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 deductible?	$800/individual or $1,600/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services include but are not limited to: Primary care, Specialist, Preventive care, Lab tests, Urgent Care, Outpatient (OP) Behavior/ Substance abuse, Prenatal and preconception.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Prescription drug coverage $25/Individual or $50/Family	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $3,000 individual/$6,000 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?	Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't 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.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	Yes.	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.

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; Deductible does not apply.	Not covered	None
	Specialist visit	$25/visit; Deductible does not apply.	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	Preventive care/screening/ immunization	No charge	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	Lab $20/visit; Deductible does not apply. X-ray $40/visit; Deductible does not apply.	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100/visit; Deductible does not apply.	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**	Generic drugs	$5 copay/prescription	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 Service: 1 copay = up to 30-day supply for tier 1-4
	Preferred brand drugs	$25 copay/prescription.	Not covered	
	Non-preferred brand drugs	$45 copay/prescription	Not covered	
	Specialty drugs	15% up to $150 per script.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance; Deductible does not apply.	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	Physician/surgeon fees	15% coinsurance; Deductible does not	Not covered	

[* 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)	
		apply.		
If you need immediate medical attention	Emergency room care	Facility - $150/visit; Deductible does not apply.	Facility - $150/visit; Deductible does not apply.	None
		Physician - No charge	Physician - No charge	
	Emergency medical transportation	$75/transport. Deductible does not apply.	$75/transport. Deductible does not apply.	None
	Urgent care	$15/visit; Deductible does not apply.	$15/visit; Deductible does not apply.	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)	25% coinsurance	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	Physician/surgeon fees	25% coinsurance; Deductible does not apply.	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15/visit; Deductible does not apply.	Not covered	Prior written authorization may be required. Charges may incur with no prior authorization.
		Other items $0/visit; Deductible does not apply.		
	Inpatient services	Facility 15% coinsurance	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
		Physician 15% coinsurance; Deductible does not apply.		
If you are pregnant	Office visits	No charge	Not covered	None
	Childbirth/delivery professional services	15% coinsurance; Deductible does not	Not covered	Prior written authorization is required. Charges may incur with no prior

[* 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)	
		apply.		authorization.
	Childbirth/delivery facility services	15% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	$15/visit; Deductible does not apply.	Not covered	Includes physical therapy, speech therapy, and occupational therapy. Prior written authorization is required. Charges may incur with no prior authorization.
	Rehabilitation services	$15/visit; Deductible does not apply.	Not covered	100 visits/calendar year. Prior written authorization is required. Charges may incur with no prior authorization.
	Habilitation services	$15/visit; Deductible does not apply.	Not covered	
	Skilled nursing care	25% coinsurance	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	Durable medical equipment	15% coinsurance; Deductible does not apply.	Not covered	None
	Hospice services	No charge	Not covered	Coverage limited to one exam per year.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage limited to one pair of glasses per year (or contact lenses in lieu of glasses).
	Children's glasses	No charge	Not covered	None
	Children's dental check-up	No charge	Not covered	Includes physical therapy, speech therapy, and occupational therapy. Prior written authorization is required. Charges may incur with no prior authorization.

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.)

- Chiropractic care
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Nutritional Counseling
- Private-duty nursing
- Routine Eye Care (Adult)
- Weight loss programs

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Abortion	• Bariatric surgery
• Acupuncture	• 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.

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 the 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).

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

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: Զանգահարեք 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)

هجوت: اگر به زبان فارسی وگتفگ ی م کنید، تسهیلات زبانی بصورت رایگان برای امشد فراهم ی م 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 ੇ 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 برق م
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).

(Cambodian) **,** **1.888.421.8444** (California Relay Service (CRS) 711)។

(Lao) **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	**$800**
Specialist *copayment*	**$25**
Hospital (facility) *coinsurance*	**25%**
Other *coinsurance*	**25%**

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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$75
Copayments	$400
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,535**

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

The plan's overall deductible	**$800**
Specialist *copayment*	**$25**
Hospital (facility) *coinsurance*	**25%**
Other *coinsurance*	**25%**

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	$100
Copayments	$700
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

The plan's overall deductible	**$800**
Specialist *copayment*	**$25**
Hospital (facility) *coinsurance*	**25%**
Other *coinsurance*	**25%**

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	$500
Coinsurance	$40
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$540**

The plan would be responsible for the other costs of these EXAMPLE covered services.