SUMMARY OF BENEFITS AND COVERAGE TABLE

COVERED CALIFORNIA PLAN
VHP SILVER 73 HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.valleyhealthplan.org or by calling 1-888-421-8444 (toll-free).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$1,600** Medical and **$250** Brand Drug coverage. There are no other specific **deductibles.**	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. For participating providers **$5,200** person **/ $10,400** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
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 **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.valleyhealthplan.org or call 1-888-421-8444 (toll-free)** for a list of participating 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 I 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 the plan's permission before you see the **specialist.**
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-888-421-8444 (toll-free) or visit us at www.valleyhealthplan.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.valleyhealthplan.org or call 1-888-421-8444 (toll-free) to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit	Not Covered	——————none——————
	Specialist visit	$50 copay/visit	Not Covered	Prior written authorization required. Charges may incur with no prior authorization.
	Other practitioner office visit	$40 copay/visit	Not Covered	Prior written authorization required. Charges may incur with no prior authorization.
	Preventive care/screening/immunization	No charge	Not Covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	$50 copay/test	Not Covered	——————none——————
	Imaging (CT/PET scans, MRIs)	$250 copay/test	Not Covered	Prior written authorization required. Charges may incur with no prior authorization.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
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 (retail and mail order)	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)
	Preferred brand drugs	$35 copay/ prescription (retail and mail order)	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Prior written authorization required. Charges may incur with no prior authorization. Deductible applies.
	Non-preferred brand drugs	$60 copay/ prescription (retail and mail order)	Not Covered	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription). Prior written authorization required. Charges may incur with no prior authorization. Deductible applies.
	Specialty drugs	20% coinsurance	Not Covered	Covers up to a 30-day supply (retail prescription). Prior written authorization required. Charges may incur with no prior authorization. Deductible applies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not Covered	Prior written authorization required. Charges may incur with no prior authorization.
	Physician/surgeon fees	No Charge	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$250 copay/visit	$250 copay/visit	Deductible applies.
	Emergency medical transportation	$250 copay/visit	$250 copay/visit	Deductible applies.
	Urgent care	$80 copay/visit	$80 copay/visit	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 delayed treatment.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not Covered	Deductible applies.
	Physician/surgeon fee	No Charge	Not Covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay/office visit	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance	Not Covered	Deductible applies.
	Substance use disorder outpatient services	$40 copay/office visit	Not Covered	——————none——————
	Substance use disorder inpatient services	20% coinsurance	Not Covered	Prior written authorization required. Charges may incur with no prior authorization. Deductible applies.
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	——————none——————
	Delivery and all inpatient services	20% coinsurance	Not Covered	Deductible applies.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	$40 copay/office visit	Not Covered	100 visits per benefit period. Prior written authorization required. Charges may incur with no prior authorization.
	Rehabilitation services	$40 copay/office visit	Not Covered	Prior written authorization required. Charges may incur with no prior authorization.
	Habilitation services	$40 copay/office visit	Not Covered	Prior written authorization required. Charges may incur with no prior authorization.
	Skilled nursing care	20% coinsurance	Not Covered	100 visits per benefit period. Prior written authorization required. Charges may incur with no prior authorization. Deductible applies.
	Durable medical equipment	20% coinsurance	Not Covered	Prior written authorization required. Charges may incur with no prior authorization.
	Hospice service	No Charge	Not Covered	——————none——————
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	Limited to one exam per year
	Glasses	No Charge	Not Covered	Limited to one pair of glasses per year (or contact lenses in lieu of glasses)
	Dental check-up	No Charge	Not Covered	——————none——————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

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

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Bariatric surgery
- Routine eye care (Adult) ***with limits***
- Routine foot care ***with limits***
- Weight loss programs

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-421-8444 (toll-free). You may also contact your state insurance department at 1-800-927-HELP (4357).

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Department of Managed Health Care (DMHC) Consumer Help-Line.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,650
- **Patient pays** $2,800

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,600
Copays	$0
Coinsurance	$1,200
Limits or exclusions	$0
Total	**$2,800**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,000
- **Patient pays** $2,400

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,900
Copays	$200
Coinsurance	$300
Limits or exclusions	$0
Total	**$2,400**

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: 1-888-421-8444 (toll-free).

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Valley Health Plan®
Speaking the language of health

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