VENTURA COUNTY
HEALTH CARE PLAN
A Department of Ventura County Health Care Agency

BENEFIT SUMMARY GUIDE

WHAT'S INSIDE

This guide outlines some of the important materials that you, as the member, will find useful in understanding and utilizing your Ventura County Health Care Plan.

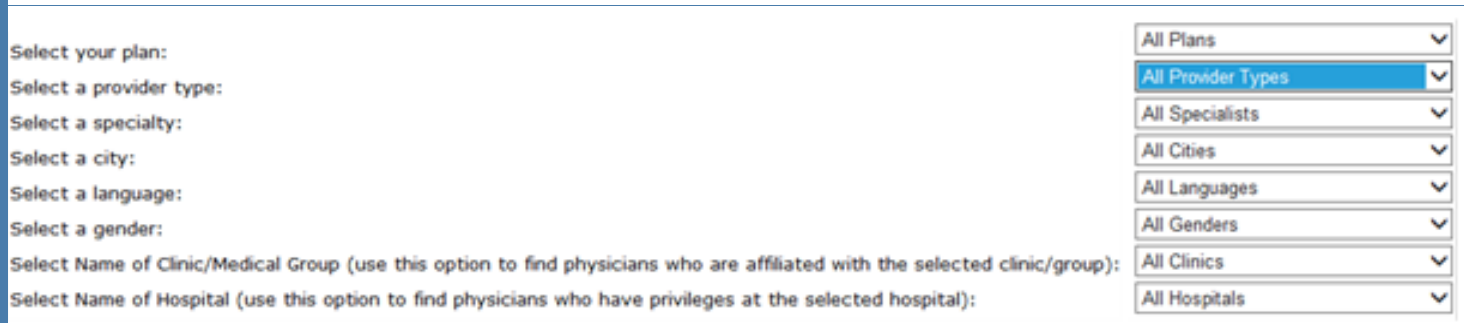
How to Find a Provider

Utilizing our online Provider Search Engine is the most efficient way to find a provider!

The Search Engine can be found on our website at www.vchealthcareplan.org via the "Find a Provider" link. This is updated on a weekly basis thus providing the most accurate information available.

Tip: When searching for a specialist, make sure to select a specialty but ensure that the provider type is set at "All Provider Types" as selecting a provider type will limit the options available.

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



How to Submit a Claim

The Plan will reimburse you if you are required to pay out-of-pocket for urgently needed services incurred outside of the Service Area. A reimbursement claim form is available on our website at www.vchealthcareplan.org or by calling Member Services at (805) 981-5050 or (800) 600-8247. You will need to sign the form and include the following information:

1. Your member ID number.
2. The provider information.
3. The provider's itemized statement of charges (including procedure codes and description of service) and
4. Proof of payment.

HOW TO OBTAIN CARE

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

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

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

Member Notification When a Physician Is No Longer Available: In the event your PCP is no longer available, you will be notified and given the opportunity to select a new PCP. In the event that you do not make such a selection, VCHCP will select a new PCP for you taking into account your city of Residence. We will mail you a letter of explanation and a new Identification Card. If you would prefer another PCP, follow the steps in the above paragraph. For information on the provision of continuity of care when your PCP is no longer available, please see the section titled "Continuity of Care with a Terminated Provider" of this document.

Timely Access to Care:

Members should be offered appointments within the following time frames in accordance with regulations:

- Within 48 hours of a request for an urgent care appointment for services that do not require Authorization,
- Within 96 hours of a request for an urgent care appointment for services that do require Authorization,
- Within ten (10) business days of a request for a non-urgent primary care appointment,
- Within fifteen (15) business days of a request for an appointment with a Specialist,
- Within ten (10) business days of a request for an appointment with non-physician mental health care providers,
- Within ten (10) business days of the prior appointment for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition, and not to be limited to one every ten (10) business days,
- Within fifteen (15) business days of a request for a non-urgent appointment for ancillary services for the diagnosis or treatment of injury, illness, or other health condition,
- Within six (6) weeks for periodic health exam,
- Telephone triage waiting time not to exceed 30 minutes.

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

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

For Authorization requests received prior to or concurrent with the provision of services, the Plan faxes its written decision to your PCP and the provider requesting the service within twenty-four (24) hours of making the decision. If the Plan receives a request for authorization of services after the services are provided, we will notify you and your provider of our decision within thirty (30) days of our receipt of request. If the Plan cannot process your Provider's request within the specified time frame, you and your provider will receive a written explanation of the reason for the delay and the anticipated date on which a decision may be made. Decisions that are based on medical necessity resulting in approval, denial, delay or modification of all or part of the requested health care service are mailed to you or to your representative within two (2) business days of making the decision.

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

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

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

You may obtain a copy of VCHCP's Standing Referral to a Specialist Policy or Direct Access to OB/GYN Services Policy and a list of contracted Direct Access Providers or Standing Referral Specialists by contacting

the Plan's Member Services Department at (805) 981-5050 or toll free at (800) 600-8247, or by accessing our website at www.vchealthcareplan.org. Please see below for additional information.

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

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

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

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

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

- The Member questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.
- The Member questions the reasonableness or necessity of recommended surgical procedures.
- If the clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition, and the Member requests an additional opinion.
- If the treatment plan in progress is not improving the medical condition of the Member within an appropriate period of time given the diagnosis and plan of care, and the Member requests a second opinion regarding the diagnosis or the continuance of the treatment.

- If the Member has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.
- Any other reasonable circumstance that is authorized by the Plan's Medical Director.

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

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

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

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

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

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

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

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

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

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

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

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

EMERGENCY AND URGENTLY NEEDED CARE

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

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

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

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

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

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

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

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

Urgently Needed Care means any Covered Service necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member is able to see his or her PCP. This

includes maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the enrollee's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the enrollee is able to see her Provider.

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

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

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

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

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

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

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

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

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

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

IF YOU FEEL THAT YOU WERE IMPROPERLY BILLED FOR SERVICES THAT YOU RECEIVED FROM A NON-CONTRACTED PROVIDER, PLEASE CONTACT THE PLAN AT 805-981-5050 OR TOLL-FREE AT (800) 600-8247 OR BY FAX AT (805) 981-5051.

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

Follow-up Care: After your medical problem no longer requires Emergency Care or Urgently Needed Care or ceases to be an emergency and your condition is stable, any additional care you receive is considered "Follow-Up Care". The follow-up care related to Emergency and Urgently Needed Care must be provided by or

coordinated by your PCP, and obtained in-network, unless otherwise authorized by the Plan. Mental health, behavioral health, and substance use disorder services need not be coordinated by your PCP.

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

SUMMARY OF BENEFIT EXCLUSIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10. Durable medical equipment, devices or appliances, including but not limited to:
    a. Exercise equipment
    b. Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services).
    c. Stockings, corrective shoes, and arch supports. This exclusion does not apply to podiatric devices to prevent or treat diabetes complications.
    d. Replacement equipment, devices, or appliances due to an item being lost, misplaced, stolen, or damaged due to improper usage.

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

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

13. Emergency room services for Non-Emergency purposes.

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

    You must receive all covered services from In-Network Providers in the Service Area unless otherwise Authorized by the Plan. With the exception of Emergency Services and Out of Area Urgent Care, services are not covered and you may be required to pay the full cost of services obtained when outside the Service Area or with Out-of-Network Providers.

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

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

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

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

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

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

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

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

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

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

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

    Foot orthotics (whether or not custom fit) that are not incorporated into a cast, splint, brace or strapping of the foot are not covered, except in the following situations:

    - members with diabetes who need foot orthotics to prevent or treat diabetic foot complications
    - members needing post-surgical stabilization in place of a cast
    - members with any foot disfigurement due to:
        - cerebral palsy
        - spina bifida
        - arthritis
        - diabetes
        - polio
        - accident or developmental disability

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

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

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

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

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

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

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

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

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

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

35. Reversal of sterilization.

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

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

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

Definitions

The following terms are used in the Ventura County Health Care Plan's member materials. These definitions will help you better understand and utilize your health insurance.

"**Appeal**" refers to a process, a request for reconsideration, available to the member, their family member, treating provider or an authorized representative. It refers to the decision of a previous determination that adversely affects coverage, benefits or a subscriber's relationship.

"**Authorization**" requires utilization review and determination made by or on behalf of VCHCP's Medical Director for medical services or supplies. If approved, the authorization will include the extent and duration to which such covered services, are or were medically necessary, and meets or met the other standards and criteria for authorization established by VCHCP. The standards and criteria shall be consistent with professionally recognized standards of care prevailing in the community at the time of request for authorization.

"**Complaint**" is a statement of disagreement or discontent.

"**Copayment**" means any fixed fee paid by you for covered services. This fee is paid to the provider, not VCHCP, and usually collected at the time of service. Also "Copayment" can be referred to as "Coinsurance," which is a type of Copayment usually figured as a percentage rather than a fixed dollar amount.

"**Deductible**" is a set amount paid, by members, prior to their insurance coverage (payment) for services or supplies. VCHCP does not have a deductible.

"**Department of Managed Health Care**" is a regulatory body governing most managed health care plans in California, including Health Maintenance Organizations (HMOs)

"**Direct Referral**" is a referral for a covered service that does not require review by your insurance. This means that your PCP can provide you with a referral to a specialist without the need to wait for an authorization from the Plan.

"**Grievance**" means a written or oral expression of dissatisfaction regarding the Plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by an enrollee or the enrollee's representative.

"**HMO**" stands for Health Maintenance Organization. HMO is a type of health insurance, with a specific service area, that utilizes a network of doctors, hospitals, and other healthcare providers. HMO insurances require that you select a contracted Primary Care Physician (PCP) that will direct/manage your care.

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

"**Out of Network Provider**" means any health care provider or group that does not belong to the VCHCP provider network; not contracted with VCHCP.

"**Out of Pocket**" is a specific amount paid by Plan members or families for covered services including medical, pharmacy and behavioral health.

"**Out of Pocket Maximum**" is the most an individual, or family, will pay, per Plan year, for covered services.

"**Provider Network**" is a network of specific providers contracted by VCHCP to deliver medical services to the members.

"**Service Area**" means the specific geographical area where Members must obtain covered services from an individual or group within VCHCP's provider network. Ventura County is the geographical area that has been approved by the DMHC (Department of Managed Health Care).

New Medical Technology

DID YOU KNOW that VCHCP has a policy in place to evaluate any new technology or new applications of existing technology on a case-by-case basis? There are four categories we look at – medical procedures, behavioral health procedures, pharmaceuticals (medications) and medical devices.

VCHCP's Medical Director, or designee, evaluates new technology that has been approved by the appropriate regulatory body, such as the Food and Drug Administration (FDA) or the National Institutes of Health (NIH). Scientific evidence from many sources, specialists with expertise related to the technology and outside consultants when applicable are used for the evaluation. Technology must demonstrate improvement in health outcomes or health risks, the benefit must outweigh any potential harm and it must be as beneficial as any established alternative. The technology must also be generally accepted as safe and effective by the medical community and not investigational.

For help with new medication evaluations, the Plan looks to our Pharmacy Benefit Manager, Express Scripts, for their expertise. For new behavioral health procedures, the Plan uses evaluations done by our Behavioral Health delegate, OptumHealth Behavioral Solutions of California (also known as Life Strategies).

Once new technology is evaluated by the Plan, the appropriate VCHCP committee reviews and discusses the evaluation and makes a final decision on whether to approve or deny the new technology. This final decision may also determine if any new technology is appropriate for inclusion in the plan's benefit package in the future.

For any questions, please contact the VCHCP Utilization Management Department at (805) 981-5060.

CONTACT INFORMATION

Health Plan Contact Information

- **Ventura County Health Care Plan**
  2220 E. Gonzales Road, Suite 210B, Oxnard, CA 93036
  Phone: (805) 981-5050 / Toll-Free: (800) 600-8247
  Fax: (805) 981-5051
  Email: VCHCP.Memberservices@ventura.org
  (Email is responded to Mon-Fri, 8:30 a.m. - 4:30 p.m.)
  Hours: Monday - Friday, 8:30 a.m. to 4:30 p.m.
  24-Hour Administrator access for emergency providers at (805) 981-5050 or (800) 600-8247

- **VCHCP Utilization Management Staff**
  Hours: Monday - Friday, 8:30 a.m.to 4:30 p.m.
  (805) 981-5060

- **Language Line Services**
  Phone: (805) 981-5050 / Toll-Free: (800) 600-8247

- **TDD to Voice:** (800) 735-2929

- **Voice to TDD:** (800) 735-2922

For Medical Emergencies

If you believe you are experiencing a medical emergency, please call 911 or go to the nearest emergency room.

- **Ventura County Medical Center** - 24/7 Emergency Care
  3291 Loma Vista Road, Ventura, CA 93003
  (805) 652-6000 or (805) 652-6165 (ER)

- **Santa Paula Hospital** - 24/7 Emergency Care
  (A campus of Ventura County Medical Center)
  825 N. 10th Street, Santa Paula, CA 93060
  (805) 933-8632 or (805) 933-8600

- **24 Hour Nurse Advice Line:** (800) 334-902

Other Helpful Contact Information

- **Pharmacy Help:** (800) 811-0293 (24-hour assistance)
  www.express-scripts.com

- **Behavioral Health/Life Strategies**
  (800) 851-7407 (24-hour assistance)
  www.liveandworkwell.com