

2019 BENEFIT SUMMARY COMMERCIAL PLAN

| Benefit | Member Copayment | | |
|--|---|--|---|
| Medical Benefits | Services by In-Network Providers | | Services by Out-of-Network Providers |
| Inpatient Services | VCMC | Non-VCMC | Out of Network |
| Inpatient Facility Fee Semi-Private room and board, and medically necessary services and supplies, including subacute care, inpatient dialysis, bariatric, oral, reconstructive, and transplant surgery | \$0 | \$150 per day up to 4 days; per admission | Not Covered |
| Inpatient Physician/Surgeon Fee | No Charge | No Charge | Not Covered |
| Emergency Services Benefits | | | |
| Emergency Room Physician Fee | No Charge | No Charge | No Charge |
| Emergency Room Facility Fee | \$150 per visit (co-pay waived if admitted) | \$150 per visit (co-pay waived if admitted) | \$150 per visit (co-pay waived if admitted) |
| Outpatient Observation Care provided in hospital | | | |
| In conjunction with ER services | ER copay applies | ER copay applies | ER copay applies |
| Not in conjunction with ER services (direct observation) | No Charge | 10% up to \$250 | 10% up to \$250 |
| Outpatient Services | VCMC | Non-VCMC | Out of Network |
| Acupuncture Benefits | | | |
| Acupuncture Services (Reimbursement Benefit) (out of pocket expenses do not accumulate to the out of pocket maximum) | Not Available | \$20 per visit member reimbursement to a combined maximum of 15 visits per plan year, no coverage thereafter | |
| Allergy Testing and Treatment Benefits | | | |
| Allergy Care (injections/serum) | \$0 | \$0 | Not Covered |
| Ambulance Benefits | | | |
| Emergency or authorized transport (Ground & Air) | Not Available | \$150 | \$150 |
| Ambulatory Surgery Center Benefits | | | |
| Ambulatory Surgery Center Outpatient Surgery Facility Fee | \$0 | 10% up to \$250 | Not Covered |
| Ambulatory Surgery Center Outpatient Surgery Physician/Surgeon Fee | No Charge | No Charge | Not Covered |
| Chiropractic Benefits | | | |
| Chiropractic Services (Reimbursement Benefit) (out of pocket expenses do not accumulate to the out of pocket maximum) | Not Available | \$20 per visit member reimbursement to a combined maximum of 15 visits per plan year, no coverage thereafter | |
| Diabetes Care Benefits | | | |
| Disease Management Program | No Charge | No Charge | Not Covered |
| Case Management | No Charge | No Charge | Not Covered |
| Dialysis Benefits | | | |
| Outpatient Dialysis Services | Not Available | \$10 | Not Covered |
| Durable Medical Equipment Benefits (as defined by Medicare) | | | |
| Breast pump (Reimbursement Benefit) | Not Available | \$200 maximum member reimbursement per pregnancy | Not Covered |
| Other Durable Medical Equipment Includes but not limited to: insulin pumps, electric wheelchairs, CPAP/BIPAP machines, Continuous Glucose Monitoring Device | Not Available | 10% copay; 50% copay for replacement when medically necessary | Not Covered |

2019 BENEFIT SUMMARY COMMERCIAL PLAN

| Outpatient Services (continued) | VCMC | Non-VCMC | Out of Network |
|--|---------------|---------------------------------|----------------|
| Family Planning Benefits | | | |
| Counseling and consulting | No Charge | No Charge | Not Covered |
| Diaphragm fitting procedure (When administered in an office location, this is in addition to the Physician office visit co-pay.) | No Charge | No Charge | Not Covered |
| Abortions | Not Available | \$100 | Not Covered |
| Implantable contraceptives | No Charge | No Charge | Not Covered |
| Infertility Services | Not Available | 50% of covered services | Not Covered |
| Injectable contraceptives | No Charge | No Charge | Not Covered |
| Insertion and/or removal of intrauterine device (IUD) | No Charge | No Charge | Not Covered |
| Intrauterine Device (IUD) | No Charge | No Charge | Not Covered |
| Tubal Ligation | No Charge | No Charge | Not Covered |
| Vasectomy | No Charge | No Charge | Not Covered |
| Health Education and Promotion Benefits | | | |
| Preventive Health Program provided by VCHCP | No Charge | No Charge | Not Covered |
| Educational Outreach provided by VCHCP | No Charge | No Charge | Not Covered |
| Community Resources Repository provided by VCHCP | No Charge | No Charge | Not Covered |
| Home Health Care Benefits | | | |
| Home Health (nursing and rehab) services 100 visit maximum. (Maximum shall not apply to Behavioral Health Treatment) | Not Available | \$20 | Not Covered |
| Hospice Program Benefits | | | |
| Hospice Care | No Charge | No Charge | Not Covered |
| Outpatient Services Benefits | | | |
| Outpatient visit: Chemotherapy, outpatient radiation, outpatient infusion therapy | \$0 | \$20 | Not Covered |
| Outpatient Laboratory and Pathology: When provided to diagnose illness or injury | \$0 | \$0 | Not Covered |
| Outpatient X-Ray and Diagnostic Imaging: including Mammogram. When provided to diagnose illness or injury; performed in free-standing radiological facilities and/or outpatient hospital based setting | \$0 | \$20 | Not Covered |
| Imaging and/or other Diagnostic Services: including CT, PET scans, MRIs, and Nuclear Imaging performed in the outpatient department of a Hospital or free-standing outpatient center | \$0 | \$125 | Not Covered |
| Genetic testing | Not Available | 10% of cost up to \$500 maximum | Not Covered |
| Outpatient Services- Other | \$0 | 10% of cost up to \$250 maximum | Not Covered |
| Pregnancy and Maternity Care Benefits | | | |
| Comprehensive prenatal care (Services other than from an OB/GYN may require a copay.) | \$0 | \$0 | Not Covered |
| All necessary Inpatient Professional Services for normal deliver, Cesarean section and complications of pregnancy | \$0 | \$0 | Not Covered |
| Postnatal Physician office visits | \$0 | \$0 | Not Covered |
| Preventive Health Benefits | | | |
| Preventive Care, Screenings and Immunizations | No Charge | No Charge | Not Covered |
| Routine Physical Exam | No Charge | No Charge | Not Covered |
| Well Child Preventive Exam | No Charge | No Charge | Not Covered |
| Professional (Physician) Benefits | | | |
| Physician office visits | \$10 | \$20 | Not Covered |
| Other Practitioner office visit | \$10 | \$20 | Not Covered |
| Specialist office visit | \$20 | \$40 | Not Covered |
| Urgent Care visit (must use In-Network while in Ventura County) | \$50 | \$50 | \$50 |

2019 BENEFIT SUMMARY COMMERCIAL PLAN

| Outpatient Services (continued) | VCMC | Non-VCMC | Out of Network |
|---|---------------|---|----------------|
| Prosthetic and Orthotic Benefits | | | |
| Prosthetic equipment and devices | Not Available | 10% copay; 50% copay for replacement when medically necessary | Not Covered |
| Orthotic equipment and devices | Not Available | 10% copay; 50% copay for replacement when medically necessary | Not Covered |
| Rehabilitative and Habilitative Services Benefits (Physical, Occupational, Speech and Respiratory Therapy) | | | |
| Rehabilitative Services by a physical, occupational, or respiratory therapist in the following settings: | | | |
| Office Location | \$10 | \$20 | Not Covered |
| Outpatient department of a Hospital | \$10 | \$20 | Not Covered |
| Skilled Nursing Facility Benefits | | | |
| Services by a free standing Skilled Nursing Facility 100 day max for rehab/skilled nursing combination | Not Available | \$50 per day up to 10 days; per admission | Not Covered |
| Vision Benefits | | | |
| Vision- refraction only (Reimbursement Benefit) (out of pocket expenses do not accumulate to the out of pocket maximum) | Not Available | Up to \$50 member reimbursement for refraction, once every 12 months | Not Covered |

| Prescription Drug Benefits | Services by Express Scripts Inc. In-Network Pharmacies | Out of Network |
|---|--|----------------|
| Retail Prescriptions (up to a 30 day supply) | | |
| Contraceptive Drugs and Devices | No Charge | Not Covered |
| Tier 1 (Most Generics) | \$9 | Not Covered |
| Tier 2 (Preferred Brand) | \$30 | Not Covered |
| Tier 3 (Non-Preferred Brand) | \$45 | Not Covered |
| Tier 4 (Specialty Drugs) Authorization is required | 10% up to \$250 per script per month | Not Covered |
| Mail Order Prescriptions (up to a 90 day supply; full copay applies regardless of quantity supplied) | | |
| Contraceptive Drugs and Devices | No Charge | Not Covered |
| Tier 1 (Most Generics) | \$18 | Not Covered |
| Tier 2 (Preferred Brand) | \$60 | Not Covered |
| Tier 3 (Non-Preferred Brand) | \$90 | Not Covered |
| Infertility Medications | 50% contracted rate | Not Covered |

2019 BENEFIT SUMMARY COMMERCIAL PLAN

| Mental Health, Substance Use Disorder and Chemical Dependency Benefits | Services by Optum Behavioral Health In-Network Providers | Out of Network |
|---|--|---|
| Mental Health, Substance Use Disorder and Chemical Dependency Benefits Authorization is required for most Mental/Behavioral Health and Substance Use Disorder benefits. Please refer to the EOC for a list of benefits that do not require authorization | | |
| Mental/Behavioral Health and Substance Use Disorder outpatient office visits: individual evaluation, treatment or counseling | \$10 | Not Covered |
| Mental/Behavioral Health and Substance Use Disorder outpatient office visits: evaluation, treatment or counseling in a group setting | \$10 | Not Covered |
| Mental/Behavioral Health and Substance Use Disorder other outpatient items and services: including but not limited to: Electroconvulsive Therapy (ECT), Transcranial Magnetic Stimulation (TMS); Behavioral Health Treatment for PDD/Autism | \$0 | Not Covered |
| Mental/Behavioral Health and Substance Use Disorder inpatient facility (e.g. hospital room) | \$0 | Not Covered |
| Mental/Behavioral Health and Substance Use Disorder inpatient physician/surgeon fee | \$0 | Not Covered |
| Mental/Behavioral Health and Substance Use Disorder Emergency Services | \$150 copay; waived if admitted to Hospital | \$150 copay; waived if admitted to Hospital |
| Mental/Behavioral Health and Substance Use Disorder Urgent Care visit (must use in-network while in Ventura County) | \$50 | Not Covered |
| Residential Treatment program and non-medical Transitional Residential Recovery Services- Mental Health | \$0 | Not Covered |
| Residential Treatment program and non-medical Transitional Residential Recovery Services- Substance Use Disorder | \$0 | Not Covered |
| Mental/Behavioral Health and Substance Use Disorder Outpatient partial hospitalization | \$10 | Not Covered |
| Outpatient Mental Health and Substance Use Disorder Care | \$10 | Not Covered |
| Methadone maintenance treatment | \$10 | Not Covered |
| Inpatient Services to treat acute medical complications of detoxification | \$0 | Not Covered |
| Psychological testing | \$10 | Not Covered |
| Psychiatric Observation | \$10 | Not Covered |
| Substance Use Disorder Day Treatment | \$10 | Not Covered |
| Substance Use Disorder Intensive Outpatient Treatment Programs | \$10 | Not Covered |
| Substance Use Disorder Medical Treatment for Withdrawal | \$10 | Not Covered |