Ventura County Health Care Plan

Medicare COB Plan

2013 - 14

Summary of

Benefits

Combined Evidence Of Coverage And Disclosure Form

Providing Health Care Coverage for County Employees and Their Families Since 1994

08/23/2013

VENTURA COUNTY HEALTH CARE PLAN

COMMERCIAL BENEFIT PLANS

COMBINED EVIDENCE OF COVERAGE & DISCLOSURE FORM

What's new since July 2013?

Transsexual surgery and related services are no longer excluded.

Member Rights have been expanded.

Grievances and Appeals for terminally ill members is further clarified.

Continuity of Care definition has been added to the Definition section.

TABLE OF CONTENTS

VENTURA COUNTY HEALTH CARE PLAN
MEDICARE "COORDINATION OF BENEFITS" BENEFIT PLAN
COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

INTRODUCTION

Welcome to Ventura County Health Care Plan (VCHCP or the Plan), Medicare Coordination of Benefits (COB) Plan, operated by the County of Ventura ("County"). As a Member who has elected to enroll with us, this Combined Evidence of Coverage and Disclosure Form discloses the terms and conditions of your/dependent(s) Coverage. You have a right to view this document prior to enrollment in the Plan. You should read this document completely and carefully. If you have special needs, you should read carefully those sections that apply to you.

This Combined Evidence of Coverage and Disclosure Form is a summary only. The County's Group Benefit Agreement with VCHCP should be consulted to determine governing contractual provisions. The Agreement is available for inspection upon request at VCHCP and at the County's benefits administration office.

To receive additional information about the benefits of the Plan, please call VCHCP at (805) 981-5050, or toll-free at (800) 600-8247. 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 facsimile at (805) 981-5051 or by sending written correspondence to Ventura County Health Care Plan, 2220 E. Gonzales Road, Suite 210-B, Oxnard, CA 93036.

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

VCHCP makes available to you and your family a comprehensive array of quality services to meet your health care needs. It is our goal to maintain you and your family in good health by providing necessary health care services and encouraging healthy lifestyles. To achieve this goal, VCHCP asks that you select a Primary Care Physician who will oversee your health care needs. Some of 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 nonphysician-surgical assistants, physicians in residency training programs, and nurses. In addition, we have contracted with Specialty Physicians, ancillary providers, and hospitals for all Covered Services. These Physicians, Providers, and hospitals are conveniently located to provide access to necessary health care services within Ventura County, the Plan's Service Area.

A Nurse Advice Line is available for your use when you have a need for medical advice. The telephone number is (800) 334-9023

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.

Information contained in this Combined Evidence of Coverage and Disclosure Statement is subject to approval by the Department of Managed Health Care, the Plan's regulating agency.

What's A Medicare COB Plan?

A Medicare Coordination of Benefits, or "COB", plan, is an individual health plan that coordinates the member's benefits with those available to them under the Medicare program. Often, when an employee in an employer-sponsored group health plan turns 65 and becomes Medicare eligible they are disenrolled from their group plan and must enroll in Medicare or in a Medicare Advantage health plan for their health care services. Those selecting original Medicare often purchase a "Medicare supplement" insurance policy to cover the cost of their deductibles and coinsurance. ***This is not a Medicare Supplement policy***. Another option can be original Medicare with a COB group plan, which would also cover the cost of the enrollee's Medicare deductibles and coinsurance minus any applicable copayments as defined in the Benefit Summary on pp. 10-12.

The advantage of a COB plan to the member is that it allows the member to continue to access the providers they were previously seeing under their pre-Medicare group coverage. Additionally, the member will have the same drug formulary as before, without having to separately purchase a Medicare Part D plan.

To participate in an employer-sponsored Medicare-eligible retiree plan, the retirees are required to enroll in both Medicare Parts A and B. Since Medicare pays first after the employee retires, coverage under a COB plan is similar to coverage under a Medigap (Medicare Supplement Insurance) policy. Unlike a supplement plan however, the COB plan may provide additional benefit coverage beyond Medicare, like coverage for extra days in the hospital.

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.

- For language services call (800) 774-4344.
- If you are deaf, hard of hearing or have a speech impairment, you may also receive language assistance services by calling TDD/TTY (800) 735-2929 for English (800) 855-3000 for Spanish.
- If you have a preferred language, please notify us of your personal language needs by calling VCHCP at (805) 981-5050.

You, as the Medicare eligible subscriber, may enroll yourself and your eligible dependents, in VCHCP, if you are in a Group that has an Agreement with VCHCP, and you have not been previously terminated from VCHCP due to fraud. 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, proof of Domestic Partner status, etc. 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 the County of Ventura. Your Group is required to inform its former employees of its eligibility requirements.

Service Area Eligibility Requirements: The Subscriber must live in our Service Area to be eligible for enrollment. The Service Area for VCHCP is Ventura County. The Definitions Section (beginning at page 36) 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. All health care coverage must be provided or arranged for in the Service Area by the Plan, except for Emergency and Urgently Needed Services.

Eligible Dependents: Eligible Dependents may include your spouse, Domestic Partner (as discussed below), and any dependent children under twenty-six (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.

Timely Dependent Enrollment: Any child born to you will be covered from the

newborn's date of birth, if you notify the Group by submitting a Health Plan Enrollment Form within thirty-one (31) days of birth. 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 thirty-one (31) days of adoption or placement or legal custody. A spouse and a spouse's child(ren) will be covered from the date of marriage, if you notify the Group by submitting a completed Health Plan Enrollment Form within thirty-one (31) 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 thirty-one (31) days of the loss of coverage. This thirty-one (31) day period is called your "special enrollment period".

Dependent Incapable of Self-Support: Coverage may be extended for Dependents twenty-six (26) years of age or older, who are incapable of self-support due to mental retardation or physical handicap. If the Dependent is enrolled in VCHCP on the date the Dependent reaches age twenty-six (26), you must provide VCHCP with evidence of the handicap within thirty-one (31) days of this date. If you enroll a Dependent over age twenty-six (26), you must provide evidence that you or your spouse has supported the Dependent due to mental retardation or physical handicap from the date the Dependent child reached age twenty-six (26) to the present, within thirty-one (31) days of enrollment in the Plan.

Domestic Partners: Enrollment of a Domestic Partner is available to a person who has officially registered with the State of California or with any other California county or municipality domestic partner registry listed at the San Francisco Human Right Commission Internet site www.ci.sf.ca.us 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, including, without limitation, the Dependent's living outside of the Service Area. 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 or first of the month after your enrollment forms are received by VCHCP, processed, and the first payroll deduction is taken. If you add Dependents during a special enrollment period (for example, within thirty-one (31) 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 processed and received by the Plan.

Renewal Provisions: The Agreement between the Group and VCHCP may be renewed for additional periods of twelve (12) calendar months. VCHCP reserves the right to change the Premium or other terms of the Agreement upon renewal or with forty-five (45) 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

Medicare Coordination of Benefits (COB

This Plan is a Medicare Coordination of Benefits Plan. Please note that you must enroll in Medicare Part A and Part B to be eligible for this Plan. For services and supplies covered under Medicare part A and Part B, claims are first submitted to the Medicare intermediary for determination and payment of allowable amounts. The Medicare intermediary then sends your medical care provider a Medicare Summary Notice (MSN).

In most cases, you will receive a notice from Medicare intermediary that they have received a claim from your provider. This notice will indicate (1) the amount that

Medicare paid to your provider, and (2) the balance due from you. You should forward a copy of this notice to VCHCP who will process this as a secondary claim. Based on the amount due as per the notice, VCHCP, as secondary payor, will pay the provider either all or a portion of the amount due according to the benefit coverage as described in this booklet. Your liability, if any, will be equal to the member cost share as shown in the benefit summary matrix in this booklet.

For example:

- You visit your PCP, who subsequently bills Medicare for the service.
- In this example, if the Medicare allowable fee is $100, then Medicare Part B pays $80. (80%), leaving a balance due of $20.
- In this example, the amount you pay the Doctor as your copay for this visit is $20.
- The remaining balance of $0 will be paid by VCHCP to the Doctor.

Choosing a Physician or Medical Group: When your Coverage becomes effective, VCHCP will ask you to select a Participating Primary Care Physician or medical group listed in the Plan's Provider Directory. You are required to contact your Primary Care Physician or medical group to access Coverage. Your Primary Care Physician 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 Referrals to Specialist Physicians, when appropriate, ordering x-ray and laboratory tests, prescribing medicines, and arranging for hospitalization. Some of 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 assistants, physicians in residency training programs, and nurses.

Can Medicare COB members utilize out of network doctors?

On the Medicare COB Plan, members do not assign their Medicare Parts A and B benefits over to VCHCP, preserving the portability of their basic Medicare benefits. However, should you utilize a non contracted physician or access services that are not coordinated through your primary care physician, you will be responsible for Medicare deductibles and co-insurance.

Changing Medical Groups or Primary Care Physicians: If you wish to change your Primary Care Physician or medical group, you may do so by contacting the Member Services Department. Changes will take effect on the day of your request. You may change your medical group or primary care physician as often you need.

Member Notification When a Physician Is No Longer Available: In the event your

Primary Care Physician ("PCP") is no longer available, 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*" on page 28 of this document.

Scheduling Appointments: Contact your Primary Care Physician or medical group to schedule appointments. You should expect to receive an appointment for Urgently Needed Services within forty-eight (48) hours, an appointment within ten to fifteen (10-15) business days for routine services, and an appointment within four (4) weeks for periodic health exams.

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. Your PCP must ask VCHCP for prior approval for Referrals to Covered services including Specialist Physicians (non applicable to Medicare eligible subscriber or Medicare eligible dependent). The Plan processes routine requests 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 information that is reasonably necessary and requested by the Plan to make the determination. 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 (non applicable to Medicare eligible subscriber or Medicare eligible dependent) received prior to or concurrent with the provision of services, the Plan faxes its written decision to your PCP within twenty-four (24) hours of making the decision. If the Plan first receives a request for authorization of services after the services are provided, we will notify you of our decision within thirty (30) days of our receipt of information that is reasonably necessary to make this determination. If the Plan cannot process your Provider's request within the specified time frame, you 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 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, without prior approval, from any Ventura County Medical Center clinic offering those services or from any private Provider contracted with the Plan to provide Direct Access OB/GYN Services. A Member may also seek maternity or gynecologic care directly from her Primary Care Physician. You may obtain a copy of VCHCP's Policy on Standing Direct Access to OB/GYN Services and a list of contracted Direct Access Providers by contacting Member Services.

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 obtain a copy of VCHCP's Policy on Standing Referral to a Specialist and a list of contracted Standing Referral Specialists by contacting the Plan's Member Services Department. Please see below for additional information.

Accessing Mental Health/Substance Abuse Services: Information on and authorization of Plan mental health and substance abuse benefits are available by calling Life Strategies/Optum Behavioral Health Solutions, the Plan's Behavioral Health Administrator (BHA), at (800) 851-7407. A Life Strategies/Optum Behavioral Health Solutions Representative is available twenty-four (24) hours-a-day to assist in emergency mental health or substance abuse care coordination. For non-emergency requests either you or your Primary Care Physician may contact Life Strategies/Optum Behavioral Health Solutions for the required Authorization (Authorization does not apply to Medicare eligible subscriber or Medicare eligible dependent) of benefits prior to seeking mental health and substance abuse care. Further information may also be obtained by consulting your Life Strategies Supplement to the Ventura County Health Care Plan Commercial Members Combined Evidence of Coverage and Disclosure Form.

Standing Referral to Specialty Care: You may receive a Standing Referral to a Specialist if your continuing care and recommended treatment plan is determined necessary by your Primary Care Physician, 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 Primary Care Physician with regular reports on the health care provided. Extended access to a Participating 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 Primary Care Physician or

Specialist.

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 Participating Physicians, pharmacies, hospitals, surgery centers, laboratory draw sites, imaging centers, and physical therapists. Primary Care Physicians are listed alphabetically by last name and under their medical group, with information about the practice location. Specialty Care Physicians are listed alphabetically by last name, by specialty, and by medical group, with information about practice locations. The Provider Directory does not list the names of Participating hospital-based physicians, 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 Participating mental health and substance abuse practitioners and treatment facilities by calling Life Strategies, the Plan's Behavioral Health Administrator, at (800) 851-7407, You may obtain the names, professional degrees, board certifications, and subspecialty qualifications of all of other Participating Providers by contacting the Plan's Member Services Department.

Second Medical Opinions: The Plan has a second opinion policy, under which second opinions will be authorized (Authorization does not apply to Medicare eligible subscriber or Medicare eligible dependent) for the following circumstances:

1. 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.

2. The Member questions the reasonableness or necessity of recommended surgical procedures.

3. 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 diagnosis.

4. 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.

5. 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.

6. Any other reasonable circumstance that is authorized by the Plan's Medical Director.

Second Opinion Referrals will be made to appropriately qualified health professionals, which means licensed health care providers who are acting within their scope of practice and who possess a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request. Unless authorized by the Plan, second opinion Referrals are limited to the Participating Providers if there is an appropriately qualified Provider under contract with the Plan. Please note that the Plan does **not** provide coverage for third opinions.

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

EMERGENCY AND URGENTLY NEEDED CARE

Definitions Related to Emergency and Urgently Needed Care: The following terms are located in the "Definitions" section of this document but are repeated here for your convenience.

"Emergency Care" is any otherwise Covered Service that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms (including symptoms of Severe Mental Illness and Serious Emotional Disturbances of a child), and believed that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger).
- His or her bodily functions, organs, or parts would become seriously damaged.
- His or her bodily organs or parts would seriously malfunction.

Emergency Care includes paramedic, ambulance and ambulance transport services provided through the 911 emergency response system.

Emergency Care also includes the treatment of severe pain or active labor.

Emergency Care also includes additional screening, examination and evaluation by a Physician (or other health care provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate such 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.

"Urgently Needed Care" is 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 returns to the Service Area. This includes maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the Member's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the Service Area.

What to Do When You Require Emergency or Urgently Needed Services: 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. Prior Authorization from the Plan or from your Primary Care Physician, however, is not required if you reasonably believe that an Emergency Medical Condition exists. The Plan has a 24/7 Nurse Advice Line at (800) 334-9023, to triage medical conditions which includes going to the emergency room/urgent care, if needed.

If you are treated at a facility other than the Ventura County Medical Center or Santa Paula Hospital, that facility must contact the Plan for prior Authorization if additional care is needed after your Emergency Medical Condition is stabilized. (Authorization does not apply to Medicare eligible subscriber or Medicare eligible dependent.) If your condition requires admission for inpatient care, you have the option to be transferred to the Ventura County Medical Center or Santa Paula Hospital.

If you are at an out-of-network facility and you require inpatient admission, once your condition has stabilized VCHCP has the option to transfer you to an in-network facility; if you refuse such transfer you will be financially responsible for services rendered.

Follow-up Care: After your medical problem (including Severe Mental Illness and Serious Emotional Disturbances of a Child) 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 your PCP, unless otherwise authorized by the Plan.

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 either to either one of the Ventura County Urgent Care Centers or to another Urgent Care center if more convenient. 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 a facility other than the Ventura County Medical Center or Santa Paula Hospital (Notification does not apply to Medicare eligible subscriber or Medicare eligible dependent.). If you feel that you were improperly billed for services that you received from a non-contracted provider, please contact VCHCP at (805) 981-5050.

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 Specialists, and for hospitalizations and certain other benefits. Exceptions to this policy are as follows:

- Exception to this policy does not apply to Medicare eligible subscriber or Medicare eligible dependent.
- Non-Emergency Covered Services may not be covered if obtained from Emergency Services Providers. For further information on Emergent Care and Follow-up Care, please see the discussion above in the Emergency And Urgently Needed Care Section
- Female Members may self-refer to an Obstetrician/Gynecologist ("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, and only if such benefits are Medically Necessary.
- Non-emergency services with a non-participating provider are covered only when such services have been pre-authorized by the Plan, or when the member requires care and the Plan cannot be directly notified, such as after hours, week-ends, and holidays. In the latter case, (Plan cannot be notified), 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.

- If you are admitted to an out-of-network facility as a result of an emergency medical condition, once your condition is stabilized VCHCP has the option to transfer you to an in-network; if you refuse such transfer, you will be financially responsible for services rendered.
- Emergency Contraception or the "Morning After" Pill: Female Members who require emergency contraception 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.

Ventura County Health Care Plan
Medicare COB Benefit Plan
Medical and Hospital Services

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.

TABLE GOES HERE

INTRODUCTION

Welcome to Ventura County Health Care Plan (VCHCP or the Plan), Medicare Coordination of Benefits (COB) Plan, operated by the County of Ventura ("County"). As a Member who has elected to enroll with us, this Combined Evidence of Coverage and Disclosure Form discloses the terms and conditions of your/dependent(s) Coverage. You have a right to view this document prior to enrollment in the Plan. You should read this document completely and carefully. If you have special needs, you should read carefully those sections that apply to you.

This Combined Evidence of Coverage and Disclosure Form is a summary only. The County's Group Benefit Agreement with VCHCP should be consulted to determine governing contractual provisions. The Agreement is available for inspection upon request at VCHCP and at the County's benefits administration office.

To receive additional information about the benefits of the Plan, please call VCHCP at (805) 981-5050, or toll-free at (800) 600-8247. 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 facsimile at (805) 981-5051 or by sending written correspondence to Ventura County Health Care Plan, 2220 E. Gonzales Road, Suite 210-B, Oxnard, CA 93036.

VCHCP makes available to you and your family a comprehensive array of quality services to meet your health care needs. It is our goal to maintain you and your family in good health by providing necessary health care services and encouraging healthy lifestyles. To achieve this goal, VCHCP asks that you select a Primary Care Physician who will oversee your health care needs. Some of 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 nonphysician-surgical assistants, physicians in residency training programs, and nurses. In addition, we have contracted with Specialty Physicians, ancillary providers, and hospitals for all Covered Services. These Physicians, Providers, and hospitals are conveniently located to provide access to necessary health care services within Ventura County, the Plan's Service Area.

A Nurse Advice Line is available for your use 24 hours a day, seven days a week when you have a need for medical advice. The telephone number is (800) 334-9023

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.

Information contained in this Combined Evidence of Coverage and Disclosure Statement is subject to approval by the Department of Managed Health Care, the Plan's regulating agency.

What's A Medicare COB Plan?

A Medicare Coordination of Benefits, or "COB", plan, is an individual health plan that coordinates the member's benefits with those available to them under the Medicare program. Often, when an employee in an employer-sponsored group health plan turns 65 and becomes Medicare eligible they are disenrolled from their group plan and must enroll in Medicare or in a Medicare Advantage health plan for their health care services. Those selecting original Medicare often purchase a "Medicare supplement" insurance policy to cover the cost of their deductibles and coinsurance. Another option can be original Medicare with a COB group plan, which would also cover the cost of the enrollee's Medicare deductibles and coinsurance.

The advantage of a COB plan to the member is that it allows the member to continue to access the providers they were previously seeing under their pre-Medicare group coverage. Additionally, the member will have the same drug formulary as before, without having to separately purchase a Medicare Part D plan.

To participate in an employer-sponsored Medicare-eligible retiree plan, the retirees are required to enroll in both Medicare Parts A and B. Since Medicare pays first after the employee retires, coverage under a COB plan is similar to coverage under a Medigap (Medicare Supplement Insurance) policy. Unlike a supplement plan however, the COB plan may provide additional benefit coverage beyond Medicare, like coverage for extra days in the hospital.

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.

- For language services call (800) 774-4344.
- If you are deaf, hard of hearing or have a speech impairment, you may also receive language assistance services by calling TDD/TTY (800) 735-2929 for English (800) 855-3000 for Spanish.

- If you have a preferred language, please notify us of your personal language needs by calling VCHCP at (805) 981-5050.

You, as the Medicare eligible subscriber, may enroll yourself and your eligible dependents, in VCHCP, if you are in a Group that has an Agreement with VCHCP, and you have not been previously terminated from VCHCP due to fraud. 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, proof of Domestic Partner status, etc. 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 the County of Ventura. Your Group is required to inform its former employees of its eligibility requirements.

Service Area Eligibility Requirements: The Subscriber must live in our Service Area to be eligible for enrollment. The Service Area for VCHCP is Ventura County. The Definitions Section (beginning at page 36) 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. All health care coverage must be provided or arranged for in the Service Area by the Plan, except for Emergency and Urgently Needed Services.

Eligible Dependents: Eligible Dependents may include your spouse, Domestic Partner (as discussed below), and any dependent children under twenty-six (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.

Timely Dependent Enrollment: Any child born to you will be covered from the newborn's date of birth, if you notify the Group by submitting a Health Plan Enrollment Form within thirty-one (31) days of birth. 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 thirty-one (31) days of adoption or placement or legal custody. A spouse and a spouse's child(ren) will be covered from the date of marriage, if you notify the Group by submitting a completed Health Plan Enrollment Form within thirty-one (31) 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 thirty-one (31) days of the loss of coverage. This thirty-one (31) day period is called your "special enrollment period".

Dependent Incapable of Self-Support: Coverage may be extended for Dependents twenty-six (26) years of age or older, who are incapable of self-support due to mental retardation or physical handicap. If the Dependent is enrolled in VCHCP on the date the Dependent reaches age twenty-six (26), you must provide VCHCP with evidence of the handicap within thirty-one (31) days of this date. If you enroll a Dependent over age twenty-six (26), you must provide evidence that you or your spouse has supported the Dependent due to mental retardation or physical handicap from the date the Dependent child reached age twenty-six (26) to the present, within thirty-one (31) days of enrollment in the Plan.

Domestic Partners: Enrollment of a Domestic Partner is available to a person who has officially registered with the State of California or with any other California county or municipality domestic partner registry listed at the San Francisco Human Right Commission Internet site www.ci.sf.ca.us 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, including, without limitation, the Dependent's living outside of the Service Area. 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 or first of the month after your enrollment forms are received by VCHCP, processed, and

the first payroll deduction is taken. If you add Dependents during a special enrollment period (for example, within thirty-one (31) 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 processed and received by the Plan.

Renewal Provisions: The Agreement between the Group and VCHCP may be renewed for additional periods of twelve (12) calendar months. VCHCP reserves the right to change the Premium or other terms of the Agreement upon renewal or with forty-five (45) 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

Medicare Coordination of Benefits (COB

This Plan is a Medicare Coordination of Benefits Plan. Please note that you must enroll in Medicare Part A and Part B to be eligible for this Plan. For services and supplies covered under Medicare part A and Part B, claims are first submitted to the Medicare intermediary for determination and payment of allowable amounts. The Medicare intermediary then sends your medical care provider a Medicare Summary Notice (MSN).

In most cases, you will receive a notice from Medicare intermediary that they have received a claim from your provider. This notice will indicate (1) the amount that Medicare paid to your provider, and (2) the balance due from you. You should forward a copy of this notice to VCHCP who will process this as a secondary claim. Based on the amount due as per the notice, VCHCP, as secondary payor, will pay the provider either all or a portion of the amount due according to the benefit coverage as described in this booklet. Your liability, if any, will be equal to the member cost share as shown in the benefit summary matrix in this booklet.

For example:

- You visit your PCP, who subsequently bills Medicare for the service.

- In this example, if the Medicare allowable fee is $100, then Medicare Part B pays $80. (80%), leaving a balance due of $20.
- In this example, the amount you pay the Doctor as your copay for this visit is $20.
- The remaining balance of $0 will be paid by VCHCP to the Doctor.

Choosing a Physician or Medical Group: When your Coverage becomes effective, VCHCP will ask you to select a Participating Primary Care Physician or medical group listed in the Plan's Provider Directory. You are required to contact your Primary Care Physician or medical group to access Coverage. Your Primary Care Physician 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 Referrals to Specialist Physicians, when appropriate, ordering x-ray and laboratory tests, prescribing medicines, and arranging for hospitalization. Some of 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 assistants, physicians in residency training programs, and nurses.

Can Medicare COB members utilize out of network doctors?

On the Medicare COB Plan, members do not assign their Medicare Parts A and B benefits over to VCHCP, preserving the portability of their basic Medicare benefits. However, should you utilize a non contracted VCHCP physician or access services that are not coordinated through your primary care physician, you will be responsible for Medicare deductibles and co-insurance.

Changing Medical Groups or Primary Care Physicians: If you wish to change your Primary Care Physician or medical group, you may do so by contacting the Member Services Department. Changes will take effect on the day of your request. You may change your medical group or primary care physician as often you need.

Member Notification When a Physician Is No Longer Available: In the event your Primary Care Physician ("PCP") is no longer available, 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*" on page 28 of this document.

Scheduling Appointments: Contact your Primary Care Physician or medical group to schedule appointments. You should expect to receive an appointment for Urgently

Needed Services within forty-eight (48) hours, an appointment within ten to fifteen (10-15) business days for routine services, and an appointment within four (4) weeks for periodic health exams.

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. Your PCP must ask VCHCP for prior approval for Referrals to Covered services including Specialist Physicians (non applicable to Medicare eligible subscriber or Medicare eligible dependent). The Plan processes routine requests 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 information that is reasonably necessary and requested by the Plan to make the determination. 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 (non applicable to Medicare eligible subscriber or Medicare eligible dependent) received prior to or concurrent with the provision of services, the Plan faxes its written decision to your PCP within twenty-four (24) hours of making the decision. If the Plan first receives a request for authorization of services after the services are provided, we will notify you of our decision within thirty (30) days of our receipt of information that is reasonably necessary to make this determination. If the Plan cannot process your Provider's request within the specified time frame, you 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 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, without prior approval, from any Ventura County Medical Center clinic offering those services or from any private Provider contracted with the Plan to provide Direct Access OB/GYN Services. A Member may also seek maternity or gynecologic care directly from her Primary Care Physician. You may obtain a copy of VCHCP's Policy on Standing Direct Access to OB/GYN Services and a list of contracted Direct Access Providers by contacting Member Services.

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 obtain a copy of VCHCP's Policy on Standing Referral to a Specialist and a list of contracted Standing Referral Specialists by contacting the Plan's Member Services Department. Please see below for additional information.

Accessing Mental Health/Substance Abuse Services: Information on and authorization of Plan mental health and substance abuse benefits are available by calling Life Strategies/Optum Behavioral Health Solutions, the Plan's Behavioral Health Administrator (BHA), at (800) 851-7407. A Life Strategies/Optum Behavioral Health Solutions Representative is available twenty-four (24) hours-a-day to assist in emergency mental health or substance abuse care coordination. For non-emergency requests either you or your Primary Care Physician may contact Life Strategies/Optum Behavioral Health Solutions for the required Authorization (Authorization does not apply to Medicare eligible subscriber or Medicare eligible dependent) of benefits prior to seeking mental health and substance abuse care. Further information may also be obtained by consulting your Life Strategies Supplement to the Ventura County Health Care Plan Commercial Members Combined Evidence of Coverage and Disclosure Form.

Standing Referral to Specialty Care: You may receive a Standing Referral to a Specialist if your continuing care and recommended treatment plan is determined necessary by your Primary Care Physician, 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 Primary Care Physician with regular reports on the health care provided. Extended access to a Participating 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 Primary Care Physician or Specialist.

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 Participating Physicians, pharmacies, hospitals, surgery centers, laboratory draw sites, imaging centers, and physical therapists. Primary Care Physicians are listed alphabetically by last name and under their medical group, with information about the practice location. Specialty Care

Physicians are listed alphabetically by last name, by specialty, and by medical group, with information about practice locations. The Provider Directory does not list the names of Participating hospital-based physicians, 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 Participating mental health and substance abuse practitioners and treatment facilities by calling Life Strategies, the Plan's Behavioral Health Administrator, at (800) 851-7407, You may obtain the names, professional degrees, board certifications, and subspecialty qualifications of all of other Participating Providers by contacting the Plan's Member Services Department.

Second Medical Opinions: The Plan has a second opinion policy, under which second opinions will be authorized (Authorization does not apply to Medicare eligible subscriber or Medicare eligible dependent) for the following circumstances:

1. 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.

2. The Member questions the reasonableness or necessity of recommended surgical procedures.

3. 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 diagnosis.

4. 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.

5. 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.

6. Any other reasonable circumstance that is authorized by the Plan's Medical Director.

Second Opinion Referrals will be made to appropriately qualified health professionals, which means licensed health care providers who are acting within their scope of practice and who possess a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request. Unless authorized by the Plan, second opinion Referrals are limited to the Participating Providers if there is an appropriately qualified Provider under contract with the Plan. The Plan

provides no coverage for third opinions.

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

EMERGENCY AND URGENTLY NEEDED CARE

Definitions Related to Emergency and Urgently Needed Care: The following terms are located in the "Definitions" section of this document but are repeated here for your convenience.

"Emergency Care" is any otherwise Covered Service that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms (including symptoms of Severe Mental Illness and Serious Emotional Disturbances of a child), and believed that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger).
- His or her bodily functions, organs, or parts would become seriously damaged.
- His or her bodily organs or parts would seriously malfunction.

Emergency Care includes paramedic, ambulance and ambulance transport services provided through the 911 emergency response system.

Emergency Care also includes the treatment of severe pain or active labor.

Emergency Care also includes additional screening, examination and evaluation by a Physician (or other health care provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate such 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.

"Urgently Needed Care" is 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 returns to the Service Area. This includes maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the Member's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee returns to the Service Area.

What to Do When You Require Emergency or Urgently Needed Services: 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. Prior Authorization from the Plan or from your Primary Care Physician, however, is not required if you reasonably believe that an Emergency Medical Condition exists. The Plan has a 24/7 Nurse Advice Line at (800) 334-9023, to triage medical conditions which includes going to the emergency room/urgent care, if needed.

If you are treated at a facility other than the Ventura County Medical Center or Santa Paula Hospital, that facility must contact the Plan for prior Authorization if additional care is needed after your Emergency Medical Condition is stabilized. (Authorization does not apply to Medicare eligible subscriber or Medicare eligible dependent.) If your condition requires admission for inpatient care, you have the option to be transferred to the Ventura County Medical Center or Santa Paula Hospital.

If you are at an out-of-network facility and you require inpatient admission, once your condition has stabilized VCHCP has the option to transfer you to an in-network facility; if you refuse such transfer you will be financially responsible for services rendered.

Follow-up Care: After your medical problem (including Severe Mental Illness and Serious Emotional Disturbances of a Child) 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 your PCP, unless otherwise authorized by the Plan.

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 either to either one of the Ventura County Urgent Care Centers or to another Urgent Care center if more convenient. 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 a facility other than the Ventura County Medical Center or Santa Paula Hospital (Notification does not apply to Medicare eligible subscriber or Medicare eligible dependent.). If you feel that you were improperly billed for services that you received from a non-contracted provider, please contact VCHCP at (805) 981-5050.

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 Specialists, and for hospitalizations and certain other benefits. Exceptions to this policy are as follows:

- Exception to this policy does not apply to Medicare eligible subscriber or Medicare eligible dependent.
- Non-Emergency Covered Services may not be covered if obtained from Emergency Services Providers. For further information on Emergent Care and Follow-up Care, please see the discussion above in the Emergency And Urgently Needed Care Section
- Female Members may self-refer to an Obstetrician/Gynecologist ("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, and only if such benefits are Medically Necessary.
- Non-emergency services with a non-participating provider are covered only when such services have been pre-authorized by the Plan, or when the member requires care and the Plan cannot be directly notified, such as after hours, week-ends, and holidays. In the latter case, (Plan cannot be notified), 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.
- If you are admitted to an out-of-network facility as a result of an emergency medical condition, once your condition is stabilized VCHCP has the option to transfer you to an in-network; if you refuse such transfer, you will be financially responsible for services rendered.
- Emergency Contraception or the "Morning After" Pill: Female Members who require emergency contraception 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.

Ventura County Health Care Plan
Medicare COB Benefit Plan
Medical and Hospital Services

SUMMARY OF COVERED SERVICES AND SUPPLIES

This section describes your Plan Benefits. These Benefits are subject to the Exclusions and Limitations in the following sections and the Copayments and maximums listed in the Benefit Summary and applicable Optional Benefit Riders.

Hospitals and Other Healthcare Facilities

(A) Inpatient Services

General hospital services, in a room of two or more, with customary furnishings and equipment, meals (including special diets as medically necessary), and general nursing care. All medically necessary ancillary services such as: use of operating room and related facilities; intensive care unit and services; drugs, medications, and biologicals; anesthesia and oxygen; diagnostic laboratory and x-ray services; special duty nursing as medically necessary; physical, occupational, and speech therapy, respiratory therapy; administration of blood and blood products; other diagnostic, therapeutic and rehabilitative services as appropriate; and coordinated discharge planning, including the planning of such continuing care as may be necessary. The costs of processing and transporting self-donated (autologous), donor-directed or donor-designated blood transfusions are covered when used for an authorized procedure that has been scheduled.

Exclusions: Personal or comfort items or a private room in a hospital are excluded unless medically necessary.

(B) Outpatient Services:

The following outpatient services are covered:

1. Emergency Room Services

All medically necessary Emergency Services provided by a hospital emergency room in the Service Area, and in a hospital emergency room or urgent care facility outside the Service Area, are covered when the illness or injury meets Plan's "Emergency and Urgently Needed Services" definition. The Emergency Services copayment is waived if Member is admitted to hospital directly from its emergency room.

2. Other Outpatient Services

Participating hospital services and supplies authorized by the Plan and performed by a hospital or outpatient facility, such as outpatient surgery, radiology, pathology, cardiology, hemodialysis and other diagnostic services, required for treatment excluding prescription drugs and take-home supplies, are covered.

Professional Services

Medically necessary professional services and consultations by a physician or other licensed health care provider acting within the scope of his or her license. In the case of those surgical procedures known as mastectomies and lymph node dissections, it shall be the attending physician and surgeon, using sound clinical principles and processes and in consultation with the patient, who determine the length of a hospital stay associated with those procedures. Nor shall such determination require prior approval from the Plan. Surgery, assistant surgery and anesthesia (inpatient or outpatient); inpatient hospital and skilled nursing facility visits; professional office visits including visits for allergy tests and treatments, radiation therapy, chemotherapy, and dialysis treatment; and home visits when medically necessary. In addition, professional services include:

Allergy testing and treatment, including the cost of allergy serum.

Diagnostic testing and supplies including laboratory, radiology, diagnostic imaging, and other services.

Cancer Clinical Trial

Clinical trials are research studies in which patients help doctors find ways to improve health and cancer care. A cancer clinical trial is one of the final stages of a long and careful cancer research process. Studies are done with cancer patients to find out whether promising approaches to cancer prevention, diagnosis, and treatment are safe and effective.

Clinical trials vary with the type of study being conducted. The following are the

different types of cancer clinical trials:

- ï Treatment trials test new treatments, such as a new cancer drug, new approaches to surgery or radiation therapy, new combinations of treatments, or new methods such as gene therapy.
- ï Prevention trials test new approaches, such as medications, vitamins, minerals, or other supplements that doctors believe may lower the risk of a certain type of cancer.
- ï Screening trials test the best way to find cancer, especially in its early stages.
- ï Quality of life trials (also called supportive care trials) explore ways to improve comfort and quality of life for cancer patients.

For a member diagnosed with cancer and accepted into a phase I, II, III, or IV clinical trial for cancer, the Ventura County Health Care Plan covers routine patient care costs in clinical trials according to the limitations outlined below, which are consistent with HCFA policy.

VCHCP covers routine patient care for patients in clinical trials in the same way that it reimburses routine care for patients not in clinical trials. ALL of the following limitations apply to such coverage:

1. To qualify, a clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled. Providers will not routinely be required to submit documentation about the trial to VCHCP, but VCHCP can, at any time, request such documentation to confirm that the clinical trial meets current standards for scientific merit and has the relevant IRB approval(s); and
2. The member's treating physician has determined that participation in the trial has a meaningful potential to benefit the member; and
3. Members must meet all applicable plan requirements for pre-authorization, registration, and referrals; and
4. All applicable plan limitations for coverage of out-of-network care will apply to routine patient care costs in clinical trials; and
5. 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; and
6. All utilization management rules and coverage policies that apply to routine care for patients not in clinical trials will also apply to routine patient care for patients in clinical trials.

Routine patient care costs are costs for health care services that would occur and be covered if the member was receiving standard treatment through the health plan system. Routine costs include regular office visits, medications, items and devices, normal radiological or diagnostic testing services, hospital stays, services required for the provision of the medication, device or medical treatment being tested in the clinical trial,

clinically appropriate monitoring of the effects of the medication, device or treatment being tested, and any reasonable and necessary care for the prevention of complications. In addition, VCHCP will cover costs of treating conditions that result as unintended consequences (complications) of clinical trials.
The following clinical trial costs are not eligible for coverage:

1. The experimental intervention itself is not covered (except for certain pre-approved "investigational devices"), certain promising interventions for patients with terminal illnesses, and other clinical trials meeting specified criteria;
2. Medications or devices not approved by the Food and Drug Administration (FDA);
3. Costs of data collection and record keeping that would not be required but for the clinical trial;
4. Other services to clinical trial participants necessary solely to satisfy data collection needs of the clinical trial (i.e., "protocol-induced costs");
5. 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;
6. Travel, housing, companion expenses and other non-clinical expenses;
7. Health care services that would normally be excluded are provided only as a result of the member's participation in the clinical trial;
8. Items and services generally made available by the trial sponsor without charge.

VCHCP members participating in clinical trials must continue to seek care for primary health care services from their primary care physician (PCP) or specialist.

Durable Medical Equipment

(A) Durable Medical Equipment (DME) is covered when provided by a Participating Provider and authorized by the Plan. DME means Medically Necessary physical accessories designed to serve a repeated medical purpose and appropriate for use in VCHCP Member's home. DME that is primarily for the personal convenience of VCHCP Member or caretaker is not covered. Plan reserves the right to determine if the DME services will be purchased or rented. If rented, the member must contact the Plan (or supplier) to return the device when it is no longer medically necessary. Coverage is limited to the least expensive device which the Plan determines to be medically necessary.

(B) See Benefit Exclusions section for non-covered DME items.

Education and Health Promotion

(A) Information at no charge on the following services: Health education services including personal health behavior, health care services, blood pressure management, smoking cessation, cholesterol management, stress management, childbirth preparation, breast-feeding, and risk factor reduction.

(B) Diabetes outpatient self-management training, education, and medical nutrition therapy, by an appropriately licensed or registered health care professional, necessary to enable a Member to properly use the equipment, supplies, and medications covered by the Plan. Additional visits

with Plan Authorized referral from a Participating Physician. 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. Subject to the copayment of a physician office visit.

Nurses, and home health aides; physical, occupational and speech therapy; and respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure. Home health services are limited to those services that are prescribed or directed by the attending physician or other appropriate authority designated by the plan. 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. VCHCP exercises prudent medical case management to ensure that appropriate care is rendered in the appropriate setting. Medical case management may include consideration of whether a particular service or setting is cost-effective when there is a choice among several medically appropriate alternative services or settings.

Visits on a part-time intermittent basis to VCHCP Member for the usual and customary skilled service(s) during each visit not to exceed a combined total of three (3) visits per day at a maximum of two (2) hours per visit for all types of providers, except home health aides, including:

(A) Skilled nursing services provided by a licensed registered or vocational nurse.

(B) Physical, Occupational, Speech and other rehabilitation therapy services. Subject to the rehabilitation therapy benefits described in Item #(20) of this Section: "*Physical, Speech, and Occupational Therapy Services*" (see page 19).

(C) Non-custodial home health aid services furnished by a licensed home health aide. Four hours or less is counted as one visit.

(D) Counseling and other mental health services as described in Item # (12) of this Section: "*Mental Health and Alcohol/Substance Abuse Services*" (see page 17). Subject to copayments.

Exclusions: Custodial care, except when provided as part of Hospice care.

Hospice Care

Hospice care is available for Members diagnosed as terminally ill by a Plan Physician. To be considered terminally ill, a Member must have been given a medical prognosis of one year or less to live.

Members with a terminally ill diagnosis will be provided with the following services, at a minimum, when the member qualifies for and chooses hospice care:

(A) Interdisciplinary team care with development and maintenance of an appropriate plan of care.

(B) Skilled nursing services, certified home health aide services, and homemaker services under the supervision of a qualified registered nurse.

(C) Bereavement Services.

(D) Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, shall also be provided when needed.

(E) Medical direction with the medical director being also responsible for meeting the general medical needs of the enrollees to the extent that these needs are not met by the attending physician.

(F) Volunteer services.

(G) Short-term inpatient care arrangements: Five consecutive days, maximum 14 days per calendar year.

(H) Pharmaceuticals, medical equipment and supplies are covered to the extent reasonable and necessary for the palliation and management of terminal illness and related conditions.

(I) Physical therapy, occupational therapy, and speech-language pathology services are covered services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.

VCHCP will make covered services available on a 24-hour basis to the extent necessary to meet the needs of individuals, for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions.

Immunizations and Injections

Immunizations and injections, professional services to inject the medications and the medications that are injected are covered.
Member physicians will provide immunizations that are recommended by guidelines published by the Advisory committee on Immunizations Practices (ACIP) of the U.S. Public Health Services or the American Academy of Pediatrics (AAP), if those Immunizations are covered by MediCare.

Medical Supplies and Equipment

Ostomy and other medical supplies to support and maintain gastrointestinal, bladder, or respiratory function, and medical supplies needed to operate home medical equipment, prostheses, and orthoses are covered when appropriately authorized.
Disposable insulin needles and syringes, pen delivery systems, diabetic testing supplies, including lancets, lancet puncture devices, blood and urine testing strips, and test tablets are covered by the Outpatient Prescription Medication benefit. No prescription is required by law for pen delivery systems (prior authorization is required) or diabetic supplies; however, in order to be covered by the Outpatient Prescription Medication benefit, the member's physician must order them. Medications and diabetic supplies must be ordered by the Member's Participating Physician and be listed in the Plan's Preferred Drug List. Non-prescription (over-the-counter) medical equipment or supplies that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a

prescription order for a non-prescription item, are not covered under this benefit plan except as specifically provided under Home Health Care Services, Hospice Care, Durable Medical Equipment, Prosthetic and Orthotic Services, or otherwise provided.

Medical Transportation Services

Medical transportation 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) Non-emergency transportation for a Plan-requested transfer or upon prior Authorization of the Plan upon certification of the Participating Provider that the Member must be transported in an ambulance because other means of transportation are medically contraindicated.

Mental Health and Alcohol/Substance Abuse Services

(Additional information may be obtained by consulting your Optum Behavioral Health Solutions Supplement to the Ventura County Health Care Plan Commercial Members Combined Evidence of Coverage and Disclosure Form.)

(A) Inpatient psychiatric, acute inpatient detoxification, residential care, partial-day treatment, and intensive outpatient therapy; Outpatient counseling, or group sessions. Eligible services are for evaluation, crisis intervention, acute stabilization and management of a mental disorder as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM). Coverage for Severe Mental Illnesses or Serious Emotional Disturbances is described below in Subsection (B). Services must be Medically Necessary, provided by a Plan Provider and authorized by the Plan. Eligible services are the most appropriate, safe, and least restrictive level of care and must be medically necessary pursuant to a treatment plan.

(B) Mental health coverage will be provided under the same terms and conditions applied to other medical conditions for the diagnosis and Medically Necessary treatment of a Severe Mental Illness (SMI) (as defined herein) at any age and for diagnosis and Medically Necessary treatment of a Serious Emotional Disturbance (SED) of a child (as defined herein). Services must be provided by a Plan Provider and authorized by the Plan. Copayments for the equivalent medical service apply.

Obstetrician and Gynecologist (OB/GYN) Self-Referral

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

If you need OB/GYN preventive care, are pregnant, or have a gynecological ailment, you may go directly to an OB/GYN specialist, or a Physician who provides such services, and is a participating VCHCP network provider. The OB/GYN Physician will consult with the Member's Primary Care Physician regarding the member's condition, treatment, and any need for follow-up care. *Copayment requirements may differ depending on the*

service provided.

Oral Surgery

Oral surgical services are covered, secondary to any dental plan covering Member. These may including 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. ..
See also Exclusions — Disorders of the Jaws in this document.

Dental Services

General anesthesia and hospital or surgery center services at a Participating facility 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. Plan prior authorization is required. This coverage is provided only for the following Members:

- ï Members who are under seven years of age.
- ï Members who are developmentally disabled, regardless of age.
- ï 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.
See also Exclusions — Disorders of the Jaws.

Other Outpatient Services

(A) All other Plan outpatient services and supplies, such as provided in non-hospital ambulatory surgery center, hemodialysis unit, imaging facility, laboratory draw site and other diagnostic services required for treatment, excluding prescription drugs and take-home supplies, are covered.

(B) Testing and treatment of phenylketonuria (PKU) including coverage of enteral formulas and specially formulated food products used in place of normal products, to the extent that their cost exceeds the cost of a normal diet.

Health Evaluations (Preventive Health Services)

(A) 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.

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.

(B) 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). For persons through the age of 16, this includes vision and hearing testing to screen for deficiencies. This does not apply to refraction exams. The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the subscriber including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

(C) 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 annual cervical cancer screening tests. Coverage for an annual cervical cancer screening test shall include the conventional Pap test, human papillomavirus (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 subscriber including: a subscriber's desire for physical examinations; or reports or related services for the purpose of obtaining or maintaining employment, licenses, insurance, or a school sports clearance.

(C)

Prosthetic and Orthotic Services

Prosthetic and Orthotic Services are covered when provided by a Participating Provider and authorized by the Plan. These services include 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.

Physical, Speech and Occupational Therapy Services

Outpatient rehabilitative services including physical, speech and occupational therapy services and inhalation therapy, as determined Medically Necessary by the Member's Participating Primary Care Physician and Plan's Medical Director. VCHCP may require

periodic evaluations as long as therapy, which is medically necessary, is provided. Such evaluations may use significant improvement as part of the determination of medical necessity. All such services must be obtained from Participating licensed and/or certified therapists, as applicable.

Reconstructive Surgery

(A) VCHCP covers medically necessary reconstructive surgery to improve function or create a normal appearance to the extent possible. Reconstructive surgery is performed to correct or repair abnormal structures of the body caused by congenital defects developmental abnormalities, trauma, infection, tumors or disease to improve function.

(B) VCHCP also covers reconstructive surgery following a medically necessary mastectomy, including reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce symmetrical appearance; and treatment for physical complications for all stages of a mastectomy, including lymphedema. "Medically necessary mastectomy" includes a medically necessary prophylactic mastectomy.

(C) VCHCP covers medically necessary reconstructive surgery for cleft palate condition, including dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures

(D) Reconstructive Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance ("cosmetic surgery") is not a covered service.

See also Exclusions — Dental Services in this document.

Skilled Nursing, Extended Care and Acute Rehabilitation Facility Services

Non-custodial care in a Participating licensed skilled nursing/extended care, and acute rehabilitation facility or area of a hospital (including sub-acute and transitional care if VCHCP determines they are less costly alternatives to the basic minimum benefits), 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, when in a Plan contracted facility and Authorized by Plan.

(A) A room of two or more beds, including meals, services of dietitian and general nursing care. Private room will be provided if authorized by Plan as Medically Necessary due to the nature of the illness or injury. 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.

(D) Blood transfusions: the costs of processing and transporting self-donated (autologous), donor-directed or donor-designated blood transfusions are covered when used for an authorized procedure that has been scheduled.

(E) Physical, occupational, speech and other rehabilitative therapy services, when medically necessary.

Transplantation Services

Hospital and professional services provided in connection with transplants are a benefit if prior authorization is obtained. Services incident 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, parents' whole siblings, siblings, and half-siblings of the candidate) for matching transplants will be covered.

The following procedures are eligible for coverage under this provision, only if: (1) performed at a Transplant Network Facility approved by VCHCP to provide the procedure, (2) prior written authorization is obtained from the VCHCP Medical Director, and (3) the recipient of the transplant is an eligible member of the Plan.

Eligible transplants may include heart transplants, lung transplants, heart and lung transplants in combination, liver transplants, kidney and pancreas transplants in combination, bone marrow transplants, including autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is medically necessary and is not experimental or investigational, pediatric small bowel transplants, pediatric and adult small bowel and liver transplants in combination, autologous chondrocyte (the only cells found in cartilage) implantation/transplantation. The Plan may cover additional types of transplants when medically necessary.

Additional Benefits

See also Exclusions — Conception by medical procedures in this document.

If you wish to give the gift of life after your own death, you may designate yourself as a tissue and organ donor by signing a uniform donor card or by indicating you are a donor on your California driver's license. However, at the time of death, the next-of-kin will still be asked to sign a consent form. Therefore, it is important to discuss your wishes, in advance, with your family.

Additional Benefits

Pharmacy Benefit

Mental Health and Alcohol/Drug Abuse Outpatient Benefits

Annual Vision Exam Reimbursement

Alternative Care Reimbursement

Prescription Drugs

The Ventura County Health Care Plan ("Plan") offers Prescription Medication coverage.

The Plan covers medically necessary outpatient prescription medications ordered by a Participating Physician when dispensed by a Participating Retail or Mail Order Pharmacy, subject to certain conditions, limitations, exclusions and member cost share. 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 a participating physician 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.

COVERED MEDICATIONS

Upon presentation to a Participating Pharmacy of a valid member identification pharmacy card, or submission of a completed mail form to the PBM Mail Order Service, members may have a prescription filled for the outpatient medications described below. Such covered medications and supplies include:

Those medically necessary prescription medications listed in the Plan's Preferred Drug List (PDL).

Diabetic drugs, including: Insulin for the treatment of diabetes, other prescriptive drugs for the treatment of diabetes, and glucagon.

Pediatric asthma medically necessary education, supplies, and equipment, including inhaler spacers, nebulizers (including face masks and tubing) and peak flow meters.

Prescription inhalers.

Prescription vitamins, including prenatal vitamins.

Pain management medications for terminally ill patients, retail-only.

Prescription contraceptive methods listed in the Plan's PDL. Contraceptive methods that are mandated by law, such as Plan B.

Medically necessary prescription drugs if prescribed by a member's Primary Care Physician or VCHCP-referred psychiatrist for the treatment of a Severe Mental Illness at any age or for treatment of a Serious Emotional Disturbance of a child as defined herein.

Off-label drugs in certain circumstances with prior authorization.

Prescription Drug Exclusions and Limitations

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

Covered Medications must be dispensed by a Participating Pharmacy. The PBM maintains a nationwide network of Participating Pharmacies. Locations within the Service Area are listed in the Provider Directory. Members are encouraged to call the PBM's toll-free number printed on

their member identification pharmacy card for locations of Participating Pharmacies outside the Service Area. Covered medications dispensed by a non-Participating 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 Participating Pharmacy. The PBM will reimburse member claims for prescriptions, subject to dispensing limits and Plan authorization requirements.

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.

The amount of covered medication per retail prescription is limited to a 30-day supply and the amount of covered medication per mail order prescription is limited to a 90-day supply, unless otherwise set forth in this Plan benefit description. If the prescription includes refills, each allowed refill may be obtained in the same manner as the original without requiring a new prescription.

Patent or over-the-counter medicines, or medicines not requiring a written prescription, with the exception of insulin and Prilosec OTC, are excluded.

Medically necessary prescriptions not on the Plan's PDL may be covered when authorized by the Plan. Copays for these prescriptions will be at the 3rd tier level. Certain PDL medications are also subject to obtaining prior 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, when the Member has completely run out of the medication, within 24 hours and requests for other refills within 48 hours of the Plan's receipt of the information requested by the Plan to make the decision. A verbal authorization is given to the pharmacy. The authorization is transmitted by facsimile to the prescribing physician for distribution to the member. Denials shall indicate any alternative drug or treatment offered by the Plan and shall inform the member of Plan Grievance Procedures.

Certain medications have maximum quantity limits per prescription.

Medications that are experimental, investigational or not approved by the United States Food and Drug Administration 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)", page 31, for additional information.

Except for insulin, medically necessary specialty drugs, including injectable medications, are covered subject to member copayment as disclosed in the Benefit Summary matrix, and are only available from VCHCP's Specialty Drug Program.

Medications not medically necessary for the treatment of the condition for which it is administered are excluded.

Cosmetics, health or beauty aids, dietary supplements (except for conditions of PKU), anorexants (i.e., appetite suppressants) or any other diet medications (except when medically necessary for treatment of morbid obesity), and drugs when prescribed for cosmetic purposes 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.

Placebo injections and medications are excluded, except when medically necessary.

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

Enhancement medications when prescribed for sexual performance are excluded, except when medically necessary.

The prescribing practitioner must be an individually licensed and currently DEA certified Participating Primary Care Physician, VCHCP-referred specialist, Provider of Emergency or Urgently Needed Service or Provider of Out-of-Area Coverage acting within the scope of his or her license. During the first thirty (30) days of enrollment, and for ninety (90) days after a Participating Provider's termination from the Plan, prescription refills ordered by a non-Participating physician are covered. Exceptions to the above may occur when insuring the continuity of care for a new enrollee or for a member whose provider is terminated by the Plan. For further information on Continuity of Care, please see the section titled "*Continuity of Care"* on page 26 of this document.

Medications related to, or as a follow-up to, or as a result of complications from, services and supplies that are specified as excluded or beyond the limitations set forth in the Plan's medical coverage are excluded. Medically necessary drugs for urgent and emergent conditions that arise due to complications from non-covered services will be covered.

The following items are excluded under this Optional Pharmacy Benefit Rider but information is given if they are covered under other medical benefits of your health plan:

- Allergy desensitization products: Please see Item # (2.A) ***Professional Services*** under *Summary of Covered Services and Supplies*.
- Immunizing agents: Please see Item # (8) ***Immunizations and Injections*** under *Summary*

of Covered Services and Supplies.

- Injectable infertility medications: Please see Item # (22) ***Additional Benefits*** under *Summary of Covered Services and Supplies*.

Member Liabilities: The Plan reserves the right of recovery for prescription claims which have been processed in error relating to member's eligibility.
You may contact Member Services at (805) 981-5050 for any of the following information:

- Names of Participating Pharmacies
- Mail Order Envelopes
- Member submitted claim forms
- Whether certain medications are covered or on the Plan's Drug Formulary
- Whether certain medications require a Prior Authorization and the process to follow

Annual Vision Exam

The Plan will reimburse up to $50 for an annual refraction (vision check) exam, provided by a licensed optometrist or ophthalmologist. For reimbursement, Subscriber must submit a Reimbursement Claim form to Plan, accompanied by a receipt, within one hundred and twenty (120) days of the date of service. PCP or Plan authorization is not required for such examination. Please see *"Summary of Covered Services and Supplies"* Item # (17), *"Health Evaluations (Preventive Health Services)"*, page 18 in this document, for additional benefit information on vision screening testing for persons through the age of 16 years.

Chiropractic or Acupuncture Care Reimbursement

Chiropractic or acupuncture procedures performed for therapeutic purposes are covered, when obtained from a Chiropractor or Acupuncturist, acting within the scope of his or her license, with a per visit reimbursement limit, payable quarterly and with a limited number of visits in a Plan Year. Please see the Benefit Summary Table for reimbursement and visit limit information. Ancillary services ordered by a Chiropractor or Acupuncturist must be obtained by agreement of the Plan and at VCMC facilities. PCP referral or prior authorization is not required. Subscriber must submit to Plan a Reimbursement Claim form accompanied by receipt(s) for reimbursement within one hundred and twenty (120) days of service

Mental Health and Alcohol/Drug Abuse Outpatient Benefits

Outpatient counseling or group sessions for chemical dependency, substance abuse, and mental health are covered benefits, subject to Copayments and prior authorization.

SUMMARY OF BENEFIT EXCLUSIONS

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 Evidence of Coverage (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, will not be covered.

Air purifiers, air conditioners, humidifiers, dehumidifier

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

Alternate birthing center or home delivery, (also see "Home Birth").

Alternative Care Services such as faith healing including Christian Science Practitioner; Homeopathic medicine; Hypnotherapy; Sleep therapy; Biofeedback; Behavior therapy unless determined to be medically necessary.

Any expense 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.

Any services, supplies or benefits that are not Medically Necessary.

Non-prescription (over-the-counter) medical equipment or supplies that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, are not covered under this benefit plan except as specifically provided under Home Health Care Services, Hospice Care, Durable Medical Equipment, and Prosthetic and Orthotic Services.

Conception by medical procedures. VCHCP does not cover services or supplies that are intended to impregnate a woman. Excluded procedures include, but are not limited to:

- In-vitro fertilization (IVF), gamete intrafallopian transfer (ZIFT), or any process that involves harvesting, transplanting or manipulating a human ovum. Also not covered are services or supplies (including injections and injectable medications) which prepare the Member to receive these services.
- Collection, storage, or purchase of sperm or ova.

Cosmetic surgery, including surgery for psychological reasons and complications resulting from such surgery. Pre-op examinations for medical clearance for excluded surgeries. All services to retard or reverse the effects of aging of the skin or hair; Tattoo removal. *Medically necessary emergency services as a result of complications from non-covered services are covered.*

Custodial or Domiciliary Care. Except for those services provided as a part of *Hospice Care* (please see Item # (8) in the section titled "Summary Of Covered Services And Supplies", page 16), VCHCP does not cover services and supplies that 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, a Physician Assistant or rehabilitative (physical, occupational or speech) therapist.

Dental services, including care of teeth, gums or dental structures, extractions or corrections of impactions, dental implants, dental prosthetics, dental splints; Orthodontic services, including braces and appliances.

Exceptions

- When Dental examinations and treatment of the gingival tissues are performed for the diagnosis or treatment of a tumor.
- When immediate Emergency Care to sound natural teeth as a result of an accidental injury is required.

VCHCP does cover medically necessary reconstructive surgery for cleft palate condition, including dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

Disorders of the Jaws. VCHCP does not cover treatment for disorders of the jaw except in the following situations:

- 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.
- 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. However, crowns, inlays, onlays, bridgework, or other dental appliances are never covered under any circumstances.
- Surgical procedures for any condition directly affecting the upper or lower jawbone and are part of medically-necessary basic health care services.

Disposable supplies for home use that are available over-the-counter, such as dressing supplies or incontinence supplies. Surgical dressings, except for primary dressings applied by a Physician or Hospital to lesions of the skin or surgical incisions.

Certain durable medical equipment, devices or appliances may not be covered, except as specifically provided herein. Examples of non-covered DME include:

- Exercise equipment
- Hygienic equipment and supplies (to achieve cleanliness, even when related to other covered medical services), including bath and shower equipment supplies.

Elevators, chair lifts, wheelchair ramps, etc.

Emergency room services for non-Emergency purposes; Non-Emergency Services provided outside VCHCP's Service Area without a Referral Authorization from VCHCP Medical Director.

Exercise programs, equipment and weight reduction programs, dietary supplements

Experimental or investigational services — VCHCP does generally not cover experimental drugs, devices, procedures or other therapies except when:

- ï Independent review deems them appropriate;
- ï Clinical trials for cancer patients are deemed appropriate
- ï No alternative treatment options exist and the Member has a life-threatening or seriously debilitating condition; or
- ï VCHCP's Medical Director and your Primary Care Physician agree it is the best and only course of treatment.

Once one of the above exceptions occurs, *VCHCP may require that treatment be carried out through a recognized clinical trial program.*

Please see the section, in this document, titled "Independent Medical Review (Experimental/Investigational)", page 31, for additional information.

Furnishing, fitting, installing or replacing of eyeglasses or contact lenses, Radial keratotomy and other refractive procedures, Eye exercises are excluded for everyone. Eye refractions for the purpose of determining the need for eyeglasses or contact lenses except for limited reimbursements as noted on page 21 above; routine vision exams for Members age seventeen (17) years of age or older;

Furnishing, fitting, installing or replacing hearing aids are excluded for everyone. Hearing examinations for Members seventeen (17) years of age or older except as Medically Necessary;

Routine foot care, including trimming of corns, calluses, nails; orthopedic shoes, arch supports, shoe inserts, built-up, special-ordered, custom-made, supportive or regular shoes, or other devices for the feet. Podiatric devices or care to prevent or treat diabetes−related complications are not excluded. Special footwear permanently attached to a Medically Necessary orthopedic brace is not excluded.

Orthotics. Orthotics which are not custom made to fit the Member's body are not covered. Foot Orthotics, even if custom made, are not covered.

Foot orthotics (whether or not custom fit) that are not incorporated into cast, splint, brace, or strapping of the foot are not covered. This exclusion shall not apply to members with diabetes who need foot orthotics to prevent diabetic foot complications, members with plantar faciitis, and members needing post-surgical stabilization in place of a cast.

Reversal of sterilization

Home birth is only covered when the criteria for Emergency Care, as defined in this Evidence of coverage, have been met.

Over-the-counter medications not requiring a prescription; Nonprescription drugs; Outpatient

Prescription drugs unless the group elects optional Pharmacy Benefit.

Physical examinations including sports physical exams, ancillary tests, and reports for the purpose of obtaining or continuing employment, insurance, government licensure, travel, sports, school admissions, premarital purposes, camp or school physical, compliance with court order, or for purposes of obtaining or retaining certification or licensure; Immunizations for the purpose of work or travel.

Private duty or special duty nursing is not covered if the patient is:

a resident of a nursing facility;

a resident of a licensed intermediate care facility for people with developmental disabilities;

in a hospital;

in a licensed residential care facility.

if the purpose is solely to allow the client's family or caregiver to work or go to school;

if the purpose is solely to allow respite for caregivers or client's family.

Private duty or special duty nursing services which are medically necessary and appropriate, and are prescribed by the member's physician, are covered by the Plan when provided in accord with Plan authorization requirements. Usually, these services are provided by an RN or LVN through a Home Health Care services agency. The services provided must be pursuant to a plan of care established by the physician

Recreational, art, dance, sex, sleep, or music therapy and other similar therapies.

Saunas, Jacuzzi, whirlpools, and pools

Services from Skilled Nursing Facilities, sub-acute, transitional care, extended care facilities and home health agencies, except as specifically provided herein; Custodial care; Domestic services. [Those services provided as a part of *Hospice Care* (please see Item # (8) in the section titled *"Summary of Covered Services and Supplies"*, page 16) are covered benefits.]

Services required by court order or as a condition of parole or probation, unless Medically Necessary and Member is self-motivated to receive services.

Supplies for comfort, hygiene, or beautification including cosmetics

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, is not a covered health benefit.

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

Treatment for disability, illness or injury related to military service or temporary active duty.

Work-related illnesses or injuries, or services provided or arranged by a 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, the rendering of Covered Services is delayed or rendered impractical, neither VCHCP nor any Participating 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 or 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.

CONTINUITY OF CARE

Continuity of Care for New Enrollees by Non-Participating Providers: 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 a Non-Participating Provider you may request the Plan to arrange for you to receive continuation of Covered Services from the Non-Participating Provider, including continuation of Covered Services received from a Non-Participating hospital. Such treatment must be:

- for an acute condition,
- for a serious chronic condition,
- for a pregnancy including the duration of the pregnancy and immediate postpartum care,
- for a terminal illness,
- for care for children from birth to age thirty-six (36) months, or
- if you have a surgery or other procedure that has been recommended and documented by the Non-Participating Provider to occur within one hundred eighty (180) days of the effective date of Coverage.

The Non-Participating 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 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 a Non-

Participating 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.
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 terminal illness,
- care for children from birth to age thirty-six (36) months, or
- 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.

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 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.

COORDINATION OF BENEFITS, THIRD PARTY AND MEMBER LIABILITY

Coordination of Benefits: This benefit plan is referred to as a "Coordination of Benefits" or "COB" plan because it coordinates the financial coverage of health benefits with your Medicare Part A (hospital, hospice and home health) and Part B (doctors' services, outpatient care and other medical services) coverage. Under this program, Medicare is the "primary" payer for services you receive. However,

because you will not need to purchase Part D (prescription drug) coverage from Medicare, there is no coordination of benefits necessary.
Since Medicare pays first after you retire, your retiree coverage is likely to be similar to coverage under what is referred to as a Medigap (Medicare Supplement Insurance) policy. Retiree coverage is not the same thing as a Medigap policy. However, like a Medigap policy, it usually offers benefits that fill in some of Medicare's gaps in coverage, such as coinsurance and deductibles, and it sometimes includes extra benefits, like coverage for extra days in the hospital.
To make sure that you get the most from this benefit plan, be sure to tell your doctor, hospital, and all other health providers about your VCHCP insurance coverage. This will also help to make sure your bills are sent to the right payer, and to avoid delays in payment. If they have any questions or concerns, have them contact our member services department at the number indicated on the back of your member ID card.
Third Party Liability: VCHCP will furnish Covered Services in case of injury, illness caused by a third party and complications incident thereto, such as injuries from an automobile accident. As a Member, you agree to reimburse VCHCP or the Provider, as appropriate, the reasonable cost of hospital services, from any payment you receive from the third party, such as an automobile insurance company, after deducting your reasonable attorney's fees and costs. You also agree to reimburse VCHCP or the Provider, as appropriate, the reasonable cost of non-hospital medical services provided on a fee-for-service basis, and the amount equal to eighty percent (80%) of the prevailing usual and customary charge of non-hospital medical services provided on a capitated basis from any payment you receive from the third party. However, for non-hospital medical services, the maximum amount you owe VCHCP is 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 agreement, less one-third of your reasonable attorney's fees and costs. 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.
Non-Liability of Member: In the event that VCHCP fails to pay a Participating Provider, 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 enrollee 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.

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.

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 Eligibility, Enrollment and Effective Dates section beginning on page 3, you and/or your enrolled Dependent children will be terminated automatically on the midnight before their twenty-sixth (26th) birthday. Dependent children in college will be terminated automatically on the midnight before their twenty-sixth (26th) birthday. 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.

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.

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.

Non-payment: If you or the Group fail to pay, or fail to make satisfactory arrangements to pay, any amount due VCHCP for Coverage, including but not limited to Premiums and Copayments, VCHCP may terminate your Coverage, subject to the reinstatement provisions below. The Plan will send written notice of the termination to you at least (fifteen) 15 days before the termination date. If full payment is received before the termination date, the Plan will not terminate your membership.

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. 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.

CONTINUATION COVERAGE

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, or if VCHCP terminates the Agreement because of nonpayment of the Premiums, 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. If VCHCP terminates the Agreement for any reason other than non-payment by the Group of the Premiums, VCHCP may, at its option, offer continuation of 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.

Reinstatement: Notwithstanding any other provision to the contrary, receipt by the Group or VCHCP of the proper Premium after termination of Coverage for nonpayment will reinstate the Coverage as though there never was a termination. The Premium must be received on or before the due date for the succeeding Premium (within the thirty (30) day grace period of the Premium due date).

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.

Notifying You of Changes in the Plan: VCHCP publishes a member newsletter that is distributed to all Subscribers. Subscribers will be informed of changes in the 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.

How Providers Are Compensated: Most Participating Providers are paid on a fee-for-service basis. This means the Provider is paid according to the amount of Covered Services provided to Members. Some Participating 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 amount 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 Participating Providers, will be refunded within thirty (30) days and neither VCHCP nor any Participating 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. The Standing Committee will hear any matter of public policy related to the Plan.

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE

If you have a grievance against your health plan, you should first telephone your health plan at 805-981-5050 and use the health plan's grievance process before contacting the department. 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. 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 a Participating 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 process 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.

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.

*__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.__

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) HMO-2219, or fax (916) 229-4328

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.

MEMBER GRIEVANCE PROCEDURE

You may register complaints with VCHCP by calling, writing, or online @ www.vchealthcareplan.org:

Ventura County Health Care Plan
2220 E. Gonzales Road, Suite 210-B,
Oxnard, CA 93036
(805) 981-5050 or (800) 600-VCHP

In addition, the Plan's website provides an on-line form that a Member may use to file a grievance on-line. The link to this on-line Grievance Form is found on the right-hand side of the Plan's web portal, (www.vchealthcareplan.org.)

VCHCP encourages the informal resolution of problems and complaints, especially if they resulted from misinformation or misunderstanding. However, if a complaint cannot be resolved in this manner, a formal Member Grievance Procedure is available.

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 available complaint forms at its offices and provides complaint forms to each Participating Provider. A Member may initiate a grievance in any form or manner (form, letter, or telephone call to the Member Services Department), and 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.

If a Grievance/Complaint is received pertaining 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 business days if the participating 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.

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, Participating Providers, or agents undergo voluntary mediation.
If you seek voluntary mediation, you must send written notice to VCHCP's Administrator (address above) 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 Process 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 (805) 981-5050 or toll-free at 1-800-600-VCHP and use your health plan's grievance process 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-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.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 (as described below).

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

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.

"Ambulatory Care" means a general term for care that doesn't involve admission to an inpatient hospital bed. Visits to a doctor's office are a type of ambulatory care.

"Ambulatory Surgery" means surgical procedures performed that do not require an overnight hospital stay. Procedures can be performed in a hospital or a licensed surgical center. Also called Outpatient Surgery.

"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" is a disorder that is characterized by severe deficiencies in reciprocal social interaction, verbal and non-verbal communication, and restricted interests. Autism isn't a disease, it's a symptom. It ranges in severity from a handicap that limits an otherwise normal life to a devastating disability requiring institutional care. Autism is one of the most common developmental disabilities. It usually commences before the age of 3 years and lasts over the whole lifetime. [*Also see definition for Pervasive Developmental Disorders (PDD).*] (Source: <http://www.webmd.com> and the Yale Child Study Center at the Yale School of Medicine.)

"Behavioral Health Services" means assessment and therapeutic services used in the treatment of mental health and substance abuse problems.

"Benefit Plan" means the Covered Services, Copayments or deductible requirements, limitations and exclusions contained in the Agreement.

"Benefits" means the portion of the costs of covered services paid by a health plan. For example, if a plan pays the remainder of a doctor's bill after an office visit copayment has been made, the amount the plan pays is the "benefit."

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

"Copayment" means any 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.

"Consultation" means a discussion with another health care professional when additional feedback is needed during diagnosis or treatment. Usually, a consultation is by referral from a primary care physician.

"Continuity of Care" means the continuation of care that a new member was receiving from a provider affiliated with his/her prior health plan prior to becoming a VCHCP member, or the continuation of care for existing plan members when a plan provider leaves the VCHCP.

"Cosmetic Surgery" means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

"Coverage" or "Covered Services" 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.

"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 the failure to meet certain normal developmental milestones, such as sitting, walking, and talking, during infancy and early childhood. Developmental delay may be caused by organic, psychological, or environmental factors, and may indicate a problem in development of the central nervous system. There are many different types of developmental delays in infants and young children. They can include problems with: language or speech, vision, movement — motor skills, social and emotional skills, and thinking — cognitive skills. Sometimes, a delay occurs in many or all of these areas.

"Domestic Partners" are officially registered with the State of California or with any other California county or municipality domestic partner registry listed at the San Francisco Human Right Commission Internet site (www.ci.sf.ca.us) and meets Plan eligibility criteria.

"Durable Medical Equipment" means equipment that can withstand repeated use and is primarily and usually used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in the home.

"Emergency Care" means any otherwise Covered Service that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms (including symptoms of Severe Mental Illness and Serious Emotional Disturbances of a child), and believed that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger).
- His or her bodily functions, organs, or parts would become seriously damaged.
- His or her bodily organs or parts would seriously malfunction.

Emergency Care includes paramedic, ambulance and ambulance transport services provided through the "911" emergency response system.

Emergency Care also includes the treatment of severe pain or active labor.

Emergency Care also includes additional screening, examination and evaluation by a Physician (or other health care Provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate such condition, within the capability of the facility.

"Emergency Medical Condition" means a sudden, serious and unexpected illness, injury or condition requiring immediate diagnosis and treatment both in and out of the Plan's Service Area.

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

"Exclusion" means any provision of this Combined Evidence of coverage and Disclosure Form whereby coverage for a specified illness or condition or a specified service or supply is entirely eliminated.

"Grievance Procedure" means the system for the receipt, handling and disposition of Member complaints and grievances as described in this Combined Evidence of Coverage and Disclosure Form.

"Group" OR **"Subscriber Group**" means the employer or other organization that has entered into an Agreement with VCHCP for the provision of Covered Services for its Medicare-eligible retirees and their eligible dependents. It is the County of Ventura as the Employer of active employees and former Employer of Medicare-eligible retired employees.

"Health Care Team" means licensed nurse practitioners, certified physician assistants, certified nonphysician-surgical assistants, physicians in residency training programs and nurses who work with and are supervised by Primary Care Physicians.

Hospice Care" or "Hospice Program" means a specialized form of interdisciplinary health care that is designed to provide palliative care, (care that alleviates the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phases of life due to the existence of a terminal disease), and to provide support to the primary caregiver and the family of the Member.

"Hospital Services" are those inpatient or outpatient general hospital services including room with customary furnishings and equipment, meals, general nursing care, use of operating room and related facilities, intensive care unit and services, Emergency Care, drugs, medications, biologicals, anesthesia and oxygen services, ambulatory care services, diagnostic, therapeutic and rehabilitative services, and coordinated discharge planning, as appropriate.

"Investigational And/Or **Experimental"** means a procedure, device, or drug which is considered investigational for the specific clinical application being reviewed. A procedure, device or drug may be considered investigational for one clinical application even if it is considered a Standard of Care in other clinical applications where there is reasonably good data to support its use. Further research is required to clarify clinical indications, contraindications, dosage/duration, comparison to alternative technologies, and/or impact on clinical outcomes. If a drug or device, it may be approved by the FDA for other applications or indications. It may be endorsed in a limited/restrictive context by a federal agency or a scientific organization for the application under consideration.

"Knox-Keene Act" means the Knox-Keene Health Care Service Plan Act of 1975, as amended, Division 2, Chapter 2.2 (commencing with Section 1340) of the California Health and Safety Code, and all regulations promulgated thereunder.

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

"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.

"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 Disorder" is a nervous or mental condition that meets all of the following conditions:

- ï It is a clinically significant behavioral or psychological syndrome or pattern;
- ï It is associated with a painful symptom, such as distress;
- ï It impairs a person's ability to function in one or more of life's activities; or
- ï It is a condition listed as an Axis I disorder in the most recent edition of the DSM by the American Psychiatric Association.

"Non-Participating" refers to those Physicians and other Providers that have not entered into contracts with VCHCP to provide Covered Services to Members.

"Orthosis" or "Orthotic Device" means a device used to support, align, prevent, or correct deformities of a movable part of the body**.**

"Out-of-Area" means that geographic area outside the Service Area.

"Out-of-Area Coverage" means coverage while a Member is anywhere outside the Plan's Service Area, and shall only include coverage for Emergency Care and Urgently Needed

Care to prevent serious deterioration of the Member's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the Member returns to the Service Area.

"Out-of-Area Urgent Care" means a health condition that requires prompt medical attention, but is not an Emergency Medical Condition. 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.

"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.

"Participating Providers" refers to those Physicians and other Providers that have entered into contracts with VCHCP to provide specific Covered Services to Members, under terms and conditions which, among other things, require compliance with the applicable requirements of the Knox-Keene Act with respect to the provision of Covered Services to Members.

"PCP" or "Primary Care Physician" or "Primary Care Provider" means the Participating Physician, who is selected by or assigned to a Member by VCHCP, and who has the responsibility of providing initial and primary care services, for referring, supervising, and coordinating the provision of all other services to Members in accordance with VCHCP's Quality Assurance and Utilization Management Programs. A Primary Care Physician may be a family/general practitioner, internist, pediatrician, or obstetrician/gynecologist, who has entered, 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.

"Pervasive Developmental Disorder" also called "PDD", 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: <http://www.webmd.com> and the Yale Child Study Center at the Yale School of Medicine.)

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

"Plan" or "VCHCP" means the Ventura County Health Care Plan, operated by the County of Ventura, and licensed to provide prepaid medical and hospital services under the Knox-Keene Act.

"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.

"Prosthesis" or "Prosthetic Device" means a device used to substitute for a missing body part.

"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.

"Reconstructive Surgery" means surgery performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to either:

improve function, or

create a normal appearance, to the extent possible.

"Referral" means the process by which the Primary Care Physician directs a Member to seek and obtain Covered Services from other Providers.

Respite Care" is short-term inpatient care provided to a Member only when necessary to relieve family members or other persons caring for the Member.

"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.

"Severe Emotional Disturbances Of A Child" or ("SED") means a minor under the age of eighteen (18) who has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms; AND

As a result of the mental disorder, the child has substantial impairment in at least two (2) of the following areas: self-care; school functioning; family relationships; or ability to function in the community; and either of the following occur:

a. The child is at risk of removal from the home or has already been removed from the home; or

b. The mental disorder and impairments have been present for more than six (6) months or are likely to continue for more than one (1) year without treatment;

OR

The child displays one of the following: (a) psychotic features, (b) risk of suicide or (c) risk of violence due to a mental disorder; OR The child meets special education eligibility requirements under Chapter 26.5 of the California Government Code.

"Severe Mental Illnesses" or "SMI" mean a mental disorder which is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Severe Mental Illnesses shall include: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

"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.

"Standard of Care" means the procedure, device or drug is accepted medical practice as evidenced by an abundance of scientific literature and well-designed clinical trials. A drug that is a Standard of Care will have been approved by the FDA for that specific clinical application. A medical device that is a Standard of Care will have FDA approval, but not necessarily for a specific clinical application.

"Standing Referral" means a Referral to a Participation Specialist for more than one visit

without the Member's Primary Care Physician having to provide a specific referral for each visit.

"Subscriber" means the individual who qualifies, because of employment, to enroll himself and his qualifying dependents in the plan, and signs the enrollment form at the time of enrollment in this plan.

"Telemedicine Services" mean 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.

"Terminal Disease" or "Terminal Illness" means a medical condition resulting in a prognosis of life of one year or less, if the disease follows its natural course, or, supported by evidence-based medical and psychosocial criteria, or other guidelines consistent with the standards among palliative care professionals.

"Totally Disabled" or "Total Disability" means an "impairment" in body function or structure. Impairments may include physical, sensory, and cognitive or developmental disabilities. A physical impairment is any disability which limits the physical function of limbs or fine or gross motor ability. Mental disorders (also known as psychiatric or psycho social disabilities) and various types of chronic disease may also be considered qualifying disabilities. A disability may occur during a person's lifetime or may be present from birth.

"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.

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:

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

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

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

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

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

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

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.

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

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

(Footnotes)

1 Services provided in a facility or freestanding residential treatment center that provides overnight mental health or substance abuse services for members who do not require acute inpatient care but who do require 24-hour structure.

2 Partial hospital/day treatment program in a freestanding or hospital-based program that provides services for at least 20 hours per week.