VCHCP Ventura County Health Care Plan

AIM
Access for Infants and Mothers

Benefits Booklet
February 1, 2009 through June 30, 2009

Ventura County Health Care Plan
Combined Evidence of Coverage and Disclosure Form

VENTURA COUNTY HEALTH CARE PLAN
ACCESS FOR INFANTS AND MOTHERS (AIM) PROGRAM
COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

INTRODUCTION

Welcome to the Ventura County Health Care Plan ("VCHCP" or the "Plan"), operated by the County of Ventura. The Plan's Service Area is Ventura County. This Combined Evidence of Coverage and Disclosure Form discloses the terms and conditions of coverage that we will make available to the Subscriber in the AIM Program. You have a right to view this document prior to enrollment in the Plan. You should read this document completely and carefully and if you have special needs, you should read carefully those sections that apply to you. For your convenience a glossary of terms used in this document has been provided, beginning at page 34.

Eligibility and Enrollment

Information about eligibility, enrollment, the starting date of coverage, coverage limitations, transfers to another health plan, infant registration, subscriber contributions, and disenrollment, is included in the Access for Infants and Mothers (AIM) Handbook that was mailed to you by the AIM Program. If you have questions on these topics or would like another copy of the Handbook, please contact the AIM Program at the address listed below.

Health Coverage for Infants

Your infant is automatically eligible for enrollment in the Healthy Families Program (HFP) if you qualify for Access for Infants and Mothers (AIM) Program. Once enrolled, your infant will receive care through HFP by the same plan that you have in AIM. However, your infant cannot be enrolled in the HFP if they are enrolled in either employer-sponsored health insurance or in the no-cost full-scope Medi-Cal Program. The State will mail you a packet of information about thirty (30) days prior to your expected due date. Once you deliver your baby, complete and mail the Infant Registration Form, along with other requested information and any premiums that are due, to the State at:

Access for Infants and Mothers (AIM)
P.O. Box 15559
Sacramento, CA 95852
1-800-433-2611 (phone)
1-888-889-9238 (fax)
1-800-735-2929 (California Relay Service for the hearing impaired)
Monday – Friday 8:00 a.m. – 8:00 p.m.
Saturday 8:00 a.m. – 5:00 p.m.

Refer to the HFP Evidence of Coverage booklet to learn more about covered services for your baby.

Additional information about the AIM Program is available at the Managed Risk Medical Insurance Board website at www.mrmib.ca.gov

Disclosure

This Combined Evidence of Coverage and Disclosure Form (EOC) constitutes only a summary of the Plan's policies and coverage under the Access for Infants and Mothers (AIM) Program. The Plan's contract and the AIM regulations (California Code of Regulations, Title 10, Chapter 5.6) issued by the California Managed Risk Medical Insurance Board (MRMIB), should be consulted to determine the exact terms and conditions of coverage. These regulations may be viewed on the Internet at http://www.mrmib.ca.gov. Additionally, the AIM regulations require the Plan to comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, as amended (California Health and Safety Code section 1340, et seq.), and the Act's regulations (California Code of Regulations, Title 28). Any provision required to be a benefit of the program by either the Act or the Act's regulations shall be binding on the Health Plan, even if it is not included in the Evidence of Coverage booklet or the Health Plan contract.

You may contact the Plan by telephone at (805) 677-8787, by facsimile at (805) 677-5179, or by sending written correspondence to Ventura County Health Care Plan, 2323 Knoll Drive, # 417, Ventura, California 93003. The Plan's toll-free number is (800) 600-8247. Member Services representatives, bilingual in Spanish and English, are available from 8:30 a.m. to 4:30 p.m. Pacific Time on regular business days. Telephone communication services of a professional language interpreter are available twenty-four hours a day for Subscribers who do not speak English and need assistance in accessing Plan Benefits. After regular business hours, this access is made through your Primary Care Provider. The speech and hearing impaired may contact the Plan through the California Relay Service at (800) 735-2929 to communicate in English or (800) 855-3000 to communicate in Spanish. You may call the Plan if you need an interpreter for medical appointments. You may submit any claims for reimbursement of payment you made for covered services to VCHCP at the Plan's address above.

Ventura County Health Care Plan

BENEFIT SUMMARY MATRIX

Access for Infants and Mothers Program	Maximum
Annual or lifetime Covered Benefit financial maximum	None
Benefit year maximums:	
Mental health	20 outpatient visits and 30 equivalent inpatient days, excluding treatment for Severe Mental illnesses (SMI) and serious Emotional Disturbance (SED) which is unlimited
Substance abuse outpatient visits	20 visits
Home health care	100 visits

Benefit	Your Payment
HOSPITAL SERVICES	
Inpatient hospital services	No charge
Organ transplant services	No charge
Inpatient Mental Health Care Services • Mental health care in a participating hospital when ordered and preforment by a participating mental health professional for the treatment of a mental health condition	No charge
Basic Mental Health Care Services • Diagnosis and treatment of a mental health condition • 30 days per benefit year. Additional days may be authorized by the Plan. • 2 days of residential treatment • 3 days o day care treatment, or • 4 outpatient visits	No Charge
Severe Mental Illnes (SMI)	No Charge
* Inpatient mental health care service for the treatment of severe mental illnesses. • Unlimited days	No Charge
Serious Emotional Disturbance (SED) Services • Inpatient mental health care services for the treatment for SED condition • Unlimited days	No Charge

Benefits	Your Payment
OTHER MENTAL HEALTH BENEFITS	
Outpatient mental health care services	
• Mental health care when ordered and performed by a participating mental health professional	
Basic Mental Health Care Services	No Charge
• This includes the treatment for members who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, divorce, or bereavement in the treatment.	
• Family members may be involved in the treatment when medically necessary for the health and recovery of the child.	
• 20 visits per benefit year, Additional days may be authorized by the Plan.	
Severe Mental Illness (SMI)	No Charge
• Outpatient mental health care visits for the treatment of severe menal illnesses.	
• Unlimited visits	
Serious Emotional Disturbance (SED) Services	No Charge
• Outpatient mental health care visits for the treatment for SED condition	
• Unlimited visits	
Inpatient drug detoxification	No charge
Emergency and urgently needed services (Emergency Room)	No charge
Other outpatient facility services	No charge
Inpatient therapy and drugs administered in the hospital	No charge
OTHER BENEFITS	
Periodic health exams, diagnostic testing, vision and hearing tests	No charge
Allergy treatment visits	No charge
Standard immunizations and other drugs administered in the office	No charge
Surgery and anesthesia services	No charge
Radiation, chemotherapy, or dialysis (facility and professional services)	No charge
Inpatient professional services	No charge
Prenatal care visits	No charge
Family planning visits	No charge
Contraceptive devices	No charge
Other outpatient professional services (office or home visits)	No charge

Benefits	Your Payment
PHARMACY BENEFITS	
Retail prescriptions (30 days supply at a time)	No charge
Maintenance prescriptions (90 days mail order at a time or 30 days retail supply at a time.)	No charge
Outpatient or home physical, occupational and speech therapy	No charge
Home health care nurse or home health aide	No charge
Hospice	No charge
Orthotics, prosthetics and durable medical equipment	No charge
Diagnostic laboratory and radiology services	No charge
Ambulance or other approved medical transportation services	No charge
Blood and blood products	No charge
Voluntary termination of pregnancy	No charge
Health Education including nutritional assessment	No charge
OTHER BENEFITS	
Outpatient or home physical, occupational and speech therapy	No charge
Home health care nurse or home health aide	No charge
Hospice	No charge
Outpatient mental health visits	No charge
Orthotics, prosthetics and durable medical equipment	No charge
Diagnostic laboratory and radiology services	No charge
Ambulance or other approved medical transportation services	No charge
Blood and blood products	No charge
Voluntary termination of pregnancy	No charge
Health Education including nutritional assessment	No charge

ACCESSING CARE

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

Choosing a Physician: If you did not select a Primary Care Physician when you enrolled in VCHCP, VCHCP will ask you to make a selection. You have twenty (20) days after the effective date of your coverage to make a Primary Care Physician selection. If you do not choose a Primary Care Physician, VCHCP will select a Primary Care Physician for you, taking into account your city of residence and the primary language listed on your Enrollment Form. Your Primary Care Physician is responsible for directing your medical care and for coordinating the provision of Medically Necessary Benefits, including Referrals to Specialist Physicians, ordering x-ray and laboratory tests, prescribing medicines, and arranging for hospitalization. You are required to contact your Primary Care Physician or medical group for all Covered Services, except for emergency and out-of-area urgent care services. Some of our PCPs work with and supervise other members of a Health Care Team by whom you may be seen, including licensed nurse practitioners, certified physician assistants, certified nurse-anesthetists, certified nonphysician-surgical assistants, physicians in residency training programs and nurses. For your convenience a list of providers has been included in this booklet, beginning at page 32.

Changing Medical Groups or PCPs: If you wish to change your PCP or medical group, you may do so by contacting the Member Services Department. Changes will take effect on the first day of the month following your request. You may change your medical group or PCP as often as every thirty (30) days.

Member Notification When a Physician Is No Longer Available: In the event your PCP is no longer available, VCHCP will select a new Physician for you, taking into account your city of residence and the primary language listed on your Enrollment Form. We will mail you a letter of explanation with a new Identification Card. If you would prefer another physician, follow the instructions in the above paragraph. For information on the provision of continuity of care when your physician is no longer available, please see the section entitled "Continuity of Care by Terminated Provider" at page 23.

Scheduling Appointments: Contact your PCP or medical group to schedule appointments. You should expect to receive an appointment within 24 hours for urgently needed services, an appointment within two weeks for routine services, and an appointment within four weeks for periodic health exams.

Referrals for Health Care Services: The Plan has contracted with a broad range of Providers who are conveniently located to provide access to Medically Necessary Benefits. Your PCP must ask VCHCP for prior approval for referrals to health care services including Specialist Physicians. The Plan processes routine requests for health care services made by your PCP within five business days and urgent requests made by your PCP or treating provider within 72 hours from the Plan's receipt of information that is reasonably necessary and requested by the Plan to make the determination. 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. The Plan faxes the written authorization to both the PCP and the referred specialist. Decisions resulting in denial, delay, or modification of all or part of the requested health care service are mailed to the Member. If the Plan cannot process your PCP's request within the specified time frames, you will receive a written explanation for the delay.

Accessing Mental Health/Substance Abuse Services: Information and authorization of Plan mental health and substance abuse benefits are available by calling the Plan's Behavioral Health Administrator, Life Strategies/PBHC, at (800) 851-7404. A Life Strategies Representative is available 24 hours a day to assist in emergency mental health or substance abuse care coordination. For non-emergency requests either the Member or the Member's PCP can contact Life Strategies for the required authorization of benefits prior to seeking mental health and substance abuse care.

Prior Authorization for Out-of-Network Providers: Your PCP must ask VCHCP for prior approval for referrals to out-of-network providers. If the requested services are covered Benefits and are determined as Medically Necessary by the Plan, and if VCHCP does not have a Contracted Provider who can provide the requested services, VCHCP will approve the request.

If a Plan decision is made to modify the request such that care is authorized to be provided by a contracted provider, VCHCP will notify the PCP and the Member in writing. The Plan will notify the requesting Provider of decisions to deny or modify requests for authorization of Covered Services within twenty-four (24) hours of the decision. You are notified of decisions, in writing, within two (2) business days of the decision. The written decision will include the specific reason(s) for the decision, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity, and information about how to file an appeal of the decision with the Plan. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon your request. The Member has the right to appeal this decision.

Standing Referrals: You may receive a Standing Referral to a specialist for a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling. You may obtain copies of VCHCP's Standing Referral to a Specialist Policy by contacting Member Services. A female Member can directly seek obstetrical and gynecologic services from a Ventura County Medical Center Clinic offering these services or from an obstetrician/gynecologist contracted with the Plan to provide covered services to AIM Members. A female Member may also seek maternity care directly from her PCP. The VCHCP Provider Directory identifies those OB/GYN direct access providers and PCP's who provide maternity care.

UTILIZATION REVIEW

Prior Authorizations for Referrals
Your PCP must request, arrange for, and obtain the Plan's Prior Authorization for referrals to specialists, hospitalizations, and for certain other benefits.

Criteria and Timeframes for Authorization of Services
When Covered Services are requested, the Plan uses established utilization management criteria, developed using industry standards, to approve, deny, delay or modify authorization of benefits based on Medical Necessity. The criteria used to deny, delay, or modify requested services in your specific case will be provided upon request to the Participating Provider and to you. The decisions to deny, delay, or modify requests for authorization of Covered Services, based on Medical Necessity, are made within the following timeframes as required by California state law:

- Decisions based on Medical Necessity will be made in a timely fashion appropriate for the nature of your condition, not to exceed five (5) business days from the Plan's receipt of information reasonably necessary to make the decision.
- If the your condition poses an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life, limb, or other major bodily functions, or lack of timeliness would be detrimental in regaining maximum functions, the decision would be

rendered in a timely fashion appropriate for the nature of the your condition, not to exceed seventy-two (72) hours after the Plan's receipt of the information reasonably necessary and requested the Plan to make the determination.

If the decision cannot be made within these timeframes because (i) the Plan is not in receipt of all the information reasonably necessary and requested, or (ii) the Plan requires consultation by an expert reviewer, or (iii) the Plan has asked that an additional examination or test be performed, provided the examination or test is reasonable and consistent with good medical practice, the Plan will notify the Participating Provider and you, in writing, that a decision cannot be made within the required timeframe. The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested by the Plan, then the Plan shall approve or deny the request for authorization within the timeframe specified above as applicable.

Notifications

The Plan will notify requesting Participating Providers of decisions to deny or modify request for authorization of Covered Services within twenty-four (24) hours of the decision. You are notified of decisions, in writing, within two (2) business days of the decision. The written decision will include the specific reason(s) for the decision, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity, and information about how to file an appeal of the decision with the Plan. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon your request.

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.

The Plan's timeline for authorizing second medical opinions may be obtained by contacting Member Services at (805) 677-8787 or by writing to the Plan at 2323 Knoll Drive, #417, Ventura, CA 93003. Expedited second opinions are available in cases of imminent and serious health threat.

Facilities and Provider Locations: The Provider Directory will be mailed to you at the time of enrollment. 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 Website www.vchca.org/hcp. The Provider Directory lists the Plan's Participating

Physicians, pharmacies, hospitals, laboratories, imaging centers, dietitians, podiatrists, and physical therapists. Physicians are listed alphabetically by name with a reference to their medical group and specialty listing. Primary care medical groups and solo practices are listed alphabetically by city with information about the practice location. Specialist Physicians are listed alphabetically by specialty with information about the practice location. If the Physician or the Physician's on-site staff is bilingual in Spanish and English, this is designated in each listing. The Provider Directory does not list the names of Participating hospital-based Physicians, such as radiologists, emergency room physicians and pathologists. The Provider Directory also does not list the names of Participating Physicians associated with tertiary care referral hospitals. You may obtain the names and qualifications of Participating mental health and substance abuse practitioners and treatment facilities by calling (805) 654-5138. You may request the names, professional degrees, board certifications, and subspecialty qualifications of all other Participating Providers by contacting the Plan's Member Services Department.

Service Area: To enroll in the Plan, the Subscriber must reside within its approved Service Area. The Service Area for VCHCP is Ventura County. If you no longer reside in VCHCP'S Service Area, you must contact the Access for Infants and Mothers Program and request a transfer of enrollment to another Plan by calling (800) 433-2611.

EMERGENCY AND URGENT CARE SERVICES

What To Do When You Require Emergency Services: If you reasonably believe that an Emergency Medical or Psychiatric condition exists, go to the nearest hospital emergency room, or call 911. You may call your PCP, during or after regular office hours, if you are unsure whether an Emergency Medical Condition exists. Prior Authorization from the Plan or from your PCP is not required. If you are treated at a facility other than Ventura County Medical Center (VCMC), that facility must contact the Plan for prior Authorization if additional care is needed after your Emergency Medical Condition is stabilized. You may then be transferred to VCMC.

What To Do When You Require Urgently Needed Services: You may self-refer to the Ventura County Medical Center, Urgent Care Facilities listed in your Plan Provider Directory, or to any licensed Urgent Care Clinic, whether in- or out-of-area. Follow up care, if necessary, should be provided by your Primary Care Provider.

Emergency Follow-up Care: The follow-up care related to Emergency and Urgently Needed Services must be provided by the Member's Primary Care or maternity physician.

What To Do When Your PCP Is Not Available: When your PCP or medical group's office is closed for care that does not meet the definition of "Emergency Services" or "Urgent Care Services", you may contact your Primary Care Provider for advice and instructions. Participating Providers are required to have coverage 24 hours a day, seven days a week. If you anticipate frequently needing after-hours services, you may consider selecting a Primary Care Provider with extended hours as listed in the Provider Directory.

Non-covered Services: The Plan does not cover non-Emergency or non-Urgent Care Services or follow-up care at Emergency Rooms.

PAYMENT RESPONSIBILITIES

Subscriber Liabilities for Emergency Services: You, or someone acting on your behalf, must notify the Plan if you are hospitalized in a facility other than the Ventura County Medical Center as soon as reasonably possible following your Admission. You must agree to a Plan-arranged transfer when your condition permits. You must comply with these procedures for services to be covered. In the event that a Member experiences an Emergency Medical Condition, VCHCP has a responsibility

to reimburse providers of Emergency Services whether or not they are directly contracted with VCHCP.

Subscriber Liabilities for Non-emergency Services: Your PCP must request, arrange and obtain the Plan's prior Authorization for Referrals to Specialists, hospitalizations, and certain other Benefits. Exceptions to this policy are as follows:

- Female Members may only self-refer to an Obstetrician or Family Practitioner contracted with the Plan to provide Covered OB/GYN Direct Access Services. Benefits are covered only if they are Medically Necessary.

- The Plan will cover non-Emergency services provided by a non-Contracted Provider only when the services are prior Authorized by the Plan. (As noted above, you may self-refer to any urgent care center.) If you receive health care services without following these requirements, you may be financially responsible for the cost of services. The determination of whether services are Medically Necessary, an Emergency exists, or whether hospitalization, Non-Participating provider services, and supplies are Authorized, will be made by VCHCP. This determination will be based upon an objective review consistent with professionally recognized medical standards.

Subscriber Liabilities for Covered Services to Contracted Providers: In the event that VCHCP fails to pay a Participating Provider for Covered and Authorized services, the Member will 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.

BENEFITS

This section describes your Plan Benefits. These Benefits are subject to the Exclusions and Limitations in the following sections and the maximums listed in the Benefit Summary Matrix. Infants born to AIM subscribers will be eligible for enrollment in the Healthy Families Program. Please refer to *Health Coverage for Infants* on page 1 of this booklet.

DETAILED DESCRIPTION OF BENEFITS

1. **Health Facilities:**

(A) Inpatient Hospital 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.

Inpatient hospital care will be provided for 48 hours following a normal vaginal delivery and 96 hours following delivery by cesarean section. You do not have to leave the hospital before 48 hours after a vaginal delivery or 96 hours after a C-section unless you and your doctor decide this together. If your doctor decides with you to discharge you before the 48- or 96- hour time period, the Plan will cover a post discharge follow up visit within 48 hours of discharge when prescribed by your doctor. The visit includes parent education, assistance, and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal

physical assessments. The doctor and you will decide whether the post-discharge visit will occur in the home, at the hospital, or at the doctor's office depending on the best solution for you.

The length of stay for inpatient hospital care associated with mastectomies and lymph node dissections shall be determined by the attending physician and surgeon in consultation with the patient, consistent with sound clinical principles and processes. The Plan does not require a treating physician and surgeon to receive prior approval from the Plan in determining the length of hospital stay following those procedures.

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

(B) Outpatient Services: Diagnostic, therapeutic and surgical services performed at a hospital or outpatient facility. Includes physical, occupational, and speech therapy as appropriate; and those hospital services, which can reasonably be provided on an ambulatory basis, including outpatient surgery. Related services and supplies in connection with these services including operating room, treatment room, ancillary services, and medications which are supplied by the hospital or facility for use during the Member's stay at the facility.

2. **Durable medical equipment:** Medical equipment appropriate for use in the home which: 1) is intended for repeated use; 2) is generally not useful to a person in the absence of illness or injury, and 3) primarily serves a medical purpose. The health plan may determine whether to rent or purchase standard equipment. Repair or replacement is covered unless necessitated by misuse or loss. Oxygen and oxygen equipment; blood glucose monitors and blood glucose monitors for the visually impaired as medically appropriate for insulin dependent, non-insulin dependent, and gestational diabetes; insulin pumps and all related supplies; visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin, and apnea monitors; podiatric devices to prevent or treat diabetes complications; pulmoaides and related supplies; nebulizer machines, tubing and related supplies, and spacer devices for metered dose inhalers; ostomy bags and urinary catheters and supplies.

   Exclusions: Coverage for comfort or convenience items; disposable supplies except ostomy bags and urinary catheters and supplies consistent with Medicare coverage guidelines; exercise and hygiene equipment; experimental or research equipment; devices not medical in nature such as sauna baths and elevators, or modifications to the home or automobile; deluxe equipment; or more than one piece of equipment that serve the same function.

3. **Medical Transportation Services:** Emergency ambulance transportation in connection with emergency services to the first hospital which actually accepts the Member for emergency care. Includes ambulance and ambulance transport services provided through "911" emergency response system.

   Non-emergency transportation for the transfer of a Member from a hospital to another hospital or facility or facility to home when:

   (A) medically necessary, and

   (B) requested by a plan provider, and

   (C) authorized in advance by the participating health plan

   Exclusions: Coverage for transportation by airplane, passenger car, taxi or other form of public conveyance.

4. **Emergency Medical and Psychiatric Health Care Services and Urgent Care Services:** Twenty-four hour emergency care for Active Labor or a medical condition manifesting itself by acute symptoms of a sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

   (A) Placing the patient's mental or physical health in serious jeopardy, (and in the case of a pregnant woman, would put the health of her unborn child in serious jeopardy).

   (B) Serious impairment to bodily functions,

   (C) Serious dysfunction of any bodily organ or part,

   This care will be provided both in and out of the Plan's service area, and in and out of the Plan's participating facilities.

   Urgent care services are services needed to prevent serious deterioration of your health resulting from an unforeseen illness, an injury, prolonged pain, or a complication of an existing condition, including pregnancy, for which treatment cannot be delayed. VCHCP covers urgent care services any time you are outside our service area or on nights and weekends when you are inside our service area. To be covered, the urgent care service must be needed because the illness or injury will become much more serious if you wait for a regular doctor's appointment. On your first visit to your primary care provider, discuss what he or she wants you to do when the office is closed and you feel urgent care may be needed. Follow up care, if necessary, should be provided by your Primary Care Provider.

5. **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. 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. Examples of benefits covered under this section are: breast cancer screening, diagnosis, and treatment, and mastectomy or lymph node dissection. In addition, professional services include:

   (A) Eye Examinations: Eye refractions to determine the need for corrective lenses, and dilated retinal eye exams.

   (B) Hearing tests, hearing aids and services: Hearing tests, hearing aids, and services: Audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation to determine the most appropriate make and model of hearing aid. Hearing aid: Monaural or binaural hearing aids including ear mold(s), the hearing aid instrument, the initial battery, cords and other ancillary equipment. Visits for fitting, counseling, adjustments, repairs, etc., at no charge for a one-year period following the provision of a covered hearing aid.

   Exclusions: The purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase and charges for a hearing aid which exceeds specifications prescribed for correction of a hearing loss. Replacement parts for hearing aids, repair of hearing aid after the covered one-year warranty period, replacement of a hearing aid more than once in any period of thirty-six months, and surgically implanted hearing devices.

   (C) Immunizations for Subscribers: Immunizations for adults as recommended by the ACIP. Immunizations required for travel as recommended by the ACIP. Immunizations such as Hepatitis B for

individuals at occupational risk, and other age appropriate immunizations as recommended by the ACIP.

(D) Periodic Health Examinations for Subscribers: Periodic health examinations including all routine diagnostic testing, (including, but not limited to, breast cancer), routine cancer screening, (including, but not limited to, breast and cervical), and laboratory services appropriate for such examinations.

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.

(E) 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.

6. **Cancer Clinical Trials:** Routine patient care costs related to the cancer clinical trial if the Member's treating physician recommends participation in the cancer clinical trial because he or she feels the trial will have a meaningful potential to benefit the Member. Routine costs would include drugs, items, devices, and services that would otherwise be covered by VCHCP if the Member were not in the cancer clinical trial program.

   Exclusions: "routine patient care costs" relating to a cancer clinical trial program do not include the costs associated with: (1) drugs or devices not approved by the FDA; (2) non-health care services such as travel, housing, companion expenses; (3) any item or service provided solely to satisfy data collection and analysis needs; (4) health care services that are otherwise specifically excluded from coverage; and (5) health care expenses that are normally covered by the entity funding the cancer clinical trial program.

7. **Health Education Services:** Effective health education services, including information regarding personal health behavior and health care, and recommendations regarding the optimal use of health care services provided by VCHCP or health care organizations affiliated with VCHCP. Health education services include services related to tobacco use and drug and alcohol abuse.

   Health education services relating to tobacco use means tobacco use prevention and education services including tobacco use cessation services, in accordance with protocols established by the board in coordination with the Tobacco Control Section of the State Department of Health Services.

8. **Nutrition Services:** Direct patient care nutrition services, including nutritional assessment.

9. **Prescription Drugs:** Medically necessary prescription drugs when prescribed by a licensed practitioner acting within the scope of his or her licensure. Includes injectable medication and needles and syringes necessary for the administration of the covered injectable medication. Also includes insulin, glucagon, syringes and needles and pen delivery systems for the administration of insulin, blood glucose testing strips, ketone urine testing strips, lancets and lancet puncture devices in medically appropriate quantities for the monitoring and treatment of insulin dependent, non-insulin dependent and gestational diabetes. Prenatal vitamins and fluoride supplements included with vitamins or independent of vitamins, if such vitamins require a prescription. Medically

necessary drugs administered while a Member is a patient or resident in a rest home, nursing home, convalescent hospital, or similar facility when prescribed by a Plan physician in connection with a covered service and obtained through a VCHCP designated pharmacy. VCHCP may specify that generic equivalent prescription drugs must be dispensed if available, provided that no medical contraindications exist. If the prescribing provider has qualified a prescription for a brand name medication by noting "Do Not Substitute" or "Dispense As Written", the pharmacist must dispense according to the provider's direction. You may contact the Plan's Member Services Department (805-677-8787) to determine if a specific drug is listed in the Plan's Drug Formulary or to request a copy of the Plan's Drug Formulary. In addition, the Plan's Drug Formulary is available through the link on the Ventura County Health Care Plan website at www.vchca.org/hcp.

Contraceptive Drugs and Devices: All FDA approved oral, transdermal, and injectable contraceptive drugs and prescription contraceptive devices are covered including internally implanted time-release contraceptives.

Emergency Contraceptive: VCHCP covers the cost of emergency contraception when dispensed by a contracted physician or pharmacist or, in the event of a medical emergency, when dispensed by a non-contracted provider.

Exclusions: Experimental or investigational drugs, unless accepted for use by the standards of the medical community; drugs to treat sexual dysfunctions; appetite suppressants and other weight loss products (except when used to treat morbid obesity); dietary supplements (except for prenatal vitamins, formulas or special food products to treat PKU);drugs or medications for cosmetic purposes; patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, condoms, etc.; medicines not requiring a written prescription order (except insulin and smoking cessation drugs as previously described). Please refer to the Plan's Drug Formulary for an updated list of excluded drugs.

For more information on your Pharmacy Benefits, please see page 20.

10. **Reconstructive Surgery:** 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 do any of the following:

    (A) To improve function

    (B) To create a normal appearance to the extent possible

    (C) To restore and achieve symmetry incident to mastectomy. Services for this purpose include reconstructive surgery and associated procedures following a mastectomy and breast prosthesis required incidental to the surgery.

11. **Phenylketonuria (PKU):** Testing and treatment of PKU, including, to the extent that their cost exceeds the cost of a normal diet, those formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the plan, provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

12. **Organ Transplants:** Coverage for medically necessary organ transplants and bone marrow transplants which are not experimental or

investigational in nature. Reasonable medical and hospital expenses of a donor or an individual identified as a prospective donor if these expenses are directly related to the transplant for a subscriber.

Charges for testing of relatives for matching bone marrow transplants: Charges associated with the search and testing of unrelated bone marrow donors through a recognized Donor Registry and charges associated with the procurement of donor organs through a recognized Donor Transplant Bank, if the expenses are directly related to the anticipated transplant of a subscriber.

13. **Maternity Care:** Medically necessary professional and hospital services relating to maternity care including: pre-natal and post-natal care and complications of pregnancy; newborn examinations and nursery care while the mother is hospitalized. Includes providing coverage for participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program. Maternity care is covered outside the Service Area when the mother is in active labor.

14. **Family Planning:** Voluntary family planning services including counseling and surgical procedures for sterilization as permitted by state and federal law, diaphragms, and coverage for other federal Food and Drug Administration approved devices and contraceptive drugs pursuant to the prescription drug benefit.

    Please Note: 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 (805-677-8787, M-F, 8:30 am – 4:30 pm) to ensure that you can obtain the health care services that you need.

15. **Diagnostic X-ray and Laboratory Services:** Diagnostic laboratory services, diagnostic imaging and diagnostic and therapeutic radiological services necessary to appropriately evaluate, diagnose, treat, and follow-up on the care of Members. Other diagnostic services, which shall include, but not be limited to, electrocardiography, electro-encephalography, prenatal diagnosis of genetic disorders of the fetus in cases of high-risk pregnancy, and mammography for screening or diagnostic purposes. Laboratory tests appropriate for the management of diabetes, including at a minimum: cholesterol, triglycerides, microalbuminuria, HDL/LDL and Hemoglobin A-1C (Glycohemoglobin).

16. **Diabetic Care:** Equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without prescription, including:

    (A) Blood glucose monitors and blood glucose testing strips
    (B) Blood glucose monitors designed to assist the visually impaired
    (C) Insulin pumps and all related necessary supplies
    (D) Ketone urine testing strips
    (E) Lancets and lancet puncture devices
    (F) Pen delivery systems for the administration of insulin
    (G) Podiatric services to prevent or treat diabetes-related complications
    (H) Insulin syringes
    (I) Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of

insulin
(J) Insulin
(K) Prescriptive medications for the treatment of diabetes
(L) Glucagon

Coverage also includes outpatient self-management training, education, and medical nutrition therapy necessary to enable a member to properly use the equipment, supplies, and medications and as prescribed by the member's VCHCP provider.

17. **Home Health Care Services:** Health services provided by a licensed "home health agency" at the Member's home by health care personnel. "Home health agency" means an organization licensed by the State Department of Health Services in accordance with relevant provisions of the Health and Safety Code. Home Health Care includes: (1) skilled nursing services provided by Registered Nurses, Licensed Vocational Nurses, and home health aides; (2) physical, occupational and speech therapy, respiratory therapy when prescribed by a licensed practitioner acting within the scope of his or her licensure.

"Home health care" means, as per statute 1374.10 of the Health and Safety Code, the continued care and treatment of a covered Member who is under the direct care and supervision of a physician but only if:

(A) Continued hospitalization would have been required if home health care were not provided,

(B) The home health treatment plan is established and approved by a physician within 14 days after the Member was confined as an impatient and such treatment plan is for the same or related condition for which the Member was hospitalized, and

(C) Home health care services commence within 14 days after the hospital confinement has ended.

The above requirements do not prohibit the Members from receiving care in an inpatient setting if required.

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 and are limited to 100 visits per benefit year. 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 shall exercise 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.

Exclusions: Custodial care

18. **Physical, Occupational, and Speech Therapy:** Therapy may be provided in a medical office or other appropriate outpatient setting, hospital, skilled nursing facility or home. Plans may require periodic evaluations as long as therapy, which is medically necessary, is provided.

19. **Blood and Blood Products:** Processing, storage, and administration of blood and blood products in inpatient and outpatient settings. Includes the collection and storage of autologous blood when medically indicated.

20. **Cataract Spectacles and Lenses:** Cataract spectacles, cataract contact lenses, or intraocular lenses that replace the natural lens

of the eye after cataract surgery are covered. Also, one pair of conventional eyeglasses or conventional contact lenses is covered if necessary after cataract surgery with insertion of an intraocular lens.

21. **Skilled Nursing Care:** Services prescribed by a Plan physician or nurse practitioner and provided in a licensed skilled nursing facility when medically necessary. Skilled nursing on a 24-hour per day basis; bed and board; x-ray and laboratory procedures; respiratory therapy; physical, occupational and speech therapy; medical social services; prescribed drugs and medications; medical supplies; and appliances and equipment ordinarily furnished by the skilled nursing facility. This benefit shall be limited to a maximum of 100 days per benefit year.

22. **Hospice:** The hospice benefit shall include skilled nursing care, medical social services, home health aide services, physician services, drugs, medical supplies and appliances, counseling and bereavement services. The benefit shall also include physical therapy; occupational therapy, speech therapy, short-term inpatient care, pain control and symptom management. The hospice benefit may include, at the option of the health plan, homemaker services; services of volunteers, and short-term inpatient respite care. The hospice benefit is limited to those individuals who are diagnosed with a terminal illness with a life expectancy of twelve months or less and who elect hospice care for such illness instead of the traditional services covered by the plan.

    Individuals who elect hospice care are not entitled to any other benefits under the plan for the terminal illness while the hospice election is in effect. The hospice election may be revoked at any time.

23. **Orthotics and Prosthetics:** Orthotics and prosthetics including medically necessary replacement prosthetic devices as prescribed by a licensed practitioner acting within the scope of his or her licensure, and medically necessary replacement orthotic devices when prescribed by a licensed practitioner acting within the scope of his or her license. Coverage for the initial and subsequent prosthetic devices and installation accessories to restore a method of speaking incident to a laryngectomy, and therapeutic footwear for diabetics. Also includes prosthetic devices to restore and achieve symmetry incident to mastectomy.

    Exclusions: Corrective shoes and arch supports, except for therapeutic footwear and inserts for individuals with diabetes; non-rigid devices such as elastic knee supports, corsets, elastic stockings, and garter belts; dental appliances; electronic voice producing machines; or more than one device for the same part of the body. Also does not include eyeglasses (except for eyeglasses or contact lenses necessary after cataract surgery).

24. **Mental Health Services:**

    Inpatient Mental Health Services
    Cost to Member
    No copayment

    Description
    Mental health care in a participating hospital when ordered and performed by a participating mental health professional

    Basic Mental Health Services
    (Provided by the Plan or Plan sub-contractor)
    Diagnosis and treatment of a mental health condition.

    Limitations
    Basic mental health care services are limited to thirty (30) days per benefit year. Additional days may be authorized by the Plan. Plans, with the agreement of the subscriber or applicant

or other responsible adult if appropriate, may substitute for each day of inpatient hospitalization any of the following:

- 2 days of residential treatment
- 3 days of day care treatment, or
- 4 outpatient visits

Severe Mental Illness (SMI)

Inpatient mental health care services for the treatment of Severe Mental Illness. Examples of SMI include, but are not limited to:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive Disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia Nervosa
- Bulimia Nervosa

Limitations
Unlimited days

Serious Emotional Disturbance (SED) Services
Diagnosis and treatment for SED condition.

Limitations
Unlimited days

Outpatient Mental Health Services
Cost to Member
No copayment

Description
Mental health care services when ordered and performed by a participating Plan mental health Provider.

Basic Mental Health Services

- Treatment for members who have experienced family dysfunction or trauma, including child abuse and neglect, domestic violence, substance abuse in the family, divorce, or bereavement.
- Involvement of family members in the treatment to the extent the provider determines it is appropriate for the health and recovery of the member

Limitations
Basic mental health care services are limited to twenty (20) visits per benefit year, except that the number of treatment days may be increased when outpatient treatment days are substituted for inpatient hospitalization days as described in the **Inpatient Mental Health Services** benefit description of this Evidence of Coverage (EOC) booklet.

Severe Mental Illness (SMI)

Inpatient mental health care services for the treatment of Severe Mental Illness. Examples of SMI include, but are not limited to:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive Disorders
- Panic disorder
- Obsessive-compulsive disorder
- Pervasive developmental disorder or autism
- Anorexia Nervosa
- Bulimia Nervosa

Limitations
Unlimited days

Serious Emotional Disturbance (SED) Services
Treatment of SED conditions.

Limitations
Unlimited days

25. Alcohol and Drug Abuse Services:

(A) Inpatient: Hospitalization for alcoholism or drug abuse as medically appropriate to remove toxic substances from the system.

(B) Outpatient: Crisis intervention and treatment of alcoholism or drug abuse on an outpatient basis as medically appropriate. VCHCP provides coverage for 20 visits per benefit year.

Excluded Benefits

These benefits are excluded for infants born to subscribers. Infants born to AIM subscribers will be eligible for enrollment in the Healthy Families Program. Please refer to *Health Coverage for Infants* on page 1 of this booklet. The health benefit plan offered under this program excludes all of the following:

1. Services which are not medically necessary. "Medically necessary" as applied to the diagnosis or treatment of illness is an article or service that is not investigational and is necessary because:

   (A) It is appropriate and is provided in accordance with accepted medical standards in the state of California, and could not be omitted without adversely affecting the patient's condition or the quality of medical care rendered; and

   (B) As to inpatient care, it could not have been provided in a physician's office, in the outpatient department of a hospital, or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered; and

   (C) If the proposed article or service is not commonly used, its application or proposed application has been preceded by a thorough review and application of conventional therapies; and

   (D) The service or article has been demonstrated to be of greater therapeutic value than other, less expensive, services or articles.

2. Any services which are received prior to the Member's effective date of coverage, except as noted in Section 2699.303, Chapter 5.6, Title 10, California Code of Regulations.

3. Custodial care, domiciliary care, or rest cures, for which facilities 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.

4. Personal or comfort items, or a private room in a hospital unless medically necessary.

5. Emergency facility services for nonemergency conditions.
6. Those medical, surgical (including implants), or other health care procedures, services, products, drugs, or devices which are either:

   (A) Outmoded or not efficacious, or

   (B) Experimental or investigational or which are not recognized in accord with generally accepted medical standards as being safe and effective for use in the treatment in question. VCHCP provides eligible Members with the opportunity to seek an external, independent medical review (IMR) to examine the Plan's coverage decisions regarding experimental or investigational therapies. Please see "Independent Medical Review Of Experimental/Investigational Treatment," page 29 of this document, for information regarding this process.

7. Transportation except as specified in

Item 3 – Medical Transportation Services, of the Detailed Description of Benefits section in this document.

8. Implants, except cardiac pacemakers, intraocular lenses, screws, nuts, bolts, bands, nails, plates, and pins used for the fixation of fractures or osteotomies and artificial knees and hips; and except as specified in Item 10 (C) – Reconstructive Surgery, of the Detailed Description of Benefits section in this document.

9. Eyeglasses, except those eyeglasses or contact lenses necessary after cataract surgery, which are covered under Item 20 – Cataract Spectacles and Lenses, of the Detailed Description of Benefits section in this document.

10. Long-term care benefits including long-term skilled nursing care in a licensed facility and respite care are excluded except as a participating health plan shall determine they are less costly, satisfactory alternatives to the basic minimum benefits. This section does not exclude short-term skilled nursing care or hospice benefits as provided pursuant to Items 21 – Skilled Nursing Care, and 22 – Hospice, of the Detailed Description section in this document.

11. Dental services, including dental treatment for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that the repair commences within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible, and reconstructive surgical procedures for any medical condition directly affecting the upper or lower jawbone, or associated bone joints.

12. Cosmetic surgery, including treatment for complications of cosmetic surgery, that is solely performed to alter or reshape normal structures of the body in order to improve appearance, except as specifically provided in Item 10 – Reconstructive Surgery, of the Detailed Description of Benefits section in this document. Coverage of emergency and urgently needed services resulting from complications of cosmetic surgery is not excluded.

13. Clinical trial program: "routine patient care costs" relating to a clinical trial program do not include the costs associated with: (1) drugs or devices not approved by the FDA; (2) non-health care services such as travel, housing, companion expenses; (3) any item or service provided solely to satisfy data collection and analysis needs; (4) health care services that are otherwise specifically excluded from coverage; and (5) health care expenses that are normally covered by the entity funding the clinical trial program.

14. Any benefits in excess of limits specified in the Benefits Section.

15. Treatment for infertility is excluded. Diagnosis of infertility is not covered unless provided in conjunction with covered gynecological services. Treatments of medical conditions of the reproductive system are not excluded.

16. Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit, or gain for which such benefits are provided or payable under any Worker's Compensation benefit plan. The participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such benefits.

17. Services which are eligible for reimbursement by insurance or covered under any other insurance or health care service plan. The participating health plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating health plan is reimbursed for such benefits.

PHARMACY BENEFITS

The Plan covers Medically Necessary outpatient prescriptions ordered by a Participating Physician when dispensed by a Participating Pharmacy, subject to certain exclusions and limitations.

DETAILED DESCRIPTION OF PHARMACY BENEFIT

Upon presentation to a Participating Pharmacy of a valid pharmacy identification card, or submission of a completed mail form to the Pharmacy Benefits Manager (PBM) Mail Order Service, you may have a prescription filled for the outpatient medications described below. Pharmacy Benefits include Medically Necessary prescription medications listed in the Plan's Drug Formulary and the following:

1. Medications to be taken by or administered to a Member while a patient or resident in a rest home, nursing home, convalescent hospital, or similar facility when provided through a Participating Pharmacy.

2. Needles and syringes necessary for the administration of covered injectable medications are covered.

3. Disposable devices that are necessary for the administration of covered drugs, such as spacers and inhalers for the administration of aerosol prescription drugs and syringes for self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes. The term "disposable" includes devices that may be used more than once before disposal.

4. Insulin for the treatment of diabetes, including insulin syringes, blood glucose monitors and blood glucose testing strips, special blood glucose monitors designed for the visually impaired, ketone urine testing strips, lancets and lancet puncture devices, and glucagon is covered.

5. Prescription prenatal vitamins and fluoride supplements.

6. Prescription Food and Drug Administration (FDA)-approved contraceptive devices such as diaphragms and oral and injectable contraceptive medications, including depo-provera, listed in the Plan's Drug Formulary. Non-formulary FDA-approved prescription contraceptive methods with a letter of medical necessity from the Member's treating plan Provider, and when no plan-designated method is medically appropriate.

7. Tobacco cessation drugs. The Plan shall require the Subscriber to attend a tobacco use cessation class or program when taking tobacco cessation drugs.

8. Pain management medications for a terminally ill Member.

9. Medically Necessary prescription drugs if prescribed by a Member's PCP or VCHCP-referred psychiatrist for the treatment of a Severe Mental Illness at any age.

PHARMACY BENEFIT EXCLUSIONS AND LIMITATIONS

The Pharmacy Benefit is subject to the following exclusions and limitations:

1. Covered Medications must be dispensed by a Participating Pharmacy. Locations of Participating Pharmacies within the Service Area are listed in the Provider Directory. You are encouraged to call the Pharmacy Benefit Manager (PBM), at their toll-free number printed on your Subscriber identification pharmacy card, for locations of Participating Pharmacies outside the Service Area. If you pay for covered medications, you may submit a claim for reimbursement to the PBM. When obtaining medications not authorized by the Plan from a non-

Participating Pharmacy, in an emergent or urgent circumstance, you will be reimbursed by the PBM the amount that would have been paid to a Participating Pharmacy, subject to dispensing limits and formulary requirements.

2. The pharmacist must dispense generic equivalent medications, if available, provided no medical contraindications exist. If the prescribing provider has qualified the prescription by adding "Do Not Substitute" or "Dispense As Written" to it, the pharmacist must dispense according to the provider's direction. "Available" refers to general marketplace availability, not to specific Pharmacy availability. If you elect brand, you shall pay the additional cost. 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.

3. The prescribing practitioner must be a Participating PCP, VCHCP referred specialist or Provider of Urgent or Emergency Services acting within the scope of his or her license, either within the Plan's service area or for out of-area Urgent or Emergency Services.

4. 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. Mail order is available for maintenance prescriptions that are prescribed for 90 days or longer for chronic conditions such as arthritis, heart disease, diabetes, or hypertension.

5. The Plan uses a Preferred Medication List or Drug Formulary, which is a list of covered prescription drugs by major therapeutic category. This List is approved by the Plan Pharmacy and Therapeutics Committee annually. The Plan Pharmacy & Therapeutics Committee, which is responsible for developing, modifying and overseeing the Plan's Preferred Medication List, shall review 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 List quarterly and considers additions and deletions, including drugs approved by the FDA. The presence of a drug on the List does not guarantee that the Member's physician will prescribe the drug. You may contact the Plan's Member Services Department (805-677-8787) to determine if a specific drug is listed in the Plan's Preferred Medication List or to request a copy of the Plan's Preferred Medication List. In addition, the Plan's Preferred Medication List is available through the link on the Ventura County Health Care Plan website at www.vchca.org/hcp .

6. Medically Necessary non-formulary medications are covered when authorized by the Plan. Certain formulary medications are also subject to obtaining Authorization from the Plan. Requests for emergency authorization after regular business hours may be made by telephone by the prescribing physician to the Plan. Requests for non-emergency authorization 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. Denials shall be made in writing to the Member and to the prescribing physician, and indicate the reason for the denial, any alternative drug or treatment offered by the Plan, and shall inform the Member of Plan Grievance Procedures.

7. Patent or over-the-counter medicines, including non-prescription contraceptive jellies, ointments, foams, condoms, etc., or medicines not requiring a written prescription order, are

excluded unless specifically identified in this coverage.

8. Experimental or investigational drugs, unless accepted for use by the Food and Drug Administration for the Member's condition, are excluded.

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

10. Medications which are intended for cosmetic, appearance, or performance enhancement purposes, including, but not limited to, hair growth, athletic performance, anti-aging, and mental performance are excluded except when Medically Necessary. Please refer to the Plan's Preferred Medication List for an updated list of excluded drugs. You may contact the Plan's Member Services Department (805-677-8787) to request a copy of the Plan's Drug Formulary. In addition, the Plan's Drug Formulary is available through the link on the Ventura County Health Care Plan website www.vchca.org/hcp .

11. Anorexants or other weight loss drugs (for example diet pills and appetite suppressants) are excluded, except when used to treat morbid obesity. Examples of these include:
    a. Didrex®
    b. Diethylpropion®
    c. Meridia®
    d. Tenuate®
    e. Xenical®
    f. Dextrostat®
    g. Desoxy

    Please refer to the Plan's Drug Formulary for an updated list of excluded drugs. You may contact the Plans' Member Services Department (805-677-8787) to request a copy of the Plan's Drug Formulary. In addition, the Plan's Drug Formulary is available though the link on the Ventura County Health Care Plan website www.vchca.org/hcp .

12. Dietary supplements (except for formulas or special food products to treat phenylketonuria or PKU) are excluded, including vitamins (except prenatal) and fluoride supplements, health or beauty aids, herbal supplements and/or other "alternative" medicine.

Subscriber Liabilities: The Plan reserves the right of recovery for prescription claims which have been processed in error relating to eligibility.

Member Services: You may contact the Plan at (805) 677-8787 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

BENEFIT LIMITATIONS

Your ability to obtain Covered Services from VCHCP and its obligation to provide Covered Services may be limited in the following circumstances.

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, disability of a significant part of VCHCP personnel or similar causes, the rendition of 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 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 for such services due to lack of available facilities or personnel if reasonable efforts have been made to arrange for such care, but it is unavailable as the result of disaster or epidemic.

Continuity of Care for New Members: 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, but not limited to, a Non-Participating Hospital Provider). Such treatment must be for an acute condition, a pregnancy including duration of the pregnancy and immediate postpartum period, a serious chronic condition, a terminal illness, or if you have a surgery or other procedure that has been recommended and documented by the Non-Participating Provider to occur within 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. The Plan is not obligated to continue to provide such services if the Non-Participating Provider does not agree to the terms, conditions and rates. 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) 677-8787.

Continuity of Care for Transferred Members: If you are hospitalized in an inpatient facility on the scheduled date of transfer to another Plan, you will continue to receive coverage under this Plan and you will not be transferred to a new health plan until the first day of the month following completion of your inpatient stay.

Continuity of Care by Terminated Provider: Please note that, for the purposes of this section "Provider" shall include, but not be limited to, a Provider Hospital. If the Agreement between the Plan and your Provider is terminated 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: Maternity care from the Terminated Provider through the course of your pregnancy and during the immediate postpartum period, ongoing treatment of an acute condition, a serious chronic condition, a terminal illness, 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 180 days of the contract's termination date. 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 the Agreement's termination or nonrenewal 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. The Plan is not obligated to continue to provide such services if the Terminated Provider does not agree to the terms, conditions and rates. 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) 677-8787. At least sixty (60) days prior to termination, VCHCP will send written notice to Members who are assigned to the

terminated provider or in the service area of the terminated hospital.

Refusal of Treatment: Except for medically necessary services or emergent or urgent care services that arise from complications due to refusal of treatment, coverage is not provided for care of conditions where a Member has refused recommended treatment for personal reasons, when VCHCP believes that no acceptable alternative treatment exists.

GENERAL INFORMATION

Eligibility For Services: You may enroll in VCHCP, if you are eligible for the Access for Infants and Mothers Program and reside within VCHCP's Service Area, and you have not been previously terminated from VCHCP for cause. Your eligibility will be determined according to the Rules of the Program by the Administrator of Enrollment. To be eligible for benefits, the Administrator of Enrollment must notify the Plan of your enrollment.

Identification Cards: Within 10 days of your enrollment in the Plan, we will send you a VCHCP Identification Card. This card will list your name, your Plan identification number, and the name and telephone number of your PCP or medical group. Your Identification Card also lists your Plan name, address, and telephone numbers. You should present your Identification Card to all providers of Benefits under this Plan. If you engage in fraud or deception, or knowingly permit such fraud or deception by another person in obtaining Benefits under this Plan, then VCHCP may request that the Access for Infants and Mothers Program terminate your Coverage. This includes, but is not limited to, permitting the use of your Plan Identification Card by any other person.

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 description of how VCHCP protects the confidentiality of medical information and that any disclosure beyond the provisions of law is prohibited.
- ◆ 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.
- ◆ The circumstances under which medical information may be disclosed without prior authorization as permitted by law.
- ◆ How Members may obtain access to copies of medical information created by and in the possession of the Plan or a contracting organization. In addition, please refer to your AIM Handbook for information on AIM Program Privacy Notification.

Medical Information Authorization: You are required to execute the following authorization upon enrollment: I authorize the Plan and/or my Providers to release medical information to and/or obtain medical information from appropriate providers/agencies if needed to provide necessary health care services and/or administrative services for me.

COORDINATION OF COVERAGE WITH OTHER PAYERS

Coordination of Benefits: If you receive Covered Services from VCHCP, and you are eligible for the same services under any other health plan or payer (except Medi-Cal), we will not pay for the services. This coverage is excess to, and will not duplicate, any other medical benefits available to you, whether you claim them or not. If VCHCP pays benefits greater than it should have, VCHCP shall have the right to recover the excess payment from you or from any other person or entity which may have benefited from the overpayment. You

must cooperate to assure that VCHCP recovers any overpayments.

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. You shall agree to reimburse VCHCP or the Provider, as appropriate, for the cost of such services, if you receive any payments from the third party, such as an automobile insurance company.

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. In the event that you settle claims for any injury caused by a third party, and the settlement 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 sum of reasonable costs actually paid by the Plan for medical care provided hereunder, subject to further restrictions depending on the method of compensation. You shall be required to pay for any services provided by VCHCP if you fail to provide requested information to VCHCP.

Non-Duplication of Benefits with Worker's Compensation: Treatment for any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain for which benefits are provided or payable under any Workers' Compensation benefit plan may be covered, but the Plan reserves the right to a lien, reimbursement or coordination of benefits, as applicable..

ENDING COVERAGE (TERMINATION OF BENEFITS)

Termination of Coverage with Plan: Your coverage ends when: 1) You voluntarily cancel your coverage or transfer your enrollment to another Plan; 2) You move out of Ventura County; 3) At midnight of the 60th day following the birth of your Child under this Program or other termination of your pregnancy; 4) VCHCP's contract with the Program ends; 5) the Program ends; or 6) As otherwise approved or directed by the Program.

Disenrollment by VCHCP: If you are disenrolled by VCHCP, you will be notified in writing of the reason for the disenrollment, the effective date of disenrollment, your final day of Coverage, and an explanation of the appeals process. The Plan will request that members be disenrolled from the program if: 1) 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; 2) you fail to pay, or fail to make satisfactory arrangements to pay, any amount due VCHCP or Participating Providers, including but not limited to non-Covered Services; or 3) you fail to establish and maintain a satisfactory relationship with the Plan or with your Participating Provider.

Notifying You of Changes in the Plan: VCHCP publishes a quarterly newsletter entitled "Health Coverage News" that is distributed to all Subscribers. Subscribers will be informed of changes in the Plan, which occur during the Benefit Year in this newsletter. Such changes may include, but are not limited to, implementation of new State regulations for health care service plans licensed by the Department of Managed Health Care.. This Evidence of Coverage may be changed without your consent or concurrence upon 30 days' written notice to you.

How Providers are Compensated: Most Participating Providers are paid according to a fee-for-service basis. This means the Provider is paid according to the amount of services provided to you. 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 services provided to you. Monthly capitation fees paid to Providers do not include or depend on the cost or number of specialist referrals.

STANDING COMMITTEE PARTICIPATION BY SUBSCRIBERS

Ventura County Health Care Plan's Standing Committee includes Member representatives. If you wish to address the Committee at one of their scheduled quarterly 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.

REIMBURSEMENT PROVISIONS – IF YOU RECEIVE A BILL

If you receive a bill for a covered service, or if you have paid out-of-pocket for a covered service, please contact our Member Services Department for payment or reimbursement information.

LIMITATIONS OF OTHER COVERAGE

This health plan coverage is not designed to duplicate any benefits to which members are entitled under government programs, including CHAMPUS/TRICARE, Medi-Cal or Workers' Compensation. By executing an enrollment application, a member agrees to complete and submit to VCHCP such consents, releases, assignments, and other documents reasonably requested by VCHCP or order to obtain or assure CHAMPUS/TRICARE or Medi-Cal reimbursement or reimbursement under the Workers' Compensation Law.

ORGAN AND TISSUE DONATION

Donating organs and tissues provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities. The Department of Health and Human Services' Internet website (http://www.organdonor.gov) has additional information on donating your organs and tissues.

DISABILITY ACCESS

Physical Access: VCHCP has made every effort to ensure that our offices and the offices and facilities of the Plan Providers are accessible to the disabled. If you are not able to locate an accessible provider, please call our Member Services Department toll free at (800) 600-8247 and a Member Services representative will help you find an alternate provider.

VCHCP routinely inspects the offices of its contracted PCPs, OB/GYN physicians, and high volume specialist physicians to ensure that their facilities provide access to the physically disabled. If you encounter a physical access barrier at a Contracted Provider's office, you should first ask the Provider to make the necessary accommodations. If you are not satisfied, you may contact the Plan. VCHCP will ask the Provider to take corrective action and will direct you to a Provider who can meet your physical access needs.

Access for Hearing Impaired: The speech and hearing impaired may contact the Plan through the California Relay Service at (800) 735-2929 to communicate in English or (800) 855-3000 to communicate in Spanish. The California Relay Service is available 24 hours a day, seven days a week.

Access for Vision Impaired: This Evidence of Coverage (EOC) and other important plan materials will be made available in large print for the vision impaired. For alternative formats, or for direct help in reading this document and other materials, please call our Member Services Department at (805) 677-8787.

The Americans with Disabilities Act of 1990

VCHCP complies with the Americans with

Disabilities Act of 1990 (ADA). This Act prohibits discrimination on the basis of disability. The Act protects Members with disabilities from discrimination concerning program services. In addition, Section 504 of the Rehabilitation Act of 1973 states that no qualified disabled person shall be excluded, based on disability, from participating in any program or activity which receives or benefits from federal financial assistance, nor be denied the benefits of, or otherwise be subjected to discrimination under such a program or activity.

Disability Access Grievances: If you believe VCHCP or its Providers have failed to respond to your disability access needs, you may file a grievance with VCHCP by calling (805) 677-8787.

If your disability access complaint remains unresolved, you may contact:

ADA Coordinator
Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769
(916) 324-4695 (voice)

The hearing impaired should call the California Relay Service at 711 (TTY)

MEMBER GRIEVANCE AND APPEALS PROCEDURE

You may register complaints against VCHCP or any of its Contracting Providers by writing, e-mailing, or calling:

Ventura County Health Care Plan
2323 Knoll Drive, #417
Ventura, California 93003
(805) 677-8787 or 1-800-600-VCHP
VCHCP.MemberServices@ventura.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 Grievance Procedure is available. A Member may file a grievance up to 180 days following any incident or action that caused dissatisfaction.

The 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, on its website (www.vchcp.org/hcp) and provides 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 Grievance Procedure.

Except as described below, the Plan shall provide written acknowledgment of a Member's grievance within five (5) days of receipt and a written response containing the Plans' decision within thirty (30) days. 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 a written response containing the Plan's decision within three (3) days. Subscribers with grievances of this sort (also known as "Urgent Grievances") have the right to contact the Department of Managed Health Care, and are so notified by the Plan. There is no requirement that the Subscriber with such a grievance participate in the Plan's grievance process prior to applying to the Department for review of the Urgent Grievance. Department contact information is listed below under "Review By The Department Of Managed Health Care". The Plan shall provide a written statement on the disposition or pending status of a case requiring an expedited review no later than three days from receipt of the grievance. A written acknowledgement and response is not made for grievances that are received over the telephone and resolved by the close of the next business day that do not involve coverage disputes, medical necessity, or experimental or investigational treatment.

INDEPENDENT MEDICAL REVIEW SYSTEM

Beginning January 1, 2001, you have the right to request an independent medical review (IMR) for a Disputed Health Care Service. A Disputed Health Care Service means any health care service eligible for coverage and payment by the Plan that has been denied, modified, or delayed by a decision of the Plan, or by its mental health benefits administrator, based in whole or in part due to a finding that the service is not Medically Necessary. You may apply for an IMR when all of the following conditions are met:

1. Your Provider has recommended a health care service as Medically Necessary, or you received Urgent Care or emergency services that a provider determined were Medically Necessary, or you have been seen by an in-plan Provider for the diagnosis or treatment of the medical condition for which you seek an IMR; and

2. The Disputed Health Care Service has been denied, modified, or delayed by the Plan, or by its mental health administrator, based in whole or in part on a decision that the health care service is not Medically Necessary; and

3. You participate in the Plan's grievance process for the time period required by the Department of Managed Health Care. For a routine grievance you must participate for 30 days; however, if the case involves an imminent and serious threat to your health, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, you are not required to participate for more than three days. (The Department of Managed Health Care may also waive your participation in the Plan's grievance process in extraordinary and compelling cases where you have acted reasonably); and

4. Your request is made within six months of the denial. (The Department of Managed Health Care may extend your application deadline if the circumstances of the case so warrant.)

You may obtain an IMR application by writing or calling:

Ventura County Health Care Plan
2323 Knoll Drive, Suite 417
Ventura, CA 93003
(805) 677-8787 or 1-800-600-VCHP

Your IMR application will be sent to the Department of Managed Health Care. If the Department of Managed Health Care finds that your grievance meets the requirements for review, an IMR will be conducted at no cost to you by an impartial, independent entity contracted by the State of California for this purpose. If the Department of Managed Health Care finds that a Disputed Health Care Service does not meet the requirements for an IMR or that the grievance is a Coverage Decision, an IMR will not be conducted. A grievance that is not approved for an IMR remains eligible for the Department's review (refer to Member Appeal Process found in this Evidence of Coverage.)

The IMR entity is selected by the Department of Managed Health Care through a process that complies with the requirements of Health and Safety Code Section 1374.32 and is designed to ensure that there exist none of the material professional, familial, or financial affiliations prohibited by these regulations.

The IMR entity selects medical professional reviewer(s) to determine whether the Disputed Medical Service was Medically Necessary based on the specific medical need of the Member any of the following:

1. Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service; or
2. Nationally recognized professional standards; or
3. Expert opinion; or
4. Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

VCHCP will provide the IMR entity with all of the required information within three (3) business days of notification by the Department of Managed Health Care. The IMR organization will complete its review and make its determination in writing, and in layperson's terms within 30 days of its receipt of the IMR application and supporting documentation, or in less time if specified by the Department of Managed Health Care. If the Disputed Health Care Service has not been provided and an imminent and serious threat to the health of the Member may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the Member's health, VCHCP will provide the IMR entity with all of the required information within 24 hours of notification by the Department of Managed Health Care. The IMR shall provide an analysis and determination of a case requiring an expedited review no later than three days from receipt of the application and supporting documentation. The IMR review deadlines for a routine or expedited review may be extended for up to three days by the Department of Managed Health Care in extraordinary circumstances or for good cause.

If a majority of the IMR reviewer(s) recommends providing the proposed treatment or therapy or if the reviewers are split, the Department of Managed Health Care will issue a written decision that will be binding on VCHCP. If less than a majority of the experts on the panel recommend providing the services, VCHCP will not be required to pay for the services.

INDEPENDENT MEDICAL REVIEW OF EXPERIMENTAL/INVESTIGATIONAL TREATMENT

You may also be entitled to an Independent Medical Review, through the Department of Managed Health Care, when we deny coverage for treatment we have determined to be experimental or investigational.

- We will notify you in writing of the opportunity to request an Independent Medical Review of a decision denying an experimental/investigational therapy within five (5) business days of the decision to deny coverage.

- You are not required to participate in VCHCP's grievance process prior to seeking an Independent Medical Review of our decision to deny coverage of an experimental/investigational therapy.

- If a physician indicates that the proposed therapy would be significantly less effective if not promptly initiated, the Independent Medical Review decision shall be rendered within seven (7) days of the completed request for an expedited review.

MEDIATION

You may request that an unresolved disagreement, dispute, or controversy concerning any issues including the provision of medical services, arising between you, and 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 Member is not restricted from discussing or reporting the underlying facts, outcome, results, or decision with the DMHC nor is the Member precluded from submitting a grievance or complaint to the DMHC

(as described below) upon completion of mediation. You need not participate in the voluntary mediation process for any longer than thirty (30) days prior to submitting a complaint to the DMHC.

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, 1280 et. seq. This will apply to any controversy, as noted above, including and not limited to the employer, 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. Pursuant to Health and Safety Code Section 1373.20(c), the Plan may assume all or a portion of an enrollee's or subscriber's share of the fees and expenses of the neutral arbitrator in cases of extreme hardship. The enrollee or subscriber may obtain information on how to apply for this relief by contacting the Plan. THE DECISION OF THE ARBITRATOR SHALL BE FINAL AND BINDING. The arbitration decision shall not restrict the Member from discussing or reporting the underlying facts, outcome, results, or decision with the DMHC.

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.

BENEFITS APPEAL RIGHTS FOR AIM PROGRAM SUBSCRIBERS

If you are dissatisfied with the plan resolution of your grievance you can appeal to the California Managed Risk Medical Insurance Board (MRMIB) at:

Executive Director
Managed Risk Medical Insurance Board
P.O. Box 2769
Sacramento, CA 95812-2769

The appeal must be submitted to MRMIB in writing within sixty (60) calendar days following the Plan's decision. The appeal must include the following:

- A copy of any decision being appealed or a written statement of the action or failure to act being appealed;
- A statement specifically describing the issue you are disputing;
- A statement of the resolution you are requesting; and
- Any other relevant information you would like to include.

Appeals that do not include the above information will be returned. You may resubmit the complete appeal within the sixty (60) calendar days from the plan's denial or within twenty (20) calendar days of the receipt of the returned appeal, whichever is later.

REVIEW BY THE DEPARTMENT OF MANAGED HEALTH CARE

After either completing the grievance process or participating in the grievance process for at least thirty (30) days, or immediately 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, including the Ventura County Health Care Plan. If you have a grievance against your Health Plan, you should first telephone VCHCP at 805-677-8787 or toll-free at 1-800-600-VCHP and use VCHCP's grievance procedure before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1- 888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet website (http://www.hmohelp.ca.gov) has complaint forms, IMR application forms, and instructions online.**
>
> **The Plan's grievance process and the Department of Managed Health Care's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.**

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.

LIST OF PARTICIPATING PROVIDERS

Fillmore

Clínicas del Camino Real, Inc.
355 Central Avenue
Fillmore, CA 93015
(805) 524-4926

Fillmore Medical Group
828 Ventura Street
Fillmore, CA 93015
(805) 524-9601

Moorpark

Moorpark Family Care Center
35 West Los Angeles Ave.
Moorpark, CA 93021
(805) 529-4624

Newbury Park

Clínicas del Camino Real, Inc.
1000 Newbury Road, Suite 150
Newbury Park, CA
(805) 640-8293

Ojai

Clínicas del Camino Real, Inc.
(Ojai Valley Community Health Center)
1200 Maricopa Highway
Ojai, CA 93023
(805) 640-8293

Ojai Valley Family Medicine Group
117 Pirie Road, Suite D
Ojai, CA 93023
(805) 646-7246

Oxnard

Las Islas Family Medical Group
325 W. Channel Islands Blvd.
Oxnard, CA 93033
(805) 385-8662

Magnolia Family Medical Clinic
2240 E. Gonzales Rd, #100
Oxnard, CA 93036
(805) 981-5151

Mandalay Bay Women & Children's Medical Group
2000 Outlet Center Drive, Suite 110
Oxnard, CA 93036
(805) 604-4588

Clínica de la Comunidad de Oxnard
650 Meta Street
Oxnard, CA 93030
(805) 487-5351

Clinicas del Camino Real, Inc. – North Oxnard
1200 N. Ventura Road, Ste. E
Oxnard, CA 93030
(805) 988-0053

Clínicas del Camino Real, Inc.
(Maravilla Community Health Center)
450 W. Clara St.
Oxnard, CA 93030
(805) 488-0210

Clínicas del Camino Real ,Inc.
(Oceanview Health Center)
4400 Olds Road
Oxnard, CA 93030
(805) 986-5551

Rose Avenue Family Medical Group
1100 W.Gonzalez Rd.,#210
Oxnard, CA 93030
(805) 988-1443

Piru

Piru Family Care Clinic
4061 Center St.
Piru, CA 93040
(805) 521-0960

LIST OF PARTICIPATING PROVIDERS CONTINUED

Santa Paula

Santa Paula Medical Clinic
1334 E. Main St., Suite A & B
Santa Paula, CA 93060
(805) 933-1122

Santa Paula Medical Clinic - West
254 W.Harvard Blvd,Suite B
Santa Paula, CA 93060
(805) 921-1600

Santa Paula Hospital Clinic
825 N. 10th Street
Santa Paula, CA 93060
(805) 525-0215

Clínicas del Camino Real, Inc. – Santa Paula
500 East Main Street
Santa Paula, CA 93060
(805) 933-0895

Valley Medical Group
247 W. Harvard Blvd.
Santa Paula, CA 93060
(805) 525-0907

Alan W. Lyne, MD.
245 N. 10th St.
Santa Paula, CA 93060
(805) 525-7515

Simi

Sierra Vista Family Medical Center
4531 Alamo St.
Simi Valley, CA 93065
(805) 520-3248

Thousand Oaks

Conejo Valley Family Medical Group
223 E. Thousand Oaks Blvd., Suite 102
Thousand Oaks, CA 91360
(805) 370-0600

Ventura

Faculty Medical Group
133 W. Santa Clara Street
Ventura, CA 93001
(805) 641-6300

Family Care Center
3291 Loma Vista Road
Ventura, CA 93001
(805) 652-6635

West Ventura Medical Clinic
133 W. Santa Clara St.
Ventura, CA 93001
(805) 641-5600

Clínicas del Camino Real, Inc.
200 South Wells Road, Suite 100
Ventura, CA 93004
(805) 647-6322

GLOSSARY OF TERMS

1. "**Active Labor**" means a labor at a time at which either of the following would occur: (1) There is inadequate time to effect a safe transfer to another hospital prior to deliver; or, (2) Transfer poses a threat to health and safety of the enrollee or the unborn child.

2. "**Acute Condition**" means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

3. "**Accidental Injury**" means physical harm or disability which is the result of a specific, unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

4. "**Administrator of Enrollment**" means the Program's contractor that handles processing of applications, determination of eligibility, enrollment, collection of your Contribution, transfer of enrollment to another Plan and termination of coverage.

5. "**Ancillary Medical 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, urgent or Emergency care, and other Covered Services customarily deemed ancillary to the care furnished by Primary Care or Specialist Physicians and provided to a Member upon Referral.

6. "**Applicant**" means a pregnant woman 18 years of age or older who is applying on her own behalf, or a legal guardian or a natural parent, foster parent, or stepparent with whom the child resides, who applies for coverage under the program on behalf of a child. "Applicant" also means a pregnant woman who is applying for coverage on her own behalf who is under 18 years of age, or who is an emancipated minor, or who is a minor not living in the home of a natural or adoptive parent, a legal guardian, foster parent, or stepparent.

7. "**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 Services that were provided to a Member, including the extent and duration to which such Covered Services are or were Medically Necessary, and meet or met the other standards and criteria for Authorization established by VCHCP. The standards and criteria shall be consistent with the professionally recognized Standard of Care prevailing in the community at the time.

8. "**Benefit Year**" or "**Plan Year**" means the twelve (12) month period commencing July 1st of each year at 12:01 a.m.

9. "**Child**" means the Subscriber's child(ren) born while the Subscriber is enrolled in the Program.

10. "**Combined Evidence of Coverage and Disclosure Form**" means the document issued to a Subscriber which describes in summary the Coverage to which a Subscriber is entitled.

11. "**Contribution**" means the amount the Subscriber must pay to the Administrator of Enrollment each month to enable the Subscriber to participate in the AIM Program.

12. "**Cosmetic Surgery**" means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance and self-esteem.

13. "**Coverage**" means the payment for benefits provided through the program.

14. “**Coverage Decision**” means the approval or denial of health care services by the Plan or by the Plan’s Mental Health Benefit Administrator, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the Agreement.

15. “**Covered Services**” or “**Coverage**” or “**Benefit**” means those Medically Necessary health care services that an enrolled Subscriber is entitled to receive from VCHCP.

16. “**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 benefit of the AIM Program.

17. “**Disenroll**” means to terminate coverage by the program.

18. “**Emergency Medical Condition**” means Active Labor or a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absent of immediate medical attention could reasonable be expected to result in any of the following:
    (A) Placing the patient’s health in serious jeopardy, (and in the case of a pregnant woman, would put the health of her unborn child in serious danger);
    (B) Serious impairment to bodily function; or
    (C) Serious dysfunction of any bodily organ or part.

19. “**Emergency Services and Care**” means (a) medical screening, examination, and evaluation by a Physician, or to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if a an Emergency Medical Condition or Active Labor exists and, if it does, the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the capability of the facility; and (b) an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

20. “**Grievance Procedure**” means the system for the receipt, handling, and disposition of Subscriber complaints and grievances as described in this Combined Evidence of Coverage and Disclosure Form.

21. “**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 Participating PCPs.

22. “**Hospital Services**” are those Plan benefits to include short term 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 Services, drugs, medications, biologicals, anesthesia and oxygen services, ambulatory care services, diagnostic, therapeutic and rehabilitative services, and coordinated discharge planning, as appropriate.

23. “**Investigational and/or Experimental**” means a procedure, device, or drug 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.

24. "**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, rules or applicable medical survey standards adopted by the California Department of Corporations.

25. "**Medically Necessary**" as applied to the diagnosis or treatment of illness is an article or service that is not investigational and is necessary because: (a) It is appropriate and is provided in accordance with accepted medical standards in the State of California, and could not be omitted without adversely affecting the patient's condition or the quality of medical care rendered; and (b) As to inpatient care, it could not have been provided in a physician's office, in the outpatient department of a hospital, or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered; and c) If the proposed article or service is not commonly used, its application or proposed application has been preceded by a thorough review and application of conventional therapies; and d) The service or article has been demonstrated to be of greater therapeutic value than other, less expensive, services or articles.

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

27. "**Out-of-Area Coverage**" means coverage while a Member is anywhere outside the Plan's Service Area, and shall include coverage for urgently needed services to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the Member returns to the Plan's Service Area.

28. "**Out-of-Area**" means that geographic area outside VCHCP's Service Area.

29. "**Participating**" or "**Contracted**" refers to those physicians and other Providers that have entered into contracts with VCHCP to provide specific Covered Services to a Member, 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 Subscribers.

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

31. "**Plan**" or "**VCHCP**" or "**We**" 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. The Plan is contracted with the Program to provide Covered Services to Members.

32. "**Primary Care Physician**" or "**PCP**" means the physician, who is selected by or assigned to a Member by VCHCP, and who shall have the responsibility of providing initial and primary care services, for referring, authorizing, supervising, and coordinating the provision of all other services to the 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 a party to, a written contract to provide primary care services, and who has met VCHCP's requirements as a Primary Care Physician.

33. “**Program**” or “**AIM Program**” means the Access for Infants and Mothers Program.

34. “**Provider**” means a Physician, dentist, nurse, pharmacist, psychologist, and other health care professionals, pharmacy, hospital or other health care facility or entity, including, a provider of ancillary services 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.

35. “**Reconstructive Surgery**” means surgery performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

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

    (A) To improve function.
    (B) To create a normal appearance, to the extent possible.

37. “**Resident**” means a person who is present in California with intent to remain present except when absent for transitory or temporary purposes.

38. “**Rules of the Program**” mean the laws of the State of California, found in Part 6.3 of Division 2 (beginning with Section 12695) of the California Insurance Code, that govern the Program. The Rules of the Program also mean the regulations of the Managed Risk Medical Insurance Board, found in Chapter 5.6 of Title 10 of the California Administrative Code, that operate the Program.

39. “**Serious Chronic Condition**” means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious

40. “**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. Pervasive Mental Disorders may include Autistic Disorder, Rett’s Disorder, Childhood Disintegrative Disorder, Asperger’s Disorder and Pervasive Developmental Disorders not otherwise specified (including Atypical Autism), in accordance with the Diagnostic and Statistical Manual for Mental Disorders – IV – Text Revision (June 2000).

41. “**Service Area**” means the geographic area that is approved by the California Department of Corporations for VCHCP. The approved Service Area is Ventura County.

42. “**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 a Member upon Referral, as authorized by VCHCP Medical Director, or his designate.

43. “**Standard of Care**” means the procedure, device or drug is accepted medical practice in the State of California 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.

44. “**Subscriber**” or “**You**” means an individual who is eligible for and enrolled in the program.

45. “**Terminal Disease**” or **“Terminal Illness**” is an incurable or irreversible condition that has a high probability of causing death within one year or less.

46. “**Urgent Care Services**” means services rendered, in or our of the Plan’s Service Area, for an unexpected illness, injury, or complication of an existing condition, other than an emergency medical condition, that is not life threatening but requires immediate outpatient medical care that, in order to prevent serious deterioration of the health of a member, cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering or severe pain, such as a high fever. This also includes maternity services necessary to prevent serious deterioration of the health of the enrollee or the enrollee’s fetus, based on the enrollee’s reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee is able to see her regular health care provider.

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 Access for Infants and Mothers Program Members Rights and Responsibilities are as follows:

Members have a right to receive information about the managed care organization, its services, its practitioners and providers, and Members' rights and responsibilities.

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

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

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

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

Members have a right to file a complaint or grievance if their linguistic needs are not met.

Members have a responsibility to provide, to the extent possible, information that the managed care organization and its practitioners and providers need in order to care for them.

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

Members have the following rights:

- The right to request an interpreter, during discussions of medical information such as diagnoses of medical conditions and accompanying proposed treatment options, and explanations of plans of care or discussions of providers;
- The right not to use family members or friends, including minors, as interpreters except for only the most extraordinary circumstances, such as medical emergencies;
- The right to use an interpreter provided by the Plan at no cost or an alternative interpreter of their choice at their cost for a scheduled appointment, when the need for an interpreter has been identified by their provider or requested by them;
- The right to receive Member materials, including this Evidence of Coverage and Disclosure Form, in Spanish; and
- The right to file a complaint or grievance, if their cultural and linguistic needs were not met.

NOTES & NUMBERS

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