Valley Health Plan

2022 Schedule of Benefits & Coverage Matrix: Large and Small Group

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE (EOC) AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Accumulation Period

The Accumulation Period for this plan is 01/01/22 through 12/31/22 (Calendar year).

Calendar Year Out-of-Pocket Maximum

You will not pay any more Cost Share during a calendar year if the Copayments and Coinsurance you pay add up to one of the following amounts:

For Self-only enrollment (a Family of one Member)	$1,000 per calendar year
For an entire Family of two or more Members	$2,000 per calendar year

Plan Deductible

You must meet your Plan Deductible before your Cost Share applies (except those services that have "No charge"):

Medical Deductible	No Deductible
Pharmacy Deductible	No Deductible

Lifetime Maximum	None

Professional Services (Plan Provider office visits)	Your Cost Share
Most Primary Care Visits for evaluations and treatment	$0 Copayment
Most Specialty Care Visits for consultations, evaluations and treatment	$0 Copayment
Other Practitioner Office Visits*	$0 Copayment
Routine physical maintenance exams, including well woman exams	$0 Copayment
Well-child preventative exams (through age 23 months)	$0 Copayment
Family planning counseling and consultations	$0 Copayment
Scheduled prenatal care exams	$0 Copayment
Routine eye exams with a Plan Optometrist for Members under age 19	$0 Copayment
Hearing exams	$0 Copayment
Most Physical, occupational, and speech therapy	$0 Copayment
Urgent care consultations, evaluations, and treatment	$0 Copayment
Note: Urgent care includes Mental/Behavioral health and Chemical dependency (Substance Use Disorder) crisis intervention services.	
Chiropractic services	$10 Copayment
Note: Up to 20 visits per member, per calendar year	
Acupuncture services	$10 Copayment

Note:

1. Benefits provided are for treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain only.
2. Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in-person.

Outpatient Services	Your Cost Share
Outpatient surgery facility fee	$0 Copayment
Outpatient Physician/surgeon fee	Included in Outpatient surgery facility fee
Outpatient Visit	$0 Copayment
Most Immunizations (including the vaccine)	$0 Copayment
Most X-rays	$0 Copayment
Most Laboratory tests	$0 Copayment
MRI, most CT, and PET scans	$0 Copayment
Rehabilitation/Habilitation services	$0 Copayment

Covered individual health education counseling	$0 Copayment
Covered health education programs	$0 Copayment

Hospitalization Services	Your Cost Share
Inpatient stay (facility fee)	$0 Copayment
Physician/surgeon fee for surgery	Included in Inpatient stay (facility fee)

Emergency Health Coverage	Your Cost Share
Emergency room facility fee	$0 Copayment
Emergency room physician fee	Included in Emergency room facility fee
Note: Emergency room fees do not apply if admitted directly to the hospital as an inpatient for Covered Services.	
Mental health and chemical dependency crisis intervention services	$0 Copayment

Ambulance Services	Your Cost Share
Ambulance Services	$0 Copayment

Prescription Drug Coverage		Your Cost Share
Covered outpatient items in accord with our drug formulary guidelines:		
Generic drugs	At a Plan Pharmacy	$0 Copayment
	Refills through our mail-order service	$0 Copayment
Brand drugs	At a Plan Pharmacy	$0 Copayment
	Refills through our mail-order service	$0 Copayment

Drug Tiers	Categories
1	• Generic drugs
2	• Brand name drugs

Mental/Behavioral Health (MH) Services	Your Cost Share
Inpatient:	
MH psychiatric hospitalization fee	$0 Copayment
MH psychiatric physician/surgeon fee	Included in psychiatric hospitalization fee
MH psychiatric observation	Included in psychiatric hospitalization fee
MH psychological testing	Included in psychiatric hospitalization fee
MH individual and group treatment	Included in psychiatric hospitalization fee
MH individual and group evaluation	Included in psychiatric hospitalization fee
MH crisis residential program	Included in psychiatric hospitalization fee
Outpatient:	
MH office visits	$0 Copayment
MH monitoring of drug therapy	$0 Copayment
MH individual and group treatment	$0 Copayment
MH individual and group evaluation	$0 Copayment
Outpatient, Other Items and Services:	
Applied behavior analysis and behavioral health treatment	$0 Copayment
MH multidisciplinary treatment in an intensive outpatient psychiatric treatment program	$0 Copayment

Neuropsychological testing	$0 Copayment
MH partial hospitalization	$0 Copayment
MH psychological testing	$0 Copayment

Note: Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in-person.

Chemical Dependency (Substance Use Disorder) Services	Your Cost Share
Inpatient:	
Chemical dependency hospitalization fee	$0 Copayment
Chemical dependency physician/surgeon fee	Included in hospitalization fee
Inpatient detoxification	Included in hospitalization fee
Individual and group treatment	Included in hospitalization fee
Individual and group chemical dependency counseling	Included in hospitalization fee
Individual and group evaluation	Included in hospitalization fee
Transitional residential recovery services	$0 Copayment
Outpatient:	
Chemical dependency office visits	$0 Copayment
Chemical dependency individual and group evaluation	$0 Copayment
Chemical dependency individual and group counseling	$0 Copayment
Methadone Maintenance	$0 Copayment
Outpatient, Other Items and Services:	
Chemical dependency intensive outpatient programs	$0 Copayment
Chemical dependency day treatment programs	$0 Copayment

Note: Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in-person.

Durable Medical Equipment (DME)	Your Cost Share
DME items that are essential health benefits	$0 Copayment
Home Health Services	**Your Cost Share**
Home health care (up to 100 visits per calendar year)	$0 Copayment
Other	**Your Cost Share**
Skilled Nursing Facility care (up to 100 days per benefit period)	$0 Copayment
Hospice care	$0 Copayment

Notes:

* Other Practitioner Office Visits include visits not provided by either Primary Care or Specialty Practitioners.

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of- pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the "Benefits and Cost Share", "Limitations & Exclusions", and "Payment & Reimbursement Responsibility" sections in your EOC.