2024

COMMERCIAL BENEFIT PLAN

Quick Reference Guide

CONTACT INFORMATION

Ventura County Health Care Plan
2220 E. Gonzales Road, Suite 210-B, Oxnard, CA 93036

Regular Business Hours are:
Monday—Friday, 8:30 a.m. to 4:30 p.m.

- vchealthcareplan.org
- E-mail: VCHCP.Memberservices@ventura.org
- Phone: (805) 981-5050
- Toll-free: (800) 600-8247
- FAX: (805) 981-5051
- Language Line Services (free): Phone: (805) 981-5050
  - TDD to Voice: (800) 735-2929
  - Voice to TDD: (800) 735-2922
- Nurse Advice Line: (800) 334-9023
- Teladoc: (800) 835-2362
- Pharmacy Help: (800) 811-0293 or express-scripts.com
- Behavioral Health/Life Strategies: (24-hour assistance) (800) 851-7407 liveandworkwell.com

Hospital Admissions:

- 24-hour On-call Administrator: (805) 981-5050

MEDICAL EMERGENCIES

Call 911, or go to the nearest emergency room if you believe that an emergency medical condition exists.

Ventura County Health Care Plan
On-call Administrator available 24-hours per day for emergency Providers & Hospital Admissions
(805) 981-5050 or (800) 600-8247

Ventura County Medical Center - Emergency Room
300 Hillmont Avenue, Ventura, CA 93003
(805) 652-6165 or (805) 652-6000

Santa Paula Hospital
A Campus of Ventura County Medical Center
825 N 10th Street, Santa Paula, CA 93060
(805) 933-8632 or (805) 933-8600

This is only a summary. Your Employer's Group Agreement Evidence of Coverage (EOC) should be consulted to determine details of governing contractual provisions.

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	Services by In-Network Providers	Services by Out-of-Network Providers
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 Program provided by VCHCP	No Charge	Not Covered
Dialysis Benefits		
Outpatient Dialysis Services	$10	Not Covered
Durable Medical Equipment Benefits (as defined by Medicare)		
Breast pump (Reimbursement Benefit)	$200 max 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

Outpatient Services (continued)	In-Network	Out-of-Network
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: including Maternal Mental Health screening, treatment, and services during prenatal, perinatal, or postnatal period		
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: Including Maternal Mental Health screening, treatment, and services (Services other than from an OB/GYN may require a copay.)	$0	Not Covered
All necessary Inpatient Professional Services for: Normal delivery, Cesarean section and complications of pregnancy including Maternal Mental Health screening, treatment, and services	$0	Not Covered
Postnatal Physician office visits: Including Maternal Mental Health screening, treatment, and services	$0	Not Covered
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

Outpatient Services (continued)	In-Network	Out-of-Network
Professional (Physician) Benefits		
Physician office visits (Primary Care)	$15	Not Covered
Other Practitioner 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 some 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 copay; waived if admitted to Hospital	$100 copay; waived if admitted to Hospital
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

PURPOSE AND SCOPE OF THE UTILIZATION MANAGEMENT (UM) PROGRAM

The UM Program is designed to ensure that medically appropriate services are provided to all members of the Plan through a comprehensive framework that assures the provision of high quality, cost effective, and medically appropriate healthcare services in compliance with the patient benefit coverage and in accordance with regulatory requirements. The UM structures and processes are clearly defined and responsibility is assigned to appropriately trained individuals. The Medical Director of the Plan acts as the Medical Director of the UM Program.

PRIOR AUTHORIZATION/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. Your PCP must ask VCHCP for prior approval for Referrals to Covered Services including certain Specialist Physicians and certain services. The Plan processes normal/non-urgent pre-service requests for Covered Services made by your PCP or treating Provider within five (5) business days and urgent pre-service requests made by your PCP or treating Provider within seventy-two (72) hours from the Plan's receipt of request. For normal/non-urgent pre-service and urgent pre-service requests, the Plan faxes the notification of decision to your PCP or treating Provider within 24-hours of decision.

CONCURRENT REVIEW

Authorization requests received at the time the service is provided are called Concurrent Review requests. For urgent concurrent authorization requests such as initial inpatient stay, the Plan makes a determination within 24-hours of receipt of request. For non-urgent concurrent authorization requests such as extension of inpatient stay, the Plan makes a determination within seventy-two (72) hours of receipt of request. For urgent and non-urgent concurrent authorization requests, the Plan faxes the written decision to your PCP or treating Provider within twenty-four (24) hours of decision.

POST SERVICE REVIEW

Authorization requests received after the service has been provided are called Post Service Review requests. For these authorization requests, the Plan makes a determination and faxes the written decision to your PCP or treating Provider within thirty (30) calendar days of receipt of the request.

CASE MANAGEMENT & DISEASE MANAGEMENT PROGRAMS

To ensure the effective management of complicated and costly or chronic cases, the case management and disease management staff collaborate with the members and their health care team to ensure coordination of care. Referrals to case management and disease management may be made by VCHCP staff, providers, hospital staff, employers, and members to facilitate the continuity and coordination of the member's care. The referral is made to a VCHCP case manager or disease manager who is a qualified licensed health professional and functions within the scope of his/her license to practice (e.g., RN).

AFFIRMATIVE STATEMENT

The following Affirmative Statement is posted in the UM Department and includes the following associates: medical and clinical directors, physicians, UM directors and managers, licensed UM staff including management personnel who supervise clinical staff and any associate in any working capacity that may come in contact with members during their care continuum:

- *UM decision making is based only on appropriateness of care and service and existence of coverage.*
- *The organization does not specifically reward practitioners or other individuals for issuing denials of coverage or care.*
- *Financial incentives for UM decision makers do not encourage decisions that may result in underutilization.*
- *VCHCP does not use incentives to encourage barriers to care and service.*
- *VCHCP does not make hiring, promotion or termination decisions based upon the likelihood or perceived likelihood that an individual will support or tend to support the denial of benefits.*

VCHCP UTILIZATION MANAGEMENT STAFF

• Regular Business Hours: Monday—Friday 8:30 a.m. to 4:30 p.m. • Phone: (805) 981-5060

LANGUAGE ASSISTANCE AND NONDISCRIMINATION

Language and Communication Assistance

Good communication with VCHCP and with your providers is important. If English is not your first language, VCHCP provides interpretation services and translations of certain written materials.

- To ask for language services call VCHCP at (805) 981-5050 or (800) 600-8247. You may obtain language assistance services, including oral interpretation and translated written materials, free of charge and in a timely manner. You may obtain interpretation services free of charge in English and the top 15 languages spoken by limited-English proficient individuals in California as determined by the State of California Department of Health Services.
- If you are deaf, hard of hearing or have a speech impairment, you may also receive language assistance services by calling TDD/TTY at (800) 735-2929.
- If you have a preferred language, please notify us of your personal language needs by calling VCHCP at (805) 981-5050 or (800) 600-8247 or by completing the Language/Ethnicity Questionnaire in this packet.
- Interpreter services will be provided to you, if requested and arranged in advance, at all medical appointments.

If you have a disability and need free auxiliary aids and services, including qualified interpreters for disabilities and information in alternate formats, including written information in other formats, you may request that they be provided to you free of charge and in a timely manner, when those aids and services are necessary to ensure an equal opportunity for you to participate.

Nondiscrimination

VCHCP complies with applicable Federal and California laws and does not exclude people or otherwise discriminate against them because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age or disability.

The Department of Health and Human Services (HHS) Office for Civil Rights (OCR) enforces certain Federal civil rights laws that protect the rights of all persons in the United States to receive health and human services without discrimination based on race, color, national origin, disability, age, and in some cases, sex and religion.

If you believe that you have been discriminated against you may file a complaint with the Office for Civil Rights (OCR). You can file your complaint by email at OCRcomplaint@hhs.gov, or you can mail your complaint to:

Centralized Case Management Operations
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Bldg.
Washington, D.C. 20201

If you have any questions, or need help to file your complaint, call OCR (toll-free) at 1(800) 368-1019 (voice) or 1(800) 537-7697 (TDD), or visit their website at: hhs.gov/ocr.
You may also send an email to OCRMail@hhs.gov.

GRIEVANCE & APPEAL PROCESS

VCHCP recognizes that, under certain circumstances, our performance or that of our contracted providers, may not agree with or match our members' expectations. Therefore, the Plan has established a grievance/ complaint and appeal system for the Plan Members to file a grievance. We endeavor to assure our members of their rights to voice complaints and appeals, and to expedite resolutions.

VCHCP encourages the informal resolution of problems and complaints, especially if they resulted from misinformation or misunderstanding. However, if a complaint cannot be resolved in this manner, a formal Member Grievance Procedure is available.

VCHCP makes available complaint forms at its offices and provides complaint forms to each Participating Provider. A Member may initiate a grievance in any form or manner (form, letter, or telephone call to the Member Services Department). Grievances must be filed within 180 calendar days following any incident or action that is the subject of the dissatisfaction.

Procedures

Members may register complaints with VCHCP by calling, writing, or via email or fax or by using the on-line form available on the VCHCP website:

Ventura County Health Care Plan
2220 E. Gonzales Rd. Ste. 210-B
Oxnard, CA 93036
Phone: (805) 981-5050 or (800) 600-8247
Fax: (805) 981-5051
Email: VCHCP.Memberservices@ventura.org
Website: vchealthcareplan.org

The Plan shall provide written acknowledgment of a Member's grievance within five (5) days of receipt. The Plan shall provide a written response to a grievance within thirty (30) days. If, however, the case involves an imminent and serious threat to the health of the Member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function, the Plan shall provide an expedited review. This also applies to grievances for terminations for non-renewals, rescissions, and cancellations. The Plan shall provide a written statement on the disposition or pending status of a case requiring an expedited review no later than three days from receipt of the grievance.

If the grievance has been unresolved for more than 30 days or was not satisfactorily resolved by the plan, the member may seek assistance from the Department of Managed Health Care (DMHC). The DMHC's website (**dmhc.ca.gov**) has complaint forms and instructions online. The DMHC also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired.