



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 allowd 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?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Yes	This plan does not have a <u>deductible</u> . See the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For <u>network providers</u> \$1,000 individual/\$2,000 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 out-of-pocket limit?	Premiums, balance-billed charges, and health care this plan 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 network provider?	Yes. See Valley Health Plan Provider Search or call 1-888-421-8444 for a list of <u>network providers</u> .	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do you need a referral to see a specialist?	Yes. You need a written referral to see a specialist. Exceptions include self-referral to Plan OB/GYNs.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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 \$200 per month per state law.

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	\$0 Copay	Not covered	None
	<u>Specialist</u> visit	\$0 Copay	Not covered	Prior written authorization is required. If you don't get <u>preauthorization</u> , charges may incur.
	<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 – \$0 Copay	Not covered	None
		X-ray – \$0 Copay		
	Imaging (CT/PET scans, MRIs)	\$0 Copay	Not covered	Prior written authorization is required. If you don't get <u>preauthorization</u> , charges may incur.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at Valley Health Plan Prescription Drug Coverage	Generic drugs (Tier 1)	\$0 Copay	Not covered	Fill up to 90-day supply. Prescribed contraceptives at no charge.
	Preferred brand drugs (Tier 2)	\$0 Copay	Not covered	
	Non-preferred brand drugs (Tier 3)	\$0 Copay	Not covered	Fill up to 90-day supply. Prescribed contraceptives at no charge. Charges may incur with no prior written authorization.
	<u>Specialty drugs</u> (Tier 4)	\$0 Copay	Not covered	Fill up to 30-day supply. Charges may incur with no prior written authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$0 Copay	Not covered	Prior written authorization is required. If you don't get <u>preauthorization</u> , charges may incur.
	Physician/surgeon fees	\$0 Copay	Not covered	None
If you need immediate medical attention	<u>Emergency room care (waived if admitted)</u>	Facility - \$0 Copay	Facility - \$0 Copay	None
		Physician - \$0 Copay	Physician - \$0 Copay	
	<u>Emergency medical transportation</u>	\$0 Copay	\$0 Copay	None
	<u>Urgent care</u>	\$0 Copay	Not covered	Urgent care from non-participating providers when outside of the service area is covered if a reasonable person would believe that your health would seriously deteriorate if you

[* 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)	
				delayed treatment.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0 Copay	Not covered	None
	Physician/surgeon fees	\$0 Copay	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$0 Copay	Not covered	None
	Inpatient services	Facility - \$0 Copay	Not covered	Prior written authorization is required. If you don't get <u>preauthorization</u> , charges may incur.
Physician - \$0 Copay				
If you are pregnant	Office visits	No charge	Not covered	None
	Childbirth/delivery professional services	\$0 Copay	Not covered	None
	Childbirth/delivery facility services	\$0 Copay	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$0 Copay	Not covered	Prior written authorization is required. If you don't get <u>preauthorization</u> , charges may incur
	<u>Rehabilitation services</u>	\$0 Copay	Not covered	
	<u>Habilitation services</u>	\$0 Copay	Not covered	
	<u>Skilled nursing care</u>	\$0 Copay	Not covered	100 visits/calendar year. Prior written authorization is required. If you don't get <u>preauthorization</u> , charges may incur.
	<u>Durable medical equipment</u>	\$0 Copay	Not covered	Prior written authorization is required. If you don't get <u>preauthorization</u> , charges may incur.
	<u>Hospice services</u>	No charge	No charge	<u>None</u>
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Prior written authorization is required. If you don't get <u>preauthorization</u> , charges may incur
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	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.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Routine eye care (Adult) with limits
- Routine foot care with limits
- Weight loss programs

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 are: U.S Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov, or you may contact the plan at 1-408-885-4760 or 1-888-421-8444 (toll-free). 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: the plan at 1-408-885-4760 or 1-888-421-8444 (toll-free) first and use your health plan's grievance process. You may also contact The California Department of Managed Health Care (DMHC) [whom is responsible for regulating health care service plans] Consumer Help-Line at **1-888-466-2219** or a **TDD line (1-877-688-9891)** for the hearing and speech impaired. Refer to DMHC's website <http://www.hmohelp.ca.gov> for complaint forms, IMR application forms and instructions online. For the hearing and speech impaired, call the California Relay Service (CRS) by simply dialing 711 or the 800 CRS number of your modality).

Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by your health plan, or a Grievance that has remained unresolved for more than 30 days, you may call the DMHC for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

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.

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 <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$0
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	0%

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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$0

Managing Joe's type 2 Diabetes

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$0
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	0%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles*	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$0

Mia's Simple Fracture

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

■ The plan's overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$0
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	0%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles*	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$0