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.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$8,200/individual or $16,400/family</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Services include but are not limited to: Preventive care, Prenatal and preconception.</td>
<td>This plan covers some items and services even if you haven’t yet met the deductible amount. See the chart starting on page 2 which identifies services with or without a deductible. 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>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.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For network providers $8,150 individual/$16,300 family</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Copayments for certain services, premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See Valley Health Plan Provider Search or call 1-888-421-8444 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>Yes.</td>
<td>A written referral is needed to see a specialist for covered services with the exception of self-referral to Plan OB/GYNs.</td>
</tr>
</tbody>
</table>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Member cost-share for oral anti-cancer drugs shall not exceed $250 per month per state law.

All cost shares shown in this chart where the deductible does not apply for the 1st three non-preventive visits means that the deductible is waived for the first three non-preventive visits combined. Services may include office visits (primary care and other practitioner), urgent care visits, or OP Mental Health/Substance Use Disorder visits.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>0% coinsurance; Deductible does not apply for the 1st three non-preventive visits.</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>Prior written authorization is required. Charges may incur with no prior authorization.</td>
</tr>
<tr>
<td>Preventive care/screening/ immunization</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic test (x-ray, blood work)</td>
<td>Lab – 0% coinsurance X-ray – 0% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>Prior written authorization is required. Charges may incur with no prior authorization.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at Valley Health Plan Prescription Drug Coverage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic drugs (Tier 1)</td>
<td>0% /prescription</td>
<td>Not covered</td>
<td>Prescription 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.</td>
</tr>
<tr>
<td>Preferred brand drugs (Tier 2)</td>
<td>0% /prescription</td>
<td>Not covered</td>
<td>Retail: 1 copay = to 30 day supply for tier 1-4 Mail: 2 copays = 61 to 90 day supply for tier 1-3</td>
</tr>
<tr>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>0% /prescription</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Specialty drugs (Tier 4)</td>
<td>0% /prescription</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>0% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------------------------------</td>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you need immediate medical attention</th>
<th>Emergency room care (waived if admitted)</th>
<th>0% coinsurance</th>
<th>0% coinsurance</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physician - No charge</td>
<td>Physician- No charge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Emergency medical transportation</th>
<th>0% coinsurance</th>
<th>0% coinsurance</th>
<th>None</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Urgent care</th>
<th>0% coinsurance;</th>
<th>0% coinsurance;</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply for the 1st three non-preventive visits.</td>
<td>Deductible does not apply for the 1st three non-preventive visits.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you have a hospital stay</th>
<th>Facility fee (e.g., hospital room)</th>
<th>0% coinsurance</th>
<th>Not covered</th>
<th>Prior written authorization is required. Charges may incur with no prior authorization.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you need mental health, behavioral health, or substance abuse services</th>
<th>Outpatient services</th>
<th>0% coinsurance;</th>
<th>Not covered</th>
<th>Prior written authorization may be required. Charges may incur with no prior authorization.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Facility - 0% coinsurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other items: 0% coinsurance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Inpatient services</th>
<th>Facility - 0% coinsurance</th>
<th>Not covered</th>
<th>Prior written authorization is required. Charges may incur with no prior authorization.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physician - 0% coinsurance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you are pregnant</th>
<th>Office visits</th>
<th>No charge</th>
<th>Not covered</th>
<th>None</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Childbirth/delivery professional services</th>
<th>0% coinsurance</th>
<th>Not covered</th>
<th>Prior written authorization is required. Charges may incur with no prior authorization.</th>
</tr>
</thead>
</table>

|                                           | Childbirth/delivery facility services     | 0% coinsurance | Not covered |                                                                                  |

[* For more information about limitations and exceptions, see the plan or policy document at www.valleyhealthplan.org.]*
### If you need help recovering or have other special health needs

<table>
<thead>
<tr>
<th>Service</th>
<th>0% coinsurance</th>
<th>Not covered</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td></td>
<td></td>
<td>100 visits/year. Prior written authorization is required. Charges may incur with no prior authorization.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td></td>
<td></td>
<td>Includes physical therapy, speech therapy, and occupational therapy. Prior written authorization is required. Charges may incur with no prior authorization.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td></td>
<td>100 visits/calendar year. Prior written authorization is required. Charges may incur with no prior authorization.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td></td>
<td>Prior written authorization is required. Charges may incur with no prior authorization.</td>
</tr>
<tr>
<td>Hospice services</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### If your child needs dental or eye care

<table>
<thead>
<tr>
<th>Service</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s eye exam</td>
<td>Coverage limited to one exam per year.</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>Coverage limited to one pair of glasses per year (or contact lenses in lieu of glasses).</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>None</td>
</tr>
</tbody>
</table>

### 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 Exam (Adult)
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.):**

- Abortion
- Acupuncture
- 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, HHS, DOL, and/or call your contact state insurance at 1-800-927-HELP (4357). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

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

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

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

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

#### 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)*

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

<table>
<thead>
<tr>
<th>Example Event</th>
<th>Total Example Cost</th>
<th>In this example, Peg would pay:</th>
<th>In this example, Joe would pay:</th>
<th>In this example, Mia would pay:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Cost Sharing</td>
<td>Cost Sharing</td>
<td>Cost Sharing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductibles*</td>
<td>Deductibles*</td>
<td>Deductibles*</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$8,150</td>
<td>$7,180</td>
<td>$1,370</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Copayments</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>What isn’t covered</td>
<td>What isn’t covered</td>
<td>What isn’t covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Limits or exclusions</td>
<td>$0</td>
<td>Limits or exclusions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$0</td>
<td>$60</td>
<td>$0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The total Peg would pay is</td>
<td>$8,150</td>
<td>The total Joe would pay is</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$8,150</td>
<td>$7,240</td>
<td>$1,370</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The total Mia would pay is</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$1,370</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-888-421-8444.

*Note: This plan has other **deductibles** for specific services included in this coverage example. See "Are there other deductibles for specific services?" on page one.