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

2020

BRONZE 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.

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

Hospital Admissions:

- 24-hour On-call Administrator: (805) 981-5050 or Toll-free: (800) 600-8247

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.

DEDUCTIBLE / OUT-OF-POCKET (OOP) COSTS

⇒ Deductible (Individual / Family)
- Medical = $6,300 / $12,600
- Pharmacy = $500 / $1,000
- Dental = $0 / $0

⇒ OOP Costs:
- Individual= $7,800
- Family = $15,600

Copayments made to providers for covered medical, pharmacy and behavioral health services apply towards the OOP maximum.

PRIMARY CARE PHYSICIAN OFFICE VISITS

⇒ $65 copayment (Deductible waived for first 3 non-preventive visits)

⇒ No copayment for preventive health services

⇒ Large physician network with locations throughout Ventura County - see VCHCP Provider Directory

SPECIALIST PHYSICIAN OFFICE VISITS

⇒ $95 copayment (Deductible waived for first 3 non-preventive visits)

⇒ No copayment for preventive health services

⇒ Referred by Primary Care Provider (PCP)

WELL-CHILD CARE

⇒ No copayment for these services

⇒ Primary care by a network physician

⇒ Immunizations

WOMEN'S HEALTH

⇒ No copayment for comprehensive prenatal care (Services other than from an OB/GYN may require a copay)

⇒ No copayment for preventive health services

⇒ Self-referral for OB/GYN Direct Access Services

HOSPITAL INPATIENT SERVICES

⇒ 60% coverage (member pays 40% co-insurance*)

OUTPATIENT SERVICES / OUTPATIENT SURGERY

⇒ Directed by PCP and approved by Plan

⇒ $40 copayment for routine lab work

⇒ X-Ray, Imaging, Diagnostic imaging (ultrasound, mammogram), and/or other Diagnostic Services (MRI, CT, PET)
- 60% coverage (member pays 40% co-insurance*)

⇒ Outpatient Surgery
- 60% coverage (member pays 40% co-insurance*)

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, HABILITATIVE AND REHABILITATIVE SERVICES

⇒ $65 copayment

⇒ Directed by PCP or orthopedic surgeon and approved by Plan

⇒ Therapists available throughout Ventura County

URGENT CARE

⇒ $65 copayment (Deductible waived for first 3 non-preventive visits)

⇒ Out-of-area coverage for Urgent Care

⇒ Follow-up care must be with your PCP otherwise **Plan authorization is required**

⇒ See Provider Directory for locations of in-network Urgent Care centers

⇒ **The use of non-contracted Urgent Care facilities in Ventura County,** the Plan's licensed service area**, is not covered.**

EMERGENCY CARE

⇒ Covers Emergency Services only

⇒ 60% coverage at any ER facility (member pays 40% co-insurance*)

⇒ Worldwide Coverage for emergency medical condition

⇒ After stabilization of emergency medical condition, Plan approval required for additional services in an out-of-network facility

⇒ Ambulance: 60% coverage (member pays 40% co-insurance*)

NURSE ADVICE LINE

Available to you and your family 24 hours per day, 7 days per week at no additional cost

(800) 334-9023

SKILLED NURSING / ACUTE REHAB

⇒ 60% coverage at network provider (member pays 40% co-insurance*)

⇒ Limited to 100 combined days per plan year

⇒ Length of stay coverage limited to 60 consecutive days

⇒ Directed by PCP and approved by Plan

DURABLE MEDICAL EQUIPMENT

⇒ 60% coverage (member pays 40% co-insurance*)

⇒ Directed by PCP and approved by Plan

⇒ Replacement due to damage, loss, or theft are the financial responsibility of the member

OTHER SERVICES

⇒ $75 copayment for Acupuncture

⇒ Acupuncture benefits provided only for treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain

⇒ Acupuncture coverage provided by American Specialty Health (ASH) - (800) 678-9133

⇒ Covered services provided only by acupuncturists listed in the ASH Provider Directory

⇒ Ancillary Services, such as x-ray, ordered by an acupuncturist require prior authorization from VCHCP

⇒ Annual Eye Refraction Exam, up to $50 reimbursement

BEHAVIORAL HEALTH SERVICES

The following services are Administered by OptumHealth Behavioral Solutions (Life Strategies) 24-hour assistance (800) 851-7407

Member calls behavioral solutions program for provider selection and authorization if required

⇒ **RESIDENTIAL ALTERNATIVE TREATMENT**

⇒ **INPATIENT MENTAL HEALTH & SUBSTANCE USE**

- 60% coverage (member pays 40% co-insurance*)

⇒ **OUTPATIENT MENTAL HEALTH & SUBSTANCE USE**

- $65 copayment per visit
- PCP referral not required

HOME HEALTH SERVICE

⇒ 60% coverage (member pays 40% co-insurance*)

⇒ 100 visits per Plan year

PHARMACY

www.express-scripts.com
(800) 811-0293

	Retail (up to 30 day supply)	Mail Order or Smart 90 Pharmacy (up to 90 day supply)
Tier 1	$18	$36
Tiers 2—4	Member pays 40% up to $500/script after pharmacy deductible	

PEDIATRIC DENTAL & VISION SERVICES

The following benefits apply only to dependent children under the age of 19. Please refer to the applicable EOC booklet for more detail on these benefits.

Pediatric Dental:

⇒ Benefits provided by California Dental Network

⇒ No cost for Diagnostic and Preventive (x-rays, exams, cleanings, sealants)

⇒ $0 deductible

⇒ No annual max

⇒ No waiting period

⇒ Contact California Dental Network at (877) 433-6825

Pediatric Vision:

⇒ Benefits provided by Vision Service Plan (VSP)

⇒ $0 for routine eye exam annually

⇒ $0 for one pair of eye glasses or contact lenses annually; standard frames, standard lenses, no lens treatment

⇒ Contact VSP at (800) 877-7195 or online at www.vsp.com

* Co-insurance= a co-sharing agreement between the insured and the insurer under a health insurance policy which provides that the insured will cover a set percentage of the covered costs after the deductible has been paid.

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.

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.*

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).

VCHCP UTILIZATION MANAGEMENT STAFF

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