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?	$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?	Yes	This plan does not have a deductible. See the chart starting on page 2 for other costs for services this plan covers.
Are there other deductibles for specific services?	No	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,000 individual/$2,000 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.
What is not included in the out-of-pocket limit?	Premiums, and health care this plan does not cover.	Even though you pay these expenses, they do not 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.	If you use an in-network doctor or other health care provider, 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 provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
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 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.

(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)

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
	Specialist visit	$0 Copay	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
If you have a test	Diagnostic test (x-ray, blood work)	Lab – $0 Copay X-ray – $0 Copay	Not covered	None
	Imaging (CT/PET scans, MRIs)	$0 Copay	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 Valley Health Plan Prescription Drug Coverage	Generic drugs	$0 Copay/prescription (retail & mail order).	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. Retail: Up to 90-day supply for Generic and Brand drugs Mail Order: Up to 90-day supply for Generic and Brand Maintenance drugs
	Brand drugs	$0 Copay/prescription (retail & mail order).	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$0 Copay	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	$0 Copay	Not covered	None

If you need immediate medical attention	Emergency room care	Facility - $0 Copay Physician - $0 Copay	Facility - $0 Copay Physician - $0 Copay	None
	Emergency medical transportation	$0 Copay	$0 Copay	None
	Urgent care	$0 Copay	$0 Copay	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. 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)	$0 Copay	Not covered	Prior written authorization is required for elective admissions. If you do not get preauthorization, you may be financially responsible for the full cost of such services.
	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	$0 Copay	Not covered	Prior written authorization is required for elective admissions. If you do not get preauthorization, you may be financially responsible for the full cost of such services.
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	Home health care	$0 Copay	Not covered	100 visits/benefit 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	$0 Copay	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.
	Habilitation services	$0 Copay	Not covered	
	Skilled nursing care	$0 Copay	Not covered	100 days/benefit period. 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	$0 Copay	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	No charge	Prior written authorization is required. If you do not get preauthorization, you may be financially responsible for the full cost of such services.
If your child needs dental or eye care	Children's eye exam	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.
	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
- 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 is not a complete list. Please see your plan document.)

- Acupuncture (Limited to a maximum of 24 prescribed visits per Plan Year)
- Bariatric surgery
- Chiropractic care (Limited to a maximum of 24 prescribed visits per Plan Year)
- Hearing aids
- Infertility treatment
- Routine eye exam (1 visit limit for refraction eye exams)
- 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 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, 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 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: 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 does not 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**	**$0**
■ **Specialist Copayment**	**$0**
■ **Hospital (facility) coinsurance**	**0%**
■ **Other coinsurance**	**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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What is not 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 deductible**	**$0**
■ **Specialist Copayment**	**$0**
■ **Hospital (facility) coinsurance**	**0%**
■ **Other coinsurance**	**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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$0
Coinsurance	$0
What is not 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 deductible**	**$0**
■ **Specialist Copayment**	**$0**
■ **Hospital (facility) coinsurance**	**0%**
■ **Other coinsurance**	**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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$0
Copayments	$0
Coinsurance	$0
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

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