VENTURA COUNTY
HEALTH CARE PLAN

Combined Evidence of Coverage & Disclosure Form

(EOC)

Commercial Benefit Plans

Plan Year 2025

Meeting Our Members' Health Care Needs Since 1994

Revised September 2024

What's New for 2025:

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INTRODUCTION

Welcome to the Ventura County Health Care Plan (VCHCP or the Plan, sometimes referred to as "we" or "us"), operated by the County of Ventura. As a Member (sometimes referred to as "you") who has elected to enroll with us, this *Combined Evidence of Coverage & Disclosure Form* (*EOC*) discloses the terms and conditions of your health care coverage. It is important to become familiar with your coverage by reading this *EOC* completely, so that you can take full advantage of your health plan benefits. If you have special needs, you should read carefully those sections that apply to you. Some words used in this booklet are explained in the Definitions section. When reading through this booklet, check that the Definitions section to be sure you understand what these words mean. Each time defined words are used they are capitalized.

When you join VCHCP, you and your eligible family members are enrolling in a region-based health plan, called your Service Area. The Service Area, in this *EOC*, is defined as the geographical area in which the Plan's In-Network Providers provide covered services to Members. Ventura County is the geographical area that has been approved by the California Department of Managed Health Care (DMHC). The coverage information in this *EOC* applies when you obtain care in your Service Area with In-Network Providers as listed in the *Provider Directory*. You must receive all covered services from In-Network Providers in the Service Area unless otherwise Authorized by the Plan. With the exception of Emergency Services and Out of Area Urgent Care, services are not covered and you may be required to pay the full cost of services obtained when outside the Service Area or with Out-of-Network Providers.

This *EOC* describes our Large Group Commercial Benefit Plan health care coverage provided under the Group Agreement (Agreement) between VCHCP and your Group (County of Ventura). The Agreement is available for inspection at VCHCP and the employer's benefits administration office. This *EOC* is for the plan or benefit year, established by your employer, and is defined by a specific start and end date in the Agreement.

This Evidence of Coverage constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

You have a right to review the health plan contract, which shall be furnished upon your request. In the event that there is a conflict between this Evidence of Coverage and the health plan contract, the terms of this Evidence of Coverage will prevail.

It is the Plan's goal to maintain you and your eligible family members in good health by providing Medically Necessary health care services and encouraging healthy lifestyles through the Plan's health education programs and disease management programs. VCHCP requires that you select a Primary Care Physician who will oversee your health care needs. You may choose any available Primary Care Physician that is an In-Network Provider with the Plan. You can find a list of Primary Care Physicians in the *Provider Directory* or on the Plan's website and also check to see if they are

accepting new patients. At any time, you may change your Primary Care Physician. Sometimes our Primary Care Physicians work with and supervise other members of a health care team by whom you may be seen, including licensed nurse practitioners, certified physician assistants, certified non-physician-surgical assistants, physicians in residency training programs, and nurses. In addition, we have contracted Specialist Physicians, ancillary providers, and hospitals for covered services. These providers are located throughout the Service Area to provide access to Medically Necessary health care services.

VCHCP does not discriminate in employment or in the delivery of health care services on the basis of age, race, color, ancestry, religious creed, gender, sexual orientation, marital status, medical condition or physical or mental disability.

To receive additional information about the benefits of the Plan, visit our website at www.vchealthcareplan.org, or call VCHCP at (805) 981-5050, or toll-free at (800) 600-8247, or by fax at (805) 981-5051. Member Services representatives, bilingual in English and Spanish, are available from 8:30 a.m. to 4:30 p.m. Pacific Time on regular County of Ventura business days. You may also contact VCHCP by sending written correspondence to Ventura County Health Care Plan, 2220 E. Gonzales Road, Suite 210-B, Oxnard, CA 93036.

For Language Assistance services, call VCHCP at (805) 981-5050 or toll free at (800) 600-8247. TDD/TTY is available for the hearing impaired at (800) 735-2929 to communicate in English or (800) 855-3000 to communicate in Spanish.

Standards for Members' Rights and Responsibilities

Ventura County Health Care Plan is committed to maintaining a mutually respectful relationship with its Members that promotes effective health care. Standards for Members Rights and Responsibilities are as follows:

1. Members have a right to receive information about VCHCP, its services, its Practitioners and Providers, and Members' Rights and Responsibilities.

2. Members have a right to be treated with respect and recognition of their dignity and right to privacy.

3. Members have a right to participate with Practitioners and Providers in decision making regarding their health care.

4. Members have a right to a candid discussion of treatment alternatives with their Practitioner and Provider regardless of the cost or benefit coverage of the Ventura County Health Care Plan.

5. Members have a right to make recommendations regarding VCHCP's Member Rights and responsibility policy.

6. Members have a right to voice complaints or appeals about VCHCP or the care provided.

7. Members have a responsibility to provide, to the extent possible, information that VCHCP and its Practitioners and Providers need in order to care for them.

8. Members have a responsibility to follow the plans and instructions for care that they have agreed upon with their Practitioners and Providers.

9. Members have a responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Member Notice - Language Assistance Services

English	If you, or someone you are helping, has questions, you have the right to get help and information in your language at no cost. To speak with an interpreter, call 1-800-600-8247 (TTY: 1-800-735-2929).
Spanish	Si usted, o alguien a quien usted está ayudando, tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-600-8247 (TTY: 1-800-735-2929).
Chinese	如果您或您正在說明的人有疑問，您有權免費獲得您的語言的幫助和資訊。要與口譯員交談，請致電 1-800-600-8247 （TTY： 1-800-735-2929）。
Vietnamese	Nếu bạn, hoặc ai đó bạn đang giúp đỡ, có thắc mắc, bạn có quyền nhận trợ giúp và thông tin bằng ngôn ngữ của bạn miễn phí. Để nói chuyện với thông dịch viên, hãy gọi số 1-800-600-8247 (TTY: 1-800-735-2929).
Tagalog	Kung ikaw, o ang isang taong tinutulungan mo, ay may mga katanungan, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang interpreter, tumawag sa 1-800-600-8247 (TTY: 1-800-735-2929).
Korean	귀하 또는 귀하가 돕고 있는 사람이 질문이 있는 경우 귀하는 무료로 귀하의 언어로 도움과 정보를 얻을 권리가 있습니다. 통역사와 통화하려면 1-800-600-8247(TTY: 1-800-735-2929)로 전화하십시오.
Armenian	Եթե դուք կամ ձեզ օգնող մեկը հարցեր ունի, դուք իրավունք ունեք անվճար ստանալ ձեր լեզվով օգնություն եւ տեղեկատվություն: Թեկնածուով խոսելու համար զանգահարեք 1-800-600-8247 (TTY: 1-800-735-2929):
Persian (Farsi)	اگر شما یا کسی که به او کمک می کنید، سوالی دارید، حق دارید بدون هیچ هزینه ای کمک و اطلاعات به زبان خود دریافت کنید. برای صحبت با مترجم، با شماره 1-800-600-8247 تماس بگیرید (TTY: 1-800-735-2929).
Russian	Если у вас или у кого-то, кому вы помогаете, есть вопросы, вы имеете право бесплатно получить помощь и информацию на своем языке. Чтобы поговорить с переводчиком, позвоните по номеру 1-800-600-8247 (телетайп: 1-800-735-2929).
Japanese	あなた、またはあなたが助けている誰かが質問を持っている場合、あなたには無料であなたの言語で助けと情報を得る権利があります。通訳者と話すには、 1-800-600-8247(TTY:1-800-735-2929)に電話してください。
Arabic	إذا كان لديك، أو لدى أي شخص تساعده، أسئلة، فيحق لك الحصول على المساعدة والمعلومات بلغتك دون أي تكلفة. للتحدث مع مترجم فوري ، اتصل بالرقم 1-800-600-8247 (الهاتف النصي: 1-800-735-2929).
Punjabi	ਜੇ ਤੁਹਾਡੇ, ਜਾਂ ਤੁਹਾਡੇ ਵੱਲੋਂ ਮਦਦ ਕਰ ਰਹੇ ਕਿਸੇ ਵਿਅਕਤੀ ਦੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੇ ਖ਼ਰਚੇ ਦੇ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਕਿਸੇ ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ, 1-800-600-8247 (TTY: 1-800-735-2929) 'ਤੇ ਕਾਲ ਕਰੋ।
Mon-Khmer, Cambodian	បើ អ្នក ឬ នរណា ម្នាក់ ដែល អ្នក កំពុង ជួយ មាន សំណួរ អ្នក មាន សិទ្ធិ ទទួល បាន ជំនួយ និង ព័ត៌មាន ជា ភាសា របស់ អ្នក ដោយ មិន គិត ថ្លៃ។ ដើម្បី និយាយ ជាមួយ អ្នក បក ប្រែ សូម ទូរស័ព្ទ មក លេខ 1-800-600-8247 (TTY: 1-800-735-2929)។
Hmong	Yog koj, los sis ib tug neeg koj pab koj, muaj lus nug, koj muaj txoj cai nrhiav kev pab thiab koj cov lus nyob rau hauv koj hom lus tsis muaj nqi. Nrog ib tug neeg txhais lus, hu rau 1-800-600-8247 (TTY: 1-800-735-2929).
Hindi	यदि आप, या आप किसी ऐसे व्यक्ति की मदद कर रहे हैं, जिसके कोई प्रश्न हैं, तो आपको बिना किसी लागत के अपनी भाषा में सहायता और जानकारी प्राप्त करने का अधिकार है। एक दुभाषिया से बात करने के लिए, 1-800-600-8247 (TTY: 1-800-735-2929) पर कॉल करें।
Thai	หากคุณหรือคนที่คุณกำลังช่วยเหลือมีคำถามคุณมีสิทธิ์ที่จะได้รับความช่วยเหลือและข้อมูลในภาษาของคุณโดยไม่มีค่าใช้จ่าย หากต้องการพูดคุยกับล่ามโทร 1-800-600-8247 (TTY: 1-800-735-2929)

- ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

Language and Communication Assistance: Good communication with VCHCP and with your providers is important. If English is not your first language, VCHCP provides interpretation services and translations of certain written materials.

- To ask for language services call VCHCP at (805) 981-5050 or (800) 600-8247. You may obtain language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner. You may obtain interpretation services free of charge in English and the top 15 languages spoken by limited-English proficient individuals in California as determined by the State of California Department of Health Services.
- If you are deaf, hard of hearing or have a speech impairment, you may also receive language assistance services by calling TDD/TTY at (800) 735-2929.
- If you have a preferred language, please notify us of your personal language needs by calling VCHCP at (805) 981-5050 or (800) 600-8247.
- Interpreter services will be provided to you, if requested and arranged in advance, at all medical appointments.

If you have a disability and need free auxiliary aids and services, including qualified sign language interpreters for disabilities and information in alternate formats, including written information in other formats, you may request that they be provided to you free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity for you to participate.

VCHCP complies with applicable Federal and California laws and does not exclude people or otherwise discriminate against them because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability

HOW TO FILE A DISCRIMINATION COMPLAINT WITH THE OFFICE FOR CIVIL RIGHTS

The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) enforces certain Federal civil rights laws that protect the rights of all persons in the United States to receive health and human services without discrimination based on race, color, national origin, disability, age, and in some cases, sex and religion.

If you believe that you have been discriminated against because of your race, color, national origin, disability, age, sex or religion by a health care or human services provider (such as a hospital, nursing home, social service agency, etc.) or by a State or local government health or human services agency, you may file a complaint with the Office for Civil Rights (OCR). Complaints alleging discrimination based on disability by programs directly operated by HHS may also be filed with OCR. You may file a complaint for yourself or for someone else.

Complaints to the Office for Civil Rights should be filed in writing, either on paper or electronically. You can use OCR's Discrimination Complaint Form which can be found on our web site or at an OCR Regional office. If you do not use OCR's form, your complaint should include the following information:

1. Your name, address and telephone number.
2. If you are filing a complaint for someone else, include that person's name, address and telephone number.
3. The name and address of the organization or person you believe discriminated against you.
4. How, why and when you believe you (or the person on whose behalf you are filing the complaint) were discriminated against.
5. Any other information that would help OCR understand your complaint.

You must file your complaint within 180 days of the date when the discrimination happened. OCR may extend the 180-day period if you can show "good cause."

You can file your complaint by email at OCRcomplaint@hhs.gov, or you can mail or fax your complaint to the OCR Regional Office that is responsible for the state in which you allege the discrimination took place. To find out where to file your complaint, use the OCR Regions list at the end of this Fact Sheet or you can look at the regional office map to help you determine where to send your complaint.

MORE INFORMATION ABOUT HOW TO GET A COPY OF OCR'S DISCRIMINATION COMPLAINT FORM

Option 1: Open and print out the Discrimination Complaint Form in PDF format (you will need Adobe Reader software) and fill it out. Return the completed complaint to the appropriate OCR Regional Office by mail or fax.

Option 2: Download the Discrimination Complaint Form in Microsoft Word format to your own computer, fill out and save the form using Microsoft Word. Use the Tab and Shift/Tab on your keyboard to move from field to field in the form. Then, you can either: (a) print the completed form and mail or fax it to the appropriate OCR Regional Office; or (b) email the form to OCR at OCRComplaint@hhs.gov.

If you have any questions, or need help to file your complaint, call OCR (toll-free) at 1-800-368-1019 (voice) or 1-800-537-7697 (TDD). You may also send an email to OCRMail@hhs.gov.

Website: http://www.hhs.gov/ocr

Enrollment: You may enroll yourself and your eligible Dependents in VCHCP if you are in a Group that has an Agreement with VCHCP. At the time of enrollment, or any time thereafter, the Plan may request that you provide proof of a dependent relationship, such as a copy of a marriage certificate, proof of Residence, a birth certificate, court papers, or proof of Domestic Partner status.

Such proof may not be required if you have already provided proof with a previous VCHCP enrollment. The Plan applies the same terms and conditions to Domestic Partners as are applied to spouses. To enroll and to continue enrollment, you must meet all of the eligibility requirements in this section.

Group Eligibility Requirements: You must meet your Group's eligibility requirements, as approved by VCHCP. Your Group is required to inform its employees of its eligibility requirements, such as the minimum number of hours that an employee must work to be eligible for coverage.

Service Area Eligibility Requirements: The Subscriber must live or work in our Service Area to be eligible for enrollment. The Service Area for VCHCP is Ventura County. The Definition Section further describes our Service Area. You must receive Covered Services from Plan Providers inside our Service Area, except for Emergency Care, Urgent Care, and Post-stabilization care received from non-Plan Providers when authorized by the Plan. Post stabilization care must be authorized by the Plan while Emergency and Urgent Care do not require prior authorization by the Plan.

Eligible Dependents: Dependents may include your spouse or Domestic Partner (as discussed below), and any dependent children under 26 years of age. A Dependent child includes your child, your stepchild, child of your Domestic Partner (as discussed below), or child adopted, placed for adoption or under your legal custody or the legal custody of your spouse. Please see further qualifying criteria below.

Note: Dependents not living in the service area are covered for urgent and emergent services only, while outside of the service area.

Timely Dependent Enrollment: Any child born to you will be covered for thirty-one (31) days from the newborn's date of birth. This thirty-one (31) day period is called your "special enrollment period". For coverage to extend beyond the Special Enrollment Period (31 days), you must notify the Group by submitting a Health Plan Enrollment Form within sixty (60) days of the birth of the child. A newly adopted child or a child newly placed for adoption or under your legal custody will be covered from the date of adoption, placement or legal custody, if you notify the Group by submitting a completed Health Plan Enrollment Form within sixty (60) days of adoption or placement or legal custody. A spouse and a spouse's eligible child(ren) will be covered from the date of marriage, if you notify the Group by submitting a completed Health Plan Enrollment Form within sixty (60) days of marriage. If your eligible Dependent lost other coverage, your eligible Dependent will be covered from the day after the other coverage ended if you notify the Group by submitting a completed Health Plan Enrollment Form within sixty (60) days of the loss of coverage.

Dependent Children and Adult Children:

All eligible children must be under the limiting age of 26.

The following categories are eligible:

- your natural or legally adopted children;
- your spouse's natural or legally adopted children (your stepchildren);
- your eligible domestic partner's natural or legally adopted children;

- children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes;
- children for whom you are legally required to provide group health insurance pursuant to an administrative or court order. (Child must also meet VCHCP eligibility requirements.)

Adult Children Incapable of Self Support: Any child described above who is incapable of self-sustaining employment due to a physical or mentally disabling injury, illness, or condition and is chiefly dependent upon the subscriber for support and maintenance may continue to be covered past age 26.

The Plan shall send notification to subscriber of child reaching limiting age at least 90 days prior to child reaching limiting age.

Application for coverage beyond age 26 due to disability must be made to the Plan sixty (60) days prior to the date coverage is to end due to reaching limiting age. If application is received timely but Plan does not complete determination of the child's continuing eligibility by the date the child reaches the Plan's upper age limit, the child will remain covered pending the Plan's determination. The Plan may periodically request proof of continued disability, but not more than once a year after the initial certification. Disabled children approved for continued coverage under a health plan are eligible for continued coverage under any other product offered by this Plan. If enrollment is transferred from one plan to another, a new application for continued coverage is not required; however, the new Plan may require proof of continued disability, but not more than once a year and not within two years of initial acceptance of coverage under this section. If you are a newly hired Employee with a disabled child over age 26 or if you newly acquire a disabled child over age 26 (through marriage or adoption), you may also apply for coverage for that child. The child's disability must have begun prior to the child turning age 26. Additionally, the child must have had continuous group medical coverage since age 26, and you must apply for County coverage during your Period of Initial Eligibility. The Plan will ask for proof of continued disability, but not more than once a year and not within two years after the initial certification.

Important Note: Health and welfare benefits and eligibility requirements, including dependent eligibility requirements are subject to change (e.g., for compliance with applicable laws and regulations). VCHCP dependent eligibility requirements may change following health care reform legislation, regulatory guidance, or other applicable laws.

Domestic Partners: Enrollment of a Domestic Partner is available to a person who has officially registered with the State of California Secretary of State or with any other California County or municipality domestic partner registry listed at the Secretary of State's Internet site http://www.sos.ca.gov/registries/domestic-partners-registry and meets Plan eligibility criteria. At the time of enrollment, or any time thereafter, the Plan may request a copy of your Domestic Partnership registration. Children of your Domestic Partner are eligible for enrollment under the same rules that apply to stepchildren.

Change in Dependent Status: It is the Subscriber's and Dependent's responsibility to promptly advise the Plan of any change in a Dependent's status or circumstances affecting eligibility. VCHCP may, at any time, request written verification of the status and continued eligibility of any dependent. The Subscriber and the Dependent are responsible for cooperating with any such request

and must provide reasonable authorizations or releases as may be requested by VCHCP for purposes of verifying information from third parties. Failure to provide appropriate proof of continued eligibility shall be grounds for a determination of ineligibility. VCHCP has the right to approve benefits based on expressed or implied (failure to notify us otherwise) representations of continued eligibility, but to subsequently deny Coverage and payment if it is later determined that the Dependent was in fact ineligible. In the event of such denial of Coverage, the Subscriber/Dependent shall be responsible for paying for all covered Services rendered subsequent to the effective date the Dependent became ineligible, including reimbursing VCHCP for payments made for such services.

Effective Date of Coverage: Your Coverage begins on the first day of the pay period after your enrollment forms are processed, received by VCHCP, and the first payroll deduction is taken. If you add Dependents during a special enrollment period (for example, within sixty (60) days of birth, marriage or adoption), your Dependent's benefits will become effective on the date of the birth, marriage or adoption. If the Group accepts your late request for Dependent enrollment, your Dependent's benefits will become effective on the first day of the pay period after your enrollment change forms are received and processed by the Plan.

Renewal Provisions: The Agreement between the Group and VCHCP may be renewed for additional periods of twelve (12) calendar months or equivalent employee pay periods. VCHCP reserves the right to change the Premium or other terms of the Agreement upon renewal or within sixty (60) days of written notification to you. If the Agreement is renewed, your renewal is automatic as long as you maintain your eligibility with VCHCP. You are required to update your enrollment information for yourself and your dependents as changes occur or at least annually.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

- HOW TO OBTAIN CARE

Choice of Physicians and Providers: When your coverage becomes effective, VCHCP will ask you to select a Primary Care Physician (PCP) or medical group listed in the Plan's Provider Directory. You are required to contact your PCP or medical group to access coverage. Your PCP or medical group will be responsible for coordinating the provision of covered services to you and your family. They will direct your medical care, including making Referrals to Specialist Physicians, when appropriate, ordering x-ray and laboratory tests, prescribing medicines, and arranging for hospitalization. A Primary Care Physician may be a family/general practitioner, internist, pediatrician, obstetrician/gynecologist, or HIV specialist who has entered into, or is party to, a written contract with VCHCP to provide primary care services, and who has met VCHCP's requirements as a Primary Care Physician.

Some of our PCPs work with and supervise other members of a health care team by whom you may be seen, including licensed nurse practitioners, certified physician assistants, certified assistants, physicians in residency training programs, and nurses. Information about specific providers and provider groups is available upon request. If you fail to choose a PCP or medical group, the Plan will assign one. Your choice or assignment of a PCP may affect where you may obtain hospital services depending on the hospital with which the PCP has an affiliation or admitting privileges. Such limitations shall not apply to medical emergencies or out-of-area urgently needed services or where medically necessary services cannot be provided by the assigned hospital.

The following information on our contracted providers is available on our website at https://www.vchealthcareplan.org/: name, address, telephone number, professional qualifications, specialty, and board certification status. This information is also available by calling the Plan, along with the medical school attended and residency completion.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your Plan contract and that you or your family member might need: family planning, contraceptive services; including emergency contraception, sterilization, tubal ligation at the time of labor and delivery; infertility treatments, or abortion. You should obtain more information before you enroll. Call your prospective provider, medical group, independent practice association, or clinic, or call the Health Plan at (805) 981-5050 or (800) 600-8247 to ensure that you can obtain the health care services that you need.

Changing Medical Groups or Primary Care Physicians: If you wish to change your PCP or medical group, you may do so by contacting the Member Services Department. Changes will take effect on the day of your request.

Member Notification When a Physician Is No Longer Available: In the event your PCP is no longer available, you will be notified and given the opportunity to select a new PCP. In the event that you do not make such a selection, VCHCP will select a new PCP for you taking into account your city of Residence. We will mail you a letter of explanation and a new Identification Card. If you would prefer another PCP, follow the steps in the above paragraph. For information on the

provision of continuity of care when your PCP is no longer available, please see the section titled "Continuity of Care with a Terminated Provider" of this document.

Timely Access to Care:

VCHCP adheres to patient care access and availability standards as required by the Department of Managed Health Care (DMHC). The DMHC implemented these standards to ensure that members can get an appointment for care on a timely basis, can reach a provider over the phone and can access interpreter services, if needed. Contracted providers are expected to comply with these appointments, telephone access, practitioner availability and linguistic service standards.

If a timely appointment is not available at any of our contracted clinics/facilities, then an out-of-network (OON) referral request should be sent by the referring provider to the Plan for authorization. The authorization request must include the details regarding the access issue and why an OON referral is required.

Note: *The referring provider may allow for an appointment outside of the timely access requirements if it will not be harmful to the patient's health. These instances must be documented in the patient's chart and communicated to the patient.*

Type of Care	Wait Time or Availability
Emergency Services	Immediately, 24 hours a day, 7 days a week
Urgent Need – No Prior Authorization Required	Within 48 hours
Urgent Need – Requires Prior Authorization	Within 96 hours
Primary Care	Within 10 business days
Specialty Care	Within 15 business days
Ancillary services for diagnosis or treatment	Within 15 business days
Mental Health and Substance Use Disorder including nonurgent follow-up appointments with nonphysician mental health care or substance use disorder providers	Within 10 business days
Phone wait time for triage or screening by the provider office	Not to exceed 30 minutes
Wait time for enrollees to speak with a qualified Plan representative during business hours	Not to exceed 10 minutes

Referrals for Health Care Services: Sometimes, you may need care that your PCP cannot provide. At such times, you will be referred to a Specialist Physician or Provider for that care. No Referrals or Authorizations are needed to access Emergency or Urgent Care needs.

The Plan has contracted with a broad range of Providers who are conveniently located to provide access to Covered Services. All VCHCP contracted specialists can be directly referred by PCPs using the direct referral form [Excluding Tertiary Referrals, (e.g. UCLA and CHLA),]. Referrals to physical therapy, occupational therapy, and nutritional counseling also use the direct referral form. Your PCP must ask VCHCP for prior approval for covered services that require prior authorization. VCHCP requires that members are seen within the VCHCP network of contracted providers unless the service is unavailable. VCHCP further requires evaluation by a local network Specialist before referral to a Specialist in a tertiary care center unless the service is unavailable locally. The Plan processes normal requests for prior authorization for Covered services made by your PCP within five (5) business days and urgent requests made by your PCP or treating Provider within seventy-two (72) hours from the Plan's receipt of request. Requests are considered to be urgent when your condition is such that you face an imminent and serious threat to your health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal time frame for the decision-making process, would be detrimental to your life or health or could jeopardize your ability to regain maximum function.

For Authorization requests received prior to or concurrent with the provision of services, the Plan faxes its written decision to your PCP and the provider requesting the service within twenty-four (24) hours of making the decision. If the Plan receives a request for authorization of services after the services are provided, we will notify you and your provider of our decision within thirty (30) days of our receipt of request. If the Plan cannot process your Provider's request within the

specified time frame, you and your provider will receive a written explanation of the reason for the delay and the anticipated date on which a decision may be made. Decisions that are based on medical necessity resulting in approval, denial, delay or modification of all or part of the requested health care service are mailed to you or to your representative within two (2) business days of making the decision.

A female Member can directly seek most obstetric and gynecologic services from any In-Network provider offering those services and contracted with the Plan to provide Direct Access OB/Gyn Services. A direct referral is required from your PCP for infertility services. A Member may also seek maternity or gynecologic care directly from her PCP.

Standing Referral to Specialty Care: You may receive a Standing Referral to a Specialist Physician for a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative or disabling. The Plan's Standing Referral process selects Providers who have demonstrated expertise in treating a condition or disease involving a complicated treatment regimen that requires ongoing monitoring.

You may receive a Standing Referral to a Specialist or a specialty care center if you are needing continuing care and the recommended treatment plan is determined necessary by your PCP, in consultation with the Specialist, VCHCP's Medical Director and you. The treatment plan may limit the number of visits to the Specialist, the period of time for which the visits are authorized, or require that the Specialist provide your PCP with regular reports on the health care provided. Extended access to a Specialist is available to Members who have a life-threatening, degenerative, or disabling condition (for example, members with HIV/AIDS). To request a Standing Referral, ask your PCP or Specialist. The Plan will approve or deny a referral within three (3) business days of the date of the request. Once the determination is made regarding the need for the standing referral to the Specialist, the referral must be communicated to the Specialist within four (4) business days.

You may obtain a copy of VCHCP's Standing Referral to a Specialist Policy or Direct Access to OB/GYN Services Policy and a list of contracted Direct Access Providers or Standing Referral Specialists by contacting the Plan's Member Services Department at (805) 981-5050 or toll free at (800) 600-8247, or by accessing our website at www.vchealthcareplan.org. Please see below for additional information.

Referrals and authorizations are not required for sexual and reproductive health care services, including but not limited to:

- the prevention or treatment of pregnancy, including birth control, vasectomies, emergency contraceptive services, pregnancy tests, prenatal care, abortion, and abortion-related services.
- the screening, prevention, testing, diagnosis, and treatment of sexually transmitted infections and sexually transmitted diseases.
- the diagnosis and treatment of sexual assault or rape, including the collection of medical evidence with regard to the alleged rape or sexual assault.
- the screening prevention, testing, diagnosis, and treatment of the human immunodeficiency virus (HIV).

Referrals for Mental Health/Substance Use Disorder Services: VCHCP has contracted with OptumHealth Behavioral Solutions of California (OHBS) to administer the "Life Strategies/ OHBS" program to provide you with behavioral health services, including Mental Health and Substance Use Disorder Treatment Services as well as behavioral health treatment for Autism Spectrum Disorder. Information on and Authorization of mental health and substance use disorder treatment services are available by calling the "Life Strategies/OHBS" Program at (800) 851-7407. A Life Strategies/OHBS Representative is available twenty-four (24) hours-a-day to assist in emergency mental health or substance use disorder care coordination. Members may self-refer for outpatient office visits.

VCHCP delegates mental health and substance use disorder (MH/SUD) services and treatments to U.S. Behavioral Health Plan, California, (USBHPC or Optum), which shall provide coverage for MH/SUD medically necessary services to its' members pursuant to Title 28 of the California Code of Regulation Rule 1300.74.72.

VCHCP, in coordination with USBHPC, shall maintain a provider network sufficient to provide all medically necessary services, including MH/SUD services, within geographic and timely access standards, pursuant to the Knox-Keene Act and its implementing regulations. If such MH/SUD services are not available to an enrollee in accordance within a geographic and timely access standard such as those required by the law, the plan shall provide and arrange coverage for medical necessary MH/SUD services from an out-of-network provider or providers. Members, and/or their authorized representatives, shall receive written notice within five (5) calendar days from the initial request for such arrangements. Please see Title 28 of the California Code of Regulation Rule 1300.74.72 et seq.

Enrollees seeking MH/SUD services, diagnosis, and/or treatment shall receive health care benefits medically necessary in accordance with generally accepted standards. Please see Title 28 of the California Code of Regulation Rule 1300.74.72.01 et seq.

Members receiving MH/SUD services, benefits, diagnosis, and/or treatment are subject to the applicable utilization review processes pursuant to Title 28 of the California Code of Regulation Rule 1300.74.721 et seq.

Facilities and Provider Locations: You may request an updated copy of the Provider Directory at any time by contacting the Plan's Member Services Department. You may also view and print the Provider Directory from VCHCP's Web Site: www.vchealthcareplan.org. The Provider Directory lists the In-Network physicians, pharmacies, hospitals, urgent care facilities, surgery centers, laboratory draw sites, imaging centers, podiatrists, and physical therapists. PCPs are listed by city and then alphabetically by last name with information about the medical group and practice location. Specialists are listed under their specialty, city, and then alphabetically by last name as mentioned above. The Provider Directory does not list the names of hospital-based In-Network Providers, such as radiologists, emergency room physicians, anesthesiologists, and pathologists. The Provider Directory also does not list the names of tertiary care referral hospitals and their contracted medical groups. You may obtain the names of In-Network mental health and substance abuse disorder practitioners and treatment facilities by calling Life Strategies/OHBS, the Plan's Behavioral Health Administrator at (800) 851-7407 and you may also obtain professional degrees, board certifications, and subspecialty qualifications of all In-Network Providers by contacting the Plan's Member Services Department.

Coverage of mental health and substance use disorder treatments pursuant to California Health and Safety Code Section 1374.72 will include behavioral health crisis services that are provided to an enrollee by a 988 center, mobile crisis team, or other provider of behavioral health crisis services, regardless of whether the service is provided by an in- network or out-of-network provider or facility.

Members are directed to VCHCP's behavioral health delegate, USBHPC and/or Optum, who shall provide enrollee(s) or the enrollee's authorized representative, and the enrollee's requesting provider(s) with all utilization review determination criteria and any education program materials identified in Title 28 of the California Code of Regulation Rule, California Health and Safety Code Section 1300.74.721(o) shall be made available upon request at no cost. Title 28 of the California Code of Regulation Rule 1300.74.721(p)

Second Medical Opinions: The Plan has a second opinion policy, under which second opinions will be authorized for the following circumstances:

- The Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
- The Member questions the reasonableness or necessity of recommended surgical procedures.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the Member requests an additional opinion.
- If the treatment plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or the continuance of the treatment.
- If the Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.
- Any other reasonable circumstance that is authorized by the Plan's Medical Director.

Second opinions will be rendered by an appropriately qualified health care professional. This is defined as a PCP or Specialist acting within his or her scope of practice and who possesses a clinical background, including training and expertise, as it relates to the particular illness, disease, condition or conditions associated with the request for a second opinion. The provider will be selected to render the second opinion as follows:

1. The provider chosen by the Member or by the provider who is treating the Member will be authorized if the provider meets the above definition of an appropriately qualified health care professional and if the provider is an In-Network Provider. This includes all contracted PCPs and all contracted Specialists.

2. Otherwise, the Plan will select a provider, taking into consideration the ability of the Member, to travel to the provider. The Plan will limit referrals to its In-Network Providers, if there is an In-Network Provider who meets the above definition of an appropriately qualified health care

professional. In general, Specialists contracted with the Ventura County Medical Center will be preferentially selected over other contracted providers of the same specialty; a provider will be selected who is not in the same practice as the provider who rendered the first opinion unless the member agrees to being seen in the same office; and Specialists located within the Service Area will be selected in preference to Specialists located outside the Service Area. If there is no provider within the Plan's network that is qualified, the Plan will authorize a referral to a qualified Out-of-Network Provider.

3. All second opinion requests may originate from a member, a member's primary care provider or the specialist who consulted for the initial opinion. Requests originating from a member's primary care provider or specialist must be submitted to the Plan on the appropriate Treatment Authorization Request form (TAR). For requests originating from a member, Medical Management will request the TAR from a member's primary care provider or specialist who consulted for the initial opinion. (Note: Member can request second opinion per Health and Safety Code 1383.15).

4. For Plan authorized second opinions, the Member will only be responsible for the applicable copayment required for similar referrals. Referrals authorized by the Plan to Out-of-Network Providers have copayments consistent with the copays that apply to In-Network providers for the same type of service.

5. The member is responsible for costs related to travel, lodging, or food incurred while obtaining such second opinion.

6. Follow up/additional visits, tests or procedures required after the second opinion, requested by the physician rendering the second opinion, will generally be authorized to be done locally/within the service area unless unavailable.

7. Second opinion providers will be advised of the requirement to provide a consultation report to the Member and to a requesting In-Network Provider who is treating the Member.

8. There is no coverage for any opinions beyond the Authorized second opinion.

Please see the Member grievance procedure section for information on what to do if your request for second opinion is denied by the Plan.

For Mental Health and Substance use Disorder Treatment Services Second Opinions please contact Life Strategies/OHBS at 1-800-851-7407, or in writing to P.O. Box 2839, San Francisco, CA 94126.

The Plan's complete policy on second medical opinions may be obtained by contacting the Plan at (805) 981-5050 or toll free at (800) 600-8247, or by writing to the Plan at 2220 E. Gonzales Road, Suite 210-B, Oxnard, CA 93036.

Members/Enrollees – Please be advised of Title 28 of the California Code of Regulation Rule 1300.74.72(h) which states:

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Optum fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must

cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Benefits or coverage for mental health and substance use disorders shall not be limited to short-term or acute treatment by a health plan. California Health and Safety Code Section 1374.72(a)(6).

Member benefits for mental health and substance use disorders shall include intermediate services, including a full range of levels of care, including, but not limited to, residential treatment, partial hospitalization, and intensive outpatient treatment. California Health and Safety Code Section 1374.72(b)(2).

EMERGENCY AND URGENTLY NEEDED CARE

The following definitions are important to understanding your coverage if you urgently need care or have an emergency situation.

Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy.
- In the case of a pregnant woman, would put the health of her unborn child in serious danger.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to himself or herself or to others.
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder.

Emergency Services means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility. Examples of emergency situations include: uncontrolled bleeding, seizure or loss of consciousness, shortness of breath, chest pain or squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, severe burns, broken bones or severe pain.

Emergency Services also means a screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility. Examples of psychiatric emergencies include: suicidal thoughts, hallucinations, and other mental health emergencies.

Rape/Sexual Assault - AB 2843 – The Plan provides coverage for emergency room medical care and follow-up health care treatment for an enrollee who is treated following a rape or sexual assault without imposing cost sharing, including copayments, coinsurance, or deductibles, for the first nine months after the enrollee initiates treatment. Follow-up health care treatment includes medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault. The Plan shall arrange for the provision of follow up health care treatment from providers outside the plan's network if those services are unavailable within the network to ensure timely access to covered health care services. The plan shall cover followup health care treatment furnished by a nonparticipating provider if those services are for emergency services and care. CA H&S § 1367.37

Urgent Care Services means prompt medical services provided in a non-emergency situation. Examples of urgent care conditions include sore throats, ear infections, sprains, high fevers, vomiting and urinary tract infections. Urgent situations are not considered to be Emergency Medical Conditions. Services must be obtained at an appropriately licensed "urgent care" or similar facility, subject to retrospective denial for services not medically indicated or supported by the examination and/or the diagnosis of the Member. No authorization required. **Urgently Needed Care** means any

Covered Service necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member is able to see his or her PCP. This includes maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee is able to see her Provider.

Out-of-Area Urgent Care services shall be a covered benefit while the member or eligible dependents are outside the Service Area. Out-of-Area Urgent Care services are covered if:

(a) You are temporarily outside the Plan's Service Area, and

(b) The services are necessary to prevent serious deterioration of your health, or your fetus, and

(c) Treatment cannot be delayed until you return to the Plan's Service Area.

Ventura County Health Care Plan Members have a responsibility to follow the plan of care and instructions that they have agreed upon with their Providers.

While members or eligible dependents are inside the Service Area, Urgently Needed Care will only be covered at In-Network facilities. No authorization is required. Use of Out-of-Network Urgent Care facilities inside the service area is not covered.

What to Do When You Require Emergency or Urgently Needed Services Inside or Outside of the Service Area: If you reasonably believe that an Emergency Medical Condition exists, go to the nearest hospital emergency room, or call 911. You may call your Primary Care Physician, during or after regular office hours, if you are unsure whether an Emergency Medical Condition exists. Authorization from the Plan or from your Primary Care Physician, however, is not required if you reasonably believe that an Emergency Medical Condition exists.

If you are treated at an In-Network facility, that facility must contact the Plan for Authorization if additional care is needed after your Emergency Medical Condition is stabilized. If your condition requires admission for inpatient care, you have the option to be transferred to the Ventura County Medical Center once stable.

If you are at an Out-of-Network facility and you require inpatient admission, you or the facility must contact the Plan for Authorization at the time of the decision to admit. Once your condition has stabilized VCHCP may transfer you to an In-Network facility. If you or the Out-of-Network facility does not notify the Plan or the admission is not Authorized by the Plan, you may be financially responsible for the additional services rendered after stabilization.

If you are not sure whether you have an emergency or require urgent care, please contact the Nurse Advice Line at 800-334-9023 to access triage or screening services, 24 hours a day, 7 days a week.

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR SERVICES THAT YOU RECEIVED FROM A NON-CONTRACTED PROVIDER, PLEASE CONTACT THE PLAN AT

805-981-5050 OR TOLL-FREE AT (800) 600-8247 OR BY FAX AT (805) 981-5051.

Observation Stay: Hospitals may provide observation care if you are not well enough to go home but not sick enough to be admitted as inpatient. These stays require a doctor's order and are considered outpatient services even though you may be in the hospital overnight. At Ventura County Medical Center, observation stays may be up to 2 midnights. At all other facilities, including tertiary, observation stays are up to 24 hours. After those time periods, if you are still in the hospital, you would be considered to be admitted as an inpatient.

Follow-up Care: After your medical problem no longer requires Emergency Care or Urgently Needed Care or ceases to be an emergency and your condition is stable, any additional care you receive is considered "Follow-Up Care". The follow-up care related to Emergency and Urgently Needed Care must be provided by or coordinated by your PCP, and obtained in-network, unless otherwise authorized by the Plan. Mental health, behavioral health, and substance use disorder services need not be coordinated by your PCP.

What to Do When Your Primary Care Physician Is Not Available: When your Primary Care Physician or medical group's office is closed or when a same day appointment is not available for care that does not meet the definition of "Emergency Care" or "Urgently Needed Care", you may self-refer to one of the In Network Urgent Care Centers within the Plan's Service Area. You may also contact your Primary Care Provider for advice and instructions. If you anticipate frequently needing after-hours services, you may consider selecting a PCP with extended hours as listed in the Provider Directory.

PAYMENT RESPONSIBILITIES

Subscriber Liabilities for Emergency Services: You, or someone acting on your behalf, must notify the Plan as soon as reasonably possible following your Admission if you are hospitalized in any facility.

Subscriber Liabilities for Non-Emergency Covered Services: Except as is noted below, your PCP must request, arrange for, and obtain the Plan's prior approval for Referrals to certain Specialists, and for hospitalizations, out of network services and certain other benefits. Exceptions to this policy are as follows:

- Female Members may self-refer to an Obstetrician ("OB/GYN") or Family Practitioner, ("FP"), contracted with the Plan to provide covered OB/GYN Direct Access Services. Benefits are covered as if the OB/GYN or FP is acting as a PCP.
- Emergency Room Services with a Non-Participating Provider/Facility and Urgent Care Services within the service area are covered. Stabilization of your emergency condition in an out- of network facility. (Note: After stabilization, if you are admitted to an out-of-network facility, VCHCP has the option to transfer you to an in-network facility.) **If the Plan is not notified or if you refuse the transfer,**

you will be financially responsible for services rendered.

- Emergency contraception or the "Morning After Pill" is covered for female members who require emergency contraception. Members are urged to see their regular PCP to obtain counseling and prescription(s), as necessary. However, in accordance with mandates of the State of California, Members may obtain such medications upon self-referral to a pharmacy which participates in the independent dispensing of such treatments to patients. In this case the Plan does not require advance notification, nor does it place any restrictions on the female Member in receiving such emergency medications.

For Covered Services to Contracted Providers: In the event that VCHCP fails to pay a Participating Provider for Covered Services, the Member shall not be liable to the Participating Provider for any sums owed by VCHCP. As required by California law, every contract between VCHCP and a Participating Provider contains a provision to this effect. Participating Providers are contractually required to accept VCHCP's payments on behalf of the Member for Covered Services and will not assert against the Member statutory or other lien rights that may exist. However, in the event you seek non-Covered Services, such as non-Emergency Care from a non-Participating Provider, you may be liable to that Provider for the cost of such services. Non-emergency services obtained in an emergency room setting may not be covered.

Out-of-Network charges from In-Network Facilities: In some cases, an out-of-network provider may provide covered services at an in-network facility where we have authorized you to receive care. You are not responsible for any amounts beyond your cost share for the covered services you receive at plan facilities or at in-network facilities where we have authorized you to receive care. An in-network facility includes, but is not limited to, a licensed hospital, ambulatory surgery center, or other outpatient setting such as a lab, or a radiology or imaging center.

Claims for Reimbursement of Covered Services: The plan will reimburse you if you are required to pay out-of-pocket for urgently needed services incurred outside of the Service Area. A reimbursement claim form is available on the plan website at www.vchealthcareplan.org or by calling member services at (805) 981-5050 or (800) 600-8247. You will need the following documentation in order to complete your claim:

1. Your employee/subscriber information.
2. Provider information for the provider you used.
3. The claim signed on the employee signature line.
4. The provider's itemized statement of charges (including procedure codes and description of services) and
5. Your payment receipt.

Ventura County Health Care Plan

BENEFIT SUMMARY

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

General		
Deductible:	**This plan has no deductible**	
Out of Pocket Maximums:		
Individual- Maximum per year (includes Rx and Life Strategies/OHBS Program)	**$3,000**	
Family- Maximum per year (includes Rx and Life Strategies/OHBS Program)	**$6,000**	
Not covered expenses do not accumulate to total out-of-pocket maximum		
Maximum Benefit Limits:	**Unlimited**	
Benefit Coverage	**Member Copayment**	
Medical Benefits		
Inpatient Services	Services by In-Network Providers	Services by Out-of-Network Providers
Inpatient Facility Fee Semi-Private room and board, and medically necessary services and supplies, including subacute care, inpatient dialysis, bariatric, oral, reconstructive, and transplant surgery	$100 per day up to five (5) days; per admission	$100 per day up to five (5) days; per admission
Inpatient Physician/Surgeon Fee	No Charge	No Charge
Clinical Trial for Treatment of Cancer or Life-Threatening Services for Members who have been accepted into an approved clinical trial for cancer when prior authorized by VCHCP (Note: The cost share indicated is in connection with Inpatient Services. If services in connection with this benefit are performed in an Outpatient setting an Outpatient facility fee may be assessed)	$100 per day up to five (5) days; per admission	$100 per day up to five (5) days; per admission
Emergency Services Benefits		
Emergency Room (ER) Physician Fee	No Charge	No Charge
Emergency Room (ER) Facility Fee	$100 per visit (co-pay waived if admitted)	$100 per visit (co-pay waived if admitted)

Inpatient Services	Services by In-Network Providers	Services by Out-of-Network Providers
Outpatient Observation Care provided in hospital		
In conjunction with ER services	ER copay applies	ER copay applies
Not in conjunction with ER services (direct observation)	10% up to $250	10% up to $250
Outpatient Services	**Services by In-Network Providers**	**Services by Out-of-Network Providers**
Acupuncture Benefits		
Acupuncture Services (out of pocket expenses do not accumulate to the out-of-pocket maximum)	$20 per visit member reimbursement to a combined maximum of 15 visits per plan year, no coverage thereafter	$20 per visit member reimbursement to a combined maximum of 15 visits per plan year, no coverage thereafter
Allergy Testing and Treatment Benefits		
Allergy Care (injections/serum)	$0	Not Covered
Ambulance Benefits Ambulance benefits are not limited to covered services from noncontracting ground ambulance providers		
Emergency or authorized transport (Ground & Air) includes noncontracted ground ambulance provider for both covered emergency and non-emergency services	$150	$150
Ambulatory Surgery Center Benefits		
Ambulatory Surgery Center Outpatient Surgery Facility Fee	10% up to $250	Not Covered
Ambulatory Surgery Center Outpatient Surgery Physician/Surgeon Fee	No Charge	Not Covered
Chiropractic Benefits		
Chiropractic Services (out of pocket expenses do not accumulate to the out-of-pocket maximum)	$20 per visit member reimbursement to a combined maximum of 15 visits per plan year, no coverage thereafter	$20 per visit member reimbursement to a combined maximum of 15 visits per plan year, no coverage thereafter
COVID-19 Benefits		

COVID-19 diagnostic, immunizations, therapeutics, and screening testing and health care services related to diagnostic and screening for COVID-19	No Charge	No Charge
Diabetes Care Benefits		
Disease Management Program provided by VCHCP	No Charge	Not Covered
Case Management provided by VCHCP	No Charge	Not Covered
Outpatient Services (continued)	Services by In-Network Providers	Services by Out-of-Network Providers
Dialysis Benefits		
Outpatient Dialysis Services	$10	Not Covered
Durable Medical Equipment Benefits (as defined by Medicare)		
Breast pump	$200 maximum member reimbursement per pregnancy	Not Covered
Other Durable Medical Equipment Includes but not limited to: insulin pumps electric wheelchairs, CPAP/BIPAP machines, Continuous Glucose Monitoring Device	10% copay; 50% copay for replacement when medically necessary	Not Covered
Family Planning Benefits		
Counseling and consulting	No Charge	Not Covered
Diaphragm fitting procedure (When administered in an office location, this is in addition to the Physician office visit co-pay.)	No Charge	Not Covered
Termination of Pregnancy (Abortion) including pre-abortion and follow-up services	No Charge	Not Covered
Implantable contraceptives	No Charge	Not Covered
Infertility Services	50% of covered services	Not Covered
Injectable contraceptives	No Charge	Not Covered
Insertion and/or removal of intrauterine device (IUD)	No Charge	Not Covered
Intrauterine Device (IUD)	No Charge	Not Covered
Tubal Ligation	No Charge	Not Covered
Vasectomy Services and Procedures	No Charge	Not Covered
Health Education and Promotion Benefits		

Preventive Health Program provided by VCHCP	No Charge	Not Covered
Educational Outreach provided by VCHCP	No Charge	Not Covered
Community Resources Repository provided by VCHCP	No Charge	Not Covered
Home Health Care Benefits		
Home Health (nursing and rehab) services 100 visit maximum. (Maximum shall not apply to Behavioral Health Treatment)	$20 per visit	Not Covered
Outpatient Services	Services by In-Network Providers	Services by Out-of-Network Providers
Hospice Program Benefits		
Hospice Care	No Charge	Not Covered
Observation Care provided in hospital		
In conjunction with ER services	ER copay applies	ER copay applies
Not in conjunction with ER services (direct observation)	10% up to $250	10% up to $250
Outpatient Services Benefits		
Outpatient visit: Chemotherapy, outpatient radiation, outpatient infusion therapy	$20 per visit	Not Covered
Outpatient Laboratory and Pathology: When provided to diagnose illness or injury	$0	Not Covered
Outpatient X-Ray and Diagnostic Imaging: Outpatient X-Ray services including Mammogram: When provided to diagnose illness or injury performed in free-standing radiological facilities and/or outpatient hospital-based settings.	$15	Not Covered
Imaging and/or other Diagnostic Services including CT, PET scans, MRIs, and Nuclear Imaging performed in the outpatient department of a Hospital or free-standing outpatient center	$100	Not Covered
Genetic/Biomarker testing	10% of cost up to $500 maximum	Not Covered
Outpatient Services - Other	10% of cost up to $250 maximum	Not Covered
Pregnancy and Maternity Care Benefits including Maternal Mental Health Screening, Treatment, and Services During Prenatal *(before birth)* or Postnatal *(up to 12 weeks after birth)* Period		

Inpatient Facility Fee Semi-Private room and board, and medically necessary services and supplies	$100 per day up to five (5) days; per admission	$100 per day up to five (5) days; per admission
Comprehensive prenatal care including Maternal Mental Health screening, treatment, and services (Services other than from an OB/GYN may require a copay.)	$0	Not Covered
All necessary Inpatient Professional Services for normal delivery, Cesarean section and complications of pregnancy including Maternal Mental Health Screening, treatment, and services	$0	Not Covered
Maternal Mental Health Screenings (Effective 01/01/2025 (AB 1936)) At least one during pregnancy At least one additional during first 6 weeks of postpartum period Additional postpartum screenings (if determined to be medically necessary & clinically appropriate in the judgment of the treating provider)	 $0 $0 $0	 Not Covered Not Covered Not Covered
Doula Services	$20 per visit	Not Covered
Donor Human Milk	$0	Not Covered
Outpatient Services (continued)	Services by In-Network Providers	Services by Out-of-Network Providers
Postnatal Physician office visits including Maternal Mental Health screening, treatment, and services	$0	Not Covered
Preventive Health Benefits		
Preventive Care, Screenings and Immunizations	No Charge	Not Covered
Routine Physical Exam	No Charge	Not Covered
Well Child Preventive Exam	No Charge	Not Covered
Professional (Physician) Benefits		
Physician office visits (Primary Care)	$15	Not Covered
Other Practitioner office visit	$15	Not Covered
Specialist office visit	$30	Not Covered
Urgent Care visit (must use In-Network while in Ventura County)	$35	$35

Prosthetic and Orthotic Benefits		
Prosthetic equipment and devices	10% copay; 50% copay for replacement when medically necessary	Not Covered
Orthotic equipment and devices	10% copay; 50% copay for replacement when medically necessary	Not Covered
Rehabilitative and Habilitative Services Benefits (Physical, Occupational, Speech and Respiratory Therapy) Rehabilitative Services by a physical, occupational, or respiratory therapist in the following settings:		
Office Location	$15	Not Covered
Outpatient department of a Hospital	$15	Not Covered
Skilled Nursing Facility Benefits		
Services by a free-standing Skilled Nursing Facility 100-day max for rehab/skilled nursing combination	$50 per day up to 10 days; per admission	Not Covered

All benefits listed below include maternal mental health

Mental Health, Substance Use Disorder and Chemical Dependency Benefits	Services by Optum Behavioral Health In-Network Providers	Out of Network
Mental Health, Substance Use Disorder and Chemical Dependency Benefits Authorization is required for most Mental/Behavioral Health and Substance Use Disorder benefits. Please refer to the EOC for a list of benefits that do not require authorization		
Mental/Behavioral Health and Substance Use Disorder outpatient office visits: individual evaluation, treatment or counseling	$15	Not Covered
Mental/Behavioral Health and Substance Use Disorder outpatient office visits: evaluation, treatment or counseling in a group setting	$15	Not Covered

Mental/Behavioral Health and Substance Use Disorder other outpatient items and services: including but not limited to: Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS); Behavioral Health Treatment for PDD/Autism	$15	Not Covered
Mental/Behavioral Health and Substance Use Disorder inpatient facility (e.g. hospital room)	$100/day up to five (5) days; per admission	$100/day up to five (5) days; per admission
Mental/Behavioral Health and Substance Use Disorder inpatient physician fee	$0	$0
Mental/Behavioral Health and Substance Use Disorder Emergency Services	$100 copay; waived if admitted to Hospital	$100 copay; waived if admitted to Hospital
Mental/Behavioral Health and Substance Use Disorder Urgent Care visit (must use in-network while in Ventura County)	$35	$35
Residential Treatment program and non-medical Transitional Residential Recovery Services - Mental Health	$50 per day up to 10 days; per admission	Not Covered
Residential Treatment program and non-medical Transitional Residential Recovery Services - Substance Use Disorder	$50 per day up to 10 days; per admission	Not Covered
Mental/Behavioral Health and Substance Use Disorder Outpatient partial hospitalization	$15	Not Covered
Mental Health, Substance Use Disorder and Chemical Dependency Benefits (continued)	Services by Optum Behavioral Health In-Network Providers	Out of Network
Outpatient Mental Health and Substance Use Disorder Care	$15	Not Covered
Methadone maintenance treatment	$15	Not Covered
Inpatient Services to treat acute medical complications of detoxification	$100/day up to five (5) days; per admission	$100/day up to five (5) days; per admission
Psychological testing	$15	Not Covered
Psychiatric Observation	$15	Not Covered
Substance Use Disorder Day Treatment	$15	Not Covered
Substance Use Disorder Intensive Outpatient Treatment Programs	$15	Not Covered
Substance Use Disorder Medical Treatment for Withdrawal	$15	Not Covered

Prescription Drug Benefit	Services by Express Scripts Inc. In-Network Pharmacies	Out of Network
Retail Prescriptions (up to a 30-day supply)		
Contraceptive Drugs and Devices	No Charge	Not Covered
Tier 1 (Most Generics)	$9	Not Covered
Tier 2 (Preferred Brand)	$30	Not Covered
Tier 3 (Non-Preferred Brand)	$45	Not Covered
Tier 4 (Specialty Drugs) Specialty 3 Tier Benefit Design (requires prior authorization) Generic Brand (preferred) Brand (non-preferred) Authorization is required	 10% (up to $100 Max) 10% (Up to $250 Max) 10% (up to $250 Max)	 Not Covered
Prescription Drug Benefit (continued)	Services by Express Scripts Inc. In-Network Pharmacies	Out of Network
Mail Order Prescriptions (up to a 90-day supply. Full copay applies regardless of quantity supplied.)		
Contraceptive Drugs and Devices	No Charge	Not Covered
Tier 1 (Most Generics)	$18	Not Covered
Tier 2 (Preferred Brand)	$60	Not Covered
Tier 3 (Non-Preferred Brand)	$90	Not Covered
Infertility Medications	50% contracted rate	Not Covered

* Please note that Schedule II drugs may be dispensed as partial fills and the member copay shall be prorated accordingly. This includes the initial and refill supplies limit on opioids, as part of the Advanced Opioid Management Program.

* Please note that if a covered prescription drug for which a member has a valid prescription, including over-the-counter, the cost-sharing shall be the lower of the pharmacy's retail price for the drug or the applicable cost-sharing amount for the drug. If the member pays retail price for the drug out-of-pocket, the pharmacy will submit the claim through VCHCP as if the member had purchased

the prescription drug by paying the cost-sharing amount when submitted by a network pharmacy. The applicable cost-sharing paid by the member will apply to the out-of-pocket maximum limit in the same manner as if the member had purchased the prescription drug by paying the cost-sharing amount.

SUMMARY OF COVERED SERVICES AND SUPPLIES

This section describes your plan health benefits. These health benefits are subject to the exclusions and limitations in the following sections and the cost sharing and maximums list in the benefit summary. Please note that most items must be Authorized by the Plan to be covered unless otherwise indicated.

Services and supplies requiring prior authorization include: specialty care, inpatient hospital care, skilled nursing, maternity care, surgery, certain diagnostic services, clinical trials, dental services, dialysis, durable medical equipment, genetic and fertility services, home health and hospice services, orthotics and prosthetics, pain management, sleeping disorder services, infusions, and specialty medications. For a complete list, please refer to the following link to the Plan's Prior Authorization Guide.
http://www.vchealthcareplan.org/providers/docs/PriorAuthorizationRequirementsServicesTable.pdf

Acupuncture Services

Acupuncture procedures performed for therapeutic purposes are covered when obtained from an acupuncturist acting within the scope of their license. There is a $20 reimbursement per visit limit and coverage is limited to 15 visits per year, which is shared with the chiropractic services coverage limit. Primary Care Physician referral or Authorization from the Plan is not required. Ancillary services, such as x-ray, ordered by an Acupuncturist require Authorization from the Plan. Member must submit a reimbursement claim form to the Plan, accompanied by a receipt, within 180 days of the date of service. Any remaining out of pocket expense not covered by the reimbursement does not accumulate to the out-of-pocket maximum.

Allergy Testing and Treatment

Allergy testing and treatment is covered when Medically Necessary. Allergy visits and services are included in the direct specialty referral and do not require authorization by the Plan. Services must be performed by a physician or other licensed health care provider acting within the scope of their license.

Ambulance Services

Ambulance services are covered when Medically Necessary, and provided in connection with:

A. Emergency Services as defined herein, including ambulance and ambulance transport services provided through the "911" emergency response system, or

B. Authorized transportation for a requested transfer.

Member shall only owe the in-network copay for such covered services, regardless of whether or not such services are provided by an in-network provider, including for air ambulance services. No remaining balance billing shall be owed by the Member.

C. Noncontracted ground ambulance provider for both covered emergency and non-emergency services.

Ambulatory Surgery Center Services

Services performed in an Ambulatory Surgery Center (ASC) are covered when Medically Necessary and Authorized by the Plan. Services may include:

- Operating room
- General or local anesthesia
- Treatment room,
- Ancillary Services, and
- Medications which are given by the ASC for use during the member's treatment at the ASC

Bariatric Surgery

Bariatric Surgical procedures are covered when Medically Necessary and Authorized by the Plan if all the following requirements are met:

- An In-Network physician who is a specialist in bariatric care determines that the surgery is Medically Necessary, submits a request for surgery and the request is Authorized by the Plan.

Biomarker Testing

Biomarker testing shall be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition, subject to utilization review management.

Pursuant to Health and Safety Code Section 1367.667(a)(1) to 1367.667(a)(5) coverage includes biomarker tests that meet any of the following:

(1) A labeled indication for a test that has been approved or cleared by the United States Food and Drug Administration (FDA) or is an indicated test for an FDA-approved drug.

(2) A national coverage determination made by the federal Centers for Medicare and Medicaid Services.

(3) A local coverage determination made by a Medicare Administrative Contractor for California.

(4) Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet

nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

(5) Standards set by the National Academy of Medicine.

Blood transfusions

The costs of processing and transporting self-donated (autologous), donor-directed or donor designated blood transfusions are covered up to $320 per unit when used for a procedure that the contracting physician has had authorized and scheduled.

Chiropractic Services

Chiropractic procedures performed for therapeutic purposes are covered when obtained from a chiropractor acting within the scope of their license. There is a $20 reimbursement per visit limit and coverage is limited to 15 visits per year, which is shared with the acupuncture services coverage limit. Primary Care Physician referral or Authorization from the Plan is not required. Member must submit a reimbursement claim form to the Plan, accompanied by a receipt, within 180 days of the date of service. Any remaining out of pocket expense not covered by the reimbursement does not accumulate to the out-of-pocket maximum.

Clinical Trial for Treatment of Cancer or Life-Threatening Conditions

Routine patient care for patients in clinical trials is covered in the same way that it reimburses routine care for patients not in clinical trials as described below:

- The Plan would have covered the services if they were not related to a clinical trial. This includes services required for the provision of the investigational drug, item, device, or service and services required for clinically appropriate monitoring of and prevention, diagnosis or treatment of complications arising from the investigational item, device or service.
- Costs of the investigational drug or device, however, are not covered.

Specified Requirements for Plan Coverage of a Clinical Trial:

- The enrollee is eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
- (i) a plan provider makes this determination;
- (ii) the enrollee provides the plan with medical and scientific information establishing this

determination;

- If any plan providers participate in the clinical trial and will accept the enrollee as a participant in the clinical trial, the enrollee must participate in the clinical trial through a plan provider unless the clinical trial is outside the state where the enrollee lives; or
- The clinical trial is an approved clinical trial, meaning it is a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition and it meets one of the following requirements:
- (i) The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration; or
- (ii) The study or investigation is a drug trial that is exempt under federal regulations from a new drug application, or
- (iii) The study or investigation is approved or funded by at least one of the following:
- (a)The National Institutes of Health;
- (b) The Centers for Disease Control and Prevention;
- (c) The Agency for Health Care Research and Quality;
- (d) The Centers for Medicare & Medicaid Services;
- (e) A cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs;
- (f) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
- (g) The Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements:
- (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and
- (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review.
- The member's treating physician has determined that participation in the trial has a meaningful potential to benefit the member; and
- The clinical or principal investigator managing the clinical trial must provide detailed information about the trial to the Plan, including the therapeutic intent and end point; and
- Copayments and deductibles for services provided in a clinical trial will be the same as for

services provided for patients that are in a non-clinical trial

The following clinical trial costs are not eligible for coverage:

- The experimental intervention itself that would not otherwise be provided by the Plan;
- Medications or devices not approved by the FDA;
- Costs of data collection and record keeping that would not be required but for the clinical trial;
- Trials to determine safety or dosing levels of a drug;
- Other services to clinical trial participants necessary solely to satisfy data collection needs of the clinical trial (i.e., "protocol-induced costs");
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the enrollee's health plan;
- Travel, housing, companion expenses and other non-clinical expenses;
- Items and services generally made available by the trial sponsor without charge.

Dental Services

General anesthesia services at an In-Network hospital or surgery center for a dental procedure, when these services are not ordinarily required, but are required by the clinical status or underlying medical condition of the patient are covered when Medically Necessary and Authorized by the Plan. This coverage is provided only for Members that meet one of the following:

- Members who are under seven years of age, or
- Members who are developmentally disabled, regardless of age, or
- Members whose health is compromised and for whom general anesthesia is Medically Necessary, regardless of age.

The Plan does not cover the dental procedure itself, including, but not limited to, the dentist's professional fee and dental supplies, such as dental implants, prosthetics, appliances, splints and braces.

The Plan covers medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. Cleft palate means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Diabetes Care

Services for the diagnosis and treatment of diabetes are covered when Medically Necessary and may require Authorization by the Plan. Covered services include but are not limited to:

- Inpatient and outpatient services
- Office visits
- Medications. Note: Insulin and glucagon do not require prior authorization.
- Foot orthotics to prevent or treat diabetic foot complications
- Diabetes self-management training, education, and medical nutrition therapy
- Instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process and the daily management of diabetic therapy, in order to thereby avoid frequent hospitalizations and complications, is also covered. These services are subject to the copayment of a physician office visit.

All services must be provided by an appropriately licensed or registered health care professional.

Other Diabetes Care Services at no charge to the member may include:

- Disease Management Program- which offers educational materials, letters informing diabetic members of needed health screenings, and supportive calls to members, and
- Case Management- for members who have multiple conditions that may make management of their diabetes more challenging.

Dialysis Services

Dialysis services are covered when Medically Necessary and Authorized by the Plan, including:

- Dialysis in an inpatient facility setting
- Dialysis in an outpatient facility setting
- Professional services

Durable Medical Equipment

Durable Medical Equipment (DME) is covered when Medically Necessary and Authorized by the Plan. DME must be provided by an appropriately licensed In-Network provider, ordered by your physician and for use in the home.

DME for home use is an item that is:

- Intended for repeated use
- Primarily and customarily used to serve a medical purpose, not for comfort or convenience
- Generally, not useful to a person who is not ill or injured
- Appropriate for use in the home

Covered DME includes repair or replacement of covered equipment, unless due to loss or misuse. The Plan reserves the right to determine if the DME services will be purchased or rented. If rented, the member must contact the supplier to return the device when it is no longer Medically Necessary. You must return the rented equipment or pay the fair market price of the equipment when the Plan is no longer covering it. Coverage is limited to the least expensive device which the Plan determines to be Medically Necessary.

Emergency Services

All Medically Necessary Emergency Services provided by a hospital emergency department are covered when the illness or injury meets the Plan's Emergency Services definition.

No Authorization is required for Emergency Services.

The Emergency Services copayment is waived if Member is admitted to the hospital directly from its emergency department. Notification and Authorization is required for hospital admissions.

Family Planning Services

The following Family Planning Services are covered and the Plan will neither impose a cost share nor require prior authorization:

- All contraceptive drugs, devices and other products for women as approved by the FDA, including all FDA-approved contraceptive drugs, devices and products available over the counter, and as prescribed by the member's provider, including but not limited to:
    - Surgical sterilization implants
    - implantable rods
    - IUD copper, IUD with progestin
    - shots/injections
    - Oral contraceptives including combined pills, progestin only pills and extended/continuous use pills
    - Patches
    - Devices including vaginal contraceptive rings, diaphragms, sponges, cervical caps, female condoms
    - Spermicide
    - Emergency contraception (Plan B/Plan B One Step/Next Choice and Ella)
    - Voluntary tubal ligation and other similar sterilization procedures
    - Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling.
- Patient education and counseling on contraception. Follow up services related to the drugs, devices, products, and procedures including but not limited to management of side effects, counseling for continued adherence, and device fitting, insertion and removal

- Emergency contraception with or without a prescription.
- Elective sterilization procedures for men and women (not reversal of sterilization)
- Vasectomy services and procedures.

Use of these drugs, devices, and other procedures for a purpose other than contraception, the applicable copay applies.

Termination of pregnancy services are covered without cost share to the member or prior authorization. This includes all abortion-related services, including pre-abortion and follow-up services.

If a covered drug, device, or product is covered without cost share but is not available or is deemed medically inadvisable by member's provider, an alternate drug, device, or product shall be provided without cost share. If there is no equivalent or if an equivalent is deemed inadvisable by the member's provider, VCHCP shall cover the original prescription without cost sharing.

Fertility Services

- Fertility preservation for iatrogenic infertility.

Health Education Information and Promotion

We cover a variety of health education, counseling, programs and materials to help you take an active role in protecting and improving your health for:

- Tobacco cessation
- Chronic Disease management-including Diabetes (please see the diabetes care section) and Asthma
- Personal health behavior
- Health care services
- Blood pressure management
- Cholesterol management
- Stress management
- Childbirth preparation and breast-feeding

For more information about our health education and promotion programs please our website at www.vchealthcareplan.org.

Home Health Care

Home Health Care is covered when Medically Necessary and Authorized by the Plan. Home Health Care means services provided in the home by registered nurses, licensed vocational nurses, and

licensed home health aides; physical, occupational and speech therapists. Home Health Care is limited to those services that are prescribed or directed by the attending physician or other appropriate authority designated by the Plan. The member must be homebound because of illness or injury and the care must not be considered custodial. If a basic health service can be provided in more than one medically appropriate setting, it is within the discretion of the attending physician or other appropriate authority designated by the Plan to choose the setting for providing the care.

The Member's attending physician will set up a treatment plan describing the length, type, and frequency of the services to be provided.

Services are limited to those authorized by the Plan: Maximum 3 visits per day, up to 2 hours per visit (nurse, social worker, physical/ occupational/ speech/ therapist) or 4 hours of non-custodial home health aide services furnished by licensed home health aide.

Hospice Care

Hospice Care is covered when Medically Necessary and Authorized by the Plan. Hospice care is a specialized form of interdisciplinary health care designed to provide end of life comfort care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the member's family. A Member who chooses hospice care is choosing to receive care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

The Plan covers the Hospice Care services listed below when all of the following requirements are met:

- An In-Network provider has diagnosed you with a terminal illness and determines that your life expectancy is 6-12 months or less
- The covered services are provided inside your Service Area
- The services are provided by a licensed hospice agency that is an In-Network provider
- The services are necessary for the management of your terminal illness and related conditions

If all the above requirements are met, the following hospice services may be covered, which are available on a 24-hour basis if necessary, for your Hospice Care:

- In-Network physician services
- Skilled Nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instructions to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you

to maintain activities of daily living

- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Drugs prescribed for pain control and symptom management of the terminal illness in accord with our drug formulary guidelines
- Durable medical equipment
- Respite care when necessary to relieve your caregivers
- Counseling and bereavement services
- Dietary counseling
- The following care during periods of crisis when you need continuous care for management of acute medical symptoms:
    - Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
    - Short-term inpatient care required at a level that cannot be provided at home

Hospital Facility Services

Inpatient Services:

General hospital services, including room with customary furnishings and equipment, meals (including special diets as Medically Necessary), and general nursing care are covered services when Medically Necessary and Authorized by the Plan. All Medically Necessary ancillary services, including but not limited to, operating room and related facilities, intensive care unit and services, drugs, medications and biologicals are also covered when Authorized by the Plan.

Outpatient Services:

Member must use In-Network hospitals, unless VCHCP agrees to an out-of-network hospital, and the Member may pay a Copayment to the hospital for each outpatient service.

Emergency Department Services:

All Medically Necessary Emergency Department Services provided by a hospital emergency department are covered when the illness or injury meets the Plan's Emergency Services definition.

No Authorization is required for Emergency Services.

The Emergency Services copayment is waived if Member is admitted to the hospital directly from its emergency department. Notification and Authorization is required for hospital admissions.

Other Outpatient Services:

Hospital services and supplies that are Medically Necessary and Authorized by the Plan and performed by a hospital or outpatient facility such as outpatient surgery, radiology, pathology, cardiology, dialysis and other diagnostic services required for treatment excluding prescription drugs and take-home supplies, are covered.

Immunizations

Immunizations are covered when recommended by guidelines published by the Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control and Prevention. Immunizations, including professional services to inject the vaccine and the vaccines that are injected are covered with no cost share to the member.

Infertility Treatment Services

Other than fertility preservation for iatrogenic infertility which is covered at 100% as a regular health benefit with the same copayment as it would have for any other normal medical/surgical health benefit, VCHCP covers 50% of basic diagnostic testing, injections, office visits, and treatments for infertility. In addition, this benefit is subject to infertility medication copayments. The following Infertility Treatment Services are covered when Medically Necessary and Authorized by the Plan, including but not limited to:

- diagnostic testing, including one (1) ultrasound
- infectious disease screening
- semen analysis
- Routine laboratory investigations
- Injection treatments provided at an In-Network provider's office when not used to prepare for In-Vitro services.
- Fertility preservation for iatrogenic infertility – not subject to 50% copay. See Fertility Services.

For purposes of this Infertility Services section, infertility is an inability to conceive a pregnancy after a year or more of regular sexual relations without contraception or the inability to carry a pregnancy to term. Additional Copayments may apply, please see the prescription drug benefit for details on infertility drugs.

Maxillofacial Surgery

Maxillofacial surgical services are covered, when Medically Necessary and Authorized by the Plan. These may include the reduction or manipulation of fractures of facial bones; excision of lesions of the mandible, other facial bones, mouth, lip, or tongue; incision of lesions of the accessory sinuses, mouth, salivary glands, or ducts.

The Plan covers medically necessary services that are an integral part of reconstructive surgery, including dental or orthodontic services, for cleft palate procedures. Cleft palate means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Medical Supply and Equipment

Ostomy and other medical supplies to support and maintain gastrointestinal, bladder, or respiratory function; medical supplies needed to operate home medical equipment; and prostheses and orthoses are covered when Medically Necessary and Authorized by the Plan.

Diabetic supplies are covered by either the Plan's Medical Benefit or Prescription Medication benefit.

Mental Health Services (Including behavioral health and substance use disorder treatment services)

VCHCP covers Mental Health, Behavioral Health and Substance Use Disorder (MH/SUD) treatment Services described in this section. VCHCP has contracted with OptumHealth Behavioral Solutions of California (OHBS) to administer these Covered Services. OptumHealth Behavioral Solutions of California also provides annual written notice of benefits for behavioral health and wellness screening for children and adolescents ages 8 to 18 years of age. If you need mental health care, behavioral health care or substance use disorder treatment services, or have questions about these benefits, please visit www.liveandworkwell.com or call Life Strategies/OHBS Member services at 1-800-851-7407 or VCHCP Member services at (805) 981-5050 or 1-800-600-8247.

Coverage of mental health and substance use disorder treatment pursuant to Health & Safety Code 1374.72, includes medically necessary treatment of a mental health or substance use disorder, including but not limited to, behavioral health crisis services provided to an enrollee by a 988 center or mobile crisis team regardless of whether the service is provided by an in-network or out-of-network provider. VCHCP will not require prior authorization for medically necessary treatment of a mental health or substance use disorder provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services to an enrollee.

Pursuant to Health & Safety Code 1374.723 specific to the Community Assistance, Recovery, and Empowerment (CARE) Court Program, the Plan will cover the cost of developing an evaluation and the provision of all health care services for an enrollee when required or recommended for the enrollee pursuant to a CARE agreement or a CARE plan approved by a court, regardless of whether the service is provided by an in-network or out-of-network provider. Prior authorization is not

required, other than prescription drugs, for services provided pursuant to a CARE agreement or CARE plan approved by a court. The Plan is required to provide for reimbursement of services provided to an enrollee, other than prescription drugs, at the greater of either of the following amounts: (1) the plan's contracted rate with the provider, or (2) the fee-for-service of case reimbursement rate paid in the Medi-Cal program for the same or similar services as identified by the State Department of Health Care Services. The Plan is required to provide for reimbursement of prescription drugs provided to an enrollee at the plan's contracted rate. The Plan will not impose cost sharing for any services provided to an enrollee pursuant to a CARE agreement or CARE plan, excluding prescription drugs.

Mental Health, Behavioral Health and Substance Use Disorder Treatment Services are those services provided or arranged by OHBS for the Medically Necessary Treatment of a Mental Health or Substance Use Disorder for the treatment of:

A mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

"Mental Health and Substance Use Disorder" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

All mental health conditions identified as a "mental disorder" in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders are covered under your Group Subscriber Contract. VCHCP does not cover services for conditions that the DSM identifies as something other than a "mental disorder". For example, the DSM identifies relational problems as something other than a "mental disorder", so VCHCP does not cover services (such as couples counseling or family counseling) for relational problems.

Mental Health and Behavioral Health Care Services for the Diagnosis and Treatment of Mental Disorders

(1) Mental/Behavioral Health Inpatient- VCHCP covers inpatient psychiatric hospitalization in participating hospitals when it qualifies as Medically Necessary Treatment of a Mental Health or Substance Use Disorder and pre-authorized when applicable. Coverage includes room and board, drugs, and inpatient professional services of participating physicians and other providers who are licensed health care professionals acting within the scope of their license, provided at a Hospital, an Inpatient Treatment Center or Residential Treatment Center. Services include, but are not limited to: Mental and Behavioral Health Inpatient Hospitalization, Psychiatric Observation for an Acute Psychiatric Condition, Mental Health short-term Treatment in a Crisis Residential Treatment Facility and Mental and Behavioral Health Residential Program.

(2) Mental/Behavioral Health Outpatient: Office Visits- VCHCP covers outpatient office services for a mental disorder. Services include, but are not limited to: Mental Health Individual and Group Evaluation and Treatment, Individual and Group Counseling, Mental Health Psychological Testing, and Mental Health Outpatient Monitoring of Drug Therapy.

(3) Mental/Behavioral Health Outpatient: Other Items and Services- VCHCP covers other outpatient services for the treatment and medical management of a mental disorder including, but not limited to: Mental and Behavioral Health Partial Hospitalization Program, Mental Health Intensive Outpatient Program, Electroconvulsive Therapy (ECT), Mental/Behavioral Health Day Treatment Programs, and Transcranial Magnetic Stimulation (TMS).

(4) A health plan shall provide coverage of health care benefits for preventing, diagnosing, and treating mental health conditions and substance use disorders as medically necessary for an enrollee, in accordance with current generally accepted standards of mental health and substance use disorder care, including but not limited to, the following:

(i) Basic health care services including the following:

(a) Emergency health care services rendered in both inside and outside the service area of the applicable network consistent with the Knox-Keene Act.

(b) Urgent care services rendered inside and outside the service area of the applicable network consistent with the Knox Keene Act.

(c) Physician services, including but not limited to consultation and referral to other health care providers and prescription drugs when furnished or administered by a health care provider or facility.

(d) Hospital inpatient services, including services of licensed general acute care, acute psychiatric, and chemical dependency recovery hospitals.

(e) Ambulatory care services, including but not limited to physical therapy, occupational therapy, speech therapy, and infusion therapy.

(f) Diagnostic laboratory services, diagnostic and therapeutic radiologic services, and other diagnostic and therapeutic services.

(g) Home health care service.

(h) Preventive health care services, regardless of whether an enrollee has been diagnosed with a mental health condition or substance use disorder.

(i) Hospice care that is, at a minimum, equivalent to hospice care provided by the federal Medicare Program.

The above benefits are distinguishable from other health care services including, but not limited to, coordinated specialty care for the treatment of first episode psychosis, day treatment, for gender dysphoria – all health care benefits identified in the most recent edition of the *Standards of Care* developed by the World Professional Association for Transgender Health, Intensive community-based treatment including assertive community treatment and intensive case management, intensive home-based treatment, medication management, outpatient prescription drugs, outpatient professional services including but not limited to individual, group, and family mental health counseling, polysomnography, psychological and neuropsychological testing, schoolsite services for mental health condition that are delivered to an enrollee at a schoolsite, transcranial magnetic stimulation, home health care services, and preventive health care services.

(A) Behavioral Health Treatment for Autism Spectrum Disorder- Professional services and treatment programs, including applied behavior analysis and evidence- based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of a Covered Person with Autism Spectrum Disorder, and that meet the criteria required by California law are covered.

Mental Health and Behavioral Health Care Services for the Diagnosis and Treatment of Mental Disorders include the types of services listed above but are not limited to the services listed. Please contact your health plan for more information.

Substance Use Disorder (SUD) Treatment Services

(1) SUD Inpatient- VCHCP covers Substance Use Disorder Services, when Medically Necessary for Treatment of Mental Health or Substance Use Disorder, including Medical Detoxification, and inpatient prescription drugs, which have been pre-authorized and are provided by a Participating Practitioner while the Member is confined in a participating Inpatient Treatment Center or at a Participating Residential Treatment Center. Services include, but are not limited to: Inpatient Detoxification, Substance Use Disorder Residential Program and Non-Medical Transitional Residential Recovery Services. All of these services in section (1) are covered within the SUD Inpatient copay and do not require a separate copay from the member.

(2) SUD Outpatient: Office Visits- VCHCP covers outpatient office services for SUD treatment. Services including, but are not limited to: individual and group chemical dependency counseling, and medical treatment for withdrawal symptoms.

(3) SUD Outpatient: Other Items and Services- VCHCP covers other outpatient services for the treatment and medical management of SUD treatment. Services include, but are not limited to: SUD Partial Stay Programs, SUD day-treatment programs, and SUD Intensive Outpatient Programs.

(4) Basic health care services including emergency health services, urgent care services, physician services including but not limited to consultation and referral to other health care providers and prescription drugs when furnished or administered by a health care provider or facility, preventive health care services, coordinated specialty care for the treatment of first episode psychosis, day treatment, drug testing both presumptive and definitive including for initial and ongoing patient assessment during substance use disorder treatment, for gender dysphoria – all health care benefits

identified in the most recent edition of the *Standards of Care* developed by the World Professional Association for Transgender Health, Intensive community-based treatment including assertive community treatment and intensive case management, intensive home-based treatment, medication management, narcotic (opioid) treatment programs, outpatient prescription drugs, outpatient professional services including but not limited to individual, group, and family substance use counseling, schoolsite services for substance use disorder that are delivered to an enrollee at a schoolsite, withdrawal management services, home health care services, and preventive health care services.

The Substance Use Disorder Treatment Services include the types of services listed above but are not limited to the services listed. Please contact your health plan for more information.

- **Other Behavioral Health Services**

(1) Ambulance – Use of an ambulance (land or air) for Emergencies including, but not limited to, ambulance or ambulance transport services provided through the "911" Emergency response system, is covered without prior authorization when the Member reasonably believes that the behavioral health condition requires Emergency Services including ambulance transport services. Use of an ambulance for a non-Emergency is covered only when specifically authorized by Life Strategies/OHBS.

(2) Laboratory Services – Diagnostic and therapeutic laboratory services are covered when ordered by a Participating Practitioner in connection with the Medically Necessary diagnosis and treatment of a Mental Disorder and/or Substance and Related Addictive Disorder when pre- authorized by Life Strategies/OHBS.

(3) Inpatient Prescription Drugs – Inpatient prescription drugs are covered only when prescribed by a Life Strategies/OHBS Participating Practitioner for treatment of a Mental Disorder or Substance and Related Addictive Disorder while the Member is confined to an Inpatient Treatment Center or, in the case of treatment of Substance and Related Addictive Disorder, a Participating Residential Treatment Center.

(4) Injectable Psychotropic Medications – Injectable psychotropic medications are covered if prescribed by a Life Strategies/OHBS Participating Practitioner for treatment of a Mental Disorder.

(5) Psychological Testing – Medically Necessary psychological testing is covered when pre-authorized by Life Strategies/OHBS and provided by a Participating Practitioner who has the appropriate training and experience to administer such tests.

Other Behavioral Health Services include the types of services listed above but are not limited to the services listed. Please contact your health plan for more information.

- **Outpatient Prescription Drug Benefits**

Effective 01/01/2025, VCHCP provides coverage ~~for medically assisted treatment of mental health and substance use disorders offering outpatient prescription drug benefit coverage~~ for at least one

medication approved by the United States Food and Drug Administration in each of the following categories without prior authorization, step therapy, or utilization review:

1) Medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist.
2) Medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product.
3) A long-acting buprenorphine product.
4) A long-acting injectable naltrexone product.

- **Prior Authorization**

The following Mental Health, Behavioral Health or Substance Use Disorder Treatment Services require Prior Authorization by OptumHealth Behavioral Solutions of California, except in the event of an emergency, in order to be covered:

- Inpatient Admissions
- Services rendered at a Residential Treatment Center
- Intensive Outpatient Program Treatment
- Outpatient Electro-Convulsive Treatment
- Partial Hospitalization
- Behavioral Health Treatment for Autism Spectrum Disorder
- Psychological Testing

* If services for the medically necessary treatment of a mental health or substance use disorder are not available in network within the geographic and timely access standards set by law or regulation, the health care service plan shall arrange coverage to ensure the delivery of medically necessary out-of-network services and any medically necessary follow-up services that, to the maximum extent possible, meet those geographic and timely access standards. As used in this subdivision, to "arrange coverage to ensure the delivery of medically necessary out-of-network services" includes, but is not limited to, providing services to secure medically necessary out-of-network options that are available to the enrollee within geographic and timely access standards. The enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from an in-network provider.

- **Exclusions from Mental Health and Substance Use Disorder Treatment Services**

Please note that these exclusions or limitations do not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder to treat mental health and substance use disorders listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

1. Any inpatient confinement, treatment, service or supply not authorized by Life Strategies/OHBS, except in the event of an Emergency.

2. Services received prior to the Member's effective date of coverage, after the time coverage ends, or at any time the Member is ineligible for coverage.

3. Services or treatments which are not Medically Necessary Treatment of a Mental Health or Substance Use Disorder, as determined by Life Strategies/OHBS.

4. Services or treatment provided to you which duplicate the benefits to which you are entitled under any applicable Workers' Compensation law are not covered.

5. Behavioral Health Treatment for Autism Spectrum Disorder must have a treatment plan that has measurable goals over a specific timeline that is developed and approved by the Participating Qualified Autism Service (QAS) Provider for the specific Member being treated and is discontinued when the treatment goals and objectives are achieved or no longer appropriate. The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available upon request.

6. Speech therapy, physical therapy and occupational therapy services provided for Developmental Delays or Specific Learning Disorders[1] are not covered. This exclusion does not apply to Medically Necessary speech therapy, physical therapy and occupational therapy services when provided under, and authorized by, the Member's medical benefit plan in connection with Behavioral Health Treatment for individuals with Autism Spectrum Disorder rendered under the direct supervision of a licensed or certified therapist, and provided by a Participating Provider acting with the scope of his or her license or as authorized under California law.

7. Routine, custodial, and convalescent care.

8. Pastoral or spiritual counseling.

9. Dance, poetry, music or art therapy services except as part of a Behavioral Health Treatment Program.

10. School counseling and support services, household management training, peer support services, tutor and mentor services, independent living services, supported work environments, job training and placement services, therapeutic foster care, Emergency aid to household items and expenses, and services to improve economic stability.

11. Genetic counseling services.

16. Community Care Facilities that provide 24-hour non-medical residential care, unless medically necessary.

17. Weight control programs and treatment for addictions to tobacco, nicotine or food when not medically necessary.

[1] Learning Disability as defined under the DSM-IV is defined as Specific Learning Disorder under DSM-5.

18. Counseling for adoption, custody, family planning or pregnancy in the absence of a DSM-diagnosis.

19. Sexual therapy programs, including therapy for paraphilic disorders[2], the use of sexual surrogates, and sexual treatment for sexual offenders/perpetrators of sexual violence. This exclusion does not apply to treatment related to other covered Mental Disorders or gender identity dysphoria disorder.

20. Personal or comfort items, and non-Medically Necessary private room and/or private duty nursing during inpatient hospitalization are not covered.

21. Surgery or acupuncture.

22. Services that are required by a court order as a part of parole or probation, or instead of incarceration, which are not Medically Necessary.

23. Services or communications provided by telephone, email, instant messaging, internet chat rooms, unsecure video, or other internet services that do not meet Health Insurance Portability and Accountability Act of 1996 (HIPAA) security requirements and current American Telemedicine Association minimum standards.

24. Applied Behavioral Analysis (ABA) and other evidence-based behavior intervention programs for the treatment of Autism Spectrum Disorder delivered via telehealth technology with the exception of supervision by a Qualified Autism Service Provider (QASP) of the treatment sessions provided for the treatment of Autism Spectrum Disorder.

25. Evaluation or treatment for education, professional training, employment investigations, fitness for duty evaluations, or career counseling.

26. Educational Services for Developmental Delays and Specific Learning Disorders are not health care services and are not covered. Educational skills related to or consisting of gaining academic knowledge for educational advancement to help students achieve passing marks and advance from grade to grade. The Plan does not cover tutoring, special education/instruction required to assist a child to make academic progress: academic coaching, teaching members how to read; educational testing or academic education during residential treatment. Teaching academic knowledge or skills that help you progress from your current levels of knowledge or learning ability to levels that would be expected from a person of your age.

    Life Strategies/OHBS refers to the *American Academy of Pediatrics Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review* for a description of Educational Services. For example, Life Strategies/OHBS does not cover:

    - Items and services that increase academic knowledge or skills.

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[2] Sexual Addiction as defined under the DSM-IV is defined as Paraphilic Disorder under DSM-5.

- Special education teaching to meet the educational needs of a person with intellectual disability, Specific Learning Disorder, or Developmental Delay. (A Specific Learning Disorder is a condition where there is a meaningful difference between a person's current level of learning ability and the level that would be expected for a person of that age. A Developmental Delay is a delayed attainment of age-appropriate milestones in the areas of speech-language, motor, cognitive, and social development.) This exclusion does not apply to covered services when they are authorized, part of a Medically Necessary treatment plan, provided by or rendered under the direct supervision of a licensed or certified healthcare professional, and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law.
- Teaching and support services to increase academic performance.
- Academic coaching or tutoring for skills such as grammar, math, and time management.
- Speech training that is not Medically Necessary, and not part of an approved treatment plan and not provided by or under the direct supervision of a Participating Healthcare Professional acting within the scope of his or her license under California law, which is intended to address speech impediments.
- Teaching you how to read, whether or not you have dyslexia.
- Educational testing.
- Teaching (or any other items or services associated with) activities such as art, dance, horse riding, music, or swimming, or teaching you how to play. Play therapy services are covered only when they are authorized, part of a Medically Necessary treatment plan, require the direct supervision of a licensed physical therapist or a Qualified Autism Service Provider, and are provided by a Participating Provider acting within the scope of his or her license or as authorized under California law. This exclusion does not apply to Medically Necessary speech therapy, physical therapy and occupational therapy services when provided under, and authorized by, the Member's medical benefit plan in connection with Behavioral Health Treatment for individuals with Autism Spectrum Disorder.

27. Conditions not listed as a Mental Disorder in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* are excluded, except for diagnostic evaluation.

28. Experimental and/or Investigational Therapies, Items and Treatments are not covered, unless required by an external, independent review panel as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Experimental and Investigational Therapies." Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by the Life Strategies/OHBS Medical Director or a designee. For the purpose of this *Combined Evidence of Coverage and Disclosure Form*, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/ guidelines are met:

- It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA), and such approval has not been granted at the time of its use or proposed use.

- It is a subject of a current investigation of a new drug or new device (IND) applications on file with the FDA.

- It is the subject of an ongoing clinical trial (Phase I, II, or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and the Department of Health and Human Services.

- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.

- It is being delivered or should be delivered subject to approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).

- Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other word of similar effect.

- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.

- It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab test or imaging ordered to evaluate the effectiveness of the Experimental therapy).

- The sources of information to be relied upon by Life Strategies/OHBS in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this Behavioral Health Plan, include but are not limited to the following:

    - The Member's Medical records;
    - The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
    - Any informed consent document the Member, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
    - The published authoritative medical and scientific literature regarding the drug, device, treatment or procedure;
    - Expert medical opinion;
    - Opinions of other agencies or review organizations (e.g., ECRI Health Technology Assessment Information Services or HAYES New Technology Summaries);
    - Regulations and other official actions and publications issued by agencies such as the FDA, DHHS and Agency for Healthcare Research and Quality (AHRQ);
    - Life Strategies/OHBS Technology Assessment Committee Guidelines.

- A Member with a Life-Threatening or Seriously Debilitating condition may be entitled to an expedited external, independent review of Life Strategies'/OHBS coverage determination

regarding Experimental or Investigational therapies as described in the Section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Experimental and Investigational Therapies".

29. Services rendered by a Non-Participating Provider are not covered, except for Emergency Services.

30. Services rendered outside the Service Area are not covered, except for Emergency Services or Urgently Needed Services

Services following discharge after receipt of Emergency Services or Urgently Needed Services are not covered without a Participating Provider's or Life Strategies'/OHBS authorization. The fact that the Member is outside the Service Area and that it is inconvenient for the Member to obtain the required services from a Participating Provider will not entitle the Member to coverage.

Outpatient X-ray, Imaging, Pathology and Laboratory Services

Preventive X-ray, Imaging, Pathology, and Laboratory services are covered when Medically Necessary. Certain services require authorization. Preventive services have no cost share, including but not limited to; Screening mammograms and screening CT scans for smokers.

Diagnostic and Therapeutic X-ray, Imaging (including but not limited to: CT, PET scans, nuclear medicine, and MRIs), Pathology and Laboratory services are covered when Medically Necessary. Certain services may need to be Authorized by the Plan. Please refer to the benefits grid for possible cost sharing.

Other Outpatient Services

All other outpatient services, provided in a hospital outpatient setting, a non-hospital ambulatory surgery center, imaging or other diagnostic facility are covered when Medically Necessary. Outpatient services include but are not limited to, diagnostic endoscopic procedures (e.g. colonoscopy, esophagogastroduodenoscopy [EGD] and bronchoscopy), cardiac stress tests, echocardiograms (e.g. 2D echo), electroencephalograms (EEG), pulmonary function tests, gastric laboratory studies, minor surgical procedures (e.g. biopsies), obstetrical non-stress tests, pain management procedures and sleep studies. Certain services require prior authorization.

Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS)

VCHCP will provide coverage for prophylaxis, diagnosis, and treatment for Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections/Pediatric Acute-onset

Neuropsychiatric Syndrome (PANDAS/PANS) that is prescribed or ordered by the treating physician and surgeon and is medically necessary, as defined by current nationally recognized clinical practice guidelines by expert treating physicians published in peer-reviewed medical literature. Treatment for PANDAS and PANS that shall be covered includes antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy.

Pregnancy and Maternity Care Services

If you are a female Member, you may obtain OB/GYN physician services without first contacting your Primary Care Physician. Inpatient services may require an Authorization.

If you need OB/GYN preventive care, are pregnant and need comprehensive prenatal care, or have a gynecological ailment, you may go directly to an In-Network OB/GYN specialist, or a Physician who provides such services. *Female members may also choose an OB/GYN to be their Primary Care Physician.* Services obtained from a specialist other than an OB/GYN may require a copay. Covered services include but are not limited to:

A. Physician services in the Physician's office for any condition or complication resulting from pregnancy or resulting childbirth and prenatal, delivery, antepartum, and postpartum care.

B. Prenatal diagnosis procedures, including diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy and participation in the Expanded Alpha Feto Protein (AFP) program of the State Department of Health Services.

C. Medically Necessary health care of the newborn child for the first thirty-one days after birth, if the child meets eligibility requirements, regardless of the timeliness of enrollment.

D. Inpatient hospital care for forty-eight (48) hours following a normal vaginal delivery and ninety-six (96) hours following a delivery by cesarean section, unless an extended stay is Authorized by the Plan. If the treating physician, in consultation with the mother, decides to discharge the mother and newborn before the 48- or 96-hour time period, the Plan will cover a post-discharge follow-up visit within 48 hours of discharge when prescribed by the treating physician. The visit shall include parent education, assistance and training in breast or bottle-feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating physician in consultation with the mother shall determine whether the post-discharge visit shall occur at home, at the hospital, or at the treating physician's office after assessment of transportation needs of the family, environmental and social risks.

E. Maternal Mental Health

Ventura County Health Care Plan (VCHCP) requires its medical providers such as primary care providers (PCPs) and OB-GYN's caring for maternal members to screen for maternal mental health conditions or issues including but not limited to post-partum depression during pregnancy or during post-partum period. When members are identified with possible mental health issues, members are referred by their medical providers to OHBS-CA. An OHBS-CA toll-free phone number (800) 851-

7407 is available 24 hours a day, 7 days a week. OptumHealth Behavioral Solutions of California ("OHBS-CA") has developed the Maternal Mental Health Program ensuring the following regulatory requirements are met. This program targets individuals who are in the prenatal, perinatal or postnatal period. The program shall consist of at least one maternal mental health screening to be conducted during pregnancy, at least one additional screening to be conducted during the first six weeks of the postpartum period, and additional postpartum screenings, if determined to be medically necessary and clinically appropriate in the judgment of the treating provider. This program provides triage and referral, intake/initial screening, assessment of services needed by Care Advocate personnel, care coordination and advocacy, clinical assessment treatment and planning. VCHCP covers all maternal mental health issues screening and treatment by medical providers and OHBS-CA covers all maternal mental health services. The program guidelines are available to all providers and members upon request.

F. Doula Services

Ventura County Health Care Plan (VCHCP) covers doula services with a direct referral from your doctor. Doulas are birth workers who provide health education, advocacy, and physical, emotional and nonmedical support for pregnant and postpartum persons before, during and after childbirth (perinatal) including support during miscarriage, stillbirth and abortion.

Doulas provide person-centered, culturally competent care that supports the racial, ethnic, linguistic and cultural diversity of our members.

Doulas are not licensed or clinical providers, and they do not require supervision.

The listing of doulas enrolled with VCHCP can be found on the Plan's website: https://www.vchealthcareplan.org

Covered Services:
A recommendation from your doctor authorizes the following doula services:

- One (1) initial visit
- Up to eight (8) additional visits that may be provided in any combination of prenatal and postpartum visits
- Support during labor and delivery (including labor and delivery resulting in a stillbirth), abortion, or miscarriage.
- Up to two (2) extended three-hour postpartum visits after the end of the pregnancy

The Plan allows up to nine (9) additional postpartum visits through a recommendation noted in the member's medical record by the recommending licensed provider, or submitted in a written format (as requested by the member), signed by the licensed provider, and given to the doula. Prior authorization is not needed. The doula is not required to submit the recommendation to the Plan.

Non-Covered Services:
The following services are not covered as doula services:

- Belly binding (traditional/ceremonial)
- Birthing ceremonies (i.e., seating, closing the bones, etc.)
- Group classes on babywearing
- Massage (maternal or infant)
- Still and Video Photography
- Placenta encapsulation
- Shopping
- Vaginal steams
- Yoga

Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure.

G. Donor Human Milk

Ventura County Health Care Plan (VCHCP) covers donor human milk subject to the following criteria:

• A mother is unable to breast feed due to medical conditions
• The infant cannot tolerate or has medical contra-indications to using formulas including elemental formulas
• The infant is born at a very low birthweight (less than 1500 g) and very premature (less than 32 weeks gestation)
• Gastrointestinal anomaly, metabolic/digestive disorder, or recovery from intestinal surgery when digestive needs require additional support
• Diagnosed with failure to thrive (not appropriately gaining weight/growing)
• Formula intolerance, with documented feeding difficulty or weight loss
• Infant hypoglycemia (low blood sugar); congenital heart disease, pre or post organ transplant
• Other serious health conditions when the use of banked donor milk is medically necessary and supports the treatment and recovery of the infant››
• Mother's milk must be contraindicated, unavailable (due to medical or psychological condition), or available but lacking in quantity or quality to meet the infant's needs,

Authorized providers who can prescribe pasteurized donor human milk (PDHM) are physicians, advance practice nurses, (Nurse Practitioners, Clinical Nurse Specialists, Certified Nurse Midwives) and Physician Assistants. This may include state licensed nutritionists or registered dieticians under a physician's supervision.

Provisions:

-Each prescription is on a case-by-case basis and good for up to what the doctor prescribes for the baby. Prescriptions must show the amount and frequency of the feedings,
- Three ounces per unit, 35 ounces per day only good for 30 days.
-Coverage may be up to 12 months of age, if is medically necessary and appropriate.
-Pasteurized donor human milk has to be obtained from a licensed tissue bank

Prescription Drug Services

The Plan provides pharmacy coverage through a contract with a pharmacy benefit manager ("PBM"). The Plan covers Medically Necessary prescription medications ordered by a licensed provider and dispensed by an In-Network pharmacy or mail-order service. Subject to the conditions, limitations, exclusions and copayments, you may have a prescription filled for the outpatient medications described as follows:

- Those Medically Necessary prescription medications listed in the Plan's *Preferred Drug List (PDL)*. Some prescriptions may require Authorization by the Plan
- Diabetic drugs, including Insulin, other prescription drugs for the treatment of diabetes, and glucagon
- Prescription inhalers and spacers
- Pain management medications for terminally ill patients
- Prescription contraceptive methods listed in the Plan's PDL. Contraceptive methods that are mandated by law, such as Plan B
- Testosterone (injectable) retail only
- All Food and Drug Administration (FDA)-approved tobacco cessation treatments, medically prescribed and over-the-counter, are covered without cost sharing
- All Affordable Care Act (ACA)-required medications are covered, without cost sharing, according to medical treatment guidelines. Such ACA-required services and tobacco cessation drugs are notated specifically in the Preferred Drug List (PDL). Please see Prescription Drug Limitations and Exclusions Section for more information about the Plan's PDL
- For members who are prescribed covered orally administered anti-cancer medications, the total amount of copayments and coinsurance shall not exceed $250 for an individual prescription of up to a 30-day supply

How to Obtain Covered Prescription Drug Services

The Plan's Prescription Drug List (PDL) is listed on the Plan's website listed below. The PDL includes details on the tier level, quantity limits, Affordable Care Act designation, and prior authorization and step therapy requirements. You may also access this information through the Plan's pharmacy benefit manager (ESI) member portal.

http://www.vchealthcareplan.org/members/programs/docs/ProviderDrugList.pdf

Members may also call the Plan to inquire about which drugs are on the PDL at (805) 981-5050 or (800) 600-8247.

You must obtain covered items at an In-Network pharmacy or through mail-order service unless you obtain the item as part of covered Emergency Services or Out-of-Area Urgent Care described in

the Emergency Services and Urgent Care sections, OR you may access prescription drug benefits at an in-network retail pharmacy unless the prescription drug is subject to restricted distribution by the U.S. Food and Drug Administration or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

Please refer to the *Provider Directory* for the locations of In-Network pharmacies in the Service Area. Please contact Express Scripts Inc. for all other In-Network pharmacies located outside the Service Area.

Per Health & Safety Code 1367.207, upon request of an enrollee or an enrollee's prescribing provider, the Plan and/or its delegate will:

- Furnish the following information:
  - The enrollee's eligibility for the prescription drug.
  - The most current formulary or formularies.
  - Cost sharing information for the prescription drug and other formulary alternatives, accurate at the time it is provided, including any variance in cost sharing based on the patient's preferred dispensing pharmacy, whether retail or mail order, or the provider.
  - Applicable utilization management requirements for the prescription drug and other formulary alternatives.
- Respond in real time to a request made by an enrollee or enrollee's prescribing provider through a standard Application Programming Interface (API).
- Allow the use of an interoperability element (integrated technologies or services necessary to provide a response to an enrollee or an enrollee's prescribing provider) to provide information to the enrollee or enrollee's prescribing provider.
- Ensure that the information provided to the enrollee or the enrollee's prescribing provider is current no later than one business day after a change is made and is provided in real time.
- Provide the information to the enrollee or to the enrollee's prescribing provider if the request is made using the drug's unique billing code and National Drug Code.

Prescription Drug Limitations and Exclusions

The outpatient prescription medications described above are subject to the following limitations, exclusions and copayments:

1. Covered medications must be dispensed by an In-Network Pharmacy. The pharmacy benefit manager maintains a nationwide network of In-Network Pharmacies. A list of locations within the Service Area is available on the Plan's website at www.vchealthcareplan.org, or please call the Member Services Department at (805) 981-5050 or toll free at (800) 600-8247 to have a printed copy mailed to you. Members are encouraged to call the PBM's toll-free number printed on their member identification pharmacy card for locations of In-Network pharmacies outside the Service Area. Covered medications dispensed by an out-of-network pharmacy will be covered only when dispensed in conjunction with, and

immediately following, an Emergency or Urgently Needed Services or Out-of-Area Coverage. In such circumstances, the member must pay for covered medications at the time they are dispensed and submit a claim for reimbursement to the PBM. The member will be reimbursed by the PBM the amount that would have been due the In-Network pharmacy. The PBM will reimburse member claims for prescriptions, subject to dispensing limits and Plan authorization requirements.

2. The pharmacist must dispense generic medications, if available, provided no medical contraindications exist. "Available" refers to general marketplace availability, not to specific pharmacy availability. The PBM establishes a maximum allowable cost (MAC) list for specified generic medications. This is the maximum amount a pharmacy will be reimbursed by the PBM for these drugs. If the provider has qualified a prescription for a brand name medication by noting "do not substitute" or "dispense as written" or if Member elects a brand name medication, the brand name medication will be provided and not substituted and the Member shall pay the copay plus the cost difference between the brand product and the MAC amount, unless there is a documented medical indication requiring the brand product.

3. The amount of covered medication per retail prescription is generally limited to a 30-day supply, except certain contraceptives, and the amount of covered medication per mail order prescription is limited to a 90-day supply, except for specialty medications which are only a 30-day supply delivery unless otherwise set forth in this Plan benefit description.

   Per Health and Safety Code Section 1367.25, the Plan shall cover up to a maximum of 12-month supply of FDA approved, self-administered hormonal contraceptives when dispensed or furnished at one time for an enrollee by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies when requested by the member.

4. Over-the-counter (OTC) medicines that do not require a prescription are not covered. There are exceptions for certain OTC medicines that are covered when a prescription is written. These include:
   a. Aspirin to reduce the risk of heart attack
   b. Iron Supplements for children
   c. Fluoride Supplements for children to reduce the risk of tooth decay
   d. Folic Acid Supplements for pregnant women to reduce the risk of birth defects
   e. Vitamin D Supplements for adults to prevent falls
   f. Tobacco Cessation Products

5. The Plan maintains a Preferred Drug List (PDL), which is a list of covered prescription drugs by major therapeutic category. This PDL is reviewed and approved by the Plan Pharmacy & Therapeutics Committee. The Plan Pharmacy & Therapeutics Committee,

which is responsible for overseeing the Plan's PDL, reviews new drugs upon request of an In-Network Provider and upon receipt of information about the new drug from the PBM. The Committee reviews the contents of the PDL quarterly and considers additions and deletions, including drugs approved by the FDA. The presence of a drug on the PDL does not guarantee that the Member's physician will prescribe the drug for a particular medical condition.

6. Although the Plan has a closed formulary, Medically Necessary prescriptions not on the Plan's PDL may be covered when Authorized by the Plan. There is a process by which members may obtain coverage for non-formulary drugs. Members may consult with their physicians regarding an individual exception and if the physician is in agreement, the physician may submit an Authorization Request for that medication. Copays for these prescriptions will be at the 3rd or 4th tier. Certain PDL medications are also subject to obtaining Authorization from the Plan. Requests for Authorization after regular business hours may be made by telephone by the prescribing physician to the Plan. Requests for Authorization during regular business hours may be made by telephone, in writing, or by facsimile by the pharmacy or the prescribing physician to the Plan. The Plan processes requests for new prescriptions, and for refills within 24 hours of receipt of request including those requests with exigent circumstances and urgency. The Plan notifies the prescribing provider and the enrollee or the enrollee's designee of its decision within 24 hours of receipt of an exigent and urgent request. The Plan notifies the prescribing provider and the enrollee or the enrollee's designee of its decision within 72 hours of receipt of a non-urgent medication request for prior authorization. A verbal Authorization may be given to the pharmacy or requesting physician. The notification letter is transmitted to the prescribing physician and mailed to the member. Denials shall indicate any alternative drug or treatment offered by the Plan and shall inform the member of Plan grievance procedures. Please see Member Grievance Procedure for further information.

   External Exception Review: VCHCP is required to maintain an external exception request review process. You (enrollee) may request an external exception review for coverage of non-formulary drug, step therapy, or a prescription drug prior authorization. VCHCP will ensure a decision within 72 hours in routine circumstances or 24 hours in exigent circumstances. The exception request review process does not affect or limit your (enrollee's) eligibility for independent medical review or to file an internal appeal with VCHCP.

   Requests for exceptions to non-formulary and step therapy processes for prescription drugs may be submitted in the same manner as a request for prior authorization for prescription drugs and shall be treated in the same manner.

Grievances may be filed for denials of non-formulary drugs step therapy, or prescription drug prior authorization.

Please see Member Grievance Procedure for further information. Grievances may be filed for denials of non-formulary drugs. Requests for exceptions to step therapy processes for prescription drugs may be submitted in the same manner as a request for prior authorization for prescription drugs and shall be treated in the same manner.

7. Certain medications have maximum quantity limits per prescription.

8. Step therapy programs have been implemented for several different classes of drugs for which specific medications, designated as Step 2 drugs, will only be approved after a trial of Step 1 medications has been documented or under certain other conditions.

9. Medications that are experimental, investigational or not approved by the United States Food and Drug Administration, including compounded drugs, are excluded. Off-label use of an FDA approved drug, when Medically Necessary, will be approved if supported by professionally recognized standards of medical practice. A copy of the policy, Prescription Medications: Coverage of Off-label Use, may be requested by contacting the Plan. If the Plan denies coverage of a drug to treat a life-threatening or chronic and seriously debilitating condition on the basis that its use is investigational or experimental, that decision is subject to Independent Medical Review. Please see the section, in this document, titled Independent Medical Review (Experimental/Investigational) for additional information.

10. Medications not Medically Necessary for the treatment of the condition for which it is administered are excluded.

11. Cosmetics, health or beauty aids, dietary supplements (except for conditions of Phenylketonuria), appetite suppressants, and drugs when prescribed for cosmetic purposes, when not Medically Necessary, are excluded. Examples within this exclusion are retinoic acid for cosmetic purposes, medications prescribed to remove or lessen wrinkles or pigmentation in the skin, medications to treat adult gynecomastia (when not Medically Necessary), and Propecia, topical Minoxidil and other medications to treat baldness. Exceptions may be made for drugs when Medically Necessary as prescribed. Dietary supplements and prescription drugs for cosmetic purposes be covered when medically necessary for the treatment of a mental health or substance use disorder.

12. Placebo injections and medications are excluded, except when Medically Necessary.

13. The Plan does not cover replacement of medications that are misplaced, lost, damaged or stolen.

14. Enhancement medications when prescribed for sexual performance are excluded. Sexual performance drugs will be covered when medically necessary for the treatment of a mental health or substance use disorder.

15. The prescribing practitioner must be an individually licensed and currently Drug Enforcement Administration certified provider.

16. Medications related to, or as a follow-up to services and supplies that are specified as excluded or beyond the limitations set forth in the Plan's medical coverage are excluded.

Preventive Health Services

For preventive health purposes, a periodic health evaluation and diagnostic preventive procedures are covered, based on recommendations published by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Health Resources and Services Administration, as well as generally medically accepted cancer screening tests subject to all terms and conditions that would normally apply.

Periodic physical examination and health screening, as required by Plan standards, guidelines, protocols and procedures, as adopted by VCHCP from time to time, and as scheduled by the PCP and Members are covered.

Preventive care services are provided without enrollee cost sharing. Visits for preventive care that also include non-preventive services, assessments, or discussions are subject to the applicable visit copay. The Plan shall not impose cost sharing for office visits associated with preventive care services if the preventive care is not billed separately, or is not tracked as an individual encounter separately, from the office visit and the primary purpose of the visit is the delivery of the preventive care service.

A. **For Children:** periodic health examinations, including all routine diagnostic testing and laboratory services appropriate for such examinations consistent with the most current Recommendations for Preventative Pediatric Health Care, as adopted by the American Academy of Pediatrics; and the most current version of the Recommended Childhood Immunization Schedule/United States adopted by the Advisory Committee on Immunization Practices (ACIP). This includes vision and hearing testing to screen for deficiencies. This does not apply to refraction exams. The Plan shall provide coverage for the human papillomavirus vaccine (HPV) for enrollees for whom the vaccine is approved by the FDA. The Plan shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage pursuant to CA Health and Safety Code sections 1367.66(b), 1342.74 on prophylaxis of HIV infection, 1367.34 on home test kits for sexually transmitted diseases, 1367.66 on cervical cancer screening, 1367.668 on colorectal cancer screening, & 1367.002 et seq. The

frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the member including: a member's desire for physical examinations; reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance. As recommended by U.S. Preventive Services Task Force (USPSTF), clinicians shall provide tobacco use interventions for: children and adolescents, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

B. **For Adults:** Periodic health examinations including all routine diagnostic testing and laboratory services appropriate for such examinations. This includes coverage for cancer screening tests including prostate-specific antigen testing and digital rectal examination for the diagnosis of prostate cancer, mammograms and cervical cancer screening tests. Coverage for a cervical cancer screening test shall include the conventional Pap test, human papilloma virus (HPV) screening test that is approved by the Federal food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the member including: a member's desire for physical examinations; reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance. The plan shall provide coverage for human papilloma virus (HPV) vaccine for enrollees for whom the vaccine is approved by the Federal Food and Drug Administration (FDA) and shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage pursuant to CA Health and Safety Code sections 1367.66(b), mental health, 1367.66(b), 1342.74 on prophylaxis of HIV infection, 1367.34 on home test kits for sexually transmitted diseases, 1367.66 on cervical cancer screening, 1367.668 on colorectal cancer screening, & 1367.002 et seq. As recommended by USPSTF, clinicians shall provide tobacco use counseling and interventions for non-pregnant adults. Clinicians shall ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. Addition interventions related to tobacco use counseling for pregnant women are that clinicians shall ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling to those who smoke.

For additional information related to Preventive Care Services, visit the Plan's website at: http://www.vchealthcareplan.org/, or for a detailed list of recommendations, visit the USPSTF website at: http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations

Professional Services

Services and consultations by a physician or other licensed health care provider acting within the scope of his or her license are covered when Medically Necessary and may require Authorization by

the Plan. Professional services include but are not limited to:

- Primary Care visits for evaluations and treatment.
- Physician specialist visits for consultation, evaluation, and treatment
- Non-physician specialist visits for consultation, evaluation and treatment

Primary care services must be obtained from a primary care provider who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referrals for specialist care. This means providing care for the majority of health care problems, including but not limited to, preventive services, acute and chronic conditions and psychosocial issues.

Specialist services must be obtained from an In-Network provider, unless services are otherwise Authorized by the Plan.

Surgery, assistant surgery and anesthesia (inpatient or outpatient); inpatient hospital and skilled nursing facility visits; certain professional office visits, radiation therapy, chemotherapy, dialysis treatment, and home visits are covered when Medically Necessary and Authorized by the Plan.

Professional services may be provided via Telemedicine Services.

Prosthetic and Orthotic Services

Prosthetic and Orthotic Services are covered when Medically Necessary and Authorized by the Plan and when the following requirements are met:

- Provided by an In-Network Provider and:
- Prescribed by a physician acting within the scope of his or her license, or is ordered by a licensed health care provider acting within the scope of his or her license

These services include but are not limited to; corrective appliances, artificial aids, and therapeutic devices, including fitting, repair, replacement, and maintenance, as well as devices used to support, align, prevent, or correct deformities of a movable part of the body (orthotics); devices used to substitute for missing body parts (prosthesis); devices implanted surgically including intraocular lenses after cataract surgery; breast prosthesis to restore and achieve symmetry for Members incident to a mastectomy for cancer; prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx; podiatric devices to prevent or treat diabetes-related complications; visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin. Prosthetic services are *not* covered when provided for other than a Medical Necessity (e.g., for cosmetic purposes), except after mastectomy.

Reconstructive Surgery Services

Reconstructive Surgery is covered when Medically Necessary and Authorized by the Plan to restore and achieve symmetry and when surgery is performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease in order to improve function.

The Plan covers reconstructive surgery following a mastectomy to include reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce symmetrical appearance; and physical complications for all stages of a mastectomy, including lymphedema.

Member benefits for preventing, diagnosing, and treating mental health conditions and substance use disorders as medically necessary is provided to members in accordance with generally accepted standards of mental health and substance use disorder care including behavioral health treatment for reconstructive surgery pursuant to Health and Safety Code section 1374.72. For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which the enrollee identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested. Title 28 of the California Code of Regulations Rule 130074.72.01(a)(20)

Rehabilitative and Habilitative Services

Rehabilitative and Habilitative services are covered when Medically Necessary and Authorized by the Plan. These services can be performed in an outpatient or inpatient setting.

Rehabilitative Services means health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology and therapy, and psychiatric rehabilitative services in a variety of inpatient and/or outpatient settings.

Habilitative Services means Medically Necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Examples of health care services that are not Habilitative services include, but are not limited to, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including, but not limited to, vocational training. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services.

The Plan may require periodic evaluations as long as the therapy is provided. Such evaluations may use significant improvement as part of the determination of Medical Necessity. All such services must be obtained from licensed and/or certified therapists, as applicable except for services obtained from qualified mental or behavioral health specialists.

Coverage shall include:

(a) Individual and group outpatient physical, occupational, and speech therapy related to Autism

Spectrum Disorder.

(b) All other individual and group outpatient physical, occupational, and speech therapy.

(c) Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitative day-treatment program, a skilled nursing facility; and in an inpatient hospital (including treatment in an organized multidisciplinary rehabilitative program).

Limits for rehabilitative and habilitative services are not combined.

Skilled Nursing Facility Services

Non-custodial care in a licensed skilled nursing/extended care, and acute rehabilitation facility or area of a hospital is covered when Medically Necessary and Authorized by the Plan. Services are limited to one hundred (100) combined days per plan year, subject to the provision that no continuous length of stay will exceed sixty (60) days.

A. A room of two or more beds, including meals, services of dietitian and general nursing care. A private room may be provided if Medically Necessary and Authorized by the Plan. If a private room is used without Authorization, an allowance of the average semiprivate (two-bed) room rate of the facility will be made toward the room charge for the accommodations occupied. The Member may be financially responsible for the balance.

B. Laboratory testing.

C. Drugs which are not Investigational and/or Experimental and are supplied by and used in the facility.

Telehealth Services

Telehealth services are available through Teladoc, 24 hours a day 7 days a week, by phone or video, for most urgent care needs at (800) TELADOC or (800) 835-2362 or by downloading the web application from the web address: www.teladoc.com

There is a $15.00 copay per visit and Teladoc services are provided to you without age restriction. These services are available to treat non-emergency issues such as cold and flu symptoms, allergies, and sinus problems. Teladoc services do not include mental/behavioral health or substance use services.

Telehealth services are also available from Participating medical providers who choose to provide such services. Medical appointments with Participating providers who choose to provide telehealth services shall have the same copay as such medical visits and/or services would have if provided by the same provider for the same services in-person.

Transplant Services

Hospital and professional services provided in connection with transplants are covered when Medically Necessary and Authorized by the Plan. Services related to obtaining the human organ transplant material from a living donor or an organ transplant bank will be covered. Reasonable charges for testing of relatives (children, parents, whole siblings, siblings, and half-siblings of the candidate) for matching transplants will be covered. Transplant procedures must be performed at an appropriately certified facility.

Urgent Services

Urgent Care Services means prompt medical services provided in a non-emergency situation. Examples of urgent care conditions include sore throats, ear infections, sprains, high fevers, vomiting and urinary tract infections. Urgent situations are not considered to be Emergency Medical Conditions. Services must be obtained at an appropriately licensed "urgent care" or similar facility, subject to retrospective denial for services not medically indicated or supported by the examination and/or the diagnosis of the Member. No authorization required.

Urgently Needed Care means any Covered Service necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member is able to see his or her PCP. This includes maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee is able to see her Provider.

Out-of-Area Urgent Care services shall be a covered benefit while the member or eligible dependents are outside the Service Area. Out-of-Area Urgent Care services are covered if:

(a) You are temporarily outside the Plan's Service Area, and

(b) The services are necessary to prevent serious deterioration of your health, or your fetus, and

(c) Treatment cannot be delayed until you return to the Plan's Service Area.

Ventura County Health Care Plan Members have a responsibility to follow the plan of care and instructions that they have agreed upon with their Providers.

While members or eligible dependents are inside the Service Area, Urgently Needed Care will only be covered at In-Network facilities. Use of Out-of-Network Urgent Care facilities inside the service area is not covered.

No authorization required.

SUMMARY OF BENEFIT EXCLUSIONS

The items and services listed in this Summary of Benefit Exclusions section are excluded from coverage. These exclusions apply to all services that would otherwise be covered under this *EOC* regardless of whether the services are within the scope of a provider's license or certificate or the provider orders or writes a prescription for an item or service.

This section does not contain an all-inclusive list of the limitations, exclusions, and restrictions that may also be present in the rest of the *EOC*. The *EOC*, as a whole, contains most benefit limitations, exclusions, and restrictions. **It is very important to read this section before you obtain services in order to know what VCHCP will and will not cover.**

VCHCP does not cover the services or supplies listed below. Also services or supplies that are excluded from coverage in the *EOC*, exceed *EOC* limitation, or are follow-up care to *EOC* exclusions or limitations, may not be covered.

1. Air Purifiers, air conditioners, humidifiers or dehumidifiers.

2. Alternate birthing center or home delivery. Home birth is only covered when the criteria for Emergency Care, as defined in this *EOC*, have been met. Midwife services are not covered.

3. Alternative Care Services such as faith healing including but not limited to: Christian Science Practitioner; Homeopathic medicine; Hypnotherapy; Sleep therapy; Biofeedback unless Medically Necessary for the treatment of PDD or Autism; Behavior therapy unless determined to be Medically Necessary.

4. Conception by medical procedures. VCHCP does not cover certain services or supplies that are intended to impregnate a woman. This exclusion does not apply to medically necessary iatrogenic services.

   Excluded procedures are as follows, but are not limited to:

   a. In-vitro fertilization (IVF), including zygote intrafallopian transfer (ZIFT), artificial insemination, and supplies (including injections and injectable medications) which prepare the Member for these services.
   b. Collection, storage, or purchase of sperm or ova.

   NOTE: This exclusion does not apply to medically necessary reproductive health (sperm preservation, oocyte or embryo freezing) for transsexual, transgender, and gender non-conforming people. No prior authorization is required for these services.

5. Cosmetic surgery, which is a surgery primarily performed to alter or reshape normal structures of the body to improve appearance which is not Medically Necessary. All services to retard or reverse the effects of aging of the skin or hair, including Retin-A, and tattoo removal. *[Medically Necessary Emergency Care as a result of complications from non-covered services are Covered Services. Reconstructive Surgery services are Covered Services.]* Cosmetic

surgery will be covered when medically necessary for the treatment of a mental health or substance use disorder.

6. Custodial or Domiciliary Care including domestic services, with the exception of those services provided as a part of Hospice Care Plan, are not covered if the services and supplies are provided primarily to assist with the activities of daily living, regardless of where performed. Custodial Care is not covered even when the patient is under the care of a supervising or attending Physician and services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comforts, or ensure the manageability of the patient. Furthermore, Custodial Care is not covered even if ordered and prescribed services and supplies are being provided by a registered nurse, a licensed vocation nurse, a licensed practical nurse, home health aide, a Physician Assistant or rehabilitative (physical, occupational or speech) therapist. This exclusion for Custodial and Domiciliary Care does not apply to behavioral health treatment prescribed for Autism Spectrum Disorder.

7. Dental services including care of teeth, gums or dental structures, extractions or corrections of impactions, crowns, inlays, onlays, bridgework, other dental appliances, dental implants, dental prosthetics, dental splints; Orthodontic services, including braces and appliances. Except in the following situations:
    a. When Dental examinations and treatment of the gingival tissues are performed for the diagnosis or treatment of a tumor.
    b. When immediate Emergency Care to sound natural teeth as a result of an accidental injury is required.

8. Disorders of the Jaws except in the following situations:
    a. Services to correct abnormally positioned or improperly developed bones of the upper or lower jaw are covered if the services are required due to recent injury, the existence of cysts, tumors or neoplasms, or a disorder which inhibits normal function, and they are Medically Necessary.
    b. Services to correct disorders of the temporomandibular (jaw) joint (also known as TMJ disorders) are covered and subject to copayment if they are Medically Necessary.

9. Disposable supplies for home use that are available over-the-counter, such as dressing, surgical or incontinence supplies.

10. Durable medical equipment, devices or appliances, including but not limited to:
    a. Exercise equipment
    b. Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services).
    c. Stockings, corrective shoes, and arch supports. This exclusion does not apply to podiatric devices to prevent or treat diabetes complications.

d. Replacement equipment, devices, or appliances due to an item being lost, misplaced, stolen, or damaged due to improper usage.

11. DME that is for the personal convenience of Members or a caretaker.

12. Elevators, chair lifts, wheelchair ramps, or similar items.

13. Emergency room services for Non-Emergency purposes.

14. Non-Emergency Services provided outside VCHCP's Service Area without an Authorization from VCHCP.

15. Exercise programs, certain dietary supplements and weight reduction programs, except those prescribed during a Bariatric Surgical program. Dietary supplements will be covered when medically necessary for the treatment of a mental health or substance use disorder.

16. Expenses incurred for services and benefits rendered prior to VCHCP Member's effective date of Coverage, after date of Coverage termination, or if covered as an extended benefit for Total Disability by prior health insurance.

17. Experimental or investigational services – VCHCP does not cover experimental drugs, devices, procedures or other therapies except when:
    a. Independent review deems them appropriate;
    b. Clinical trials for cancer patients are deemed appropriate
    c. No alternative treatment options exist and the Member has a life-threatening or seriously debilitating condition

Please see the section titled Independent Medical Review (Experimental/Investigational) for additional information.

18. Eyeglasses or contact lenses; including furnishing, fitting, installing or replacing, Radial Keratotomy and other refractive procedures, and eye exercises with the exception of contact lenses which are covered for the treatment of keratoconus. Eye refractions for the purpose of determining the need for eyeglasses or contact lenses; routine vision exams for Members seventeen (17) years of age or older.

19. Foot care, including but not limited to; routine trimming of corns, calluses, and nails, except for diabetic members.

20. Hearing Aids; including furnishing, fitting, installing or replacement.

21. There is no coverage for any medical opinion beyond the Authorized second opinion. Please see the Second Medical Opinions description section for further details.

22. Modification, alteration or other renovation of member's home/dwelling to accommodate medical equipment or appliances.

23. Non-prescription (over-the-counter), medications, medical equipment or supplies that can be purchased without a licensed provider's prescription, even if a licensed provider writes a prescription for a non-prescription item, except as specifically provided under the Home Health Care Services, Hospice Care, Durable Medical Equipment, and Prosthetic and Orthotic Services sections.

24. Orthotics which are not custom made to fit the Member's body, except as medically necessary for fracture care and/or after a surgical procedure.

    Foot orthotics (whether or not custom fit) that are not incorporated into a cast, splint, brace or strapping of the foot are not covered, except in the following situations:
    - members with diabetes who need foot orthotics to prevent or treat diabetic foot complications
    - members needing post-surgical stabilization in place of a cast
    - members with any foot disfigurement due to:
        - cerebral palsy
        - arthritis
        - polio
        - spina bifida
        - diabetes
        - accident or developmental disability

25. Physical examinations (encounter examinations), ancillary tests, and reports for the purpose of obtaining or continuing employment, insurance, government licensure, travel (please refer to approved vaccine list for exceptions), school admissions, premarital purposes, camp or school physical, school or non-school related sporting activities, health screening for adoption clearance, jail or prison medical clearance, medical clearance for behavioral health facility or program clearance, medical clearance for admission to residential institution, compliance with court order, administration examinations, disability determination, or for purposes of obtaining or retaining certification or licensure.

26. Private duty nursing for patients in a hospital or long-term care facility.

27. Recreational, art, dance, sex, sleep, or music therapy and other similar therapies except for medically necessary treatment of a mental health condition identified as a mental disorder in the most recent version of the DSM.

28. Saunas, Jacuzzi, whirlpools, other pools and other like devices.

29. Services and items not provided for or arranged by VCHCP, PCP or other In-Network Provider with the exception of in and out-of-area Emergency or Urgently Needed Services.

30. Services required by court order or as a condition of parole or probation.

31. Services, supplies or benefits that are not Medically Necessary nor specifically identified in the Covered Services section.

32. Supplies for comfort, hygiene, or beautification, unless Medically Necessary, including but not limited to; cosmetics, hair pieces, toupees, and wigs.

33. Surrogate pregnancy, one in which a woman has agreed, for compensation, to become pregnant with the intention of surrendering custody of the child to another person.

34. Testing or evaluation for custody, education, or for vocational purposes.

35. Reversal of sterilization.

36. Treatment for disability, illness or injury incurred while committing a felony.

37. Vehicle or customization of a vehicle to accommodate medical equipment or appliances.

38. Work-related illnesses or injuries (workers compensation), or services provided or arranged by another governmental agency.

Circumstances Beyond VCHCP's Control: In the event of circumstances not reasonably within the control of VCHCP, such as a complete or partial destruction of facilities, war, riot, civil insurrection, disability of a significant part of VCHCP personnel or similar causes, and the rendering of Covered Services is delayed or rendered impractical, neither VCHCP nor any In-Network Providers shall have any liability or obligation on account of such delay or such failure to provide Covered Services. In such circumstances, VCHCP will make all reasonably practicable efforts to provide or arrange for Covered Services.

Major Disasters or Epidemics: In the event of any major disaster or epidemic, VCHCP shall render the Covered Services insofar as practical, according to VCHCP's best judgment, within the limitation of such facilities, financial resources, and personnel as are available. However, VCHCP shall not have any liability or obligation for the delay or failure to provide, or arrange Covered Services due to lack of available facilities or personnel if reasonable efforts have been made to arrange for such care, but it is unavailable as the result of disaster or epidemic.

Refusal of Treatment: Coverage is not provided for care of conditions where a Member has

refused recommended treatment.

CONTINUITY OF CARE

Continuity of Care for New Enrollees by an Out-of-Network Provider: If on the date your eligibility with VCHCP becomes effective, you are in the midst of a course of treatment, as described below (including, but not limited to hospitalization), being provided by an Out-of-Network Provider you may request the Plan to arrange for you to receive continuation of Covered Services from the Out-of-Network Provider, including continuation of Covered Services received from an out-of-network hospital. Such treatment must be:

- for an acute condition, for the duration of that condition,
- for a serious chronic condition, not to exceed twelve (12) months from your effective date of enrollment,
- for a pregnancy including the duration of the pregnancy and immediate postpartum care, including issues concerning maternal mental health,
- a maternal mental health condition
- for a terminal illness, for the duration of the illness,
- for care for children from birth to age thirty-six (36) months, not to exceed twelve (12) months from your effective date of enrollment, or
- if you have a surgery or other procedure that has been recommended by the Out-of-Network Provider to occur within one hundred eighty (180) days of the effective date of coverage.

The Out-of-Network Provider must agree in writing to be subject to, and then must comply with, all contractual provisions that are imposed upon currently contracting non-capitated Providers providing similar services including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. Compensation is to be similar to that used by the Plan for currently contracting non-capitated Providers providing similar services. If such a Provider does not agree to such terms, conditions, and rates, the Plan is not obligated to continue to provide such services.

The duration for completion of Covered Services varies depending on the presenting condition. To receive further information, to receive a copy of the Plan's Continuity of Care Policy, or to request the Plan to arrange for continuity of care from an Out-of-Network Provider, please contact Member Services at (805) 981-5050 or toll free at (800) 600-8247, or by fax at (805) 981-5051. This policy describes how you may request a review of your current medical condition by the Plan.

Continuity of Care with a Terminated Provider: If the contract between the Plan and your Provider terminates or does not renew for reasons or cause unrelated to medical disciplinary action, fraud or other criminal activity, you may request the Plan to arrange for you to receive continuation of Covered Services in the following situations:

- ongoing treatment for an acute condition,
- a serious chronic condition,
- a pregnancy including the duration of the pregnancy and immediate postpartum care,

- a maternal mental health condition
- a terminal illness,
- care for children from birth to age thirty-six (36) months,
- if you have a surgery or other procedure that has been authorized by the Plan as part of a documented course of treatment and recommended and documented by the provider to occur within one hundred eighty (180) days of the contract's termination date.

Continuity of care by a terminated provider will not be provided if the terminated provider was terminated for fraud, criminal activity or due to a medical disciplinary action. Please note that this includes continuation of Covered Services received from a terminated hospital. The terminated Provider must agree in writing to be subject to, and then must comply with, all contractual provisions that were in effect prior to termination or non-renewal including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. Compensation is to be similar to that used by the Plan for currently contracted non-capitated Providers providing similar services. If the terminated Provider does not agree to such terms, conditions, and rates, the Plan is not obligated to continue to provide such services.

The duration for completion of Covered Services varies depending on the presenting condition. To receive further information, to receive a copy of the Plan's Continuity of Care Policy, or to request the Plan to arrange for continuity of care from a terminated Provider, please contact Member Services at (805) 981-5050. This policy describes how you may request a review of your current medical condition by the Plan.

At least sixty (60) days prior to termination of a contract with a medical group or general acute care hospital, the Plan will send written notice to members who are assigned to the terminated medical group or live within the customary Service Area of the hospital.

Issues regarding Continuity of Care concerning behavioral health and/or substance use disorder benefits provided by OptumHealth Behavioral Solutions should be addressed to:

OptumHealth Behavioral Solutions

P.O. Box 2839

San Francisco, CA 94126

Or at the OptumHealth Behavioral Solutions website: www.liveandworkwell.com

Phone: (800) 851-7407

COORDINATION OF BENEFITS, THIRD PARTY AND MEMBER LIABILITY

Coordination of Benefits: If you receive Covered Services from VCHCP, and you are eligible for the same services under any other plan or contract providing services or benefits for medical care, payment for the Covered Services shall be coordinated in accordance with the provisions of State law

and the regulations promulgated thereunder, and the applicable policies of VCHCP. The primary insurance carrier covers the major portion of the bill according to plan allowances, and the secondary insurance may cover any remaining allowable expenses. The Coordination of Benefits (COB) provisions of your policy or plan determine which plan is primary. The primary plan's benefits are applied to the claim first. The unpaid balance is usually paid by the secondary plan to the limit of its responsibility. Benefits are thus "coordinated" among all of the health plans, and payments do not exceed 100% of charges for the covered services. If VCHCP pays benefits greater than it should have under the applicable Coordination of Benefits (COB) provision, VCHCP shall have the right to recover the excess payment from any other person or entity which may have benefitted from the overpayment. As a Member, you agree to assist VCHCP in recovering any overpayments.

When a Member is covered under more than one health care plan, COB rules determine the order in which multiple insurance carriers pay your health plan bills, and how much each will pay. One plan is designated as the primary plan and the other as secondary. These rules apply in determining which plan pays first:

The plan that covers a Member in his/her capacity as an employee is the Member's primary plan.

1. For dependent children living with both parents, the primary plan is determined by the birthday rule: the plan of the parent whose birthday (month and date) falls earlier in the year is primary. The plan of the parent whose birthday falls later in the year is secondary.
2. The primary plan for dependent children of separated or divorced parents is the plan of the parent with custody of the child, followed by the plan of the spouse of the parent with custody, then the plan of the parent without custody of the child.
3. Medicare is generally a secondary payor for active employees and their dependents.

In order for the Plan to act as a secondary payor for non-emergency services, a Plan Provider must be used. VCHCP will coordinate benefits with your primary insurer up to the amount that VCHCP would have been responsible for paying under VCHCP provisions in the absence of any other insurance. VCHCP will pay the lesser of the balance, less any applicable copayment, deductible or coinsurance. VCHCP will not be responsible to pay any amount for services rendered if the total received from the primary insurer exceeds the amount allowed by VCHCP. VCHCP will not be responsible for the coordination of benefits for the payment of services that are not a covered benefit.

Third Party Liability: VCHCP will furnish Covered Services in case of injury, illness caused by a third party and complications incident thereto, such as, but not limited to, injuries from an automobile accident. As a Member, you agree to reimburse VCHCP or the Provider, as appropriate, the reasonable cost of health care services, from any payment you receive from the third party, such as an automobile insurance company. The amount you will owe VCHCP is the lesser of the amount paid for your health care services after deducting your reasonable attorney fees and costs or one-half of the moneys due you under a judgment, compromise or settlement agreement if you do not use an attorney or if you use an attorney, one-third of the moneys due you under the settlement agreement.

In the event that you settle claims for any injury caused by a third party, and the settlement agreement does not specifically include payment for medical costs, VCHCP or the Provider, as appropriate, nevertheless, will have a lien against any such settlement for the same amount as would apply if medical costs were specifically mentioned in the agreement. You shall agree to cooperate in protecting the Plan's interest under this provision, and to execute and deliver to VCHCP any and all assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the rights of VCHCP. VCHCP is entitled to the above rights whether or not you are made whole for all of your damages.

Third Party Liability Member Responsibilities:

In the event of an injury or illness of a member caused by a third party, members are required to do all of the following:

1. Complete any paperwork that VCHCP or its contracted providers may reasonably require to assist in enforcing the lien.

2. Give prompt notification to VCHCP of the name and location of the third party, if known, the name and address of your attorney, if you are using one, and a description of how the injuries were caused.

3. Hold any money that you or your attorney receive from the third party or their insurance companies in trust, and reimburse VCHCP for the amount of the lien as soon as you are paid by the third party.

4. Notify VCHCP immediately upon receiving any money or upon your attorney receiving any money from the third parties or their insurance companies.

5. Promptly respond to inquiries about the status of the third-party case and any settlement disclosures.

Non-Liability of Member: In the event that VCHCP fails to pay an In-Network Provider, the Member shall not be liable to the In-Network Provider for any sums owed by VCHCP. As required by California law, every contract between VCHCP and an In-Network Provider contains a provision to this effect. In-Network Providers are contractually required to accept VCHCP's payments on behalf of the Member for Covered Services and will not assert against the enrollee statutory or other lien rights that may exist. However, in the event you seek non-Covered Services, such as non-Emergency Care from an Out-of-Network Provider, you may be liable to that provider for the cost of such services.

Reimbursement Procedures: You must submit any claims for reimbursement of payment you made for Plan benefits, such as claims for Emergency Care, within one hundred eighty (180) days from the date of first service. VCHCP will accept claims after this time limit if you show that you have, in good faith, attempted to provide these claims to the Plan within this time limit. Claims should be submitted to: Ventura County Health Care Plan, 2220 E. Gonzales Road, Suite 210-B, Oxnard, CA 93036.

PREMIUMS: An enrollee under a group contract may be referred to the group contract holder for information on any amount to be withheld from the enrollee's salary or to be paid by the enrollee to the employer/group contract holder."

TERMINATION OF BENEFITS

This section describes the conditions under which enrollment in VCHCP may be terminated.

Loss of Eligibility: If you or your Dependent no longer meets the eligibility requirements of VCHCP described in the Eligibility, Enrollment and Effective Dates section, you and/or your enrolled Dependents will be terminated automatically at midnight on the last day of the pay period after the pay period in which loss of eligibility occurs. If enrollment terminates under certain circumstances, you and/or your enrolled Dependents may be able to obtain continuing coverage from VCHCP as explained below.

Proof of Creditable Coverage: Within thirty (30) days of termination of you and/or your Dependent's Coverage, VCHCP will mail you evidence of creditable coverage. This document will include your most recent dates of continuous coverage under VCHCP.

Termination by VCHCP: You and your enrolled Dependents may be terminated from VCHCP for any of the following reasons. If membership is terminated for any of these reasons, all rights to Covered Services cease as of the date of termination, and there is no right to continuing coverage or to convert to (Individual) Conversion Coverage. All such terminations are subject to VCHCP's grievance procedure.

1. Failure to furnish material information or furnishing incorrect or incomplete material information: Each Member warrants that all material information contained in enrollment applications, questionnaires, forms or statements submitted to VCHCP incident to enrollment is correct and complete. If you fail to furnish required information or you furnish incorrect or misleading material information, VCHCP may terminate you and your enrolled Dependent's membership, effective as of the date you failed to furnish material information or furnished incorrect or misleading material information. You may be liable for the costs of services rendered subsequent to such act. This includes information submitted or requested to verify Dependent status. The Plan shall send a Notice of Cancellation, Rescission, or Non-Renewal for all reasons other than non-payment of premiums, at least 30 days before the cancellation, rescission, or non-renewal. Please see section titled **Cancellation, Rescission, or Nonrenewal for Reasons Other than Nonpayment of Premiums** later in this document for additional information**.**

2. Fraud or deception: If you engage in fraud or deception in the use of the services or facilities of VCHCP or knowingly permit such fraud or deception by another person, then VCHCP may terminate your Coverage effective as of the date the fraud or deception was committed. This includes, but is not limited to, permitting the use of your Plan identification card by any other person. The Plan shall send a Notice of Cancellation, Rescission, or Non-Renewal for all reasons other than non-payment of premiums, at least 30 days before the cancellation, rescission, or non-renewal. Please see section titled **Cancellation, Rescission, or**

Nonrenewal for Reasons Other than Nonpayment of Premiums later in this document for additional information.

3. Non-payment: If VCHCP determines you or your Group Contract Holder has failed to make a premium payment by the due date, VCHCP shall send a Notice of Start of Grace Period to your group contract holder, who will notify you that a payment delinquency has triggered a 30-day grace period starting from the day the Notice of Start of Grace Period is dated. VCHCP will send the Notice of Start of Grace Period at least thirty (30) days before your coverage is terminated.

   If past due payments are not received by the end of the Grace Period, the Plan will issue a "Notice of End of Coverage" after the date coverage ends, no later than five calendar days after the date of coverage ended. Your group contract holder will send the notices promptly to you. For additional information, please see section titled **Cancellation, Rescission, or Nonrenewal for Reasons Other than Nonpayment of Premiums** later in this document for additional information.

   If full payment is received before the Grace Period ends, VCHCP will not terminate your membership and coverage will continue uninterrupted.

   If you receive notice that your coverage is being canceled or non-renewed due to failure to pay your Premium, VCHCP must provide you with a 30-day "grace period". The grace period begins the date that your Start of Grace Period Notice is dated. The Start of Grace Period Notice shall not be dated any earlier than the first date of unpaid coverage. VCHCP must continue to provide coverage during the grace period, though you will be financially responsible for the premium for the coverage provided during the grace period. The grace period must last at least 30 days from the date of this notice. During the grace period, you can avoid cancellation or nonrenewal by paying all premiums due before the 30-day grace period ends.

   If policyholder does not pay the Premium by the end of the grace period, your coverage will be terminated at the end of the grace period. You will still be legally responsible for any unpaid premiums you owe to VCHCP. If you wish to terminate your coverage immediately, contact VCHCP as soon as possible.

4. Withdrawal of health plan benefit from the market: If the Plan withdraws this health plan product from the market, the Plan shall provide Notice of Cancellation, Rescission, and Withdrawal at least 90 days before the policy period ends. For additional information, please see section titled **Cancellation, Rescission, or Nonrenewal for Reasons Other than Nonpayment of Premiums** later in this document for additional information.

Rescission, Cancellation, or Nonrenewal of Your Enrollment or Subscription for Nonpayment of Premium:

VCHCP shall send a notice of Cancellation, Rescission, and Nonrenewal for nonpayment of

premiums, as follows:

If the group fails to pay, or fails to make satisfactory arrangements to pay, any amount due VCHCP for Coverage, including but not limited to Premiums and Copayments, VCHCP may terminate Coverage, subject to the reinstatement provisions below. VCHCP will promptly send written notice of the termination and a Notice of Start of Grace Period to your group contract holder at least thirty (30) days before the termination date. If past due payments are not received by the end of the Grace Period, VCHCP will issue a Notice of End of Coverage after the date of coverage ends, no later than five (5) calendar days after the date coverage ended. Your group contract holder will send the notices promptly to the enrollee. If full payment is received before the termination date, VCHCP will not terminate your membership and coverage will continue uninterrupted.

If the group receives notice that coverage is being canceled or non-renewed due to failure to pay premium, VCHCP will provide the group with a 30-day "grace period". VCHCP will send the Notice of Start of Grace Period to the group contract holder. The grace period begins the date that the Start of Grace Period Notice is dated. The Start of Grace Period Notice shall not be dated any earlier than the first date of unpaid coverage. VCHCP will continue to provide coverage during the grace period, though the group will be financially responsible for the premium for the coverage provided during the grace period. The grace period must last at least 30 days from the date of the notice. During the grace period, the group can avoid cancellation or nonrenewal by paying all premiums due before the 30-day grace period ends.

If the group does not pay the Premium by the end of the grace period, the group's coverage will be terminated at the end of the grace period. VCHCP will send such notice via certified mail. The group will still be legally responsible for any unpaid premiums owed to VCHCP. If the group wishes to terminate coverage immediately, contact VCHCP as soon as possible.

In the event of termination, the group contract holder shall be responsible for serving each subscriber with all such termination notices.

Cancellation, Rescission, or Nonrenewal for Reasons Other than Nonpayment of Premiums

VCHCP shall send a notice of Cancellation, Rescission, and Nonrenewal for reasons other than for nonpayment of premiums, as follows:

VCHCP shall promptly send a Notice of Cancellation, Rescission, or Nonrenewal to the group contract holder.

Notice will be sent at least 30 days before the cancellation, rescission, or nonrenewal for fraud or intentional misrepresentation.

Notice will be sent at least 30 days before the cancellation, rescission, or nonrenewal

Notice will be sent at least 180 days before the discontinuation or termination of a contract if the cancellation or nonrenewal is due to VCHCP ceasing to provide or arrange for the provision of

health benefits for new plan contracts in the individual or group market in this state. A notice sent pursuant to this subdivision shall also be sent concurrently to the DMHC.

Notice will be sent at least 90 days before the withdrawal of a health benefit plan from the market. A notice sent pursuant to this subdivision shall also be sent concurrently to the DMHC.

VCHCP shall send a Notice of End of Coverage for all cancellations. This Notice shall be sent to the group contract holder after the date coverage ended, and no later than five (5) calendar days after the date coverage ended.

In the event of termination, the group contract holder shall be responsible for serving each subscriber with all such termination notices.

Extension of Coverage upon Total Disability: VCHCP will continue to provide Covered Services for Members who are Totally Disabled as of the date of the termination of the Agreement. Totally Disabled means:

(a) that the Member, if an employee, is prevented, because of injury or disease, from performing his or her occupational duties and is unable to engage in any work or other gainful activity for which he or she is fitted by reason of education, training or experience, or for which he or she could reasonably become fitted or

(b) that the Member, if a Dependent, is prevented because of non-occupational injury or non-occupational disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

This extension of Coverage shall only: (a) provide Covered Services that are Medically Necessary to treat medical conditions causing or directly related to the Total Disability; and (b) remain in effect until the earlier of the date that:

1. The Member is no longer Totally Disabled;
2. The Member has exhausted the Covered Services available for treatment of the disabling condition;
3. The Member becomes eligible for coverage from another health benefit plan which does not exclude coverage for the disabling condition; or
4. Twelve (12) months from the Member's termination date under the Agreement.

INDIVIDUAL CONTINUATION OF BENEFITS

COBRA Continuation Coverage:

Qualifying Event

Upon timely election, COBRA Continuation Coverage (COBRA Coverage) shall begin on the date of loss of Coverage due to of one of the following "qualifying events":

a) the Subscriber's termination, retirement or separation from employment other than by reason of such Subscriber's gross misconduct

b) reduction in the Subscriber's hours, or other change in employee status resulting in loss of eligibility for medical benefits

c) the death of the Subscriber

d) the divorce or legal separation of the Subscriber from the Subscriber's spouse (who is a Member)

e) an enrolled child ceases to qualify as a Dependent

f) a proceeding in a case under Title 11 of the United States Code involving the bankruptcy of the Group

Coverage will terminate on the earliest of:

a) the date which is eighteen (18) months (or twenty-nine [29] months in the case of a disability extension) after the date of termination of Coverage due to a "qualifying event" specified in Paragraph a or b above, unless the Member has a second qualifying event (e.g., divorce) following the first qualifying event (e.g., Subscriber's employment termination) which changes the termination date; or

b) the date which is thirty-six (36) months after date of termination of Coverage due to a "qualifying event" specified in Paragraph c, d, or e, above; or

c) the date on which the Group ceases to provide any group health plan to any employee/retiree.

COBRA eligibility ceases when any of the following occur:

a) the date on which Coverage ceases by reason of failure of the Member to pay the required Premium within the thirty (30) day grace period of the Premium due date (grace period does not apply to initial COBRA Premium); or

b) the date (after the date of COBRA election) on which the Member becomes covered under any other group health plan that does not exclude or limit coverage for pre-existing conditions affecting the Member; or

c) the date (after the date of COBRA election) on which the Member becomes entitled to Medicare benefits; or

d) the date on which the Member voluntarily terminates COBRA Coverage; or

e) the date on which the Member no longer permanently resides in the Service Area. Residing within the service area entails living inside the service area no less than 185 days of each year and complies with verification requests by the Plan.

Election Period

A Member must elect COBRA Coverage within the period beginning sixty (60) days prior to the date Coverage terminates by reason of a "qualifying event" and ending sixty (60) days after the date of the notice notifying the eligible person of the right to COBRA Coverage or the end of Coverage, whichever occurs last. Each Member is responsible for notifying the Plan of the occurrence of any "qualifying event" described above regarding divorce or legal separation or ceasing to qualify as a Dependent within sixty (60) days of the date of such "qualifying event" or the date on which the qualified beneficiary would lose Coverage because of the qualifying event, whichever is later. If the Member fails to provide such timely notice to the Plan, then such Member shall not be entitled to elect COBRA Coverage.

Cal-COBRA Coverage

The California Continuing Benefits Replacement Act (Cal-COBRA) requires an employer with nineteen (19) or fewer employees to provide for continuation of group coverage when certain events occur that would otherwise result in the loss of group coverage for its employees and/or their dependents.

In general, the Group is not subject to the provisions of Cal-COBRA because it is subject to COBRA. However, one provision of Cal-COBRA does apply to the Group. That provision requires the Group to provide additional group continuation coverage to certain employees and dependents who exhaust their Federal COBRA Coverage. The Plan provides this additional coverage for the Group under the terms of the Agreement.

You and/or your Dependents may be eligible for this additional coverage if you (or they) were entitled to less than thirty-six (36) months of COBRA Coverage, and elected and exhausted that coverage. If you are eligible for, and timely elect Cal-COBRA Coverage, you and/or your Dependents will receive coverage under Cal-COBRA for the number of additional months necessary to provide you with a total of thirty-six (36) months of group continuation coverage from and after the date your COBRA Coverage started.

You (and/or your Dependents) will not be eligible for Cal-COBRA Coverage under certain circumstances. Such circumstances include, but are not limited to:

- Termination of the Agreement.
- You are eligible for Medicare benefits.
- You do not Reside permanently in the Service Area.

In addition, Cal-COBRA Coverage may be terminated prior to the end of the extended coverage period under certain circumstances. Such circumstances include, but are not limited to:

- Your non-payment of Premiums or voluntary termination of Coverage.
- You become eligible for coverage from another health benefit plan that does not exclude coverage for a pre-existing condition that applies to you.

- The Agreement ends.
- You become eligible for Medicare benefits.

The Premium for your Cal-COBRA Coverage may be as high as one hundred ten percent (110%) of your COBRA Coverage Premium. The Plan will notify you of the terms and conditions of Cal-COBRA Coverage, and of the exact Premium for such Coverage, in its notice to you of the pending termination of your COBRA Coverage.

Extension of Continuation Coverage

You, your spouse and your former spouse may be entitled to extension of COBRA Coverage/Cal-COBRA Coverage under certain circumstances. If at the time of termination of employment or reduction in hours, or at any time during the first sixty (60) days of COBRA Coverage, you are determined to be disabled for Social Security purposes, and you meet certain other criteria, you may be entitled to COBRA Coverage/Cal-COBRA Coverage for up to thirty-six (36) months after the original qualifying event. Also, if you were at least sixty (60) years old when you stopped working for the Group, and worked for the Group for at least the five (5) years immediately preceding your last day of work, and you elected COBRA Coverage, then you may be entitled to up to an additional five (5) years of Senior COBRA Coverage/Cal-COBRA Coverage. Effective January 1, 2005, Senior COBRA will not be available to COBRA and Cal‑COBRA Members unless they qualified for Senior COBRA prior to January 1, 2005. Legislation (AB 254) enacted in 2004 amended Section 1373.621 of the Health & Safety Code and Section 10116.5 of the Insurance Code to eliminate Senior COBRA.

Extended COBRA Coverage/Cal-COBRA Coverage may be terminated prior to the end of the extension period on the occurrence of certain events. You may obtain complete information on extended COBRA Coverage/Cal-COBRA Coverage qualifying and termination events from the Member Services Department.

To extend COBRA Coverage/Cal-COBRA Coverage, you must notify the Plan in writing thirty (30) calendar days prior to the date the initial COBRA Coverage/Cal-COBRA Coverage is scheduled to end. You may obtain complete information on eligibility for, and the terms and conditions of, extension of COBRA Coverage/Cal-COBRA Coverage during total disability and after age sixty (60) from the Member Services Department.

The Premiums for extension of COBRA Coverage/Cal-COBRA Coverage during total disability or after age sixty (60) will be higher than Premiums payable during the initial COBRA Coverage/Cal-COBRA Coverage period. The Plan will provide you with detailed information on Premium amounts after the Plan receives all information required by the Plan for extension of COBRA Coverage/Cal-COBRA Coverage.

Deceased Peace Officers and Firefighters Survivor Benefit: Family members of a Subscriber who is a peace officer or firefighter killed in the line of duty, or who dies as the result of an accident or injury sustained in the performance of his or her duty, are entitled to continuing coverage as set forth in California Labor Code Section 4856.

Termination of the Group Agreement: If the Group terminates the Agreement and replaces it with similar coverage under another group contract within fifteen (15) days of the date of termination of the Group coverage or the Subscriber's participation, Coverage of all Members enrolled through the Group will terminate on the date the Agreement terminates. You will have no right to continue Coverage or to convert to (Individual) Conversion Coverage.

Appeal of Termination: If you or your Dependent believe that VCHCP failed to renew or canceled Coverage due to you or your Dependent's health status or requirement for health care services, you may request a review by the Director of the Department of Managed Health Care. If the Director finds that such a claim exists, the Director will notify VCHCP. Following notification, VCHCP has fifteen (15) days to request a hearing or reinstate you or your Dependent's Coverage. VCHCP shall be liable for any claims incurred from the date of cancellation or non-renewal to the date of reinstatement.

GENERAL PROVISIONS

Confidentiality of Medical Information: A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. This statement includes the following information: (a) A description of how VCHCP protects the confidentiality of medical information and that any disclosure beyond the provisions of law is prohibited. (b) A description of the types of medical information that may be collected, the sources used to collect the information, and the purposes for which medical information is collected from health care providers. (c) The circumstances under which medical information may be disclosed without prior Authorization as permitted by law. (d) How members may obtain access to copies of medical information created by and in the possession of the Plan or a contracting organization.

Medical information means any individually identifiable information, in electronic or physical form, regarding the individual's medical history, medical treatment and mental or physical condition to the types of individually identifiable information under the definition of medical treatment, or diagnosis by a health care professional, or mental health application information. This includes, but is not limited to, reproductive or sexual health application information.

Pursuant to Civil Code Section 56.109(a), VCHCP will not release medical information related to a person or entity allowing a child to receive gender-affirming health care or mental health care in response to any civil action, including a foreign subpoena, based on another state's law that authorizes a person to bring a civil action against a person or entity that allows a child to receive gender-affirming health care or mental health care.

VCHCP will not release medical information to persons or entities who have requested that information and who are authorized by law to receive that information pursuant to Civil Code § 56.10(c), if the information is related to a person or entity allowing a child to receive gender-affirming health care or mental health care, and the information is being requested pursuant to another state's law that authorizes a person to bring a civil action against a person or entity who allows a child to receive gender-affirming health care or mental health care.

As of July 1, 2022, all members have additional rights to medical confidentiality.

The confidential communication request shall be valid until the subscriber or enrollee submits a revocation of the request or a new confidential communication request is submitted.

The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication.

For the purposes of this section, a confidential communications request shall be implemented by the health care service plan within 7 calendar days of receipt of an electronic transmission or telephonic request or within 14 calendar days of receipt by first-class mail. The health care service plan shall acknowledge receipt of the confidential communications request and advise the subscriber or enrollee of the status of implementation of the request if a subscriber or enrollee contacts the health care service plan.

Any member may at any time request a confidential communication by telephone, fax, or mail to the following location.

Ventura County Health Care Plan
2220 E. Gonzales Road, Suite 210-B
Oxnard, CA 93036
Phone Number (805) 981-5050 or (800) 600-8247
Fax Number: (805) 981-5051
vchcp.memberservices@ventura.org

Notifying You of Changes in the Plan: VCHCP publishes a Member newsletter that the Plan distributes to all Subscribers. Subscribers will be informed of changes in the Benefit Plan which occur during the benefit year in this newsletter. Such changes may include, but are not limited to, changes in benefits or implementation of new State regulations for health care service plans licensed by the Department of Managed Health Care. The Plan will provide written notice of changes in Premiums at least thirty (30) days prior to the contract renewal effective date.

How Providers Are Compensated: Most In-Network Providers are paid on a fee-for-service basis. This means the Provider is paid according to the number of Covered Services provided to Members. Some In-Network Providers are paid an individual monthly capitation fee. This is a fixed amount that is paid to the Provider each month that is unrelated to the number of Covered Services provided to the Member. Monthly capitation fees paid to Providers do not include or depend on the cost or number of specialist referrals or pharmacy services.

Refunds: If your Coverage is terminated, Premiums received on account of you and your Dependents, applicable to periods after the effective date of termination, plus amounts due on claims, if any, less any amounts due to VCHCP or In-Network Providers, will be refunded within thirty (30) days and

neither VCHCP nor any In-Network Provider will have any further liability or responsibility under the Agreement.

Standing Committee Participation by Subscribers: VCHCP's Standing Committee includes Member representatives. If you wish to address the Committee at one of their regularly scheduled meetings, you must write to the Committee at VCHCP's address noted below. The Standing Committee will hear any matter of public policy related to the Plan. If you wish to become a member of the Standing Committee, please write to the Plan stating your request.

Ventura County Health Care Plan
2220 East Gonzales Road #210-B
Oxnard, CA 93036

MEMBER GRIEVANCE PROCEDURE

You may register complaints and file appeals with VCHCP by calling, writing, faxing, or completing the online grievance form at www.vchealthcareplan.org:

Ventura County Health Care Plan
2220 E. Gonzales Road, Suite 210-B
Oxnard, CA 93036
Phone Number (805) 981-5050 or (800) 600-8247
Fax Number: (805) 981-5051

The Member grievance procedure is designed to provide a meaningful, dignified and confidential process for the hearing and resolving of problems and complaints. VCHCP makes complaint forms available at its offices and provides complaint forms to each In-Network Provider. A Member may initiate a grievance in any form or manner (written, online, fax, email, form, letter, or telephone call to the Member Services Department). Enrollees may file a grievance within 180 calendar days following an incident or action that is the subject of the enrollee's dissatisfaction. When VCHCP is unable to distinguish between a complaint and an inquiry, the communication shall be considered a complaint that initiates the Member grievance procedure.

The Plan shall provide written acknowledgment of a Member's grievance within five (5) days of receipt. The Plan shall provide a written response to a grievance within thirty (30) days of receipt. If, however, the case involves an imminent and serious threat to the health of the Member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, the Plan shall provide an expedited review. The Plan shall provide a written statement on the disposition or pending status of a case requiring an expedited review no later than three (3) days from receipt of the grievance

In cases where it is medically necessary, the Plan may complete the review in less than 24 hours based upon the nature of the enrollee's medical condition. The Plan will notify the requesting physician by telephone or facsimile within 24 hours of making a decision and will notify the physician and enrollee in writing within two business days of making the determination.

If a grievance/complaint is received pertaining to a denial of services to a member with a terminal illness, the Plan shall provide the member with a statement setting forth the specific medical and scientific reasons for denying the coverage.

The Plan shall provide the member with a description of alternative treatments, services, and/or supplies covered by the Plan.

The member shall also within 5 days be provided with copies of the Plan's grievance procedures and complaint forms, with an offer to attend a conference with the Plan within 30 calendar days. The Plan shall make available a conference time within five (5) business days if the treating physician determines, after consultation with the health plan's medical director or his or her designee, based on standard medical practice, that the effectiveness of either the proposed treatment, services, or supplies or any alternative treatment, treatment, services, or supplies covered by the Plan, would be materially reduced if not provided at the earliest possible date.

VCHCP shall not cooperate with any inquiry or investigation by or providing medical information to, any individual, agency, or department from another state or, to the extent permitted by federal law, to a federal law enforcement agency that would identify an individual and that is related to an individual seeking or obtaining an abortion or abortion-related services that are lawful under the laws of California, unless the request for medical information is authorized under Civil Code Section 56.110.

RIGHT TO SUBMIT GRIEVANCE REGARDING CANCELLATION, RESCISSION, OR NONRENEWAL OF YOUR PLAN ENROLLMENT, SUBSCRIPTION, OR CONTRACT.

If you believe your health care coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a grievance with VCHCP and/or the Department of Managed Health Care (DMHC).

YOU MAY SUBMIT A GRIEVANCE TO VCHCP.

You may submit a grievance to VCHCP by calling (805) 981-5050 or (800) 647-8247 or online at http://www.vchealthcareplan.org/members/memberIndex.aspx, or by mailing your written grievance to 2220 E. Gonzales Road, Suite 210-B; Oxnard, CA 93036.

You may want to submit your grievance to VCHCP first if you believe your cancellation, rescission, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.

VCHCP will resolve your grievance or provide a pending status within three (3) calendar days. If you do not receive a response from VCHCP within three (3) calendar days, or if you are not satisfied in any way with VCHCP's response, you may submit a grievance to the Department of Managed Health Care as detailed under Option 2 below.

YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DEPARTMENT OF MANAGED HEALTH CARE (DMHC).

1. You may submit a grievance to the Department of Managed Health Care (DMHC) without first submitting it to VCHCP or after you have received VCHCP's decision on your grievance.

2. You may submit a grievance to the Department of Managed Health Care online at:

WWW.HEALTHHELP.CA.GOV

3. You may submit a grievance to the Department of Managed Health Care by mailing your written grievance to:

HELP CENTER

DEPARTMENT OF MANAGED HEALTH CARE

980 NINTH STREET, SUITE 500

SACRAMENTO, CALIFORNIA 95814-2725

4. You may contact the Department of Managed Health Care for more information on filing a grievance at:

PHONE: 1-888-466-2219

TDD: 1-877-688-9891

FAX: 1-916-255-5241

Continuation of Coverage

If you or your group contract holder files a grievance before the effective date of a cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, VCHCP shall continue to provide coverage to you pursuant to the terms of the plan contract while the grievance is pending with VCHCP and/or the DMHC.

During the period of continued coverage, the group remain responsible for paying premiums and any copayments, coinsurance, or deductible obligations as required under the contract.

If the DMHC determines the cancellation or nonrenewal for nonpayment of premiums is consistent with existing law, the cancellation date shall take effect the day after the last day of the grace period. Your group contract holder shall be responsible only for the required premium and cost sharing obligations incurred during the continued coverage period.

If the DMHC determines the rescission is consistent with existing law, VCHCP shall return all premiums paid. You and/or group are responsible for the cost of all medical services received after the effective date of the rescission.

Reinstatement of Coverage

If the DMHC determines the cancellation, rescission, or nonrenewal, including a cancellation for nonpayment of premium, does not comply with existing law, and You and/or your group contract holder submitted the grievance after the plan contract was cancelled, rescinded, or not renewed, VCHCP shall reinstate coverage, retroactive to the effective date of cancellation, rescission, or nonrenewal.

Within 15 days after receipt of the order for reinstatement, VCHCP shall either request an administrative hearing from the DMHC or reinstate coverage.

If the DMHC orders reinstatement, VCHCP shall be liable for the expenses incurred by You or the group for covered health care services, less any applicable deductibles, copayments, or coinsurance pursuant to the Evidence of Coverage, from the effective date of cancellation, rescission, or nonrenewal through the date of reinstatement. The plan shall reimburse You or group for any medical expenses incurred by You or group within 30 days of receipt of the complete claim.

The group shall be responsible for any and all premium payments accrued from the effective date of cancellation, rescission, or nonrenewal. The group must pay all outstanding premiums before reinstatement.

* Per Diem nurses, County Extra Help, and intermittent employees are NOT eligible for COBRA or Cal-COBRA.

You may file a complaint or grievance with VCHCP by calling (805) 981-5050 or (800) 600-8247, online by visiting http://www.vchealthcareplan.org/, or by writing to the Plan at:

Ventura County Health Care Plan
2220 E. Gonzales Rd #210-B
Oxnard, CA 93036

An optional DMHC complaint form is available at www.dmhc.ca.gov

For help, contact:

Help Center, DMHC
980 Ninth Street, Suite 500
Sacramento, CA 95814-2219
TDD: 1-877-688-9891
FAX: 1-916-255-5241
www.dmhc.ca.gov

There is no charge to call. Help is available in many languages.

Appealing a Mental/Behavioral Health or Substance Use Disorder Benefit Decision

Grievances pertaining to Mental/Behavioral Health or Substance Use Disorders provided by OptumHealth Behavioral Solutions should be directed to:

OptumHealth Behavioral Solutions of California
Attn: Appeals Department
P.O. Box 30512
Salt Lake City, UT 84130-0512
Or at the OptumHealth Behavioral Solutions website: www.liveandworkwell.com
Phone: (800) 985-2410

The individual initiating the appeal may submit written comments, documents, records, and any other information relating to the appeal regardless of whether this information was submitted or considered in the initial determination. The Member may obtain, upon request and free of charge, copies of all documents, records, and other information relevant to the Member's appeal. An individual, who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person, will review the appeal.

The Life Strategies/OHBS Medical Director (or designee) will review your appeal and make a determination within a reasonable period of time appropriate to the circumstances but not later than thirty (30) days after Life Strategies/OHBS's receipt of the appeal, except in the case of "expedited reviews" discussed below. For appeals involving the delay, denial, or modifications of Behavioral Health Services, Life Strategies/OHBS's written response will describe the criteria or guidelines used and the clinical reasons for its decision, including all criteria and clinical reasons related to Medical Necessity. For determinations delaying, denying, or modifying Behavioral Health Services based on a finding that the services are not Covered Services, the response will specify the provisions in the plan contract that exclude that coverage. If the complaint is related to quality of care, the complaint will be reviewed through the procedure described in the section of this *Combined Evidence of Coverage and Disclosure Form* titled **Member Grievance Procedure**.

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE

You may request an independent medical review ("IMR") of disputed health care services from the Department of Managed Health Care ("DMHC") if you believe that health care services have been improperly denied, modified, or delayed by the Plan. A "disputed health care service" is any health care service eligible for coverage and payment under the Agreement that has been denied, modified, or delayed by the Plan, in whole or in part because the service is not medically necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information

in support of the request for an IMR. The Plan must provide you with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the Plan regarding the disputed health care service.

Eligibility: Your application for IMR will be reviewed by the DMHC to confirm that:

1. a. Your Provider has recommended a health care service as medically necessary, or
   b. You have received Urgent Care or Emergency Care that a Provider determined was medically necessary, or
   c. You have been seen by an In-Network Provider for the diagnosis or treatment of the medical condition for which you seek independent review;
2. The disputed health care service has been denied, modified, or delayed by the Plan, based in whole or in part on a decision that the health care service is not medically necessary; **and**
3. You have filed a grievance with the Plan and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If your grievance requires expedited review, you may bring it immediately to the DMHC's attention. The DMHC may waive the requirement that you follow the Plan's grievance procedure in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical specialist who will make an independent determination of whether or not the case is medically necessary. You will receive a copy of the assessment made in your case. If the IMR determines the service is medically necessary, the Plan will provide the health care service.

For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within thirty (30) days of receipt of your application and supporting documents. For urgent cases involving imminent and serious threat to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three (3) business days.

For more information regarding the IMR process, or to request an application form, please contact the Plan's Member Services at (805) 981-5050 or (800) 600-8247.

INDEPENDENT MEDICAL REVIEW (EXPERIMENTAL/ INVESTIGATIONAL)

VCHCP provides eligible Members with the opportunity to seek an independent review (IMR) to examine the Plan's coverage decisions regarding experimental or investigational therapies. Only cases that meet all of the following criteria are eligible for IMR of the Plan's decision to deny provision of a health care service based on a finding that the requested health care service is experimental or investigational:

1. You have a life-threatening or seriously debilitating condition, as defined below;* and
2. Your Physician certifies that you have a condition for which standard therapies have not been effective in improving your condition, or for which standard therapies would not be medically appropriate for you, or for which there is no more beneficial standard therapy covered by VCHCP than the therapy proposed by your Physician; and
3. Either (a) your VCHCP Physician has recommended a drug, device, procedure or other therapy that he or she certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you, or your non-VCHCP Physician who is a licensed, board-certified or board-eligible Physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), cited in his/her certification, is likely to be more beneficial for you than any available standard therapy. VCHCP is not responsible for the payment of services rendered by non-VCHCP Physicians that are not otherwise covered under your VCHCP benefits; and
4. VCHCP has denied coverage for a drug, device, procedure, or other therapy recommended or requested by your Physician; and
5. The specific drug, device, procedure, or other therapy recommended by your Physician would be a Covered Service, except for VCHCP's determination that the treatment is experimental or investigational.

VCHCP will notify eligible Members in writing of the opportunity to request an IMR, within five (5) business days of its decision to deny coverage for experimental or investigational therapy. An application packet will accompany the Plan's notice. To request an IMR, mail the completed application to the DMHC in the pre-addressed envelope. You may also forward documentation, by facsimile or overnight mail to:

Department of Managed Health Care
HMO Help Center, IMR Unit
980 Ninth Street, Suite 500
Sacramento, CA 95814
(888) 466-2219, or fax (916) 255-5241; www.dmhc.ca.gov

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* **Life-threatening condition means either or both of the following: a) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted or b) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. Seriously debilitating means diseases or conditions that cause irreversible morbidity.**

You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for an IMR. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the Plan regarding the provision of denied health care services.

If the DMHC accepts your application for an IMR, the case will be submitted to an independent medical reviewer who shall base his or her determination on relevant medical and scientific evidence. For non-urgent cases, the IMR organization designated by the DMHC must provide its determination within thirty (30) days of receipt of your application and supporting documents. If your physician determines that the proposed course of treatment or therapy would be significantly less effective if not promptly initiated, the analysis and recommendation of the IMR organization will be rendered within seven (7) days of the request for expedited review. At the request of the expert, the deadline shall be extended by up to three (3) days for a delay in providing the documents required.

If the IMR recommends providing the proposed treatment or therapy, the Plan will provide the health care service. Coverage for the required services will be provided subject to the terms and conditions generally applicable to other benefits under your membership in VCHCP.

You are not required to seek review of the denial through the Plan's grievance system prior to applying for an IMR of an experimental or investigational therapy. However, you may also appeal the denial to the Plan. A Member with a life-threatening or seriously debilitating condition who is denied experimental therapy has an additional procedure available through the Plan's grievance system. The Member may request a conference with VCHCP's Medical Director to review the denial and the basis for determining that the recommended or requested treatment is experimental. If you request a conference, the conference will be held within thirty (30) days of VCHCP's receipt of your request unless your treating Physician determines, in agreement with VCHCP's Medical Director, based on standard medical practice, that the effectiveness of the proposed treatment would be materially reduced if not provided at the earliest possible date.

MEDIATION

You and your Dependents may request that an unresolved disagreement, dispute or controversy concerning any issue(s) including the provision of medical services, arising between you, and your Dependents, your heirs-at-law, or your personal representative, and VCHCP, its employees, In-Network Providers, or agents undergo voluntary mediation.

If you seek voluntary mediation, you must send written notice to VCHCP's Administrator (Ventura County Health Care Plan, 2220 East Gonzales Road #210-B, Oxnard, CA 93036) containing a request for mediation and a statement describing the nature of the dispute, including the specific issue(s) involved, the cost of services involved, the remedy sought, and a declaration that you have previously attempted to resolve the dispute with VCHCP through the established grievance procedure. VCHCP will agree to such reasonable request for mediation, if such request precedes both any registration of the unresolved dispute with the Department of Managed Health Care ("DMHC") and any request for

binding arbitration (both as described below). The use of mediation services shall not preclude the right to submit a grievance or complaint to the DMHC (as described below) upon completion of mediation.

REVIEW BY THE DEPARTMENT OF MANAGED HEALTH CARE

After participating in the grievance procedure for at least thirty (30) days, or less if you believe there is an imminent and serious threat to your health, including, but not limited to, severe pain, the potential loss of life, limb, or major bodily function, and the DMHC agrees there is such a threat to your health, or in any other case where the DMHC determines that an earlier review is warranted, you may register unresolved disputes for review and resolution by the DMHC. The following paragraph is displayed pursuant to Health and Safety Code Section 1368.02(b):

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at (**1-805-981-5050**) or toll-free at (**1-800-600-8247**) and for hearing impaired members: TDD to Voice (**1-800-735-2922**) for English or (**1-800-855-3000**) for Spanish and use your health plan's grievance procedure before contacting the department. 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 department 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. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

If the Member is a minor, or is incompetent or incapacitated, the parent, guardian, conservator, relative, or other designee of the Member, as appropriate, may submit the grievance or complaint to the DMHC as the agent of the Member. Further, a provider may join with, or otherwise assist, a Member, or the agent, to submit the grievance or complaint to the DMHC. In addition, following submission of the grievance or complaint to the DMHC, the Member, or the agent, may authorize the provider to assist, including advocating on behalf of the Member. A grievance or complaint may be submitted to the DMHC for review and resolution prior to arbitration.

BINDING ARBITRATION

Mandatory arbitration is the final process for the resolution of any dispute that may arise. As a condition of enrolling with VCHCP, you are agreeing to have any issue or dispute concerning the provision of services under the Agreement, including any issue of medical malpractice, decided by a neutral, independent arbitrator and you are giving up your right to a jury or court trial. Arbitration

shall be conducted according to the California Arbitration Act, Code of Civil Procedures, and 1280 et seq. This will apply to any controversy, as noted above, including and not limited to the Group, Member, family members (whether minors or adults), the heirs-at-law or personal representatives of a Member or family member or network providers (including any of their agents, employees or providers). Each party shall bear its/his own arbitration costs and attorney's fees, with the parties equally sharing the fees of one arbitrator, unless to do such would cause extreme hardship to the Member, as determined by the arbitrator. In the event of a determination of extreme hardship to the Member, the arbitrator shall determine that portion of the arbitrator's fees and the arbitration costs that shall be paid by the Member. The balance of such arbitration costs and arbitrator's fees shall be paid VCHCP. THE DECISION OF THE ARBITRATOR SHALL BE FINAL AND BINDING.

If you seek arbitration, you must send written notice to VCHCP's Administrator containing a demand for arbitration and a statement describing the nature of the dispute, including the specific issue(s) involved, the cost of services involved, the remedy sought, and a declaration that you have previously attempted to resolve the dispute with VCHCP through the established Grievance Procedure.

BEHAVIORAL HEALTH SERVICES BINDING ARBITRATION AND VOLUNTARY MEDIATION

If the Member is dissatisfied with the appeal, the Member may submit or request that Life Strategies/OHBS submit the appeal to voluntary mediation and/or binding arbitration before Judicial Arbitration and Mediation Service ("JAMS"). Such voluntary mediation or binding arbitration will be limited to claims that are not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

Voluntary Mediation – In order to initiate mediation, the Member or agent acting on behalf of the Member shall submit a written request for voluntary mediation. If the parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with JAMS Mediation Rules and Procedures, unless otherwise agreed to by the parties. Expenses for mediation shall be borne equally by the parties. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.

Binding Arbitration – Any and all disputes of any kind whatsoever, including, but not limited to, claims for medical malpractice (that is, as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) between Member (including any heirs, successors or assigns of Member) and Life Strategies/OHBS, except for claims subject to ERISA, shall be submitted to Binding Arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except to the extent the Federal Arbitration Act provides for judicial review of arbitration proceedings. Member and Life Strategies/OHBS further agree that neither the Court nor any arbitrator shall have the power to delay arbitration of any dispute or to refuse to order any dispute to arbitration, under any provision of Section 1281 et seq. of the California Code of Civil Procedure (including but not limited to 1281.2(c)), or any successor or replacement provision thereto, of any comparable provision of any other state law. Member and Life

Strategies/OHBS further specifically agree that any disputes about the scope of any arbitration or about the arbitration or about the arbitrability of any dispute shall be determined by the arbitrator.

Member and Life Strategies/OHBS are giving up their constitutional rights to have any such dispute decided in a court of law before a jury and are instead accepting the use of Binding Arbitration by a single arbitrator in accordance with the Comprehensive Rules of JAMS in effect at the time of the arbitration, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within 30 days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules of JAMS will be utilized.

Arbitration hearings shall be held in Orange County, California or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by California law and the Code of Civil Procedure. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by California law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship and to prevent any such hardship or unconscionability, Life Strategies/OHBS may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS and provided JAMS approves such application. The approval or denial of the hardship application will be determined solely by JAMS. The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision.

The requirement of Binding Arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action, including, but not limited to those seeking damages, restitution, or other monetary relief, shall be subject to Binding Arbitration as provided herein and any claim for permanent injunctive relief shall be stayed pending completion of the arbitration. The Federal Arbitration Act, 9 U.S.C.

Sections 1-16, shall also apply to the arbitration.

DEFINITIONS

The following terms are used in this document. These definitions will help you understand the Covered Services VCHCP will provide.

"Agreement" means the Group Benefit Agreement between Ventura County Health Care Plan and the Group, which details the terms and conditions for eligibility and enrollment, and the rights and responsibilities of the Members and VCHCP.

"Ancillary Services" means those Covered Services necessary to the diagnosis and treatment of Members, including but not limited to, ambulance, ambulatory or day surgery, durable medical equipment, imaging services, laboratory, pharmacy, mental health, physical or occupational therapy, Urgently Needed or Emergency Care, and other Covered Services customarily deemed ancillary to the care furnished by Primary Care Physicians or Specialist Physicians and provided to Members upon Referral.

"Appeal" means a process available to the patient, their family member, treating provider or authorized representative to request reconsideration of a previous adverse determination.

"Authorization" or **"Authorized"** means a utilization review determination made by or on behalf of VCHCP's Medical Director that specifies non-Emergency admission or Referral Covered Services to be provided, or Emergency Care that was provided to a Member, including the extent and duration to which such Covered Services, are or were Medically Necessary, and meets or met the other standards and criteria for Authorization established by VCHCP. The standards and criteria shall be consistent with professionally recognized standards of care prevailing in the community at the time of request for Authorization.

"Autism Spectrum Disorder" refers to a group of conditions that are chronic life-long conditions with no known cure. These conditions, including Autism, involve delays in the development of many basic skills, most notably the ability to socialize with others, to communicate, and to use imagination. Children with these conditions often are confused in their thinking and generally have problems understanding the world around them. Because these conditions typically are identified in children around 3 years of age - a critical period in a child's development - they are called development disorders. In addition to Autism, other conditions included in this category are Rett syndrome, childhood disintegrative disorder and Asperger's syndrome. *Source: Web MD.*

"Behavioral Health Treatment ("BHT")" means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with Autism Spectrum Disorder, and that meet all of the following criteria:

- The treatment is prescribed by a licensed participating physician and surgeon of the California Business and Professions Code or developed by a licensed Participating psychologist.
- The treatment is provided under a treatment plan prescribed by a Participating Qualified Autism Service Provider and is administered by one of the following:

- A Participating Qualified Autism Service Provider.
- A Participating Qualified Autism Service Professional supervised and employed by the Participating Qualified Autism Service Provider.
- A Participating Qualified Autism Service Paraprofessional supervised and employed by a Participating Qualified Autism Service Provider.
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Participating Qualified Autism Service Provider for the specific Member being treated. The treatment plan shall be reviewed no less than once every six months by the Participating Qualified Autism Service Provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the California Welfare and Institutions Code pursuant to which the Participating Qualified Autism Service Provider does all of the following:
  - Describes the Member's behavioral health impairments or developmental challenges that are to be treated.
  - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported.
  - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating Autism Spectrum Disorder.
  - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate. The treatment plan is not used for purposes of providing or for the reimbursement of respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to us upon request.

"Behavioral Health Treatment Plan" A written clinical presentation of the Life Strategies/OHBS Participating Provider's diagnostic impressions and therapeutic intervention plans. The Behavioral Health Treatment Plan is submitted routinely to Life Strategies/OHBS for review as part of the concurrent review monitoring process.

"Behavioral Health Treatment Program" A structured treatment program aimed at the treatment and alleviation of Substance and Related Addictive Disorders and/or Mental Disorders.

"Coinsurance" is your share of the costs of a health care service, usually figured as a percentage of the amount allowed to be charged for the service.

"**Combined Evidence of Coverage and Disclosure Form**" means the document issued to Subscribers which describes in summary the Coverage to which Members are entitled.

"**Consultation**" means the rendering of an opinion or advice, prescribing treatment, or the rendering of a decision regarding hospitalization or transfer by telephone or other means of communication. When determined to be Medically Necessary. This includes review of the patient's medical record, examination, and treatment of the patient in person by a consulting

provider who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient.

"**Copayment**" means any fixed fee charged by a Provider to a Member which is approved by the Director of the Department of Managed Health Care, provided for in an Agreement or VCHCP's Contract with an Individual Subscriber and disclosed in the applicable Combined Evidence of Coverage and Disclosure Form. This fee is usually paid when you receive the service.

"Cost Sharing" means the share of costs covered by your insurance that you pay out of your own pocket. This includes copays, coinsurance, or similar charges but doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services.

"Coverage" or "Covered Service" means those Medically Necessary health care services and supplies which a Member is eligible to receive from VCHCP upon enrollment in the Plan.

"Custodial Care" means domiciliary care, or rest cures, for which facilities and/or services of a general acute care hospital are not medically required. Custodial Care is care that does not require the regular services of trained medical or health professionals and that is designed primarily to assist in activities of daily living. Custodial Care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered. Custodial Care is not a Covered Service except when provided as part of Hospice Care.

"Day Treatment Center" means a Participating Facility which provides a specific Behavioral Health Treatment Program on a full or part-day basis pursuant to a written Behavioral Health Treatment Plan approved and monitored by a Life Strategies/OHBS Participating Practitioner and which is also licensed, certified, or approved to provide such services by the appropriate state agency.

"Dependent" means a person who is enrolled with VCHCP on the basis of that individual's family relationship with a Subscriber, in accordance with the provisions of the Agreement and this Combined Evidence of Coverage and Disclosure Form.

"Developmental Delay" means a delayed attainment of age-appropriate milestones in the areas of speech-language, motor, cognitive, and social development.

"Diagnosis and Statistical Manual (DSM)" means the diagnostic and Statistical Manual of Mental Disorders, which is published by the American Psychiatric Association and which contains the criteria for diagnosis of Mental Disorders and Substance and Related Addictive Disorders.

"Eligible Employee" means either of the following: (1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer's business and included as employees under a health care plan contract of a small employer, but does not include employees who work on a part-time, temporary, or

substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be eligible employees if all four of the following apply:

(A) They otherwise meet the definition of an eligible employee except for the number of hours worked.

(B) The employer offers the employees health coverage under a health benefit plan.

(C) All similarly situated individuals are offered coverage under the health plan.

(D) The employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter. The health care service plan may request any necessary information to document the hours and time period in question, including, but not limited to, payroll records and employee wage and tax filings.

"Employee" means a person employed by the County of Ventura or its clinics.

"Enrollee" means an individual who is enrolled and eligible for coverage under a health plan contract. Also called a "Member".

"Exigent Circumstance" means when an enrollee suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

"Grace Period" means the period of at least 30 consecutive days beginning the day the Notice of Start of Grace Period is dated.

"Habilitative Services" means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the plan contract.

"Health Benefit Plan" means a health care service plan contract that provides medical, hospital, and surgical benefits. The term does not include coverage of Medicare services pursuant to contracts with the United States Government, Medicare supplement coverage, or coverage under a specialized health care service plan contract

"Health Benefits" means health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, disease, or a health condition, including mental/behavioral health condition. It does not mean any cost sharing requirement such as copayments, coinsurance, or deductibles.

"Health Care Provider" means: a person who is licensed under Division 2 (commencing with Section 500) of the Business and Professions Code; an associate marriage and family therapist or

marriage and family therapist trainee functioning pursuant to Section 4980.43.3 of the Business and Professions Code, a qualified autism service provider or qualified autism service professional certified by a national entity pursuant to Section 10144.51 of the Insurance Code and Section 1374.73; an associate clinical social worker functioning pursuant to Section 4996.23.2 of the Business and Professions Code; an associate professional clinical counselor or professional clinical counselor trainee functioning pursuant to Section 4999.46.3 of the Business and Professions Code; a registered psychologist, as described in Section 2909.5 of the Business and Professions Code; a registered psychological assistant, as described in Section 2913 of the Business and Professions Code; a psychology trainee or person supervised as set forth in Section 2910 or 2911 of, or subdivision (d) of Section 2914 of, the Business and Professions Code.

"Health Care Team" means licensed nurse practitioners, certified physician assistants, certified non-physician-surgical assistants, physicians in residency training programs and nurses who work with and are supervised by Primary Care Physicians. This also includes Behavioral Health Therapy administered by a Qualified Autism Service (QAS) provider, a QAS professional, or a QAS paraprofessional.

"Inpatient Treatment Center" An acute care Participating Facility which provides Behavioral Health Services in an acute, inpatient setting, pursuant to a written Behavioral Health Treatment Plan approved and monitored by a Life Strategies/OHBS Participating Practitioner, and which also:

- provides 24-hour nursing and medical supervision; and
- is licensed, certified, or approved as such by the appropriate state agency.

"Life Strategies/OHBS Clinician" means a person licensed as a psychiatrist, psychologist, clinical social worker, marriage and family therapist, nurse, or other health care professional licensed, certified or otherwise authorized under California law with appropriate training and experience in Behavioral Health Services, who is employed or under contract with Life Strategies/OHBS related to managing Covered Behavioral Health Services.

"Life Strategies/OHBS Participating Practitioner" A psychiatrist, psychologist, or other allied behavioral health care professional who is qualified and duly licensed, certified, or otherwise authorized to practice his or her profession under the laws of the State of California and who has entered into a written agreement with Life Strategies/OHBS to provide Behavioral Health Services to Members.

"Limitation" means any provision of this Combined Evidence of Coverage and Disclosure Form which restricts Coverage other than an Exclusion.

"Medical Detoxification" means the medical treatment of withdrawal from alcohol, drug or other substance addiction is covered. In most cases of alcohol, drug or other substance abuse or toxicity, outpatient treatment is appropriate unless another medical condition requires treatment at an Inpatient Treatment Center.

"Medical Treatment" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms.

"Medically Necessary" means services or supplies which are determined by VCHCP to be (a) provided for the diagnosis or care and treatment of a medical condition; (b) appropriate and necessary for the symptoms, diagnosis or treatment of a medical condition, considering potential benefits and harm to the Member; (c) consistent with professionally recognized standards of care prevailing in the community at the time; and (d) not primarily for the convenience of a Member, his or her family, Physician, or other Provider.

"Medically Necessary Treatment of a Mental Health or Substance Use disorder" means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

1. in accordance with the generally accepted standards of mental health and substance use disorder care,

2. clinically appropriate in terms of type, frequency, extent, site, and duration, and

3. not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

"Member" means any person who is a Subscriber or Dependent as determined by VCHCP in accordance with the applicable eligibility requirements. Also, see "Enrollee".

"Mental Health and Substance Use Disorder" means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization's International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

"Observation" means care as an outpatient in the hospital setting for patients who are not well enough to go home but not sick enough to be admitted as inpatient.

"Out-of-Network Provider" means any health care provider that does not belong to the VCHCP provider network.

"Out-of-Pocket" means copayments, deductibles or fees paid by members for health services or prescriptions.

"Out-of-Pocket Maximum" means the most a plan member will pay per year for covered health expenses before the plan pays 100% of covered health expenses for the rest of that year.

"Outpatient Care" means any health care service provided to a patient who is not admitted to a facility. Outpatient care may be provided in a doctor's office, clinic, the patient's home or hospital outpatient department.

"Outpatient Treatment Center" means a licensed or certified Participating Facility which provides a Behavioral Health Treatment Program in an outpatient setting.

"Participating Qualified Autism Service Provider" means either of the following:

- A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for Autism Spectrum Disorder, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.
- A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech- language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the California Business and Professions Code, or as authorized under California law, who designs, supervises, or provides treatment for Autism Spectrum Disorder, provided the services are within the experience and competence of the licensee.

"Participating Qualified Autism Service Professional" means an individual who meets all of the following criteria:

- Provides Behavioral Health Treatment which may include clinical case management and case supervision under the direction and supervision of a Qualified Autism Service Provider.
- Is supervised by a Participating Qualified Autism Service Provider.
- Provides treatment pursuant to a treatment plan developed and approved by the Participating Qualified Autism Service Provider.
- Is a behavioral service provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program.
- Has training and experience in providing services for Autism Spectrum Disorder pursuant to Division 4.5 (commencing with Section 4500) of the California Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the California Government Code.
- Is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

"Participating Qualified Autism Service Paraprofessional" means an unlicensed and uncertified individual who as authorized under California law meets all of the following criteria:

- Is supervised by a Participating Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice.
- Provides treatment and implements services pursuant to a treatment plan developed and approved by the Participating Qualified Autism Service Provider.
- Meets education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations.
- Has adequate education, training, and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers.
- Is employed by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan.

"Physician" means a person duly licensed and qualified to practice medicine or osteopathy in the State of California.

"Plan or Benefit Year" means the twelve (12) month period commencing January 1st of each year at 12:00 a.m. and ending the same year at December 31st at 11:59 p.m. Group may set an alternate Plan Year with start and end dates encompassing one (1) year or less in duration.

"Post-Stabilization Care" means care given when your medical problem no longer requires Urgent or Emergent Care Services and your condition is stable.

"Premium" means amounts which must be paid to VCHCP each bi-week, quarter or month for or on behalf of each Subscriber and Dependent.

"Provider" means a Physician, nurse, pharmacist, psychologist, and other health care professional, pharmacy, hospital or other health care facility or entity, including, a provider of ancillary services, and a medical group engaged in the delivery of health care services. To the extent required, a Provider shall be licensed and/or certified according to Federal and/or State law.

"Provider Network" means a panel of providers contracted by VCHCP to deliver medical services to the Members.

"Qualified Beneficiary" means an individual who, on the day before the qualifying event, is a member in a group benefit plan offered by a health care service plan and has a qualifying event.

"Qualifying Event" means any of the following events that, but for the election of continuation coverage under this article, would result in a loss of coverage under the group benefit plan to a qualified beneficiary:

- The death of a covered employee
- The termination or reduction in a covered employee's hours of employment except for termination due to gross misconduct

- The divorce or legal separation of the covered employee from the covered employee's spouse
- The loss of the dependent status by a dependent enrolled in the group benefit plan
- With respect to the covered dependent only, the covered employee's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).

"Rehabilitative Services" means health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology and therapy, and psychiatric rehabilitative services in a variety of inpatient and/or outpatient settings.

"Reside/Residence" means living within the service area at least 185 days each calendar year. VCHCP reserves the right to request and obtain verification and compliance from the member and all dependents.

"Residential Treatment Center" means a residential facility that provides services in connection with the diagnosis and treatment of behavioral health conditions including but not limited to Mental Disorders and Substance and Related Addictive Disorders and which is licensed, certified, or approved as such by the appropriate state agency.

"Service Area" means the geographical area in which the Plan's network of health care providers provides Covered Services to Members. Ventura County is the geographical area that has been approved by the California Department of Managed Health Care**.**

"Small Group" means an employer that employs at last one but no more than 100 employees in a given calendar year.

"Specialist" or "Specialist Physician" means any licensed, board certified, board eligible or specially trained Physician who practices a specialty and who has entered, or is a party to, a written contract with VCHCP to deliver Covered Services to Members upon Referral, as Authorized by VCHCP's Medical Director, or his designee.

"Stabilization" means, with respect to an emergency medical condition, to provide such a medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer or discharge of the individual from one facility to another.

"**Subscriber**" means the person responsible for payment to VCHCP, or whose employment or other status, except for family dependency, is the basis for eligibility for membership in VCHCP.

"Substance and Related Addictive Disorder" means an addictive relationship between a Member and any drug, alcohol or chemical substance. Substance and Related Addictive Disorder does not include addiction to or dependency on tobacco in any form.

"Substance and Related Addictive Disorder Inpatient Treatment Program" means a structured medical and behavioral inpatient program aimed at the treatment and alleviation of Substance and Related Addictive Disorder.

"Substance and Related Addictive Disorder Services" means medically Necessary services provided for the diagnosis and treatment of Substance and Related Addictive Disorders.

"Telemedicine Services" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications. Interactive means real time or near real time two-way transfer of medical data and information. Telemedicine does not include a telephone conversation, nor does it include an electronic mail message.

"**Telemental Health"** means the provision of behavioral health services by a behavioral health provider via a secure two-way, real time interactive telecommunication system.

"Urgent Care" means prompt medical services are provided in a non-emergency situation. Examples of urgent care conditions include sore throats, ear infections, sprains, high fevers, vomiting and urinary tract infections. Urgent situations are not considered to be Emergency Medical Conditions.

"Urgently Needed Care" means any otherwise Covered Service necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member is able to see his or her PCP. This includes maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee is able to see her Provider.