

2026 Notice of Health Plan Changes

Large Group

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

SECTION I — Benefit Plan Design Changes

The cost sharing amounts for certain services, plan names and plan identifications have changed. These changes are summarized in the attached 2026 Large Group Health Plan Changes Grid.

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.

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	Dialysis Care	Removed the dialysis care exclusion.
YOUR BENEFITS	Durable Medical Equipment	Removed comfort, convenience, or luxury equipment or features from the limitations and exclusions section.
YOUR BENEFITS	Gender Dysphoria Treatment	Added Trans-Inclusive Health Care to be included in this benefit section.
YOUR BENEFITS	Health Education	Removed the health education limitation and exclusions section.
YOUR BENEFITS	Hearing Services	Removed the hearing services exclusion section.
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	Infertility and Fertility Services	Revised this section to clarify that SHP covers medically necessary services, supplies and drugs for the diagnosis and treatment of infertility and fertility services, in accordance with the guidelines of the American Society for Reproductive Medicine. Also added definitions, coverage information, and limitations and exclusions to this section.
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>

Chapter(s)	Section(s)	Summary of Change
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> <p>Removed the exclusion subsection from the mental health and substance use disorder services section.</p>
YOUR BENEFITS	Ostomy and Urological Supplies	Removed the ostomy and urological supplies exclusion.
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	<p>Removed the language referencing certain injectable drugs as not applicable in the paragraph about outpatient drugs that are not self-administered.</p> <p>Removed the limiting information for how outpatient prescription drugs must be prescribed.</p> <p>Removed the exclusions and limitations section.</p>
YOUR BENEFITS	Prior Authorization for Outpatient Prescription Drugs	Added a medication-assisted treatment section to provide coverage details about the benefit.
YOUR BENEFITS	Prosthetic and Orthotic Devices	Removed the prosthetic and orthotic devices exclusion.
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	Rehabilitation and Habilitation Services	Removed the rehabilitation and habilitation exclusion.
YOUR BENEFITS	Reconstructive Surgery	Removed the reconstructive surgery exclusion.
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	Services Associated with Approved Clinical Trials	<p>Revised this section to be consistent with the Department of Managed Health Care's standardized Evidence of Coverage.</p> <p>Removed the Services Associated with Approved Clinical Trials exclusion.</p>

Chapter(s)	Section(s)	Summary of Change
EXCLUSIONS AND LIMITATIONS	General Exclusions	Removed General Exclusion No. 9 related to the treatment of infertility, as these services are no longer excluded.
EXCLUSIONS AND LIMITATIONS	N/A	<p>Revised the entire Exclusions and Limitations section to be consistent with the Department of Managed Health Care's standardized Evidence of Coverage and to include limitations and exclusions related to the following services and supplies:</p> <ul style="list-style-type: none"> • Acupuncture & Chiropractic Services • Clinical Trials • Cosmetic Services/Surgery • Custodial/Domiciliary Care • Dental Services • Dietary/Nutritional Supplements • Disposable Home Supplies • Experimental/Investigational Services • Vision Care & Hearing Aids • Non-preventive Immunizations • Non-licensed/non-certified providers • Prescription Drugs • Private Duty Nursing • Personal/Comfort Items • Reversal of Voluntary Sterilization • Surrogate Pregnancy • Therapies • Routine Physical Exams • Travel & Lodging • Weight Control/Exercise Management
PAYMENT AND REIMBURSEMENT	How to File a Claim	Revised the language to be consistent with updated claims processing timelines.
MEMBER RIGHTS AND RESPONSIBILITIES	N/A	Revised the entire Rights and Responsibilities section to be consistent with the Department of Managed Health Care's standardized Evidence of Coverage and to provide details around a member's right to guaranteed information, access to timely and appropriate care, respect and cultural competence, participation in treatment decisions, privacy protections, language access, and fair grievance/appeal processes.
DEFINITIONS	N/A	<p>Created a new definition for the following:</p> <ul style="list-style-type: none"> • Advanced Health Care Directive • Appropriately Qualified Health Care Provider • Approved Clinical Trial Health Care Provider • Independent Medical Review • Investigational Services • Experimental Services • Mental Health or Substance Use Disorder • Prescription Drug or "drug" • Psychiatric Emergency Medical Condition • Seriously Debilitating • Trans-Inclusive Health Care
DEFINITIONS	N/A	<p>Revised the definition for the following:</p> <ul style="list-style-type: none"> • Covered Benefits • Emergency Medical Condition • Emergency Services • Evidence of Coverage • Medically Necessary • Member • Outpatient Prescription Drug • Service Area • Standard Fertility Preservation Services

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.
Mental Health & Substance Use Disorder (MH/SUD) Services		Added a video visit option for MH/SUD individual outpatient and MH/SUD group outpatient visits.
Other Services for Special Health Needs	Infertility and Fertility Services	Added infertility and fertility services benefit.
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. 8	Added language to clarify that infertility and fertility services are included in the outpatient visit (nonoffice visit) benefit.
Endnotes	Endnote No. 16	Added a new endnote to specify that covered infertility and fertility services are the same cost sharing as applicable categories of covered services.
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 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
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.
Excluded Services & Other Covered Service	Other Covered Services	Added infertility treatment as a covered service.

2026 Health Plan Changes Grid | Large Group

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

2025 Plan Name and ID	2026 Plan Name and ID
Summit ML78 HMO	Summit LG18 HMO
Summit ML79 HMO	Summit LG19 HMO
Summit ML80 HMO	Summit LG20 HMO
Summit ML81 HMO	Summit LG18 HMO
Summit ML82 HMO	Summit LG21 HMO
Summit ML83 HMO	Summit LG22 HMO
Summit ML84 HMO	Summit LG18 HMO
Peak ML85 HMO	Peak LG23 HMO
Peak ML86 HMO	Peak LG24 HMO
Peak ML87 HMO	Peak LG25 HMO
Peak ML88 HMO	Peak LG26 HMO
Peak ML89 HMO	Peak LG27 HMO
Peak ML90 HMO	Peak LG28 HMO
Peak ML91 HMO	Peak LG29 HMO
Ridge ML92 HMO	Ridge LG30 HMO
Ridge ML93 HMO	Ridge LG31 HMO
Ridge ML94 HMO	Ridge LG32 HMO
Vista HD34 HDHP HMO	Vista HL10 HDHP HMO
Vista HD35 HDHP HMO	Vista HL11 HDHP HMO
Vista HD36 HDHP HMO	Vista HL10 HDHP HMO
Vista HD37 HDHP HMO	Vista HL12 HDHP HMO
Vista HD38 HDHP HMO	Vista HL11 HDHP HMO
Vista HD39 HDHP HMO	Vista HL13 HDHP HMO
Vista HD40 HDHP HMO	Vista HL14 HDHP HMO

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

Type of Service	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
	Summit ML78 HMO	Summit LG18 HMO
Primary Care Physician (PCP) office/video visit to treat an injury or illness	<u>Office visit</u> : \$10 copay per visit; <u>Telehealth visit</u> : \$5 copay per visit	<u>Office visit</u> : \$20 copay per visit; <u>Telehealth visit</u> : \$10 copay per visit
Other practitioner office/video visit	<u>Office visit</u> : \$10 copay per visit; <u>Telehealth visit</u> : \$5 copay per visit	<u>Office visit</u> : \$20 copay per visit; <u>Telehealth visit</u> : \$10 copay per visit
Acupuncture services	\$10 copay per visit	\$20 copay per visit
Sutter Walk-In Care office/video visit, where available	<u>Office/telehealth visit</u> : \$5 copay per visit	<u>Office/telehealth visit</u> : \$10 copay per visit
Specialist office/video visit	<u>Office visit</u> : \$10 copay per visit; <u>Telehealth visit</u> : \$5 copay per visit	<u>Office visit</u> : \$40 copay per visit; <u>Telehealth visit</u> : \$20 copay per visit
Outpatient rehabilitation services	\$10 copay per visit	\$20 copay per visit
Outpatient habilitation services	Not covered	\$20 copay per visit
Outpatient surgery facility fee	\$10 copay per visit	\$50 copay per visit
Outpatient visit (nonoffice visit)	\$10 copay per visit	\$50 copay per visit
Inpatient facility fee	\$250 copay per admission	\$250 copay per day up to a maximum of 5 days per admission
Emergency room facility fee	\$100 copay per visit	\$200 copay per visit
Urgent Care visit	\$10 copay per visit	\$40 copay per visit
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 for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription for up to a 100-day supply
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600)	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$250 prescription for up to a 30-day supply	<u>Specialty Pharmacy</u> : 10% coinsurance up to \$250 prescription for up to a 30-day supply
Durable medical equipment for home use	20% coinsurance	50% coinsurance
Ostomy and urological supplies; prosthetic and orthotic devices	No charge	50% coinsurance
MH/SUD inpatient facility fee	\$250 copay per admission	\$250 copay per day up to a maximum of 5 days per admission
MH/SUD individual outpatient office/video visit	<u>Office visit</u> : \$10 copay per visit; <u>Telehealth visit</u> : \$5 copay per visit	<u>Office visit</u> : \$20 copay per visit; <u>Telehealth visit</u> : \$10 copay per visit
MH/SUD group outpatient office/video visit	\$5 copay per visit	\$10 copay per visit
MH/SUD other outpatient services	\$10 copay per visit	\$50 copay per visit

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Labor and delivery inpatient facility fee	\$250 copay per admission	\$250 copay per day up to a maximum of 5 days per admission
Skilled Nursing Facility services	\$100 copay per admission	\$125 copay per day up to a maximum of 5 days per admission
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Summit ML79 HMO	Summit LG19 HMO
Specialist office/video visit	Office visit: \$25 copay per visit; Telehealth visit: \$10 copay per visit	Office visit: \$50 copay per visit; Telehealth visit: \$25 copay per visit
Outpatient surgery facility fee	\$10 copay per visit	\$50 copay per visit
Outpatient visit (nonoffice visit)	\$10 copay per visit	\$50 copay per visit
Inpatient facility fee	\$500 copay per admission	\$100 copay per day up to a maximum of 5 days per admission
Emergency room facility fee	\$150 copay per visit	\$200 copay per visit
Urgent Care visit	\$25 copay per visit	\$50 copay per visit
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 for up to a 30-day supply Retail-90/Mail order: \$120 copay per prescription for up to a 100-day supply	Retail-30: \$75 copay per prescription for up to a 30-day supply Retail-90/Mail order: \$150 copay per prescription for up to a 100-day supply
Durable medical equipment for home use	20% coinsurance	50% coinsurance
Ostomy and urological supplies; prosthetic and orthotic devices	No charge	50% coinsurance
MH/SUD inpatient facility fee	\$500 copay per admission	\$100 copay per day up to a maximum of 5 days per admission
MH/SUD other outpatient services	\$10 copay per visit	\$50 copay per visit
Labor and delivery inpatient facility fee	\$500 copay per admission	\$100 copay per day up to a maximum of 5 days per admission
Skilled Nursing Facility services	\$250 copay per admission	\$50 copay per day up to a maximum of 5 days per admission
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Summit ML80 HMO	Summit LG20 HMO
Specialist office/video visit	Office visit: \$10 copay per visit; Telehealth visit: \$5 copay per visit	Office visit: \$20 copay per visit; Telehealth visit: \$10 copay per visit
Outpatient surgery facility fee	No charge	\$25 copay per visit
Outpatient visit (nonoffice visit)	No charge	\$25 copay per visit

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Diagnostic and therapeutic imaging and testing	No charge	\$10 copay per procedure
Inpatient facility fee	No charge	\$100 copay per day up to a maximum of 5 days per admission
Emergency room facility fee	\$50 copay per visit	\$100 copay per visit
Urgent Care visit	\$10 copay per visit	\$20 copay per visit
MH/SUD inpatient facility fee	No charge	\$100 copay per day up to a maximum of 5 days per admission
MH/SUD other outpatient services	No charge	\$25 copay per visit
Labor and delivery inpatient facility fee	No charge	\$100 copay per day up to a maximum of 5 days per admission
Skilled Nursing Facility services	No charge	\$50 copay per day up to a maximum of 5 days per admission
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Summit ML81 HMO	Summit LG18 HMO
Specialist office/video visit	<u>Office visit</u> : \$20 copay per visit; <u>Telehealth visit</u> : \$10 copay per visit	<u>Office visit</u> : \$40 copay per visit; <u>Telehealth visit</u> : \$20 copay per visit
Outpatient surgery facility fee	\$100 copay per visit	\$50 copay per visit
Outpatient surgery Professional fee	\$20 copay per visit	No charge
Outpatient visit (nonoffice visit)	\$100 copay per visit	\$50 copay per visit
Non-preventive laboratory services	\$20 copay per visit	\$10 copay per visit
Radiological and nuclear imaging	No charge	\$50 copay per procedure
Diagnostic and therapeutic imaging and testing	No charge	\$10 copay per procedure
Inpatient facility fee	\$250 copay per admission	\$250 copay per day up to a maximum of 5 days per admission
Emergency room facility fee	\$100 copay per visit	\$200 copay per visit
Urgent Care visit	\$20 copay per visit	\$40 copay per visit
Medical transportation (including emergency and nonemergency)	\$50 copay per trip	\$100 copay per trip
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 for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription for up to a 100-day supply

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$250 prescription for up to a 30-day supply	<u>Specialty Pharmacy</u> : 10% coinsurance up to \$250 prescription for up to a 30-day supply
Durable medical equipment for home use	20% coinsurance	50% coinsurance
Ostomy and urological supplies; prosthetic and orthotic devices	No charge	50% coinsurance
MH/SUD inpatient facility fee	\$250 copay per admission	\$250 copay per day up to a maximum of 5 days per admission
MH/SUD other outpatient services	\$100 copay per visit	\$50 copay per visit
Labor and delivery inpatient facility fee	\$250 copay per admission	\$250 copay per day up to a maximum of 5 days per admission
Skilled Nursing Facility services	\$200 copay per admission	\$125 copay per day up to a maximum of 5 days per admission
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Summit ML82 HMO	Summit LG21 HMO
Annual Out-of-Pocket Maximum (OOPM) (Combined Medical and Pharmacy)	Self-only: \$2,000; one member in a family: \$2,000; an entire family: \$4,000	Self-only: \$2,500; one member in a family: \$2,500; an entire family: \$5,000
Specialist office/video visit	<u>Office visit</u> : \$30 copay per visit; <u>Telehealth visit</u> : \$15 copay per visit	<u>Office visit</u> : \$60 copay per visit; <u>Telehealth visit</u> : \$30 copay per visit
Inpatient facility fee	\$500 copay per admission	\$250 copay per day up to a maximum of 5 days per admission
Emergency room facility fee	\$150 copay per visit	\$200 copay per visit
Urgent Care visit	\$40 copay per visit	\$60 copay per visit
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 for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription for up to a 100-day supply
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$100 prescription for up to a 30-day supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$250 prescription for up to a 30-day supply
Durable medical equipment for home use	20% coinsurance	50% coinsurance

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Ostomy and urological supplies; prosthetic and orthotic devices	No charge	50% coinsurance
MH/SUD inpatient facility fee	\$500 copay per admission	\$250 copay per day up to a maximum of 5 days per admission
Labor and delivery inpatient facility fee	\$500 copay per admission	\$250 copay per day up to a maximum of 5 days per admission
Skilled Nursing Facility services	No charge	\$125 copay per day up to a maximum of 5 days per admission
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Summit ML83 HMO	Summit LG22 HMO
Specialist office/video visit	Office visit: \$40 copay per visit; Telehealth visit: \$20 copay per visit	Office visit: \$80 copay per visit; Telehealth visit: \$40 copay per visit
Inpatient facility fee	\$500 copay per admission	\$500 copay per day up to a maximum of 5 days per admission
Emergency room facility fee	\$150 copay per visit	\$200 copay per visit
Urgent Care visit	\$40 copay per visit	\$80 copay per visit
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 for up to a 30-day supply Retail-90/Mail order: \$120 copay per prescription for up to a 100-day supply	Retail-30: \$75 copay per prescription for up to a 30-day supply Retail-90/Mail order: \$150 copay per prescription for up to a 100-day supply
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply	Specialty Pharmacy: 20% coinsurance up to \$100 prescription for up to a 30-day supply	Specialty Pharmacy: 20% coinsurance up to \$250 prescription for up to a 30-day supply
Durable medical equipment for home use	20% coinsurance	50% coinsurance
Ostomy and urological supplies; prosthetic and orthotic devices	No charge	50% coinsurance
MH/SUD inpatient facility fee	\$500 copay per admission	\$500 copay per day up to a maximum of 5 days per admission
Labor and delivery inpatient facility fee	\$500 copay per admission	\$500 copay per day up to a maximum of 5 days per admission
Skilled Nursing Facility services	No charge	\$250 copay per day up to a maximum of 5 days per admission

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Summit ML84 HMO	Summit LG18 HMO
Primary Care Physician (PCP) office/video visit to treat an injury or illness	<u>Office visit</u> : \$15 copay per visit; <u>Telehealth visit</u> : \$5 copay per visit	<u>Office visit</u> : \$20 copay per visit; <u>Telehealth visit</u> : \$10 copay per visit
Other practitioner office/video visit	<u>Office visit</u> : \$15 copay per visit; <u>Telehealth visit</u> : \$5 copay per visit	<u>Office visit</u> : \$20 copay per visit; <u>Telehealth visit</u> : \$10 copay per visit
Acupuncture services	\$15 copay per visit	\$20 copay per visit
Sutter Walk-In Care office/video visit, where available	<u>Office/telehealth visit</u> : \$5 copay per visit	<u>Office/telehealth visit</u> : \$10 copay per visit
Specialist office/video visit	<u>Office visit</u> : \$15 copay per visit; <u>Telehealth visit</u> : \$5 copay per visit	<u>Office visit</u> : \$40 copay per visit; <u>Telehealth visit</u> : \$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
Outpatient surgery facility fee	\$15 copay per visit	\$50 copay per visit
Outpatient visit (nonoffice visit)	\$15 copay per visit	\$50 copay per visit
Non-preventive laboratory services	No charge	\$10 copay per visit
Radiological and nuclear imaging	\$15 copay per procedure	\$50 copay per procedure
Diagnostic and therapeutic imaging and testing	No charge	\$10 copay per procedure
Inpatient facility fee	No charge	\$250 copay per day up to a maximum of 5 days per admission
Emergency room facility fee	\$35 copay per visit	\$200 copay per visit
Urgent Care visit	\$15 copay per visit	\$40 copay per visit
Medical transportation (including emergency and nonemergency)	No charge	\$100 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> : \$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	<u>Retail-30</u> : \$30 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$60 copay per prescription for up to a 100-day supply
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> : \$35 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$70 copay per prescription for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription for up to a 100-day supply

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600)	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$100 prescription for up to a 30-day supply	<u>Specialty Pharmacy</u> : 10% coinsurance up to \$250 prescription for up to a 30-day supply
Durable medical equipment for home use	No charge	50% coinsurance
Ostomy and urological supplies; prosthetic and orthotic devices	No charge	50% coinsurance
MH/SUD inpatient facility fee	No charge	\$250 copay per day up to a maximum of 5 days per admission
MH/SUD individual outpatient office/video visit	<u>Office visit</u> : \$15 copay per visit; <u>Telehealth visit</u> : \$5 copay per visit	<u>Office visit</u> : \$20 copay per visit; <u>Telehealth visit</u> : \$10 copay per visit
MH/SUD group outpatient office/video visit	<u>Office visit</u> : MH: \$7 copay per visit SUD: \$5 copay per visit <u>Telehealth visit</u> : \$5 copay per visit	<u>Office visit</u> : \$10 copay per visit; <u>Telehealth visit</u> : \$10 copay per visit
MH/SUD other outpatient services	No charge	\$50 copay per visit
Labor and delivery inpatient facility fee	No charge	\$250 copay per day up to a maximum of 5 days per admission
Skilled Nursing Facility services	No charge	\$125 copay per day up to a maximum of 5 days per admission
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services

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

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Type of Service	Peak ML85 HMO	Peak LG23 HMO
Specialist office/video visit	<u>Office visit</u> : \$20 copay per visit; <u>Telehealth visit</u> : \$10 copay per visit	<u>Office visit</u> : \$40 copay per visit; <u>Telehealth visit</u> : \$20 copay per visit
Medical transportation (including emergency and nonemergency)	No charge after deductible	10% coinsurance after deductible
Urgent Care visit	\$20 copay per visit	\$40 copay per visit
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 for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription for up to a 100-day supply

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply	<u>Specialty Pharmacy</u> : 10% coinsurance up to \$100 prescription for up to a 30-day supply	<u>Specialty Pharmacy</u> : 10% coinsurance up to \$250 prescription for up to a 30-day supply
Durable medical equipment for home use	20% coinsurance after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge	50% coinsurance after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Peak ML86 HMO	Peak LG24 HMO
Specialist office/video visit	<u>Office visit</u> : \$20 copay per visit; <u>Telehealth visit</u> : \$10 copay per visit	<u>Office visit</u> : \$40 copay per visit; <u>Telehealth visit</u> : \$20 copay per visit
Medical transportation (including emergency and nonemergency)	No charge after deductible	20% coinsurance after deductible
Urgent Care visit	\$20 copay per visit	\$40 copay per visit
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 for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription for up to a 100-day supply
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$100 prescription for up to a 30-day supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$250 prescription for up to a 30-day supply
Durable medical equipment for home use	20% coinsurance after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge	50% coinsurance after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Peak ML87 HMO	Peak LG25 HMO
Specialist office/video visit	<u>Office visit</u> : \$20 copay per visit; <u>Telehealth visit</u> : \$10 copay per visit	<u>Office visit</u> : \$40 copay per visit; <u>Telehealth visit</u> : \$20 copay per visit
Medical transportation (including emergency and nonemergency)	No charge after deductible	20% coinsurance after deductible
Urgent Care visit	\$20 copay per visit	\$40 copay per visit

	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> : \$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	<u>Retail-30</u> : \$75 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription for up to a 100-day supply
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$100 prescription for up to a 30-day supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$250 prescription for up to a 30-day supply
Durable medical equipment for home use	20% coinsurance after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge	50% coinsurance after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Peak ML88 HMO	Peak LG26 HMO
Specialist office/video visit	<u>Office visit</u> : \$20 copay per visit; <u>Telehealth visit</u> : \$10 copay per visit	<u>Office visit</u> : \$40 copay per visit; <u>Telehealth visit</u> : \$20 copay per visit
Medical transportation (including emergency and nonemergency)	No charge after deductible	20% coinsurance after deductible
Urgent Care visit	\$20 copay per visit	\$40 copay per visit
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 for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription for up to a 100-day supply
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$100 prescription for up to a 30-day supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$250 prescription for up to a 30-day supply
Durable medical equipment for home use	20% coinsurance after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge	50% coinsurance after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Peak ML89 HMO	Peak LG27 HMO
Specialist office/video visit	<u>Office visit</u> : \$20 copay per visit; <u>Telehealth visit</u> : \$10 copay per visit	<u>Office visit</u> : \$40 copay per visit; <u>Telehealth visit</u> : \$20 copay per visit

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Medical transportation (including emergency and nonemergency)	No charge after deductible	30% coinsurance after deductible
Urgent Care visit	\$20 copay per visit	\$40 copay per visit
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 for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription for up to a 100-day supply
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply	<u>Specialty Pharmacy</u> : 30% coinsurance up to \$100 prescription for up to a 30-day supply	<u>Specialty Pharmacy</u> : 30% coinsurance up to \$250 prescription for up to a 30-day supply
Durable medical equipment for home use	20% coinsurance after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge	50% coinsurance after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Peak ML90 HMO	Peak LG28 HMO
Specialist office/video visit	<u>Office visit</u> : \$45 copay per visit; <u>Telehealth visit</u> : \$20 copay per visit	<u>Office visit</u> : \$90 copay per visit; <u>Telehealth visit</u> : \$45 copay per visit
Emergency room facility fee	\$100 copay per visit after deductible	\$200 copay per visit after deductible
Urgent Care visit	\$45 copay per visit	\$90 copay per visit
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 for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription for up to a 100-day supply
Durable medical equipment for home use	30% coinsurance after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	30% coinsurance after deductible	50% coinsurance after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Peak ML91 HMO	Peak LG29 HMO
Annual Out-of-Pocket Maximum (OOPM) (Combined Medical and Pharmacy)	Self-only: \$6,500; one member in a family: \$6,500; an entire family: \$13,000	Self-only: \$9,000; one member in a family: \$9,000; an entire family: \$18,000
Specialist office/video visit	<u>Office visit</u> : \$50 copay per visit; <u>Telehealth visit</u> : \$25 copay per visit	<u>Office visit</u> : \$100 copay per visit; <u>Telehealth visit</u> : \$50 copay per visit
Emergency room facility fee	\$150 copay per visit after deductible	\$300 copay per visit after deductible

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Urgent Care visit	\$50 copay per visit	\$100 copay per visit
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 for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription for up to a 100-day supply
Durable medical equipment for home use	30% coinsurance after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	30% coinsurance after deductible	50% coinsurance after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services

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

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Type of Service	Ridge ML92 HMO	Ridge LG30 HMO
Specialist office/video visit	<u>Office visit</u> : \$40 copay per visit; <u>Telehealth visit</u> : \$20 copay per visit	<u>Office visit</u> : \$80 copay per visit; <u>Telehealth visit</u> : \$40 copay per visit
Inpatient facility fee	\$500 copay per admission after deductible	\$500 copay per day up to a maximum of 5 days per admission after deductible
Emergency room facility fee	\$150 copay per visit after deductible	\$300 copay per visit after deductible
Urgent Care visit	\$40 copay per visit	\$80 copay per visit
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 for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription for up to a 100-day supply
Durable medical equipment for home use	20% coinsurance after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge	50% coinsurance after deductible
MH/SUD inpatient facility fee	\$500 copay per admission after deductible	\$500 copay per day up to a maximum of 5 days per admission after deductible
Labor and delivery inpatient facility fee	\$500 copay per admission after deductible	\$500 copay per day up to a maximum of 5 days per admission after deductible
Skilled Nursing Facility services	\$200 copay per admission after deductible	\$250 copay per day up to a maximum of 5 days per admission after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Type of Service	Ridge LG93 HMO	Ridge LG31 HMO
Specialist office/video visit	<u>Office visit</u> : \$40 copay per visit; <u>Telehealth visit</u> : \$20 copay per visit	<u>Office visit</u> : \$80 copay per visit; <u>Telehealth visit</u> : \$40 copay per visit
Inpatient facility fee	\$500 copay per admission after deductible	\$250 copay per day up to a maximum of 5 days per admission after deductible
Emergency room facility fee	\$100 copay per visit after deductible	\$200 copay per visit after deductible
Urgent Care visit	\$40 copay per visit	\$80 copay per visit
Medical transportation (including emergency and nonemergency)	No charge	\$200 copay per trip
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 for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription for up to a 100-day supply
Durable medical equipment for home use	20% coinsurance after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge	50% coinsurance after deductible
MH/SUD inpatient facility fee	\$500 copay per admission after deductible	\$250 copay per day up to a maximum of 5 days per admission after deductible
Labor and delivery inpatient facility fee	\$500 copay per admission after deductible	\$250 copay per day up to a maximum of 5 days per admission after deductible
Skilled Nursing Facility services	\$200 copay per admission after deductible	\$125 copay per day up to a maximum of 5 days per admission after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Ridge ML94 HMO	Ridge LG32 HMO
Specialist office/video visit	<u>Office visit</u> : \$20 copay per visit; <u>Telehealth visit</u> : \$10 copay per visit	<u>Office visit</u> : \$40 copay per visit; <u>Telehealth visit</u> : \$20 copay per visit
Inpatient facility fee	\$500 copay per admission after deductible	\$250 copay per day up to a maximum of 5 days per admission after deductible
Emergency room facility fee	\$100 copay per visit after deductible	\$200 copay per visit after deductible
Urgent Care visit	\$20 copay per visit	\$40 copay per visit
Medical transportation (including emergency and nonemergency)	No charge	\$200 copay per trip

	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> : \$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	<u>Retail-30</u> : \$75 copay per prescription for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription for up to a 100-day supply
Durable medical equipment for home use	20% coinsurance after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge	50% coinsurance after deductible
MH/SUD inpatient facility fee	\$500 copay per admission after deductible	\$250 copay per day up to a maximum of 5 days per admission
Labor and delivery inpatient facility fee	\$500 copay per admission after deductible	\$250 copay per day up to a maximum of 5 days per admission after deductible
Skilled Nursing Facility services	\$200 copay per admission after deductible	\$125 copay per day up to a maximum of 5 days per admission after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services

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

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Type of Service	Vista HD34 HDHP HMO	Vista HL10 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
Annual Out-of-Pocket Maximum (Combined Medical and Pharmacy)	Self-only: \$3,300; one member in a family: \$3,300; an entire family: \$6,600	Self-only: \$3,400; one member in a family: \$3,400; an entire family: \$6,800
Specialist office/video visit	<u>Office visit</u> : \$20 copay per visit after deductible; <u>Telehealth visit</u> : \$10 copay per visit after deductible	<u>Office visit</u> : \$40 copay per visit after deductible; <u>Telehealth visit</u> : \$20 copay per visit after deductible
Outpatient surgery facility fee	\$20 copay per visit after deductible	\$100 copay per visit after deductible
Outpatient visit (nonoffice visit)	\$20 copay per visit after deductible	\$100 copay per visit after deductible
Emergency room facility fee	\$100 copay per visit after deductible	\$200 copay per visit after deductible
Urgent Care visit	\$20 copay per visit after deductible	\$40 copay per visit after deductible
Medical transportation (including emergency and nonemergency)	\$100 copay per trip after deductible	\$200 copay per trip after deductible

	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> : \$60 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription after deductible for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription after deductible for up to a 100-day supply
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$100 prescription after deductible for up to a 30-day supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$250 prescription after deductible for up to a 30-day supply
Durable medical equipment for home use	20% coinsurance after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge after deductible	50% coinsurance after deductible
MH/SUD other outpatient services	\$20 copay per visit after deductible	\$100 copay per visit after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Vista HD35 HDHP HMO	Vista HL11 HDHP HMO
Annual Deductible for Certain Medical Services (Combined Medical and Pharmacy)	Self-only: \$2,500; one member in a family: \$3,300; an entire family: \$5,000	Self-only: \$2,500; one member in a family: \$3,400; an entire family: \$5,000
Specialist office/video visit	<u>Office visit</u> : \$40 copay per visit after deductible; <u>Telehealth visit</u> : \$20 copay per visit after deductible	<u>Office visit</u> : \$80 copay per visit after deductible; <u>Telehealth visit</u> : \$40 copay per visit after deductible
Outpatient surgery facility fee	\$40 copay per visit after deductible	\$250 copay per visit after deductible
Outpatient visit (nonoffice visit)	\$40 copay per visit after deductible	\$250 copay per visit after deductible
Emergency room facility fee	\$100 copay per visit after deductible	\$200 copay per visit after deductible
Urgent Care visit	\$40 copay per visit after deductible	\$80 copay per visit after deductible
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 deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription after deductible for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription after deductible for up to a 100-day supply
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$100 prescription after deductible for up to a 30-day supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$250 prescription after deductible for up to a 30-day supply

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Durable medical equipment for home use	20% coinsurance after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge after deductible	50% coinsurance after deductible
MH/SUD other outpatient services	\$40 copay per visit after deductible	\$250 copay per visit after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Vista HD36 HDHP HMO	Vista HL10 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
Annual Out-of-Pocket Maximum (Combined Medical and Pharmacy)	Self-only: \$3,300; one member in a family: \$3,300; an entire family: \$6,600	Self-only: \$3,400; one member in a family: \$3,400; an entire family: \$6,800
Primary Care Physician (PCP) office/video visit to treat an injury or illness	<u>Office visit</u> : 10% coinsurance after deductible <u>Telehealth visit</u> : 10% coinsurance after deductible	<u>Office visit</u> : \$20 copay per visit after deductible; <u>Telehealth visit</u> : \$10 copay per visit after deductible
Other practitioner office/video visit	<u>Office visit</u> : 10% coinsurance after deductible <u>Telehealth visit</u> : 10% coinsurance after deductible	<u>Office visit</u> : \$20 copay per visit after deductible; <u>Telehealth visit</u> : \$10 copay per visit after deductible
Acupuncture services	10% coinsurance after deductible	\$20 copay per visit after deductible
Sutter Walk-In Care office/video visit, where available	<u>Office/telehealth visit</u> : 10% coinsurance after deductible	<u>Office/telehealth visit</u> : \$10 copay per visit after deductible
Specialist office/video visit	<u>Office visit</u> : 10% coinsurance after deductible <u>Telehealth visit</u> : 10% coinsurance after deductible	<u>Office visit</u> : \$40 copay per visit after deductible; <u>Telehealth visit</u> : \$20 copay per visit after deductible
Outpatient rehabilitation services	10% coinsurance after deductible	\$20 copay per visit after deductible
Outpatient surgery facility fee	10% coinsurance after deductible	\$100 copay per visit after deductible
Outpatient surgery Professional fee	10% coinsurance after deductible	No charge after deductible
Outpatient visit (nonoffice visit)	10% coinsurance after deductible	\$100 copay per visit after deductible
Non-preventive laboratory services	10% coinsurance after deductible	\$20 copay per visit after deductible
Radiological and nuclear imaging	10% coinsurance after deductible	\$50 copay per procedure after deductible
Diagnostic and therapeutic imaging and testing	10% coinsurance after deductible	\$10 copay per procedure after deductible
Inpatient facility fee	10% coinsurance after deductible	\$250 copay per day up to a maximum of 5 days per admission after deductible
Inpatient Professional fees	10% coinsurance after deductible	No charge after deductible

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Emergency room facility fee	10% coinsurance after deductible	\$200 copay per visit after deductible
Emergency room Professional fee	10% coinsurance after deductible	No charge after deductible
Urgent Care visit	10% coinsurance after deductible	\$40 copay per visit after deductible
Medical transportation (including emergency and nonemergency)	No charge after deductible	\$200 copay per trip after deductible
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 deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription after deductible for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription after deductible for up to a 100-day supply
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply	<u>Specialty Pharmacy</u> : 10% coinsurance up to \$100 prescription after deductible for up to a 30-day supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$250 prescription after deductible for up to a 30-day supply
Durable medical equipment for home use	20% coinsurance after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge after deductible	50% coinsurance after deductible
MH/SUD inpatient facility fee	10% coinsurance after deductible	\$250 copay per day up to a maximum of 5 days per admission after deductible
MH/SUD inpatient Professional fees	10% coinsurance after deductible	No charge after deductible
MH/SUD individual outpatient office/video visit	<u>Office visit</u> : 10% coinsurance after deductible <u>Telehealth visit</u> : 10% coinsurance after deductible	<u>Office visit</u> : \$20 copay per visit after deductible; <u>Telehealth visit</u> : \$10 copay per visit after deductible
MH/SUD group outpatient office/video visit	<u>Office visit</u> : 10% coinsurance after deductible <u>Telehealth visit</u> : 10% coinsurance after deductible	<u>Office visit</u> : \$10 copay per visit after deductible; <u>Telehealth visit</u> : \$10 copay per visit after deductible
MH/SUD other outpatient services	10% coinsurance after deductible	\$100 copay per visit after deductible
Labor and delivery inpatient facility fee	10% coinsurance after deductible	\$250 copay per day up to a maximum of 5 days per admission after deductible
Labor and delivery inpatient Professional fees	10% coinsurance after deductible	No charge after deductible
Skilled Nursing Facility services	10% coinsurance after deductible	\$100 copay per day up to a maximum of 5 days per admission after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Type of Service	Vista HD37 HDHP HMO	Vista HL12 HDHP HMO
Specialist office/video visit	<u>Office visit</u> : \$40 copay per visit after deductible; <u>Telehealth visit</u> : \$20 copay per visit after deductible	<u>Office visit</u> : \$80 copay per visit after deductible; <u>Telehealth visit</u> : \$40 copay per visit after deductible
Outpatient surgery facility fee	\$40 copay per visit after deductible	\$250 copay per visit after deductible
Outpatient visit (nonoffice visit)	\$40 copay per visit after deductible	\$250 copay per visit after deductible
Inpatient facility fee	\$500 copay per admission after deductible	\$500 copay per day up to a maximum of 5 days per admission after deductible
Emergency room facility fee	\$150 copay per visit after deductible	\$300 copay per visit after deductible
Urgent Care visit	\$40 copay per visit after deductible	\$80 copay per visit after deductible
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 deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription after deductible for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription after deductible for up to a 100-day supply
Durable medical equipment for home use	20% coinsurance after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge after deductible	50% coinsurance after deductible
MH/SUD inpatient facility fee	\$500 copay per admission after deductible	\$500 copay per day up to a maximum of 5 days per admission after deductible
MH/SUD other outpatient services	\$40 copay per visit after deductible	\$250 copay per visit after deductible
Labor and delivery inpatient facility fee	\$500 copay per admission after deductible	\$500 copay per day up to a maximum of 5 days per admission after deductible
Skilled Nursing Facility services	\$250 copay per admission after deductible	\$250 copay per day up to a maximum of 5 days per admission after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Vista HD38 HDHP HMO	Vista HL11 HDHP HMO
Annual Deductible for Certain Medical Services (Combined Medical and Pharmacy)	Self-only: \$2,500; one member in a family: \$3,300; an entire family: \$5,000	Self-only: \$2,500; one member in a family: \$3,400; an entire family: \$5,000
Annual Out-of-Pocket Maximum (Combined Medical and Pharmacy)	Self-only: \$5,000; one member in a family: \$5,000; an entire family: \$10,000	Self-only: \$4,000; one member in a family: \$4,000; an entire family: \$8,000
Primary Care Physician (PCP) office/video visit to treat an injury or illness	<u>Office visit</u> : No charge after deductible <u>Telehealth visit</u> : No charge after deductible	<u>Office visit</u> : \$40 copay per visit after deductible; <u>Telehealth visit</u> : \$20 copay per visit after deductible

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Other practitioner office/video visit	<u>Office visit</u> : No charge after deductible <u>Telehealth visit</u> : No charge after deductible	<u>Office visit</u> : \$40 copay per visit after deductible; <u>Telehealth visit</u> : \$20 copay per visit after deductible
Acupuncture services	No charge after deductible	\$40 copay per visit after deductible
Sutter Walk-In Care office/video visit, where available	<u>Office/telehealth visit</u> : No charge after deductible	<u>Office/telehealth visit</u> : \$20 copay per visit after deductible
Specialist office/video visit	<u>Office visit</u> : No charge after deductible <u>Telehealth visit</u> : No charge after deductible	<u>Office visit</u> : \$80 copay per visit after deductible; <u>Telehealth visit</u> : \$40 copay per visit after deductible
Outpatient rehabilitation services	No charge after deductible	\$40 copay per visit after deductible
Outpatient surgery facility fee	No charge after deductible	\$250 copay per visit after deductible
Outpatient visit (nonoffice visit)	No charge after deductible	\$250 copay per visit after deductible
Non-preventive laboratory services	No charge after deductible	\$40 copay per visit after deductible
Radiological and nuclear imaging	No charge after deductible	\$50 copay per procedure after deductible
Diagnostic and therapeutic imaging and testing	No charge after deductible	\$15 copay per procedure after deductible
Inpatient facility fee	\$50 copay per admission after deductible	\$500 copay per day up to a maximum of 5 days per admission after deductible
Emergency room facility fee	No charge after deductible	\$200 copay per visit after deductible
Urgent Care visit	No charge after deductible	\$80 copay per visit after deductible
Medical transportation (including emergency and nonemergency)	No charge after deductible	\$100 copay per trip after deductible
Tier 1 - Most Generic Drugs and low-cost preferred brand name drugs	<u>Retail-30</u> : No charge after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : No charge after deductible for up to a 100-day supply	<u>Retail-30</u> : \$10 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$20 copay per prescription after deductible 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	<u>Retail-30</u> : No charge after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : No charge after deductible for up to a 100-day supply	<u>Retail-30</u> : \$30 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$60 copay per prescription after deductible 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> : \$60 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription after deductible for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription after deductible for up to a 100-day supply
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply	<u>Specialty Pharmacy</u> : No charge after deductible for up to a 30-day supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$250 prescription after deductible for up to a 30-day supply
Durable medical equipment for home use	No charge after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge after deductible	50% coinsurance after deductible
MH/SUD inpatient facility fee	\$50 copay per admission after deductible	\$500 copay per day up to a maximum of 5 days per admission after deductible
MH/SUD individual outpatient office/video visit	<u>Office visit</u> : No charge after deductible <u>Telehealth visit</u> : No charge after deductible	<u>Office visit</u> : \$40 copay per visit after deductible; <u>Telehealth visit</u> : \$20 copay per visit after deductible
MH/SUD group outpatient office/video visit	<u>Office visit</u> : No charge after deductible <u>Telehealth visit</u> : No charge after deductible	<u>Office visit</u> : \$20 copay per visit after deductible; <u>Telehealth visit</u> : \$20 copay per visit after deductible
MH/SUD other outpatient services	No charge after deductible	\$250 copay per visit after deductible
Labor and delivery inpatient facility fee	\$50 copay per admission after deductible	\$500 copay per day up to a maximum of 5 days per admission after deductible
Skilled Nursing Facility services	No charge after deductible	\$250 copay per day up to a maximum of 5 days per admission after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Vista HD39 HDHP HMO	Vista HL13 HDHP HMO
Annual Deductible for Certain Medical Services (Combined Medical and Pharmacy)	Self-only: \$2,500; one member in a family: \$3,300; an entire family: \$5,000	Self-only: \$2,500; one member in a family: \$3,400; an entire family: \$5,000
Medical transportation (including emergency and nonemergency)	No charge after deductible	20% coinsurance after deductible
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 deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$120 copay per prescription after deductible for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription after deductible for up to a 100-day supply

	2025 Cost Sharing	2026 Cost Sharing (As of January 1, 2026)
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$100 prescription after deductible for up to a 30-day supply	<u>Specialty Pharmacy</u> : 20% coinsurance up to \$250 prescription after deductible for up to a 30-day supply
Durable medical equipment for home use	20% coinsurance after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge after deductible	50% coinsurance after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services
Type of Service	Vista HD40 HDHP HMO	Vista HL14 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: \$1,750; one member in a family: \$3,400; an entire family: \$3,500
Annual Out-of-Pocket Maximum (Combined Medical and Pharmacy)	Self-only: \$3,300; one member in a family: \$3,300; an entire family: \$6,600	Self-only: \$3,500; one member in a family: \$3,500; an entire family: \$7,000
Outpatient surgery facility fee	No charge after deductible	10% coinsurance after deductible
Outpatient surgery Professional fee	No charge after deductible	10% coinsurance after deductible
Outpatient visit (nonoffice visit)	No charge after deductible	10% coinsurance after deductible
Non-preventive laboratory services	No charge after deductible	10% coinsurance after deductible
Radiological and nuclear imaging	No charge after deductible	10% coinsurance after deductible
Diagnostic and therapeutic imaging and testing	No charge after deductible	10% coinsurance after deductible
Inpatient facility fee	\$50 copay per admission after deductible	10% coinsurance after deductible
Emergency room facility fee	No charge after deductible	10% coinsurance after deductible
Emergency room Professional fee	No charge after deductible	10% coinsurance after deductible
Urgent Care visit	No charge after deductible	10% coinsurance after deductible
Medical transportation (including emergency and nonemergency)	No charge after deductible	10% coinsurance after deductible
Tier 1 - Most Generic Drugs and low-cost preferred brand name drugs	<u>Retail-30</u> : No charge after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : No charge after deductible for up to a 100-day supply	<u>Retail-30</u> : \$10 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$20 copay per prescription after deductible 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	<u>Retail-30</u> : No charge after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : No charge after deductible for up to a 100-day supply	<u>Retail-30</u> : \$30 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$60 copay per prescription after deductible 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> : No charge after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : No charge after deductible for up to a 100-day supply	<u>Retail-30</u> : \$75 copay per prescription after deductible for up to a 30-day supply <u>Retail-90/Mail order</u> : \$150 copay per prescription after deductible for up to a 100-day supply
Tier 4 - Drugs that the Food and Drug Administration (FDA) or the manufacturer requires to be distributed through a Specialty Pharmacy, drugs that require the Member to have special training or clinical monitoring for self-administration, or drugs that cost SHP more than six hundred dollars (\$600) net of rebates for a one-month supply	<u>Specialty Pharmacy</u> : No charge after deductible for up to a 30-day supply	<u>Specialty Pharmacy</u> : 10% coinsurance up to \$250 prescription after deductible for up to a 30-day supply
Durable medical equipment for home use	No charge after deductible	50% coinsurance after deductible
Ostomy and urological supplies; prosthetic and orthotic devices	No charge after deductible	50% coinsurance after deductible
MH/SUD inpatient facility fee	\$50 copay per admission after deductible	10% coinsurance after deductible
MH/SUD other outpatient services	No charge after deductible	10% coinsurance after deductible
Labor and delivery inpatient facility fee	\$50 copay per admission after deductible	10% coinsurance after deductible
Skilled Nursing Facility services	No charge after deductible	10% coinsurance after deductible
Infertility and fertility services as described in the EOC	N/A	See applicable category of Covered Services