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

2024 Commercial Plan Benefit Summary

Out-of-Pocket (OOP) Maximum: Individual = $3,000 Family = $6,000 **Deductible:** This plan has no deductible
Copayments made to providers for covered medical, pharmacy and behavioral health services apply towards the OOP maximum.

Benefit	Member Copayment	
Medical Benefits	**In-Network**	**Out-of-Network**
Inpatient Services		
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	$100 per day up to 5 days; per admission	$100 per day up to 5 days; per admission
Inpatient Physician/Surgeon Fee	No Charge	No Charge
Emergency Services Benefits		
Emergency Room Physician Fee	No Charge	No Charge
Emergency Room Facility Fee	$100 per visit (co-pay waived if admitted)	$100 per visit (co-pay waived if admitted)
Outpatient Observation Care provided in hospital		
In conjunction with ER services	ER copay applies	ER copay applies
Not in conjunction with ER services (direct observation)	10% up to $250	10% up to $250
Outpatient Services		
Acupuncture Benefits		
Acupuncture Services (Reimbursement Benefit) (out of pocket expenses do not accumulate to the out of pocket maximum)	$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	Not Covered
Ambulance Benefits		
Emergency or authorized transport (Ground & Air)	$150	$150
Ambulatory Surgery Center Benefits		
Ambulatory Surgery Center Outpatient Surgery Facility Fee	10% up to $250	Not Covered
Ambulatory Surgery Center Outpatient Surgery Physician/Surgeon Fee	No Charge	Not Covered
Chiropractic Benefits		
Chiropractic Services (Reimbursement Benefit) (out of pocket expenses do not accumulate to the out of pocket maximum)	$20 per visit member reimbursement to a combined maximum of 15 visits per plan year, no coverage thereafter	
Diabetes Care Benefits		
Disease Management Program provided by VCHCP	No Charge	Not Covered
Case Management provided by VCHCP	No Charge	Not Covered
Dialysis Benefits		
Outpatient Dialysis Services	$10	Not Covered

Outpatient Services (continued)	In-Network	Out-of-Network
Durable Medical Equipment Benefits (as defined by Medicare)		
Breast pump (Reimbursement Benefit)	$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	10% copay; 50% copay for replacement when medically necessary	Not Covered
Family Planning Benefits		
Counseling and consulting	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	Not Covered
Termination of Pregnancy (Abortion)	No Charge	Not Covered
Implantable contraceptives	No Charge	Not Covered
Infertility Services	50% of covered services	Not Covered
Injectable contraceptives	No Charge	Not Covered
Insertion and/or removal of intrauterine device (IUD)	No Charge	Not Covered
Intrauterine Device (IUD)	No Charge	Not Covered
Tubal Ligation	No Charge	Not Covered
Vasectomy	No Charge	Not Covered
Health Education and Promotion Benefits		
Preventive Health Program provided by VCHCP	No Charge	Not Covered
Educational Outreach provided by VCHCP	No Charge	Not Covered
Community Resources Repository provided by VCHCP	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)	$20 per visit	Not Covered
Hospice Program Benefits		
Hospice Care	No Charge	Not Covered
Outpatient Services Benefits		
Outpatient visit: Chemotherapy, outpatient radiation, outpatient infusion therapy	$20 per visit	Not Covered
Outpatient Laboratory and Pathology: When provided to diagnose illness or injury	$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	$15	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	$100	Not Covered
Genetic testing	10% of cost up to $500 maximum	Not Covered
Outpatient Services - Other	10% of cost up to $250 maximum	Not Covered
Pregnancy and Maternity Care Benefits		
Inpatient Facility Fee Semi-Private room and board, and medically necessary services and supplies	$100 per day up to 5 days; per admission	$100 per day up to 5 days; per admission
Comprehensive prenatal care (Services other than from an OB/GYN may require a copay.)	$0	Not Covered
All necessary Inpatient Professional Services for normal deliver, Cesarean section and complications of pregnancy	$0	Not Covered
Postnatal Physician office visits	$0	Not Covered

Outpatient Services (continued)	In-Network	Out-of-Network
Preventive Health Benefits		
Preventive Care, Screenings and Immunizations	No Charge	Not Covered
Routine Physical Exam	No Charge	Not Covered
Well Child Preventive Exam	No Charge	Not Covered
Professional (Physician) Benefits		
Physician office visits (Primary Care)	$15	Not Covered
Other Practicioner office visit	$15	Not Covered
Specialist office visit	$30	Not Covered
Urgent Care visit (must use In-Network while in Ventura County)	$35	$35
Prosthetic and Orthotic Benefits		
Prosthetic equipment and devices	10% copay; 50% copay for replacement when medically necessary	Not Covered
Orthotic equipment and devices	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	$15	Not Covered
Outpatient department of a Hospital	$15	Not Covered
Skilled Nursing Facility Benefits		
Services by a free standing Skilled Nursing Facility 100 day max for rehab/skilled nursing combination	$50 per day up to 10 days. Limited to 60 consecutive days, per admission.	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	Generic 10% (up to $100 max/script) Brand (preferred and non-preferred) 10% (up to $250 max/script)	Not Covered
Mail Order or Smart 90 Pharmacy 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
Please note that Schedule II Drugs may be dispensed as partial fills and the member copay shall be prorated accordingly.		

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	$15	Not Covered
Mental/Behavioral Health and Substance Use Disorder outpatient office visits: evaluation, treatment or counseling in a group setting	$15	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	$15	Not Covered
Mental/Behavioral Health and Substance Use Disorder inpatient facility (e.g. hospital room)	$100 per day up to 5 days; per admission	$100 per day up to 5 days; per admission
Mental/Behavioral Health and Substance Use Disorder inpatient physician/surgeon fee	$0	$0
Mental/Behavioral Health and Substance Use Disorder Emergency Services	$100 per visit (co-pay waived if admitted)	$100 per visit (co-pay waived if admitted)
Mental/Behavioral Health and Substance Use Disorder Urgent Care visit (must use in-network while in Ventura County)	$35	$35
Residential Treatment program and non-medical Transitional Residential Recovery Services - Mental Health	$50 per day up to 10 days; per admission	Not Covered
Residential Treatment program and non-medical Transitional Residential Recovery Services - Substance Use Disorder	$50 per day up to 10 days; per admission	Not Covered
Mental/Behavioral Health and Substance Use Disorder Outpatient partial hospitalization	$15	Not Covered
Outpatient Mental Health and Substance Use Disorder Care	$15	Not Covered
Methadone maintenance treatment	$15	Not Covered
Inpatient Services to treat acute medical complications of detoxification	$100 per day up to 5 days; per admission	$100 per day up to 5 days; per admission
Psychological testing	$15	Not Covered
Psychiatric Observation	$15	Not Covered
Substance Use Disorder Day Treatment	$15	Not Covered
Substance Use Disorder Intensive Outpatient Treatment Programs	$15	Not Covered
Substance Use Disorder Medical Treatment for Withdrawal	$15	Not Covered