

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 | <p>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:</p> <ul style="list-style-type: none"> • Community paramedicine program • Mobile integrated health program • Triage to alternate destination program <p>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.</p> |
| YOUR BENEFITS | Hospital Inpatient Care | <p>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.</p> |
| YOUR BENEFITS | Medically Administered Drugs | <p>Clarified that certain medically administered drugs may require prior authorization from CVS Caremark and must be obtained from a participating pharmacy.</p> <p>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.</p> |
| YOUR BENEFITS | Mental Health and Substance Use Disorder Services | <p>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.</p> <p>Removed the requirement that outpatient prescription drugs are only covered when prescribed by a USBHPC participating practitioner or SHP participating provider.</p> <p>Removed the limiting language for injectable drugs for both mental health and substance use disorders.</p> |
| YOUR BENEFITS | Outpatient Care | <p>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.</p> |
| YOUR BENEFITS | Outpatient Prescription Drugs, Supplies, Equipment and Supplements | <p>Revised language to clarify that outpatient prescription drugs for MH/SUD services are covered when prescribed by non-participating providers.</p> |
| YOUR BENEFITS | Prior Authorization for Outpatient Prescription Drugs | <p>Added a medication-assisted treatment section to provide coverage details about the benefit.</p> |

| 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

| Type of Service | 2025 Cost Sharing | 2026 Cost Sharing (As of January 1, 2026) |
|---|--|--|
| | Platinum MP78 Plus HMO | Platinum MP90 Plus 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 | <u>Retail-30</u> : \$15 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$30 copay per prescription for up to a 100-day supply | <u>Retail-30</u> : \$20 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$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 MP72 Plus HMO | Gold MP93 Plus 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 | <u>Retail-30</u> : \$50 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$100 copay per prescription for up to a 100-day supply | <u>Retail-30</u> : \$70 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$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 MP87 Plus HMO | Gold MP97 Plus 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 | <u>Retail-30</u> : \$50 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$100 copay per prescription for up to a 100-day supply | <u>Retail-30</u> : \$60 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription for up to a 100-day supply |
| Type of Service | Gold SP22 Plus HDHP HMO | Gold SP32 Plus 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 | <u>Retail-30</u> : \$80 copay per prescription after pharmacy deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$160 copay per prescription after pharmacy deductible for up to a 100-day supply | <u>Retail-30</u> : \$100 copay per prescription after pharmacy deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$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 SP21 Plus HDHP HMO | Silver SP31 Plus 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 | <u>Retail-30</u> : \$60 copay per prescription after pharmacy deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription after pharmacy deductible for up to a 100-day supply | <u>Retail-30</u> : \$80 copay per prescription after pharmacy deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$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 MP39 HMO | Bronze MP49 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 | <u>Retail-30</u> : \$19 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$38 copay per prescription for up to a 100-day supply | <u>Retail-30</u> : \$20 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$40 copay per prescription for up to a 100-day supply |
| Type of Service | Bronze SP13 Plus HDHP HMO | Bronze SP23 Plus 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 |