
 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 <u>deductible</u>? | \$6,300/individual or \$12,600/family | Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . |
| Are there services covered before you meet your <u>deductible</u>? | Yes. Services include but are not limited to: Preventive care, Prenatal and preconception. | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. See the chart starting on page 2 which identifies services with or without a deductible. A <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other <u>deductibles</u> for specific services? | Yes. <u>Prescription drug coverage</u> \$500/individual or \$1,000/family | You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | For <u>network providers</u> \$7,800 individual/\$15,600 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. |
| 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 provider <u>network</u> . You will pay less if you use a provider 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 provider's 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. | A written referral is needed to see a <u>specialist</u> for covered services with the exception of self-referral to <u>Plan</u> OB/GYNs. |

 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, other practitioner, and specialist), urgent care visits, or OP Mental Health/Substance Use Disorder visits.

| 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 | \$65/visit; <u>Deductible</u> does not apply for the 1 st three non-preventive visits. | Not covered | None |
| | <u>Specialist</u> visit | \$95/visit; <u>Deductible</u> does not apply for the 1 st three non-preventive visits. | Not covered | Prior written authorization is required. Charges may incur with no prior authorization. |
| | <u>Preventive care/screening/immunization</u> | No charge | Not covered | None |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | Lab – \$40/visit; <u>Deductible</u> does not apply. X-ray – 40% <u>coinsurance</u> | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 40% <u>coinsurance</u> | 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 Valley Health Plan Prescription Drug Coverage | Generic drugs (Tier 1) | \$18 <u>copay</u> /prescription | Not covered | Prescriptions filled at an <u>Out-of-network</u> 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. <u>Retail</u> : 1 copay = up to 30 day supply for tier 1-4 <u>Mail</u> : 2 copays = 61 to 90 day supply for tier 1-3 |
| | Preferred brand drugs (Tier 2) | 40% up to \$500 per script | Not covered | |
| | Non-preferred brand drugs (Tier 3) | 40% up to \$500 per script | Not covered | |
| | <u>Specialty drugs</u> (Tier 4) | 40% up to \$500 per script | Not covered | |

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

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|--|---|---|---|--|
| If you have outpatient surgery | <u>Facility fee (e.g., ambulatory surgery center)</u> | 40% coinsurance | Not covered | Prior written authorization is required. Charges may incur with no prior authorization. |
| | Physician/surgeon fees | 40% <u>coinsurance</u> | | |
| If you need immediate medical attention | <u>Emergency room care (waived if admitted)</u> | <u>Facility - 40% coinsurance</u> | <u>Facility-40% coinsurance</u> | None |
| | | Physician - No charge | Physician-No charge | |
| | <u>Emergency medical transportation</u> | 40% <u>coinsurance</u> | 40% <u>coinsurance</u> | None |
| | <u>Urgent care</u> | \$65/visit; <u>Deductible</u> does not apply for the 1 st three non- <u>preventive</u> visits. | \$65/visit; <u>Deductible</u> does not apply for the 1 st three non- <u>preventive</u> visits. | <u>Urgent care</u> from non-participating providers when outside of the service area is covered. Prior written authorization is required for <u>urgent care</u> from non-participating providers when inside the service area. Charges may incur with no prior authorization for <u>urgent care</u> services from non-participating providers inside the service area. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 40% <u>coinsurance</u> | Not covered | Prior written authorization is required. Charges may incur with no prior authorization. |
| | Physician/surgeon fees | 40% <u>coinsurance</u> | Not covered | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$65/visit; <u>Deductible</u> does not apply for the 1 st three non- <u>preventive</u> visits. | Not covered | Prior written authorization may be required. Charges may incur with no prior authorization. |
| | | Other items: \$65/visit | | |
| | Inpatient services | <u>Facility - 40% coinsurance</u> | Not covered | Prior written authorization is required. Charges may incur with no prior authorization. |
| | | Physician - 40% <u>coinsurance</u> | | |
| If you are pregnant | Office visits | No charge | Not covered | None |
| | Childbirth/delivery professional services | 40% <u>coinsurance</u> | Not covered | Prior written authorization is required. Charges may incur with no prior authorization. |
| | Childbirth/delivery facility services | 40% <u>coinsurance</u> | 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 | <u>Home health care</u> | 40% <u>coinsurance</u> | Not covered | 100 visits/year. Prior written authorization is required. Charges may incur with no prior authorization. |
| | <u>Rehabilitation services</u> | \$65/visit; <u>Deductible</u> 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. |
| | <u>Habilitation services</u> | \$65/visit; <u>Deductible</u> does not apply. | Not covered | |
| | <u>Skilled nursing care</u> | 40% <u>coinsurance</u> | Not covered | 100 visits/calendar year. Prior written authorization is required. Charges may incur with no prior authorization. |
| | <u>Durable medical equipment</u> | 40% <u>coinsurance</u> | Not covered | Prior written authorization is required. Charges may incur with no prior authorization. |
| | <u>Hospice services</u> | 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 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.)

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|---|--|
| <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, 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 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 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.

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 | \$6,300 |
| ■ Specialist copayment | \$95 |
| ■ Hospital (facility) coinsurance | 40% |
| ■ Other coinsurance | 40% |

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 | \$12,800 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$3,470 |
| Copayments | \$680 |
| Coinsurance | \$3,650 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$7,860 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|--|----------------|
| ■ The plan's overall deductible | \$6,300 |
| ■ Specialist copayment | \$95 |
| ■ Hospital (facility) coinsurance | 40% |
| ■ Other coinsurance | 40% |

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 | \$7,400 |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,540 |
| Copayments | \$1,910 |
| Coinsurance | \$2,120 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$5,630 |

Mia's Simple Fracture

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

| | |
|--|----------------|
| ■ The plan's overall deductible | \$6,300 |
| ■ Specialist copayment | \$95 |
| ■ Hospital (facility) coinsurance | 40% |
| ■ Other coinsurance | 40% |

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 | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$520 |
| Copayments | \$550 |
| Coinsurance | \$340 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,410 |

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: These numbers assume the patient received care from an IHCP provider or IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from IHCP your costs may be higher.

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