


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 to request a copy.

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 plan covers.
Are there services covered before you meet your deductible ?	Not Applicable.	This plan does not have a deductible . See the chart starting on page 2 for other costs for services this plan covers. 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?	No.	There are no other deductibles for specific services. See the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan ?	For network providers \$8,700 individual/\$17,400 family	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 providers	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.
Do you need a referral to see a specialist ?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

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	Not covered	None
	Specialist visit	\$65/visit	Not covered	Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services
	Preventive care/screening/immunization	No charge	Not covered	None. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Lab – \$40/visit X-ray – \$75/visit	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$75/visit	Not covered	Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.valleyhealthplan.org	Generic drugs	\$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. If you do not get preauthorization , you may be financially responsible for the full cost of such services. <u>Retail</u> : Up to 90-day supply for Generic and Brand drugs <u>Mail Order</u> : Up to 90-day supply for Generic and Brand Maintenance drugs
	Preferred brand drugs	\$60 copay /prescription	Not covered	
	Non-preferred brand drugs	\$85 copay /prescription	Not covered	
	Specialty drugs	20% <u>up to \$250 per script</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$130/visit	Not covered	Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services.
	Physician/surgeon fees	\$40/visit	Not covered	

[* 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)	
If you need immediate medical attention	Emergency room care	Facility - \$350/visit	Facility-\$350/visit	None
		Physician - No charge	Physician - No charge	
	Emergency medical transportation	\$250/transport	\$250/transport	None
	Urgent care	\$35/visit	\$35/visit. Not covered inside service area.	Urgent care services at Non-Plan Providers within the Service Area must be Prior Authorized before services are rendered or you may be financially responsible for all charges
If you have a hospital stay	Facility fee (e.g., hospital room)	\$330 per day up to 5 days	Not covered	Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35/visit	Not covered	Prior written authorization may be required. If you do not get preauthorization , you may be financially responsible for the full cost of such services
		Other items \$35/visit		
	Inpatient services	Facility - \$330 per day up to 5 days	Not covered	Prior written authorization may be required. If you do not get preauthorization , you may be financially responsible for the full cost of such services
		Physician - No charge		
If you are pregnant	Office visits	No charge	Not covered	None
	Childbirth/delivery professional services	No charge	Not covered	Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services.
	Childbirth/delivery facility services	\$330 per day up to 5 days	Not covered	
If you need help recovering or have other special health needs	Home health care	\$30/visit	Not covered	100 days/year. Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services.
	Rehabilitation services	\$35/visit	Not covered	Includes physical therapy, speech therapy, and occupational therapy. Prior written authorization is required. If you do not get
	Habilitation services	\$35/visit	Not covered	

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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)	
				preauthorization , you may be financially responsible for the full cost of such services
	Skilled nursing care	\$150 per day up to 5 days	Not covered	100 days/calendar year. Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services
	Durable medical equipment	20% coinsurance	Not covered	Prior written authorization is required. If you do not get preauthorization , you may be financially responsible for the full cost of such services
	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 .)		
<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 Care (Adult) • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none"> • 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, California Department of Managed Health Care at 1-888-466-2219 or TDD line 1-877-688-9891 for the hearing and speech impaired or www.dmhc.ca.gov. and/or or call your contact state insurance at 1-800-927-HELP (4357) or [the Department of Labor's Employee Benefits Security Administration https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa](https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa), Office of Personnel Management Multi State Plan Program <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/> Other coverage options may be available to you too, including buying individual insurance coverage through California's Health Insurance Marketplace, Covered California, at 1-800-300-1506 or www.coveredca.com. [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 [* For more information about limitations and exceptions, see the [plan](#) or policy document at www.valleyhealthplan.org.]

[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 on how 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

[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 the 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:

Getting help in other languages

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1.888.421.8444 (California Relay Service (CRS) 711).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.888.421.8444 (California Relay Service (CRS) 711).

Tiếng Việt (Vietnamese)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.888.421.8444 (California Relay Service (CRS) 711).

Tagalog (Filipino)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.888.421.8444 (California Relay Service (CRS) 711).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.888.421.8444 (California Relay Service (CRS) 711) 번으로 전화해 주십시오.

繁體中文 (Chinese)

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.888.421.8444 (California Relay Service (CRS) 711)。

Հայաստանի (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Չանգահարեք 1.888.421.8444 (California Relay Service (CRS) 711):

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.888.421.8444

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(California Relay Service (CRS) 711).

فارسی (Farsi)

هجوته: اگر هب زبان فارسی وگننگه یم کنیده، تسهیلات زبانی بصورت رایگان برای امشد فراهم یم باشد. با 1.888.421.8444 (California Relay Service (CRS) 711) تماس بگیریده.

日本語 (Japanese)

注意事項 : 日本語を話される場合、無料の言語支援をご利用いただけます。

1.888.421.8444 (California Relay Service (CRS) 711) まで、お電話にてご連絡

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.888.421.8444 (California Relay Service (CRS) 711).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।
1.888.421.8444 (California Relay Service (CRS) 711) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 888.421.8444.1
(California Relay Service (CRS) 711)

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1.888.421.8444 (California Relay Service (CRS) 711) पर कॉल करें।

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1.888.421.8444
(California Relay Service (CRS) 711).

ខ្មែរ (Cambodian)

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ ក៏អាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1.888.421.8444 (California Relay Service (CRS) 711)។

ພາສາລາວ (Lao)

ໂປດລາວ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີ
ພ້ອມໃຫ້ທ່ານ. ໂທ 1.888.421.8444 (California Relay Service (CRS) 711).

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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](#) \$0
- [Specialist](#) copayment \$65
- Hospital (facility) copayment \$330/day
- Other (blood work) copayment \$35

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	\$12,690
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$70
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$930

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) copayment \$65
- Hospital (facility) copayment \$330/day
- Other (blood work) copayment \$35

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	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,500
Coinsurance	\$200
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,720

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) copayment \$65
- Hospital (facility) copayment \$330/day
- Other (*x-ray*) copayment \$75

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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$70
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,170

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.