
 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 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes.	This <u>plan</u> does not have a <u>deductible</u> . See the chart starting on page 2 for other costs for services this <u>plan</u> covers. See a list of covered <u>preventive</u> services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . Includes ACA preventive care requirements http://www.ncsl.org/research/health/american-health-benefit-exchanges-b.aspx .
Are there other <u>deductibles</u> for specific services?	No.	There are no other <u>deductibles</u> for specific services. See the chart starting on page 2 for other costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> \$4,500 individual/\$9,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met. Copays and <u>coinsurance</u> amount that you pay for covered services applies towards your annual maximum out-of-pocket expense.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See Valley Health Plan Provider Search or call 1-888-421-8444 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

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	\$15/visit	Not covered	None
	Specialist visit	\$30/visit	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	Preventive care/screening/immunization	No charge	Not covered	None. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab – \$15/visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	X-ray – \$30/visit	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.valleyhealthplan.org	Imaging (CT/PET scans, MRIs)	\$75/visit	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. Charges may incur with no prior authorization. Retail/Mail Order : 1 copay = up to 30 day supply for tier 1-4
	Generic drugs (Tier 1)	\$5 copay /prescription Retail/Mail Order	Not covered	
	Preferred brand drugs (Tier 2)	\$15 copay /prescription Retail/Mail Order	Not covered	
	Specialty drugs	10% up to \$250 per script Retail/Mail Order	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100/visit	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	Physician/surgeon fees	\$25/visit	Not covered	
If you need immediate medical attention	Emergency room care	Facility - \$150/visit Physician – No charge	Facility-\$150/visit Physician – No charge	None
	Emergency medical	\$150/transport	\$150/transport	None

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

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)	
	transportation			
	Urgent care	\$15/visit	\$15/visit	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. Charges may incur with no prior authorization for urgent care services from non-participating providers inside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 per day up to 5 days	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15/visit	Not covered	Prior written authorization may be required. Charges may incur with no prior authorization.
		Other outpatient services \$15/visit		
	Inpatient services	Facility - \$250 per day up to 5 days	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
		Physician - No charge		
If you are pregnant	Office visits	No charge	Not covered	None
	Childbirth/delivery professional services	No charge	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	Childbirth/delivery facility services	\$250 per day up to 5 days	Not covered	
If you need help recovering or have other special health needs	Home health care	\$20/visit	Not covered	100 visits/year. Prior written authorization is required. Charges may incur with no prior authorization.
	Rehabilitation services	\$15/visit	Not covered	Includes physical therapy, speech therapy, and occupational therapy. Prior written authorization is required. Charges may incur with no prior authorization.
	Habilitation services	\$15/visit	Not covered	
	Skilled nursing care	\$150 per day up to 5 days	Not covered	100 visits/calendar year. Prior written authorization is required. Charges may incur

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

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)	
				with no prior authorization.
	Durable medical equipment	10% <u>coinsurance</u>	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage limited to one exam per year.
	Children's glasses	No charge	Not covered	Coverage limited to one pair of glasses per year (or contact lenses in lieu of glasses).
	Children's dental check-up	No charge	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 .)		
<ul style="list-style-type: none"> • Chiropractic care • Cosmetic surgery • Dental care (Adult) • Hearing aids 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> • Nutritional Counseling • Private-duty nursing • Routine Eye Care (Adult) • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none"> • Abortion • Acupuncture 	<ul style="list-style-type: none"> • Bariatric surgery • Routine foot care with limits

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 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: Department of Managed Health Care (DMHC) Consumer Help-Line at 1-888-466-2219.

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

Does this [plan](#) provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this [plan](#) meet Minimum Value Standards? Yes.

If your [plan](#) doesn't 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:

Getting help in other languages

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1.888.421.8444 (California Relay Service (CRS) 711).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.888.421.8444 (California Relay Service (CRS) 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.888.421.8444 (California Relay Service (CRS) 711).

Tagalog (Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.888.421.8444 (California Relay Service (CRS) 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.888.421.8444 (California Relay Service (CRS) 711) 번으로 전화해 주십시오.

繁體中文 (Chinese)

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.888.421.8444 (California Relay Service (CRS) 711)。

Հայաստան (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք 1.888.421.8444 (California Relay Service (CRS) 711):

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.888.421.8444 (California Relay Service (CRS) 711).

فارسی (Farsi)

هجوته: اگر به زبان فارسی وگتفگ می کنید، تسهیلات زبانی بصورت رایگان برای امشد فراهم می باشد. با 1.888.421.8444 (California Relay Service (CRS) 711) تماس بگیرید.

日本語 (Japanese)

日本語を話される場合、無料の言語支援をご利用いただけます。 **1.888.421.8444** (California Relay Service (CRS) 711) まで、お電話にてご連絡ください。

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1.888.421.8444** (California Relay Service (CRS) 711).

ਪੰਜਾਬੀ (Punjabi)

ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲ ਏ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਧਲਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਈ ਮੁਫਤ ਉਪ ਲਬ ਹੈ। **1.888.421.8444** (California Relay Service (CRS) 711) 'ਤੇ ਕਾ ਕਰੋ।

(Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان . اتصل برقم 1.888.421.8444 (California Relay Service (CRS) 711)

ह िंं दी (Hindi)

यदद आप ह िंं दी बोलते हैं तो आपके ललए मुफ्त में भाषा सहायता सेवाए उपलब्ध हैं। **1.888.421.8444** (California Relay Service (CRS) 711) पर कॉल करें।

ภาษาไทย (Thai) ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1.888.421.8444** (California Relay Service (CRS) 711).

ខ្មែរ ខ្មែរ (Cambodian) បរិស្ថានជាអ្នកនិយាយ ភាសាខ្មែរខ្មែរ, បសវន្តន្តយេននកភាសា ពាយមិនគិត ្នួល គឺអាចមានសំរាប់បរ រ អ្នក។ ចូរ ទូរស័ព្ទ

1.888.421.8444 (California Relay Service (CRS) 711)។

ພາສາລາວ (Lao) ຖ້າວ່າ ທ່ານເວ ັ້ພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫ ຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທ **1.888.421.8444** (California Relay Service (CRS) 711).

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

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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	\$65
■ Hospital (facility) copayment	\$250/day
■ Other coinsurance	10%

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	\$12,690
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$660

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	\$65
■ Hospital (facility) copayment	\$250/day
■ Other coinsurance	10%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$700

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copayment	\$65
■ Hospital (facility) copayment	\$250/day
■ Other coinsurance	10%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$700
Coinsurance	\$20
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$720

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.