VCHCP Ventura County Health Care Plan

Benefit Year 2012-2013

Ventura County Health Care Plan

Summary of Benefits

Combined Evidence Of Coverage And Disclosure Form

Commercial Benefit Plans

Meeting Our Members Health Care Needs
Since 1994

Updated 01/25/13

VENTURA COUNTY HEALTH CARE PLAN

COMMERCIAL BENEFIT PLANS

COMBINED EVIDENCE OF COVERAGE & DISCLOSURE FORM

What's new since July 2012?

Expanded therapy coverage for autism – See definition on page 38

New definition for Habilitation and expanded definition for Rehabilitation – pages 40 and 43 respectively.

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VENTURA COUNTY HEALTH CARE PLAN

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

INTRODUCTION

Welcome to Ventura County Health Care Plan (VCHCP or the Plan), operated by the County of Ventura. 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 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. Your employer'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 the employer's benefits administration office.

To receive additional information about the benefits of the Plan, or a copy of the Plan contract, 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 non-physician-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 the Plan's Service Area. Members and dependents may choose any available Primary Care Physician that contracts with the Health Plan.

VCHCP does not discriminate in employment or in the delivery of health care services on the basis of age, race, color, ancestry, religious creed, sex, 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.

ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATES

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

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

You may enroll yourself and your eligible Dependents in VCHCP, if you are in a Group that has an Agreement with VCHCP, and if you have not been previously terminated from VCHCP. At the time of enrollment, or any time thereafter, the Plan may request that you provide proof of a dependent relationship, such as a copy of a marriage certificate, proof of residence, a birth certificate, court papers, 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 VCHCP. Your Group is required to inform its employees of its eligibility requirements, such as the minimum number of hours that an employee must work to be eligible for coverage.

Service Area Eligibility Requirements: The Subscriber must live or work in our Service Area to be eligible for enrollment. The Service Area for VCHCP is Ventura County. The Definition Section (beginning at page 37) further describes our Service Area. You must receive Covered Services from Plan Providers inside our Service Area, except for Emergency Care, Urgent Care, and post-stabilization care received from non-Plan Providers when authorized by the Plan.

Eligible Dependents: Eligible Dependents must reside with you, the Subscriber, except as otherwise required by law or court order. Dependents may include your spouse, or Domestic Partner (as discussed below), and any dependent children under 26 years of age. A Dependent child includes your child, your stepchild, child of your Domestic Partner (as discussed below), or child adopted, placed for adoption or under your legal custody or the legal custody of your spouse. Dependant children over the age of 18 are not required to live with you. Please see further qualifying criteria below.

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".

Excluding pregnancy care and Covered Services provided to a newborn, newly adopted child or child newly placed for adoption, or any child under the age of 19, dependents added after Subscriber enrollment are not covered for pre-existing conditions until the next open enrollment or six (6) months, whichever is less. If the Dependent had other medical coverage that was in effect within sixty-two (62) days prior to the Dependent's enrollment in VCHCP, then the pre-existing condition requirement may be reduced by one month for each month of medical coverage that covered the pre-existing condition. VCHCP will only apply this credit for previous coverage after verification of creditable coverage of the prior carrier.

Dependent Children and Adult Children:

All eligible children must be under the limiting age of 26 The following categories are eligible:

(a) your natural or legally adopted children;

(b) your spouse's natural or legally adopted children (your stepchildren);

(c) your eligible domestic partner's natural or legally adopted children;

(d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

(e) children for whom you are legally required to provide group health insurance pursuant to an administrative or court order. (Child must also meet VCHCP eligibility requirements.)

Adult Children Incapable of Self Support: Any child described above who is incapable of self-support due to a physical or mental disability may continue to be covered past age 26 provided: - the plan-certified disability began before age 26, the child was enrolled in a County Sponsored Plan before age 26 and coverage is continuous; - the child is chiefly dependent upon you, your spouse, or your eligible domestic partner's for support and maintenance; and - the child is claimed as your spouse, or your eligible domestic partner's dependent for income tax purposes, or if not claimed as such dependent for income tax purposes, is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income.

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

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

Domestic Partners: Enrollment of a Domestic Partner is available to a person who has officially registered with the State of California 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 after your enrollment forms are processed, received by VCHCP, and the first payroll deduction is taken. If you add Dependents during a special enrollment period (for example, within 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 or equivalent employee pay periods. 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

Choice of Physicians and Providers: 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. Information about specific providers and provider groups is available upon request. If you fail to choose a Primary Care Physician, the Plan will assign one. Your choice or assignment of Primary Care Physician may affect where you may obtain hospital services depending on the participating hospital with which the PCP has an affiliation or admitting privileges. Such limitations shall not apply to medical emergencies or out-of-area urgently needed services or where medically necessary services cannot be provided by the assigned hospital.

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 as every thirty (30) days.

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

paragraph. For information on the provision of continuity of care when your PCP is no longer available, please see the section titled "Continuity of Care with a Terminated Provider" on page 27 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 without prior authorization within forty-eight (48) hours; within ninety-six (96) hours for urgently needed services requiring prior authorization. For non-urgent appointments with your primary care physician, expect to be seen within ten (10) business days and fifteen (15) business days for a specialist. Ancillary Services should be provided within fifteen (15) business days and ten (10) business days to see a mental health provider. You should get an appointment within six (6) 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 certain Specialist Physicians. The Plan processes normal 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 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 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 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 Standing Referral to a Specialist policy or Direct Access to OB/GYN Services Policy and a list of contracted Direct Access Providers or Standing Referral Specialists by contacting the Plan's Member Services Department at (805) 981-5050, or accessing our website at www.vchealthcareplan.org. 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, the Plan's Behavioral Health Administrator (BHA), at (800) 851-7407. A Life Strategies 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 for the required Authorization 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 or a specialty care center 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. The Plan will approve or deny a referral within three (3) business days of the date of the request and all appropriate medical records and other necessary information to make the decision are provided and once a standing referral is authorized, a referral must be made by the Plan within four (4) days.

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, podiatrists, and physical therapists. Primary Care Physicians are listed alphabetically by last name with and under their medical group, with information about the practice location and hours of operation. 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 and 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 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 opinions will be rendered by an appropriately qualified health care professional. This is defined as a Primary Care Physician or Specialist acting within his or her scope of practice and who possesses a clinical background, including training and expertise, relates to the particular illness, disease, condition or conditions associated with the request for a second opinion. The provider will be selected to render the second opinion as follows:

1. The provider chosen by the Member or by the Participating Provider who is treating the Member will be authorized if the provider meets the above definition of an appropriately qualified health care professional and if the provider is a Network Provider. This includes all contracted primary care physicians and all contracted specialists.

2. Otherwise, the Plan will select a provider, taking into consideration the ability of the Member, to travel to the provider. The Plan will limit referrals to its network of providers, if there is a participating Plan provider who meets the above definition of an appropriately qualified health care professional. In general, specialists contracted with the Ventura County Medical Center will be preferentially selected over other contracted providers of the same specialty; a provider will be selected who is not in the same practice as the provider who rendered the first opinion; and specialists located within the Service Area (Ventura County) will be selected in preference to specialists located outside the Service Area. If there is no participating provider within the Plan's network that is qualified, the Plan will authorize a referral to a qualified out-of-network provider.

3. For Plan authorized second opinions, the Member will only be responsible for the applicable copayment required

for similar referrals. Referrals authorized by the Plan to out-of-network providers have copayments consistent with the copays that apply to in-network providers for the same type of service.

Second opinion providers will be advised of the requirement to provide a consultation report to the Member and to a requesting participating provider who is treating the Member.

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

The Plan's complete 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.

Emergency Psychiatric Medical Condition:

A mental disorder in which there are acute symptoms of sufficient severity to render either an immediate danger to yourself or others, or you are immediately unable to provide for our use food, shelter, or clothing due to a mental disorder. Psychiatric emergencies may include transfer of an enrollee to a psychiatric unit with a general acute hospital or an acute psychiatric hospital for care and

treatment to relieve or eliminate a psychiatric emergency medical condition.

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

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR SERVICES THAT YOU RECEIVED FROM A NON-CONTRACTED PROVIDER, PLEASE CONTACT THE PLAN AT 805-981-5050.

"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.

Urgently Needed Care shall be a covered benefit while the member or dependents are outside of the service area. While members or dependents are inside the service area, Urgently Needed Care will only be covered at In-Network facilities. Use of non-contracted Urgent Care facilities inside the service area is not covered.

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.

If you are treated at a facility other than the Ventura County Medical Center, that facility must contact the Plan for prior Authorization if additional care is needed after your Emergency Medical Condition is stabilized. If your condition requires admission for inpatient care, you have the option to be transferred to the Ventura County Medical Center.

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, otherwise 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 to one of the Ventura County Urgent Care Centers. 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.

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

- Female Members may self-refer to an Obstetrician ("OB/GYN") or Family Practitioner, ("FP"), contracted with the Plan to provide covered OB/GYN Direct Access Services. Benefits are covered as if the OB/GYN or FP is acting as a PCP, 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 facility, otherwise you will be financially responsible for services rendered.

- Emergency contraception or the "Morning After Pill" is covered for 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. In most situations, non-emergency services obtained in an emergency room setting will not be covered.

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. Please note that this Plan does not have a deductible. All copayments, except for medications, count toward the enrollee's annual out-of-pocket maximum.

(1) 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 up to $120 per unit when used for a procedure that the contracting physician has authorized and 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 at no charge when provided at Ventura County Medical Center. In other Participating Hospitals, the Member will pay a Copayment to the hospital for each elective outpatient service.

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.

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.

Ventura County Health Care Plan

Medical and Hospital Services
BENEFIT SUMMARY

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

BENEFIT COVERAGE	VCMC	Non-VCMC
General		
Deductibles: This Plan has no deductibles		
Copayments		
Maximum per year (does not include Rx) - individual Maximum per year (does not include Rx) - family	$3,000 $6,000	$3,000 $6,000
Limitations		
Maximum benefit limit	Unlimited	Unlimited
Inpatient Hospitalization	$0 copay	$150 per day/$600 max
Acute care (other than bariatric surgery or removal of excess skin	$0 copay	$150 per day/ $600 max
Maternity care	$0 copay	$150 per day / $600 max
Rehabilitation and habilitation care (therapy designed to a restore member back to health)	Not Available	$50 per day / $500 max / 100 day max for Rehab/Skilled Nursing combination
Psychiatric care (See “Behavioral Health” section)		
Skilled nursing	Not Available	$50 per day / $500 max / 100 day max for Rehab/Skilled Nursing combination
Organ transplant services	Not Available	$150 per day / $600 max
Bariatric surgery	$3,000	$3,000
Medically necessary removal of excess skin	$1,500	$1,500
Surgical treatment of TMJ syndrome and malocclusion	50% copay	50% copay

BENEFIT COVERAGE	VCMC	Non-VCMC
Outpatients Services (provided in a facility)		
Emergency room	$75 per visit; no copay if admitted to hospital	$75 per visit; no copay if admitted to hospital
Urgent Care	$50 copay	$50 copay
Outpatient surgery - VCMC	$0 copay	$250 copay
Physician Services		
Primary care	$0 copay	$20 copay
Specialist	$0 copay	$30 copay
Allergy care (injections/serum)	$0 copay	$0 copay
Comprehensive prenatal care	$0 copay	$20 copay (initial visit only)*
Preventive care services	$0 copay	$0 copay**
Other Services (hospital/non-hospital based)		
Chemotherapy services	$0 copay	$20 copay (initial visit only)*
Diagnostic/screening X-ray, ultrasound, laboratory	$0 copay	$0 copay
Dialysis	Not Available	$10 copay per visit
Durable medical equipment DME (as defined by Medicare)	Not Available	$0 copay; 50% copay for replacement when medically necessary
Genetic testing	Not Available	10% of cost to $200 maximum
Home health (nursing and rehab) services 100 visit maximum. (Maximum shall not apply to Behavioral Health Treatment.)	Not Available	$15 copay per visit
Home health services for Hospice	Not Available	$0 copay
Imaging - MRI, CAT, PET	$0 copay	$125 copay
Infertility diagnosis, testing, injections & treatment	Not Available	50% of covered services
Infusion services, excluding drugs that could be self-injected	$0 copay	$20 copay
Orthotics when medically necessary, coverage limited to custom-made orthotics. Foot orthotics are excluded except for members with diabetes or plantar fasciitis	Not Available	$0 copay for initial purchase; 50% replacements

*No co-pay thereafter
**Preventive care services are provided without enrolee cost-sharing.

BENEFIT COVERAGE	VCMC	Non-VCMC
Physical, Occupational, Speech, Habilitation and Rehabilitation Therapy	$10 copay per visit	$20 copay per visit
Prosthetics	Not Available	100% coverage after $50 copay.; 50% replacements when medically necessary; unless post-mastectomy
Radiation therapy services	Not Available	$20 copay initial visit only*
Sterilization, elective	$100 copay	$100 copay
Termination of Pregnancy, elective	Not Available	$100 copay
Urgent Care	$20 copay	$50 copay
Optional Rider: Vision - refraction only	Not Available	Up to $50 copay reimbursement for refraction, once every 12 months
Optional Rider: Chiropractic / Acupuncture	Not Available	$20 copay per visit reimbursement to a combined maximum of 15 visits per plan year, no coverage thereafter
Ambulance		
Ground Transport when medically necessary	$50 copay	
Air Transport when medically necessary	$200 copay	
Perscription Medications		
Retail purchases (30-day supply max.)	generic drugs $9 copay preferred brand $30 copay non-preferred brand $45 copay	
Mail-order purchases (90-day supply max.)	generic drugs $20 copay preferred brand $60 copay non-preferred brand $90 copay	
Over-the-Counter (non-prescription)	See Plan website for listing of covered OTC medications	
Infertility medications	50% contracted rate	
Specialty drugs, including self-injectable drugs, received in any setting	25% of cost per Rx, up to $150; $300 maximum per month if multiple prescriptions	

*No co-pay thereafter

BENEFIT COVERAGE	***"Life Strategies"* Program administered by OptumHealth Behavioral Health solutions**
Behavioral Health (Mental Health + Chemical Dependency/Substance Abuse)	Through VCHCP's Life Strategies Program only.
Inpatient deductible	None
Inpatient psychiatric care	$150 per day; $600 maximum per stay
Residential/partial stay:	
Day treatment	$50/day, $500 maximum per stay
Outpatient Mental Health:	
Chemical Dependency / Substance Abuse:	
Office visits (other than for Serious Mental Illness)	$20 per visit
Behavioral Health (Mental Health + Chemical Dependency/Substance Abuse)	Through VCHCP's Life Strategies Program only.
Inpatient deductible	None
Inpatient	$150 per day; $600 maximum
Residential	$50/day, $500 maximum per stay.
Day Treatment	$50/day, $500 maximum per stay.
Inpatient or Outpatient Chemical Dependency / Substance Abuse:	
Office visits	$20 per visit
Inpatient deductible	None
Residential, partial, and day treatment	$50/day, $500 maximum per stay: 100 days maximum per year
Inpatient	$150 per day; $600 maximum per stay
Emergency and urgently needed services	$75 copay; copay waived if admitted to the hospital.

***There is currently no cost sharing, copays or deductible for inpatient or outpatient Behavioral Health Treatment for the treatment of Pervasive Developmental Disorder or Autism. This is subject to change.**

(2) 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:

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

(B) Physician services performed by an anesthetist or anesthesiologist in an ambulatory surgery center or in the Physician's office.

(C) Cancer Clinical Trial: Clinical trails 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:

- 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.
- 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.
- Screening trials test the best way to find cancer, especially in its early stages.
- 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 Centers for Medicare and Medicaid Services (CMS) 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 and 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.

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

(3) 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.

For the complete policy pertaining to DME rental and purchases, please contact the Plan for a copy of its DME policies and procedures.

(4) 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 education.

(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.

(5) Family Planning Services

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health plan at (805-981-5050, M-F 8:30 am – 4:30 p.m.) to ensure that you can obtain the health care services that you need.

(A) Family planning consultations for women of childbearing age, including the fitting, inserting, and removal of FDA-approved prescription contraceptive devices.

(B) Elective sterilization (not reversal of sterilization) procedures.

(C) Depo-provera, and FDA-approved prescription intrauterine devices.

(D) Therapeutic abortion services as permitted by law (when the life of VCHCP Member is endangered beyond the risks associated with routine pregnancy and delivery) at no charge.

(E) Elective abortion services as permitted by law.

(6) Home Health Care Services

Home Health Services are health services provided at the home by health care personnel. The Member's Primary Care Physician will set up a treatment plan describing the length, type, and frequency of the services to be provided. Includes visits by Registered Nurses, Licensed Vocational 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 #(19) of this Section: "Physical, Speech, and Occupational Therapy Services" (see page 20).

(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 #(11) of this Section: "Mental Health and Alcohol/Substance Abuse Services" (see page 17). Subject to copayments and maximum plan year and lifetime benefits for mental health and substance abuse services.

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

(7) 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.

(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.

(8) 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).

(9) 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.

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.

(10) 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.

(11) Mental Health and Alcohol/Substance Abuse Services

(Additional information may be obtained by consulting your Life Strategies 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 and partial-day treatment (counted as half day), and intensive outpatient therapy (3 hours counted as one-quarter day, 6 hours counted as one half day) combined are limited to fourteen (14) equivalent days per Plan year. Outpatient counseling, or group sessions are limited to twenty (20) outpatient visits per benefit year. Eligible services are for evaluation, crisis intervention, acute stabilization and management of a mental disorder as defined by the DSM IV and evidence of significant impairment in mental emotional or behavioral functioning. 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 designed to return the member to an adequate level of functioning. Services must have the potential of reducing or improving individual symptoms or conditions within a reasonable period of time as measured by accepted general standards of practice. Appointments not canceled 24 hours prior to a visit may count toward plan year visits limits. Subject to Copayments. Outpatient visit limits may be superseded if Group elects optional Chemical Dependency/ Substance Abuse and Mental Health Outpatient Benefit Rider.

(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. Annual outpatient visit and inpatient day benefit limits do not apply to coverage for SMI and SED. Copayments for the equivalent medical service apply.

(12) 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. *Female members may also choose an OB/Gyn to be their Primary Care Physicians.*

(13) 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.

(14) 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:

- Members who are under seven years of age.
- Members who are developmentally disabled, regardless of age.
- 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.**

(15) 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.

(16) 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, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Health Resources and Services Administration, as well as generally medically accepted cancer screening tests subject to all terms and conditions that would normally apply.

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

Preventive care services are provided without enrollee cost-sharing. (No copay).

(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. tests. Coverage for an annual cervical cancer screening test shall include the conventional Pap test, human papilloma virus (HPV) screening test, that is approved by the Federal food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA." The frequency of such examinations shall not be increased for reasons which are unrelated to the medical needs of the 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.

(17) Pregnancy Services

(A) Physician services in the Physician's office for any condition or complications resulting from pregnancy or resulting childbirth and any complications, prenatal, delivery, antepartum, and postpartum care are covered. *Subject to Copayments for certain Benefit Plans and timely newborn enrollment (within 31 days of birth). See Eligibility, Enrollment and Effective Dates.*

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

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

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

(18) 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.

(19) Physical, Speech, Occupational, Rehabilitation and Habilitation 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 except for services obtained from Qualified Autistic Specialists, QAS professionals, and QAS paraprofessionals.

(20) Reconstructive Surgery

(A) VCHCP covers medically necessary reconstructive surgery to restore and achieve symmetry and surgery performed to correct or repair abnormal structures of the body caused by congenital defects developmental abnormalities, trauma, infection, tumors or disease to improve function. This includes the cleft palate procedure.

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

(C) 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.

(21) 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 up to $120 per unit when used for a procedure that the contracting physician has authorized and scheduled.

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

(22) Transplantation Services

Hospital and professional services provided in connection with human cornea, kidney, or skin 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, 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.

(23) Additional Benefits

(A) Infertility services including diagnostic testing, infectious disease screening, semen analysis, office visits (including information and counseling) and injection treatments provided in Participating physician's office.

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

(24) Optional Benefits

The Group may offer Optional Group Benefits and Riders in its Benefit Plan subject to additional premiums when appropriate. These benefits are not in effect unless a Rider describing the benefit is included in this document.

Following are the available options:

- Pharmacy Benefit
- Annual Vision Exam Reimbursement
- Alternative Care Reimbursement

Optional Benefit Rider – Prescription Drugs

The Ventura County Health Care Plan ("Plan") provides pharmacy coverage through a contract with a pharmacy benefit manager ("PBM"). 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 the conditions, limitations, exclusions and copayments.

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:

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

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

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

d. Prescription inhalers.

e. Prescription vitamins, including prenatal vitamins.

f. Pain management medications for terminally ill patients, retail-only, inpatient and outpatient.

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

h. Testosterone (injectable) retail only

i. 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.

j. 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:

1. Covered Medications must be dispensed by a Participating Pharmacy. The pharmacy benefit manager 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.

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

3. 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.

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

5. The Plan maintains a Preferred Drug List (PDL), which is a list of covered prescription drugs by major therapeutic category. This PDL is reviewed and approved by the Plan Pharmacy & Therapeutics Committee annually. 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 for a particular medical condition.
6. 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.
7. Certain medications have maximum quantity limits per prescription.
8. 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 35, for additional information.
9. Except for insulin, medically necessary patient injectable medications are covered with a 25% up to $150 maximum copayment and are only available in a retail (30-day) supply.
10. Medications not medically necessary for the treatment of the condition for which it is administered are excluded.
11. Cosmetics, health or beauty aids, dietary supplements (except for conditions of PKU), anorexants (i.e., appetite suppressants), 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.
12. Placebo injections and medications are excluded, except when medically necessary.
13. The Plan does not cover replacement of medications that are misplaced, lost, damaged or stolen.
14. Enhancement medications when prescribed for sexual performance are excluded.
15. The prescribing practitioner must be an individually licensed and currently Drug Enforcement Administration 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 27 of this document.
16. 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.

17. 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 # (23) ***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

Optional Benefit Rider - 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 the Plan, accompanied by a receipt, within 180 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 # (16), *"Health Evaluations (Preventive Health Services)"*, page 19 in this document, for additional benefit information on vision screening testing for persons through the age of 16 years.

Optional Benefit Rider - Alternative 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. Primary Care Physician referral or prior authorization for a chiropractor or acupuncturist is not required. Ancillary services, such as x-ray, ordered by a chiropractor or acupuncturist require prior authorization from the Plan. Subscriber must submit to Plan a reimbursement claim form accompanied by receipt(s) for reimbursement within 180 days of service.

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. The exclusions and limitations relating to the optional benefits will only be included in this section if the employer purchases the coverage. **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.

1. Air purifiers, air conditioners, humidifiers, dehumidifier
2. 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.
3. Alternate birthing center or home delivery, (also see "Home Birth"). The Plan covers home delivery expenses in cases of emergency.
4. Alternative Care Services such as faith healing including Christian Science Practitioner; Homeopathic medicine; Hypnotherapy; Sleep therapy; Biofeedback unless medically necessary for the treatment of Pervasive Developmental Disorder or Autism; Behavior therapy unless determined to be medically necessary. See optional benefit rider for reimbursement for chiropractor and acupuncturist services.

5. 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.
6. Any services, supplies or benefits that are not Medically necessary.
7. 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.
8. 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.
9. Cosmetic surgery, including surgery for psychological reasons and complications resulting from such surgery, except cosmetic reconstructive surgery following a mastectomy for cancer. 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.]*
10. Custodial or Domiciliary Care. Except for those services provided as a part of Hospice Care (please see Item #(7) in the section titled "Summary Of Covered Services And Supplies", page 14), VCHCP does not cover services and supplies that are provided primarily to assist with the activities of daily living, regardless of where performed, unless medically necessary for the treatment of Pervasive Developmental Disorder or Autism. 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.
11. 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.
12. 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.
13. 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.
14. Durable medical equipment, devices or appliances not covered include:
    - Exercise equipment
    - Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services).
    - Orthotics, unless made to fit the Member's body. (Orthotics are supports or braces for weak or ineffective joints or muscles.)
    - Foot orthotics (whether or not custom fit) that

are not incorporated into cast, splint, brace, or strapping of the foot.

- Spa and whirlpools.
- Stockings, corrective shoes, and arch supports.

15. Elevators, chair lifts, wheelchair ramps, etc.
16. Emergency room services for non-Emergency purposes; Non-Emergency Services provided outside VCHCP's Service Area without a Referral Authorization from VCHCP Medical Director.
17. Exercise programs, equipment and weight reduction programs, certain dietary supplements
18. Experimental or investigational services – VCHCP does not generally cover experimental drugs, devices, procedures or other therapies except when:
    - Independent review deems them appropriate;
    - Clinical trials for cancer patients are deemed appropriate
    - No alternative treatment options exist and the Member has a life-threatening or seriously debilitating condition; or
    - VCHCP's Medical Director and your Primary Care Physician agree it is the best and only course of treatment.

    Please see the section, in this document, titled "Independent Medical Review (Experimental/ Investigational)", page 35, for additional information.
19. Eye refractions for the purpose of determining the need for eyeglasses or contact lenses; routine vision exams for Members age seventeen (17) years of age or older; furnishing, fitting, installing or replacing of eyeglasses or contact lenses; radial keratotomy and other refractive procedures. *Portions of this exclusion may be superseded if Group elects optional Vision Exam Reimbursement*.
20. Hearing examinations for Members seventeen (17) years of age or older except as Medically Necessary; furnishing, fitting, installing or replacing hearing aids.
21. Orthotics. Orthotics which are not custom made to fit the Member's body are not covered. Custom made orthotics, except for foot orthotics are a covered benefit.

    Foot orthotics (whether or not custom fit) that are not incorporated into cast, splint, brace, or strapping of the foot are not covered except for members with diabetes, plantar fasciitis or post-surgery for stabilization or as an alternative to a cast.
22. Home birth is only covered when the criteria for Emergency Care, as defined in this Evidence of coverage, have been met. Midwife services are not covered.
23. Certain over-the-counter medications not requiring a prescription; Nonprescription drugs; Outpatient Prescription drugs unless the group elects optional Pharmacy Benefit.
24. Physical examinations, ancillary tests, and reports for the purpose of obtaining or continuing employment, insurance, government licensure, travel, school admissions, premarital purposes, camp or school physical, school or non-school related sporting activities, health screening for adoption clearance, jail or prison medical clearance, medical clearance for behavioral health facility or program clearance, compliance with court order, or for purposes of obtaining or retaining certification or licensure; Immunizations for the purpose of work or travel.
25. Private duty nursing for registered bed patients in a hospital or long-term care facility.
26. Recreational, art, dance, sex, sleep, or music therapy and other similar therapies unless medically necessary for the treatment of Pervasive Developmental Disorder or Autism..
27. 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.
28. Saunas, Jacuzzi, whirlpools, other pools and other like devices.
29. 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 # (7) in the section titled *"Summary of Covered Services and Supplies"*, page 14) are covered benefits.]
30. Services required by court order or as a condition of parole or probation, unless Medically Necessary and Member is self-motivated to receive services.
31. Supplies for comfort, hygiene, or beautification

including cosmetics, hair pieces, toupees, and wigs.

32. 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.
33. Testing or evaluation for custody, education, or for vocational purposes unless medically necessary for the treatment of Pervasive Developmental Disorder or Autism.
34. Reversal of sterilization.
35. Treatment for disability, illness or injury related to military service or temporary active duty.
36. Treatment for mental illness, including chemical dependency, except as specifically provided herein; psychological testing except to evaluate the need for treatment for a psychiatric conditions; psychoanalysis; educational or vocational counseling except for the treatment of Pervasive Developmental Disorder or Autism.; non-medical treatment for mental retardation, learning or fetal alcohol syndrome disabilities.
37. Work-related illnesses or injuries, or services provided or arranged by a governmental agency.
38. Durable medical equipment, orthotics, or other covered equipment that is lost, misplaced, stolen, or damaged due to improper usage.
39. Modification, alteration or other renovation of members home/dwelling to accommodate medical equipment or appliances.
40. Vehicle or customization of a vehicle to accommodate medical equipment or appliances.
41. Any services not specifically identified in the "covered services" section.

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.

Refusal of Treatment: Coverage is not provided for care of conditions where a Member has refused recommended treatment.

CONTINUITY OF CARE

Continuity of Care for New Enrollees by 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 the duration of that condition,
- for a serious chronic condition, not to exceed 12 months from your effective date of enrollment,
- for a pregnancy including the duration of the pregnancy and immediate postpartum care,
- for a terminal illness, for the duration of the ilness,
- for care for children from birth to age thirty-six (36) months, not to exceed 12 months from your effective date of enrollment, or
- if you have a surgery or other procedure that has been recommended 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.

Continuity of care by a terminated provider will not be provided if the terminated provider was terminated for fraud or criminal activity. 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: If you receive Covered Services from VCHCP, and you are eligible for the same services under any other plan or contract providing services or benefits for medical care, payment for the Covered Services shall be coordinated in accordance with the provisions of State law and the regulations promulgated there under, and the applicable policies of VCHCP. If VCHCP pays benefits greater than it should have under the applicable Coordination of Benefits (COB) provision, VCHCP shall have the right to recover the excess payment from any other person or entity which may have benefits from the overpayment. As a Member, you agree to assist VCHCP in recovering any overpayments.

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

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

1. For dependent children living with both parents, the primary plan is determined by the birthday rule: the plan of the parent whose birthday (month and date) falls earlier in the year is primary. The plan of the parent whose birthday falls later in the year is secondary.
2. The primary plan for dependent children of separated or divorced parents is the plan of the parent with custody of the child, followed by the plan of the spouse of the parent with custody, then the plan of the parent without custody of the child.
3. If none of the above rules determines the order of benefits, the primary plan is the plan that has covered an employee or member longer. The secondary plan is the plan that has covered the person for the shorter period.
4. Medicare is generally a secondary payor for active employees and their dependents.

In order for the Plan to act as a secondary payor for non-emergency services, a Plan Provider must be used and the services must be Authorized by the Plan. Proof of Authorization by the primary payor may be required.

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.

PREMIUMS

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

TERMINATION OF BENEFITS

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

Loss of Eligibility: If you or your Dependent no longer meets the eligibility requirements of VCHCP described in Eligibility, Enrollment and Effective Dates section beginning on page 2, you and/or your enrolled Dependents will be terminated automatically at midnight on the last day of the pay period after the pay period in which loss of eligibility occurs. If enrollment terminates under certain circumstances, you and/or your enrolled Dependents may be able to obtain continuing coverage from VCHCP as explained below.

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

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

1. Failure to furnish material information or furnishing incorrect or incomplete material information: Each Member warrants that all material information contained in enrollment applications, questionnaires, forms or statements submitted to VCHCP incident

to enrollment is correct and complete. If you fail to furnish required information or you furnish incorrect or misleading material information, VCHCP may terminate you and your enrolled Dependent's membership, effective as of the date you failed to furnish material information or furnished incorrect or misleading material information. You may be liable for the costs of services rendered subsequent to such act. This includes information submitted or requested to verify Dependent status.

2. Fraud or deception: If you engage in fraud or deception in the use of the services or facilities of VCHCP or knowingly permit such fraud or deception by another person, then VCHCP may terminate your Coverage effective as of the date the fraud or deception was committed. This includes, but is not limited to, permitting the use of your Plan identification card by any other person.

3. 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.

   If you receive notice that your coverage is being canceled or non-renewed due to failure to pay your premium, VCHCP must provide you with a 30-day "grace period". The grace period begins after the last day of paid coverage. VCHCP must continue to provide coverage during the grace period, though you will be financially responsible for the premium for the coverage provided during the grace period. The grace period must last at least 30 days from the date of this notice. During the grace period, you can avoid cancellation or nonrenewal

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

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.

INDIVIDUAL CONTINUATION OF BENEFITS

COBRA Continuation Coverage:

1. Qualifying Event: Upon timely election, COBRA Continuation Coverage (COBRA Coverage) shall begin on the date of loss of Coverage due to of one of the following "qualifying events":
   a. The Subscriber's termination, retirement or separation from employment other than by reason of such Subscriber's gross misconduct.
   b. Reduction in the Subscriber's hours, or other change in employee status resulting in loss of eligibility for medical benefits.
   c. The death of the Subscriber.
   d. The divorce or legal separation of the Subscriber from the Subscriber's spouse (who is a Member).
   e. An enrolled child ceases to qualify as a Dependent.
   f. A proceeding in a case under Title 11 of the United States Code involving the bankruptcy of the Group.

   Coverage will terminate on the earliest of:

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

termination date; or

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

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

COBRA eligibility ceases when any of the following occur:

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

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

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

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

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

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

* Per diem nurses and County contracted providers are NOT eligible for COBRA, Cal-COBRA, or Conversion coverage

Cal-COBRA Coverage

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

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

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

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

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

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

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

The Premium for your Cal-COBRA Coverage may be as high as one hundred ten percent (110%) of your COBRA Coverage Premium. The Plan will notify you of the terms

and conditions of Cal-COBRA Coverage, and of the exact Premium for such Coverage, in its notice to you of the pending termination of your COBRA Coverage.

Extension of Continuation Coverage

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

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

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

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

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

Termination of the Group Agreement: If the Group terminates the Agreement and replaces it with similar coverage under another group contract within fifteen (15) days of the date of termination of the Group coverage or the Subscriber's participation, 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 or conversion to (Individual) Conversion Coverage to all Members enrolled through the Group.

Non-Group (Individual) Conversion Coverage: Once you have exhausted your Federal COBRA and Cal-COBRA coverage under the Plan, you may apply for non-group (Individual) Conversion Coverage. If your Coverage under the Plan ends, you may apply for non-group (Individual) Conversion Coverage. To do so, you must submit an application to the Plan within sixty-three (63) days of the date your Coverage ends. VCHCP will advise you of your options for Conversion Coverage, and the Premiums for such coverage, in its notice to you of the end of your Coverage. Under certain circumstances you are not eligible for a Conversion Coverage.

You are not eligible for conversion coverage if:

1. Your Coverage under the Plan ends because the Agreement terminates and is replaced by similar coverage under another group contract within fifteen (15) days of the date of termination.

2. Your Coverage under the Plan ends because premium payments are not paid when due because you (or the Subscriber who enrolled you as a Dependent) did not contribute your part, if any.

3. You are eligible for health coverage under another group plan when your Coverage ends.

4. You are eligible for Medicare when your Coverage

under the Plan ends, whether or not you have actually enrolled in Medicare.

5. You are covered under an individual health plan.

6. You were not covered under the Benefit Plan for three (3) consecutive months immediately prior to the termination of your Coverage.

The intention of Conversion Coverage is not to replace the Coverage you have under the Plan, but to make available to you a specified amount of coverage for medical benefits until you can find a replacement. Conversion Coverage provides lesser benefits than the Plan and the Premiums are higher.

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.

Right to Request Review of Recission, Cancellation, or Non-renewal of Your Enrollment or Subscription

If you believe that your health plan enrollment or subscription has been, or will be, improperly rescinded, canceled, or not renewed, you have the right to file a complaint. A complaint is also called a Grievance or Appeal.

First, file your complaint with VCHCP:

You may file a complaint with VCHCP by calling 805-981-5050 or by visiting http://www.vchealthcareplan.org/.

You should file your complaint as soon as possible after you receive notice that your health plan enrollment or subscription will be rescinded, canceled, or not renewed.

If your problem is urgent, VCHCP must give you a decision within 3 days. Your problem is urgent if there is a serious threat to your health that must be resolved quickly.

If your problem is not urgent, VCHCP must give you a decision within 30 days,

Take your complaint to the California Department of Managed Health Care (DMHC):

The DMHC oversees HMO's and other health plans in California and protects the rights of HMO members. You can file a complaint with the DMHC if:

You are not satisfied with VCHCP's decision about your complaint, or

You have not received the decision within 30 days, or within 3 days if the problem is urgent.

The DMHC may allow you to submit a complaint directly to the DMHC, even if you have not filed a complaint with your health plan, if the DMHC determines that your problem requires immediate review.

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

For help, contact:
Help Center, DMHC
980 Ninth st., Suite 500
Sacramento, CA 95814-2219
TDD: 1-877-688-9891
FAX: 1-916-255-5241
www.hmohelp.ca.gov

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

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 newsletter titled "Health Coverage News" that the Group distributes 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. The Plan will provide written notice of changes in premiums at least thirty (30) days porior to the contract renewal effective date.

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. If you wish to become a member of the Standing Committee, please write to the Plan stating your request.

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

MEMBER GRIEVANCE PROCEDURE

You may register complaints with VCHCP by calling or writing:
Ventura County Health Care Plan
2220 E. Gonzales Road, Suite 210-B,
Oxnard, CA 93036
(805) 981-5050 or (800) 600-VCHP

In cases where it is medically necessary, the Plan may complete the review in less than 24 hours based upon the nature of the enrollee's medical condition. The Plan will notify the requesting physician by telephone or facsimile within 24 hours of making a decision and will notify the physician and the enrollee in writing within two business days or making the determination. Enrollees may file a grievance for at least 180 calendar days following an incident or action that is the subject of the enrollee's dissatisfaction."

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 righthand side of the Plan's internet @ 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.

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

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

Enrollees may file a grievance for at least 180 calendar days following an incident or action that is the subject of the enrollee's dissatisfaction.

INDEPENDENT MEDICAL REVIEW OF GRIEVANCES INVOLVING A DISPUTED HEALTH CARE SERVICE

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

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for an IMR. The Plan must provide you with an IMR application form with any grievance disposition letter that denies, modifies, or delays health care services. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against the Plan regarding the disputed health care service.

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

1. a. Your Provider has recommended a health care service as medically necessary, or
   b. You have received Urgent Care or Emergency Care that a Provider determined was medically necessary, or
   c. You have been seen by 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
www.hmohelp.ca.gov

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

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

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

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

MEDIATION

You and your Dependents may request that an unresolved disagreement, dispute or controversy concerning any issue(s) including the provision of medical services, arising between you, and your Dependents, your heirs-at-law, or your personal representative, and VCHCP, its employees, 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, 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. [Also see definition for Pervasive Developmental Disorders (PDD).] *Source: Web MD.*

"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.

"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.

"Creditable Coverage" means any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation and conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care dental, vision, coverage issues as a supplement to liability insurance, insurance arising out of workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

"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" 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.

"Eligible Employee" means either of the following: (1) Any permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours, at the small employer's regular places of business, who has met any statutorily authorized applicable waiting period requirements. The term includes sole proprietors or partners of a partnership, if they are actively engaged on a full-time basis in the small employer's business and included as employees under a health care plan contract of a small employer, but does not include employees who work on a parttime, temporary, or substitute basis. It includes any eligible employee, as defined in this paragraph, who obtains coverage through a guaranteed association. Employees of employers purchasing through a guaranteed association shall be deemed to be eligible employees if they would otherwise meet the definition except for the number of persons employed by the employer. Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be eligible employees if all four of the following apply:

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

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

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

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

"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.

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

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

"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 employees and their eligible dependents. It is the County of Ventura as the Employer of active employees and former Employer of retired employees.

"Habilitation" or "Habilitative Care" means health care services that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

"Habilitation Services" health services provided in order to develop or create one's capabilities for functioning.

"**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. This also includes Behavioral Health Therapy administered by a Qualified Autism Service (QAS) provider, a QAS professional, or a QAS paraprofessional.

"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.

"Infertility" is defined as a diminished or absent ability to conceive, or an inability to carry a pregnancy to a live birth, and subsequently produce, offspring after a period of a year or more of regular and unprotected sexual relations. Infertility does not exist when the Member has gone through menopause.

"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 there under.

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

"Late enrollee" means an eligible employee or dependent who has declined enrollment in a health benefit plan offered by a small employer at the time of the initial enrollment period provided under the terms of the health benefit plan and who subsequently requests enrollment in a health benefit plan of that small employer, provided that the initial enrollment period shall be a period of at least 30 days. It also means any member of an association that is a guaranteed association as well as any other person eligible to purchase through the guaranteed association when that person has failed to purchase coverage during the initial enrollment period provided under the terms of the guaranteed association's plan contract and who subsequently requests enrollment in the plan, provided that the initial enrollment period shall be a period of at least 30 days. However, an eligible employee, any other person eligible for coverage through a guaranteed association pursuant to subdivision (o), or an eligible dependent shall not be considered a late enrollee if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) He or she was covered under another employer health benefit plan, the Healthy Families Program, or no share-of-cost Medi-Cal coverage at the time the individual was eligible to enroll.

(B) He or she certified at the time of the initial enrollment that coverage under another employer health benefit plan, the Healthy Families Program, or no share-of-cost Medi-Cal coverage was the reason for declining enrollment, provided that, if the individual was covered under another employer health plan, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) He or she has lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment **s**tatus of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation, divorce, loss of coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, or loss of no share-of-cost Medi-Cal coverage.

(D) He or she requests enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan.

(2) The employer offers multiple health benefit plans and the employee elects a different plan during an open enrollment period.

(3)A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan.

(4)(A)In the case of an eligible employee, as defined in paragraph (1) of subdivision (b), the plan cannot produce a written statement from the employer stating that the individual or the person through whom the individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed, acknowledgment of an explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from coverage for a period of 12 months as well as a six-month preexisting condition exclusion, unless the individual meets thecriteria specified in paragraph (1), (2), or (3).

"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:

- It is a clinically significant behavioral or psychological syndrome or pattern;
- It is associated with a painful symptom, such as distress;
- It impairs a person's ability to function in one or more of life's activities; or
- 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 delayed until you return to the Plan's Service Area. Ventura County Health Care Plan's Members have a responsibility to follow the plans and instructions for care that they have agreed upon with their Providers.

"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: Web MD.*

"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.

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

"Qualifying Event" means any of the following events that, but for the election of continuation coverage under this article, would result in a loss of coverage under the group benefit plan to a qualified beneficiary: death of a covered employee; termination or reduction in a covered employee's hours of employment except for termination due to gross misconduct; divorce or legal separation of the covered employee from the covered employee's spouse; loss of the dependent status by a dependent enrolled in the group benefit plan; with respect to the covered dependent only, the covered employee's entitlement to benefits under Title XVIII of the United States Social Security Act (Medicare).

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

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

a. improve function, or

b. create a normal appearance, to the extent possible.

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

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

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

"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 (a) that the Member, if an employee, is prevented, because of injury or disease, from performing his or her occupational duties and is unable to engage in any work or other gainful activity for which he or she is fitted by reason of education, training or experience, or for which he or she could reasonably become fitted or (b) that the Member, if a Dependent, is prevented because of non-occupational injury or non-occupational disease, from engaging in substantially all of the normal activities of a person of like age and sex in good health.

"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.

Standards for Members' Rights and Responsibilities

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

1. Members have a right to receive information about VCHCP, its services, its Providers, and Members' rights and responsibilities.
2. Members have a right to be treated with respect and recognition of their dignity and right to privacy.
3. Members have a right to participate with Providers in decision making regarding their health care.
4. Members have a right to a candid discussion of treatment alternatives with their Provider regardless of the cost or benefit coverage of the Ventura County Health Care Plan.
5. Members have a right to voice complaints or appeals about VCHCP or the care provided.
6. Members have a responsibility to provide, to the extent possible, information that VCHCP and its Providers need in order to care for them.
7. Members have a responsibility to follow the plans and instructions for care that they have agreed upon with their Providers.

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