

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit us at www.valleyhealthplan.org or call 1-888-421-8444. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [Copayment](#), [deductible](#), [provider](#), or other [underlined](#) terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or <https://www.dol.gov/ebsa/healthreform> or call 1-888-421-8444.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible ? | \$0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible ? | Yes | This plan does not have a deductible . See the chart starting on page 2 for other costs for services this plan covers. |
| Are there other deductibles for specific services? | No | You do not have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan ? | \$1,000 individual/\$2,000 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| What is not included in the out-of-pocket limit ? | Premiums, and health care this plan does not cover. | Even though you pay these expenses, they do not count toward the out-of-pocket limit . |
| Will you pay less if you use a network provider ? | Yes. See Valley Health Plan Provider Search or call 1-888-421-8444 for a list of network providers . | If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers . |
| Do you need a referral to see a specialist ? | Yes. You need a written referral to see a specialist . Exceptions include self-referral to Plan OB/GYNs . | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist . |

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(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|---|
| | | Network Provider (You will pay the least) | Out-of-network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$0 Copay | Not covered | None |
| | Specialist visit | \$0 Copay | Not covered | Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services. |
| | Preventive care/screening/immunization | No charge | Not covered | None |
| If you have a test | Diagnostic test (x-ray, blood work) | Lab – \$0 Copay X-ray – \$0 Copay | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | \$0 Copay | Not covered | Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Valley Health Plan Prescription Drug Coverage | Generic drugs | \$0 Copay/ prescription (retail & mail order). | Not covered | Prescriptions filled at an Out-of-network Pharmacy are covered if related to care for a medical emergency or urgently needed care. If your prescription is not listed on the formulary , prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services. |
| | Brand drugs | \$0 Copay/ prescription (retail & mail order). | Not covered | <u>Retail</u> : Up to 90-day supply for Generic and Brand drugs <u>Mail Order</u> : Up to 90-day supply for Generic and Brand Maintenance drugs |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$0 Copay | Not covered | Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services. |
| | Physician/surgeon fees | \$0 Copay | Not covered | None |

[* For more information about limitations and exceptions, see the [plan](#) or policy document at www.valleyhealthplan.org.]

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|---|--|---|---|---|
| If you need immediate medical attention | Emergency room care | Facility - \$0 Copay Physician - \$0 Copay | Facility - \$0 Copay Physician - \$0 Copay | None |
| | Emergency medical transportation | \$0 Copay | \$0 Copay | None |
| | Urgent care | \$0 Copay | \$0 Copay | Urgent care from non-participating providers when outside of the service area is covered. Prior written authorization is required for urgent care from non-participating providers when inside the service area . Urgent care services at Non-Plan Providers within the Service Area must be Prior Authorized before services are rendered or you may be financially responsible for all charges. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$0 Copay | Not covered | Prior written authorization is required for elective admissions. If you do not get preauthorization , you may be financially responsible for the full cost of such services. |
| | Physician/surgeon fees | \$0 Copay | Not covered | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$0 Copay | Not covered | None |
| | Inpatient services | \$0 Copay | Not covered | Prior written authorization is required for elective admissions. If you do not get preauthorization , you may be financially responsible for the full cost of such services. |
| If you are pregnant | Office visits | No charge | Not covered | None |
| | Childbirth/delivery professional services | \$0 Copay | Not covered | None |
| | Childbirth/delivery facility services | \$0 Copay | Not covered | |
| If you need help recovering or have other special health needs | Home health care | \$0 Copay | Not covered | 100 visits/benefit year. Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services. |
| | Rehabilitation services | \$0 Copay | Not covered | Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services. |
| | Habilitation services | \$0 Copay | Not covered | |
| | Skilled nursing care | \$0 Copay | Not covered | 100 days/benefit period. Prior written |

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|---|---|-------------|-------------|--|
| | | | | authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services. |
| | Durable medical equipment | \$0 Copay | Not covered | Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services. |
| | Hospice services | No charge | No charge | Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services. |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services. |
| | Children's glasses | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | None |

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Other Covered Services (Limitations may apply to these services. This is not a complete list. Please see your [plan](#) document.)

- Acupuncture (Limited to a maximum of 24 prescribed visits per Plan Year)
- Bariatric surgery
- Chiropractic care (Limited to a maximum of 24 prescribed visits per Plan Year)
- Hearing aids
- Infertility treatment
- Routine eye exam (1 visit limit for refraction eye exams)
- Weight loss programs

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: California, California Department of Managed Health Care at 1-888-466-2219 or TDD line 1-877-688-9891 for the hearing and speech impaired or www.dmhc.ca.gov. and/or or call your contact state insurance at 1-800-927-HELP (4357) or , the Department of Labor's Employee Benefits Security Administration <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>, Office of Personnel Management Multi State Plan Program <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/> Other coverage options may be available to you too, including buying individual insurance coverage through California's Health Insurance Marketplace, Covered California, at 1-800-300-1506 or www.coveredca.com. [Health Insurance Marketplace](#) for more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or

assistance, contact: Valley Health Plan by calling 1-888-421-8444 or Department of Managed Health Care (DMHC) Consumer Help-Line at 1-888-466-2219.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet Minimum Value Standards? Yes.

If your [plan](#) does not meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-421-8444.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-421-8444.

Vietnamese (Tiếng Việt): Để có được sự hỗ trợ tiếng Việt, gọi 1-888-421-8444.

Grandfather Status Disclosure:

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1.888.421.8444.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [Copayments](#) and [coinsurance](#)) and excluded services under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist Copayment](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|------------|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What is not covered | |
| Limits or exclusions | \$0 |
| The total Peg would pay is | \$0 |

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist Copayment](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|------------|
| Deductibles* | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What is not covered | |
| Limits or exclusions | \$0 |
| The total Joe would pay is | \$0 |

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist Copayment](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|------------|
| Deductibles* | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What is not covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$0 |