
 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](http://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 <a href="#">deductible</a> ?	\$75/individual or \$150/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Services include but are not limited to: <a href="#">Primary care</a> , <a href="#">Specialist</a> , <a href="#">Preventive care</a> , Lab tests, <a href="#">Urgent Care</a> , Outpatient (OP) Behavior/Substance abuse, Prenatal and preconception.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive</a> services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive</a> services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$900 individual/\$1,800 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="#">Valley Health Plan Provider Search</a> or call 1-888-421-8444 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.

Important Questions	Answers	Why This Matters:
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .

 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 <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$5/visit; <a href="#">Deductible</a> does not apply.	Not covered	None
	<a href="#">Specialist</a> visit	\$8/visit; <a href="#">Deductible</a> does not apply.	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	None
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	Lab \$8/visit; <a href="#">Deductible</a> does not apply.	Not covered	None
		X-ray \$8/visit; <a href="#">Deductible</a> does not apply.		
	Imaging (CT/PET scans, MRIs)	\$50/visit; <a href="#">Deductible</a> 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 <a href="#">prescription drug coverage</a> is available at <a href="http://www.valleyhealthplan.org">www.valleyhealthplan.org</a>	Generic drugs	\$3 <a href="#">copay</a> /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 <a href="#">formulary</a> , 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	\$10 <a href="#">copay</a> /prescription	Not covered	
	Non-preferred brand drugs	\$15 <a href="#">copay</a> /prescription	Not covered	
	<a href="#">Specialty drugs</a>	10% up to \$150 per script	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a> ; <a href="#">Deductible</a> does not apply.	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	Physician/surgeon fees	10% <a href="#">coinsurance</a> ; <a href="#">Deductible</a> does not apply.	Not covered	

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.valleyhealthplan.org](http://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	<a href="#">Emergency room care</a>	Facility - \$50/visit; <a href="#">Deductible</a> does not apply	Facility - \$50/visit; <a href="#">Deductible</a> does not apply	None
		Physician - No charge	Physician - No charge	
	<a href="#">Emergency medical transportation</a>	\$30/transport. <a href="#">Deductible</a> does not apply.	\$30/transport. <a href="#">Deductible</a> does not apply.	None
	<a href="#">Urgent care</a>	\$5/visit; <a href="#">Deductible</a> does not apply.	\$5/visit; <a href="#">Deductible</a> does not apply.	<a href="#">Urgent care</a> from non-participating <a href="#">providers</a> when outside of the service area is covered. Prior written authorization is required for <a href="#">urgent care</a> from non-participating <a href="#">providers</a> when inside the service area. Charges may incur with no prior authorization for <a href="#">urgent care</a> services from non-participating <a href="#">providers</a> inside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	Physician/surgeon fees	10% <a href="#">coinsurance</a> ; <a href="#">Deductible</a> does not apply.	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$5/visit; <a href="#">Deductible</a> does not apply.	Not covered	Prior written authorization may be required. Charges may incur with no prior authorization.
		Other items \$0/visit; <a href="#">Deductible</a> does not apply.		
	Inpatient services	Facility 10% <a href="#">coinsurance</a>	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
		Physician 10% <a href="#">coinsurance</a> ; <a href="#">Deductible</a> does not apply.		
If you are pregnant	Office visits	No charge	Not covered	None
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a> ; <a href="#">Deductible</a> does not apply.	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.valleyhealthplan.org](http://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)	
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$3/visit; <a href="#">Deductible</a> does not apply.	Not covered	100 visits/year. Prior written authorization is required. Charges may incur with no prior authorization.
	<a href="#">Rehabilitation services</a>	\$5/visit; <a href="#">Deductible</a> 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.
	<a href="#">Habilitation services</a>	\$5/visit; <a href="#">Deductible</a> does not apply.	Not covered	
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	Not covered	100 visits/calendar year. Prior written authorization is required. Charges may incur with no prior authorization.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a> ; <a href="#">Deductible</a> does not apply.	Not covered	Prior written authorization is required. Charges may incur with no prior authorization.
	<a href="#">Hospice services</a>	No charge	Not covered	None
<b>If your child needs dental or eye care</b>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Chiropractic care</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> <li>• Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Nutritional Counseling</li> <li>• Private-duty nursing</li> <li>• Routine Eye Care (Adult)</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)	
<ul style="list-style-type: none"> <li>• Abortion</li> <li>• Acupuncture</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Routine foot care with limits</li> </ul>

**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](http://www.dmhc.ca.gov) and/or call your contact state insurance at 1-800-927-HELP (4357) or, the Department of Labor's Employee Benefits Security Administration [\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.valleyhealthplan.org](http://www.valleyhealthplan.org).]

<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](http://www.coveredca.com). [Health Insurance Marketplace](#) for more information about the [Marketplace](#), visit [www.HealthCare.gov](http://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: 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)。

### Հայաստան (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 (California Relay Service (CRS) 711).

### فارسی (Farsi)

هجوت: اگر به زبان فارسی و گفتگ می کنید، تسهیلات زبانی بصورت رایگان برای امشد فراهم می باشد. با 1.888.421.8444 (California Relay Service (CRS) 711) تماس بگیرید.

### 日本語 (Japanese)

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、お電話にてご連絡ください。

### 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)

ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲ ੋ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਧਲਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਈ ਮੁਫਤ ਉਪ ਲਬ ਹੈ। **1.888.421.8444** (California Relay Service (CRS) 711) 'ਤੇ ਕਾ ਕਰੋ।

### (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان . اتصل برقم 1.888.421.8444 (California Relay Service (CRS) 711)

## ह िं दी (Hindi)

यद आप ह िं दी बोलते हैं तो आपके लए मुफ्त में भाषा सहायता सेवाए उपलब्ध हैं। **1.888.421.8444** (California Relay Service (CRS) 711) पर कॉल करें।

ภาษาไทย (Thai) ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1.888.421.8444** (California Relay Service (CRS) 711).

ខែ ខែ (Cambodian) បរិស័ទជាអ្នកនិយាយ ភាសាខែខែ, បសវន្តិយេននកភាសា យមិនគិត ូល គឺអាចមានសំរាប់រ រ អ្នក។ ូរ ូរស័ព្ទ

**1.888.421.8444** (California Relay Service (CRS) 711)។

ພາສາລາວ (Lao) ຖ້າວ່າ ທ່ານເວ ັພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫ ຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$75
■ <a href="#">Specialist copayment</a>	\$8
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

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*)

<b>Total Example Cost</b>	<b>\$12,690</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$75
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,035</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$75
■ <a href="#">Specialist copayment</a>	\$8
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$600</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$75
■ <a href="#">Specialist copayment</a>	\$8
■ Hospital (facility) <a href="#">coinsurance</a>	10%
■ Other <a href="#">coinsurance</a>	10%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$230</b>

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