The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please contact the Ventura County Health Care Plan (VCHCP) at 2220 E. Gonzales Road, Suite 210-B, Oxnard, CA 93036. (805) 981-5050 or toll free at (800) 600-8247 or by fax at (805) 981-5051 or vchealthcareplan.org/members/programs.aspx For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary/ to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible?	N.A.	This plan does not have a deductible. See list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No. There are no **other** specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$3,000/person and $6,000/family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in the plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges on not covered expenses, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See vchealthcareplan.org member section, or call (805) 981-5050 for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see a specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 co-pay	Not Covered	None
	Specialist visit	$30 co-pay	Not Covered	None
	Preventive care/screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$15 co-pay diagnostic/ x-rays No Charge for laboratory tests	Not Covered	None
	Imaging (CT/PET scans, MRIs)	$100 co-pay	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at vchealthcareplan.org/members/programs/docs/ProviderDrugList.pdf	Tier 1 - Generic drugs	$9 co-pay $18 co-pay	Not Covered	30-day supply - retail 90-day supply - mail order
	Tier 2 - Preferred brand drugs	$30 co-pay $60 co-pay	Not Covered	30-day supply - retail 90-day supply - mail order
	Tier 3 - Non-preferred brand drugs	$45 co-pay $90 co-pay	Not Covered	30-day supply - retail 90-day supply - mail order
	Tier 4 - Specialty drugs Specialty 3 Tier Benefits Design- Generic Brand (preferred) Brand (non-preferred)	 10% up to $100 max 10% up to $250 max 10% up to $250 max	Not Covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% up to $250 co-pay	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	None

* For more information about limitations and exceptions, see the plan or policy document at vchealthcareplan.org/members/programs.aspx

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$100 co-pay per visit	$100 co-pay per visit	None
	Professional Fee	No Charge	Not Covered	None
	Emergency medical transportation	$150 co-pay	$150 co-pay	None
	Urgent care	$35 co-pay	$35 co-pay	*Urgently Needed Care is covered while outside the service area. When inside the service area, must use an In-Network facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 per day/ $500 maximum per stay	$100 per day/ $500 maximum per stay	
	Physician/surgeon fees	No Charge	No Charge	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Outpatient Office Visit: $15 co-pay per visit Other Outpatient Visits. $15 co-pay per visit	Not Covered	None
	Inpatient services	$100 per day/ $500 maximum per stay	$100 per day/ $500 maximum per stay	None
If you are pregnant	Office visits	No Charge	Not Covered	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No Charge	No Charge	None
	Childbirth/delivery facility services	$100 co-pay per day/ $500 maximum	$100 co-pay per day/ $500 maximum	None
If you need help recovering or have other special health needs	Home health care	$20 co-pay per visit	Not Covered	None
	Rehabilitation services	$15 co-pay per day	Not Covered	None
	Habilitation services	$15 co-pay	Not Covered	None
	Skilled nursing care	$50 per day/ $500 maximum	Not Covered	None
	Durable medical equipment	10% coinsurance; 50% coinsurance for replacement	Not Covered	None
	Hospice services	No charge	Not Covered	None

* For more information about limitations and exceptions, see the plan or policy document at vchealthcareplan.org/members/programs.aspx

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge when part of routine physical (through age 17)	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Chiropractic care
- Cosmetic surgery
- Dental Care (Adults)
- Dental Care (Children)
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services). This isn't a complete list. Please see your plan document.)

- Abortion
- Bariatric Surgery

* For more information about limitations and exceptions, see the plan or policy document at vchealthcareplan.org/members/programs.aspx

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: California Department of Managed Health Care (DMHC) 980 9th Street, Suite 500, Sacramento, CA 95814; Phone: **(888) 466-2219**; **TDD: (877) 688-9891**; FAX: (916) 229-4328 **dmhc.ca.gov**. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: California Department of Managed Health Care (DMHC) 980 9th Street, Suite 500, Sacramento, CA 95814; Phone: **(888) 466-2219**; **TDD: (877) 688-9891**; FAX: (916) 229-4328 **dmhc.ca.gov**.

Does this plan provide Minimum Essential Coverage? [Yes]
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? [Yes]
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
[Spanish (Español): Para obtener asistencia en Español, llame al (800) 600-8247.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 600-8247
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 600-8247
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 600-8247

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

* For more information about limitations and exceptions, see the plan or policy document at vchealthcareplan.org/members/programs.aspx

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	100/day
Other *[cost sharing]*	0

This EXAMPLE event includes services like:
Specialist office visits (comprehensive *prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Normal Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$390
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$390**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	100/day
Other *[cost sharing]*	0

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1275
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1305**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$0
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	100/day
Other *[cost sharing]*	0

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$3,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$430
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$450**

The plan would be responsible for the other costs of these EXAMPLE covered services.