylaxis, diagnosis and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) to the list of covered services.
INDIVIDUAL CONTINUATION OF HEALTH CARE COVERAGE (COBRA AND CAL-COBRA)	Cal-COBRA Termination and Premature Termination of Continuation Coverage	Added language to explain how Cal-COBRA subscribers may voluntarily terminate their membership.
PAYMENT AND REIMBURSEMENT	N/A	Revised language to be consistent with updated claims processing timelines.
PEDIATRIC DENTAL ADDENDUM TO EVIDENCE OF COVERAGE	Introduction, Language Assistance Services, Enrollee Complaint Procedure	Updated contact information for Delta Dental's Customer Care team and enrollee complaints.
PEDIATRIC DENTAL ADDENDUM TO EVIDENCE OF COVERAGE	Non-Discrimination Disclosure	Revised to expand the list of protected classes, add details about reasonable modifications, free auxiliary aids and language assistance services, and update contact information and instructions for filing grievances related to discrimination.
PEDIATRIC DENTAL ADDENDUM TO EVIDENCE OF COVERAGE	Schedule A and Schedule B	Revised to clarify the description of benefits and cost shares for pediatric enrollees for restoration, dentures, implants, and orthodontic treatment.

SECTION III — 2026 Health Plan Benefits and Coverage Matrix (BCM) Changes

Sutter Health Plan made the following changes to the BCM to comply with recently updated regulatory requirements and for clarity. The following is not meant to be a complete list of all changes.

Section	Heading	Summary of Change
Outpatient Services		Added a video visit option for primary care physician, other practitioner, Sutter Walk-In Care and specialist visits.
Durable Medical Equipment, Prosthetics, Orthotics and Supplies		Added special footwear to the prosthetic and orthotic devices benefit.
Mental Health & Substance Use Disorder (MH/SUD) Services		Added a video visit option for MH/SUD individual outpatient and MH/SUD group outpatient visits.
Endnotes	Endnote No. 1	Updated the IRS minimum deductible amount for High Deductible Health Plans (HDHPs) to $3,400 for plan year 2026.
Endnotes	Endnote No. 5	Updated the minimum deductible amounts for High Deductible Health Plans (HDHPs) to $1,700 for self-only coverage or $3,400 for family coverage.
Endnotes	Endnote No. 7	Added an endnote that certain medically administered drugs require prior authorization from CVS Caremark and must be obtained from a Participating Pharmacy.
Endnotes	Endnote No. 16	Removed special footwear and orthotic language from the endnote.
Endnotes	Endnote No. 19	Added endnote 19 to include information about cost sharing for Covered Services when provided by a noncontracting provider in accordance with the EOC.

SECTION IV — 2026 Summary of Benefits and Coverage (SBC) Changes

Sutter Health Plan made the following changes to the SBC for clarity. The following is not meant to be a complete list of all changes.

Section	Heading	Summary of Change
What is not included in the out-of-pocket maximum?	Answers	Removed special footwear and orthotics from what is not included in the out-of-pocket limit for plus plans.
If you need drugs to treat your illness or condition	Limitations, Exceptions & Other Important Information	Revised the retail pharmacy to be CVS Health® contracted retail network pharmacy.
If you need help recovering or have other special health needs	Limitations, Exceptions & Other Important Information	Removed all references of special footwear and orthotics for plus plans, since the benefits are included in all small group plans and are not specific to plus plans.

2026 Health Plan Changes Grid | Small Group

Please refer to the following tables for changes made to the plan names, plan identifications (IDs) and cost-sharing effective January 1, 2026.

Platinum Plans — Plan Year, Plan Name and Cost Sharing Changes

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Type of Service	**Platinum MS78 HMO**	**Platinum MS90 HMO**
Annual Out-of-Pocket Maximum (Combined Medical and Pharmacy)	Self-only: $3,500; one member in a family: $3,500; an entire family: $7,000	Self-only: $4,500; one member in a family: $4,500; an entire family: $9,000
Primary Care Physician (PCP) office/video visit to treat an injury or illness	$15 copay per visit	$20 copay per visit
Other practitioner office/video visit	$15 copay per visit	$20 copay per visit
Acupuncture services	$15 copay per visit	$20 copay per visit
Sutter Walk-In Care office/video visit, where available	$15 copay per visit	$20 copay per visit
Outpatient rehabilitation services	$15 copay per visit	$20 copay per visit
Outpatient habilitation services	$15 copay per visit	$20 copay per visit
Non-preventive laboratory services	$15 copay per visit	$20 copay per visit
Radiological and nuclear imaging	$150 copay per procedure	$100 copay per procedure
Diagnostic and therapeutic imaging and testing	$25 copay per procedure	$30 copay per procedure
Emergency room facility fee	$100 copay per visit	$150 copay per visit
Urgent Care visit	$15 copay per visit	$20 copay per visit
Medical transportation (including emergency and nonemergency)	$100 copay per trip	$150 copay per trip
Tier 2 - Preferred brand name drugs, non-preferred Generic Drugs and drugs recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost	Retail-30: $15 copay per prescription for up to a 30-day supply Retail-90/Mail order: $30 copay per prescription for up to a 100-day supply	Retail-30: $20 copay per prescription for up to a 30-day supply Retail-90/Mail order: $40 copay per prescription for up to a 100-day supply
MH/SUD individual outpatient office/video visit	$15 copay per visit	$20 copay per visit
MH/SUD group outpatient office/video visit	$7.50 copay per visit	$10 copay per visit
MH/SUD other outpatient services	$15 copay per visit	$20 copay per visit
Home health care	$15 copay per visit	$20 copay per visit

Gold Plans — Plan Year, Plan Name and Cost Sharing Changes

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Type of Service	**Gold MS72 HMO**	**Gold MS93 HMO**
Annual Deductible for Certain Medical Services	Self-only: $500; one member in a family: $500; an entire family: $1,000	Self-only: $250; one member in a family: $250; an entire family: $500
Annual Out-of-Pocket Maximum (Combined Medical and Pharmacy)	Self-only: $7,500; one member in a family: $7,500; an entire family: $15,000	Self-only: $7,800; one member in a family: $7,800; an entire family: $15,600
Primary Care Physician (PCP) office/video visit to treat an injury or illness	$30 copay per visit	$35 copay per visit
Other practitioner office/video visit	$30 copay per visit	$35 copay per visit
Acupuncture services	$30 copay per visit	$35 copay per visit
Sutter Walk-In Care office/video visit, where available	$30 copay per visit	$35 copay per visit
Specialist office/video visit	$50 copay per visit	$55 copay per visit
Outpatient rehabilitation services	$30 copay per visit	$35 copay per visit
Outpatient habilitation services	$30 copay per visit	$35 copay per visit
Outpatient surgery facility fee	$500 copay per visit after deductible	$300 copay per visit after deductible
Outpatient surgery Professional fee	$30 copay per visit after deductible	$35 copay per visit
Outpatient visit (nonoffice visit)	$30 copay per visit after deductible	20% coinsurance
Non-preventive laboratory services	$30 copay per visit	$35 copay per visit
Radiological and nuclear imaging	$200 copay per procedure after deductible	$250 copay per procedure after deductible
Diagnostic and therapeutic imaging and testing	$30 copay per procedure	$55 copay per procedure
Inpatient 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
Inpatient Professional fees	No charge after deductible	No charge
Emergency room Professional fee	No charge after deductible	No charge
Urgent Care visit	$30 copay per visit	$35 copay per visit
Tier 1 - Most Generic Drugs and low-cost preferred brand name drugs	Retail-30: $5 copay per prescription for up to a 30-day supply Retail-90/Mail order: $10 copay per prescription for up to a 100-day supply	Retail-30: $15 copay per prescription for up to a 30-day supply Retail-90/Mail order: $30 copay per prescription for up to a 100-day supply
Tier 2 - Preferred brand name drugs, non-preferred Generic Drugs and drugs recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost	Retail-30: $25 copay per prescription for up to a 30-day supply Retail-90/Mail order: $50 copay per prescription for up to a 100-day supply	Retail-30: $40 copay per prescription for up to a 30-day supply Retail-90/Mail order: $80 copay per prescription for up to a 100-day supply

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Tier 3 - Non-preferred brand name drugs or drugs that are recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost	Retail-30: $50 copay per prescription for up to a 30-day supply Retail-90/Mail order: $100 copay per prescription for up to a 100-day supply	Retail-30: $70 copay per prescription for up to a 30-day supply Retail-90/Mail order: $140 copay per prescription for up to a 100-day supply
Durable medical equipment for home use	20% coinsurance after deductible	20% coinsurance
Ostomy and urological supplies; prosthetic and orthotic devices	20% coinsurance after deductible	20% coinsurance
MH/SUD individual outpatient office/video visit	$30 copay per visit	$35 copay per visit
MH/SUD group outpatient office/video visit	$15 copay per visit	$17.50 copay per visit
MH/SUD other outpatient services	$30 copay per visit after deductible	$35 copay per visit
MH/SUD inpatient 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
MH/SUD inpatient Professional fees	No charge after deductible	No charge
Labor and delivery inpatient 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
Labor and delivery inpatient Professional fees	No charge after deductible	No charge
Skilled Nursing Facility services	$225 copay per day up to a maximum of 5 days per admission after deductible	$300 copay per day up to a maximum of 5 days per admission after deductible
Type of Service	**Gold MS87 HMO**	**Gold MS97 HMO**
Tier 3 - Non-preferred brand name drugs or drugs that are recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost	Retail-30: $50 copay per prescription for up to a 30-day supply Retail-90/Mail order: $100 copay per prescription for up to a 100-day supply	Retail-30: $60 copay per prescription for up to a 30-day supply Retail-90/Mail order: $120 copay per prescription for up to a 100-day supply
Type of Service	**Gold SD22 HDHP HMO**	**Gold SD32 HDHP HMO**
Annual Deductible for Certain Medical Services (Combined Medical and Pharmacy)	Self-only: $1,650; one member in a family: $3,300; an entire family: $3,300	Self-only: $1,700; one member in a family: $3,400; an entire family: $3,400
Tier 3 - Non-preferred brand name drugs or drugs that are recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost	Retail-30: $80 copay per prescription after pharmacy deductible for up to a 30-day supply Retail-90/Mail order: $160 copay per prescription after pharmacy deductible for up to a 100-day supply	Retail-30: $100 copay per prescription after pharmacy deductible for up to a 30-day supply Retail-90/Mail order: $200 copay per prescription after pharmacy deductible for up to a 100-day supply
Male sterilization/vasectomy services and procedures	No charge after minimum deductible of $1,650 for self-only coverage or $3,300 for family coverage	No charge after minimum deductible of $1,700 for self-only coverage or $3,400 for family coverage

Silver Plans — Plan Year, Plan Name and Cost Sharing Changes

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Type of Service	**Silver SD21 HDHP HMO**	**Silver SD31 HDHP HMO**
Annual Deductible for Certain Medical Services (Combined Medical and Pharmacy)	Self-only: $2,800; one member in a family: $3,300; an entire family: $5,600	Self-only: $2,800; one member in a family: $3,400; an entire family: $5,600
Annual Out-of-Pocket Maximum (Combined Medical and Pharmacy)	Self-only: $7,200; one member in a family: $7,200; an entire family: $14,000	Self-only: $8,000; one member in a family: $8,000; an entire family: $16,000
Tier 3 - Non-preferred brand name drugs or drugs that are recommended by SHP's pharmacy and therapeutics committee based on drug safety, efficacy and cost	Retail-30: $60 copay per prescription after pharmacy deductible for up to a 30-day supply Retail-90/Mail order: $120 copay per prescription after pharmacy deductible for up to a 100-day supply	Retail-30: $80 copay per prescription after pharmacy deductible for up to a 30-day supply Retail-90/Mail order: $160 copay per prescription after pharmacy deductible for up to a 100-day supply
Male sterilization/vasectomy services and procedures	No charge after minimum deductible of $1,650 for self-only coverage or $3,300 for family coverage	No charge after minimum deductible of $1,700 for self-only coverage or $3,400 for family coverage

Bronze Plans — Plan Year, Plan Name and Cost Sharing Changes

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Type of Service	**Bronze MS39 HMO**	**Bronze MS49 HMO**
Annual Out-of-Pocket Maximum (Combined Medical and Pharmacy)	Self-only: $8,850; one member in a family: $8,850; an entire family: $17,700	Self-only: $9,800; one member in a family: $9,800; an entire family: $19,600
Non-preventive laboratory services	$40 copay per visit	$50 copay per visit
Tier 1 - Most Generic Drugs and low-cost preferred brand name drugs	Retail-30: $19 copay per prescription for up to a 30-day supply Retail-90/Mail order: $38 copay per prescription for up to a 100-day supply	Retail-30: $20 copay per prescription for up to a 30-day supply Retail-90/Mail order: $40 copay per prescription for up to a 100-day supply
Type of Service	**Bronze SD13 HDHP HMO**	**Bronze SD23 HDHP HMO**
Annual Deductible for Certain Medical Services (Combined Medical and Pharmacy)	Self-only: $6,650; one member in a family: $6,650; an entire family: $13,300	Self-only: $7,200; one member in a family: $7,200; an entire family: $14,400
Annual Out-of-Pocket Maximum (Combined Medical and Pharmacy)	Self-only: $6,650; one member in a family: $6,650; an entire family: $13,300	Self-only: $7,200; one member in a family: $7,200; an entire family: $14,400
Male sterilization/vasectomy services and procedures	No charge after minimum deductible of $1,650 for self-only coverage or $3,300 for family coverage	No charge after minimum deductible of $1,700 for self-only coverage or $3,400 for family coverage