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?	$3,700/individual or $7,400/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. See the chart starting on page 3 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 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 deductibles for specific services?	Yes. Prescription drug coverage $10/individual or $20/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. Any amount that you pay for covered services subject to deductible applies towards your annual maximum out-of-pocket expense.
What is the out-of-pocket limit for this plan?	For network providers $8,200 individual/$16,400family	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. Copays and coinsurance amount that you pay for covered services applies towards your annual maximum out-of-pocket expense.
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	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

	providers.	(such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	A written referral is needed to see a specialist for covered services with the exception of self-referral to Plan OB/GYNs.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

- 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.
- Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in-person. This service is subject to the same deductible and annual or lifetime dollar maximum.
- No balance billing for members if services are provided by in-network Providers.

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	$35/visit; Deductible does not apply.	Not covered	None
	Specialist visit	$70/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 – $40/visit; Deductible does not apply. X-ray – $85/visit; Deductible does not apply.	Not covered	None
	Imaging (CT/PET scans, MRIs)	$325/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 Valley Health Plan Prescription Drug Coverage	Generic drugs (Tier 1)	$15 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 (Tier 2)	$55 copay/prescription	Not covered	
	Non-preferred brand drugs (Tier 3)	$85 copay/prescription	Not covered	
	Specialty drugs (Tier 4)	20% up to $250 per script	Not covered	

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance; Deductible does not apply.	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	Physician/surgeon fees	20% coinsurance; Deductible does not apply.	Not covered	
If you need immediate medical attention	Emergency room care (waived if admitted)	Facility - $400/visit; Deductible does not apply. Physician - No charge	Facility - $400/visit Deductible does not apply. Physician - No charge	None
	Emergency medical transportation	$250/transport. Deductible does not apply.	$250/transport. Deductible does not apply.	None
	Urgent care	$35/visit; Deductible does not apply.	$35/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)	20% coinsurance	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	Physician/surgeon fees	20% coinsurance; Deductible does not apply.	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35/visit; Deductible does not apply. Other items $0; Deductible does not apply.	Not covered	Prior written authorization may be required. Charges may incur with no prior authorization.
	Inpatient services	Facility - 20% coinsurance Physician - 20% coinsurance; Deductible does not apply.	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
If you are pregnant	Office visits	No charge	Not covered	None
	Childbirth/delivery professional services	20% coinsurance; Deductible does not apply.	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	Childbirth/delivery facility services	20% 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	Home health care	$45/visit; Deductible does not apply.	Not covered	100 visits/year. Prior written authorization is required. Charges may incur with no prior authorization.
	Rehabilitation services	$35/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.
	Habilitation services	$35/visit; Deductible does not apply.	Not covered	
	Skilled nursing care	20% coinsurance	Not covered	100 visits/calendar year. Prior written authorization is required. Charges may incur with no prior authorization.
	Durable medical equipment	20% coinsurance; Deductible does not apply.	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.)

- 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
- Telehealth

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 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

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

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: 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 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.

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

The plan's overall deductible	$3,700
Specialist copayment	$70
Hospital (facility) copayment	20%
Other coinsurance	20%

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:

Cost Sharing	
Deductibles*	$3,700
Copayments	$600
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

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

The plan's overall deductible	$3,700
Specialist copayment	$70
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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:

Cost Sharing	
Deductibles*	$10
Copayments	$1,800
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,030**

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

The plan's overall deductible	$3,700
Specialist copayment	$70
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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:

Cost Sharing	
Deductibles*	$10
Copayments	$1,200
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,270**

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.

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