



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 <http://www.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 www.healthcare.gov/sbc-glossary to request a copy.

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

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



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 VCMC (You will pay the least)	Network Provider Non-VCMC (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	\$10 <u>co-pay</u>	\$20 <u>co-pay</u>	Not Covered	None
	Specialist visit	\$20 <u>co-pay</u>	\$40 <u>co-pay</u>	Not Covered	None
	Preventive care/screening/immunization	No Charge	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)	\$0 \$0	\$20 <u>co-pay</u> diagnostic/ x-rays No Charge for laboratory tests	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$0	\$125 <u>co-pay</u>	Not Covered	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.vhealthcareplan.org/members/programs/docs/ProviderDrugList.pdf	Tier 1 - Generic drugs	Not Available	\$9 <u>co-pay</u> \$18 <u>co-pay</u>	Not Covered	30-day supply - retail 90-day supply - mail order
	Tier 2 - Preferred brand drugs	Not Available	\$30 <u>co-pay</u> \$60 <u>co-pay</u>	Not Covered	30-day supply - retail 90-day supply - mail order
	Tier 3 - Non-preferred brand drugs	Not Available	\$45 <u>co-pay</u> \$90 <u>co-pay</u>	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)	Not Available	10% up to \$100 max 10% up to \$250 max 10% up to \$250 max	Not Covered	None
If you have	Facility fee (e.g., ambulatory)	\$0	10% up to \$250 <u>co-</u>	Not Covered	None

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		Network Provider VCMC (You will pay the least)	Network Provider Non-VCMC (You will pay the least)	Out-of-Network Provider (You will pay the most)	
outpatient surgery	surgery center)		pay		
	Physician/surgeon fees	No Charge	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room care	\$150 <u>co-pay</u> per visit	\$150 <u>co-pay</u> per visit	\$150 <u>co-pay</u> per visit	None
	Professional Fee	No Charge	No Charge	Not Covered	None
	Emergency medical transportation	\$150 <u>co-pay</u>	\$150 <u>co-pay</u>	\$150 <u>co-pay</u>	None
	Urgent care	\$50 <u>co-pay</u>	\$50 <u>co-pay</u>	\$50 <u>co-pay</u>	*Urgently Needed Care is covered while outside the service area. When inside the service area, must use an In- <u>Network</u> facility.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$0	\$150 per day/ \$600 maximum per stay	Not Covered	
	Physician/surgeon fees	No Charge	No Charge	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Available	Outpatient Office Visit: \$10 <u>co-pay</u> per visit Other Outpatient Visits. \$10 <u>co-pay</u> per visit	Not Covered	None
	Inpatient services	Not Available	No Charge	Not Covered	None
If you are pregnant	Office visits	\$20 <u>co-pay</u> per visit	\$40 <u>co-pay</u> per visit	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	No Charge	No Charge	Not Covered	None

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	Childbirth/delivery facility services	\$0	\$150 <u>co-pay</u> per day/ \$600 maximum	Not Covered	None
If you need help recovering or have other special health needs	Home health care	Not Available	\$20 <u>co-pay</u> per visit	Not Covered	None
	Rehabilitation services	\$10 <u>co-pay</u> per day	\$20 <u>co-pay</u> per day	Not Covered	None
	Habilitation services	\$10 <u>co-pay</u>	\$20 <u>co-pay</u>	Not Covered	None
	Skilled nursing care	Not Available	\$50 per day/ \$500 maximum	Not Covered	None
	Durable medical equipment	Not Available	10% <u>coinsurance</u> ; 50% <u>coinsurance</u> for replacement	Not Covered	None
	Hospice services	No charge	No charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	Not Available	No Charge when part of routine physical (through age 17)	Not Covered	None
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

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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

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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) HMO-2219; TDD: (877) 688-9891; FAX: (916) 229-4328 www.hmohelp.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 www.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) HMO-2219; TDD: (877) 688-9891; FAX: (916) 229-4328 www.hmohelp.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, kwijigo 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 <http://www.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]	\$40
■ Hospital (facility) [cost sharing]	150/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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$390
Coinsurance	\$0
<i>What isn't covered</i>	
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]	\$40
■ Hospital (facility) [cost sharing]	150/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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1275
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1275

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist [cost sharing]	\$40
■ Hospital (facility) [cost sharing]	150/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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$430
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$430