VHP Valley Health Plan

2024 Schedule of Benefits & Coverage Matrix: Platinum 90 HMO

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE (EOC) AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Coverage Period
The Coverage Period for this plan is 01/01/24 through 12/31/24 (Plan year).

Plan Year Out-of-Pocket Maximum	
You will not pay any more Cost Share during a plan year if the Copayments and Coinsurance you pay add up to one of the following amounts:	
For Self-only enrollment (a Family of one Member)	$4,500 per plan year
For an entire Family of two or more Members	$9,000 per plan year

Plan Deductible
There is no deductible under this plan.

Lifetime Maximum	None

Professional Services (Plan Provider office visits)	Your Cost Share
Most Primary Care Visits for evaluations and treatment	$15 per visit
Most Specialty Care Visits for consultations, evaluations and treatment	$30 per visit
Other Practitioner Office Visits*	$15 per visit
Routine physical maintenance exams, including well woman exams	No charge
Well-child preventative exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist for Members under age 19	No charge
Hearing exams	No charge
Most Physical, occupational, and speech therapy	$15 per visit
Urgent care consultations, evaluations, and treatment	$15 per visit

Note:

1. Urgent care includes Mental/Behavioral health and Chemical dependency (Substance Use Disorder) crisis intervention services.
2. Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in-person.

Outpatient Services	Your Cost Share
Outpatient surgery facility fee	$75 per procedure
Outpatient Physician/surgeon fee	$20 per visit
Outpatient Visit**	10% coinsurance per visit
Most Immunizations (including the vaccine)	No charge
Most X-rays	$30 per encounter
Most Laboratory tests	$15 per encounter
MRI, most CT, and PET scans	$75 per procedure
Rehabilitation/Habilitation services	$15 per visit
Covered individual health education counseling	No charge
Covered health education programs	No charge

Note: There are no cost-sharing for all abortion and abortion-related services.

Hospitalization Services	Your Cost Share
Inpatient stay (facility fee)	$225 per day up to 5 days per admission***
Physician/surgeon fee for surgery	No charge

Emergency Health Coverage	Your Cost Share

Emergency room facility fee	$150 per visit
Emergency room physician fee	No charge

Note: Emergency room fees do not apply if admitted directly to the hospital as an inpatient for Covered Services.

Ambulance Services	Your Cost Share
Ambulance Services	$150 per trip

Prescription Drug Coverage		Your Cost Share
Covered outpatient items in accord with our drug formulary guidelines:		
Tier 1	At a Plan Pharmacy or mail order service	$7 for up to a 30-day supply
Tier 2	At a Plan Pharmacy or mail order service	$16 for up to a 30-day supply
Tier 3	At a Plan Pharmacy or mail order service	$25 for up to a 30-day supply
Tier 4	Items at a Plan Pharmacy	10% coinsurance up to $250 per script for up to a 30-day supply

Drug Tiers	Categories
1	•Most generic drugs and •Low cost preferred brands
2	•Non-preferred generic drugs; •Preferred brand name drugs; and •Any other drugs recommended by plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	•Non-preferred brand name drugs or; •Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or; •Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	• Drugs that are biologics and drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through to specialty pharmacies; • Drugs that requires the enrollee to have special training or, clinical monitoring; • Drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) net of rebates for a one-month supply.

Note: Member's cost-sharing will be the lower of the pharmacy's retail price for a prescription drug or the applicable cost-sharing amount for the drug and such expenditures will accrue to the deductible and out-of-pocket maximum limit.

Mental/Behavioral Health (MH) Services	Your Cost Share
Inpatient:	
MH psychiatric hospitalization fee	$225 per day up to 5 days per admission***
MH psychiatric physician/surgeon fee	No Charge
MH psychiatric observation	Included in psychiatric hospitalization fee
MH psychological testing	Included in psychiatric hospitalization fee
MH individual and group treatment	Included in psychiatric hospitalization fee
MH individual and group evaluation	Included in psychiatric hospitalization fee
MH crisis residential program	$225 per day up to 5 days per admission***
Outpatient:	
MH office visits	$15 per visit
MH monitoring of drug therapy	$15 per visit
MH individual and group treatment	$15 per visit
MH individual and group evaluation	$15 per visit
Outpatient, Other Items and Services:	

Applied behavior analysis and behavioral health treatment	$15 per visit
MH multidisciplinary treatment in an intensive outpatient psychiatric treatment program	$15 per visit
Neuropsychological testing	$15 per visit
MH partial hospitalization	$15 per visit
MH psychological testing	$15 per visit

Note: Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in-person.

Chemical Dependency (Substance Use Disorder) Services	Your Cost Share
Inpatient:	
Chemical dependency hospitalization fee	$225 per day up to 5 days per admission***
Chemical dependency physician/surgeon fee	No Charge
Inpatient detoxification	Included in hospitalization fee
Individual and group treatment	Included in hospitalization fee
Individual and group chemical dependency counseling	Included in hospitalization fee
Individual and group evaluation	Included in hospitalization fee
Transitional residential recovery services	$225 per day up to 5 days per admission***
Outpatient:	
Chemical dependency office visits	$15 per visit
Chemical dependency individual and group evaluation	$15 per visit
Chemical dependency individual and group counseling	$15 per visit
Methadone Maintenance	$15 per visit
Outpatient, Other Items and Services:	
Chemical dependency intensive outpatient programs	$15 per visit
Chemical dependency day treatment programs	$15 per visit

Note: Telehealth are covered benefits. Your cost-share for telehealth services shall not exceed the cost-share charged for the same services delivered in-person.

Durable Medical Equipment (DME)	Your Cost Share
DME items that are essential health benefits	10% coinsurance
Home Health Services	**Your Cost Share**
Home health care (up to 100 visits per plan year)	$20 per visit
Other	**Your Cost Share**
Eyeglasses or contact lenses for Members under age 19:	
Eyeglass frame from selected styles per plan year	No charge
Standard contact lenses per plan year	No charge
Regular eyeglasses lenses per plan year	No charge
Note: Limited to one pair of glasses per year (contact lenses in lieu of glasses).	
Skilled Nursing Facility care (up to 100 days per benefit period)	$125 per day up to 5 days per admission***
Hospice care	No charge
Dental Services	
For associated cost-sharing such as oral exam, preventive cleaning, medically necessary orthodontics, etc. please see Liberty Dentals schedule of benefits with the appropriate cost-amounts.	

Notes:

* Other Practitioner Office Visits include visits not provided by either Primary Care or Specialty Practitioners.

** Outpatient Visit includes but not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.

*** Stays have no additional cost share after the first 5 days of a continuous stay.

The plan will provide coverage without any cost sharing for a colorectal cancer screening test assigned either a grade of A or B by the United States Preventive Services Task Force (USPSTF).

There is dependent coverage available to dependent parents or stepparents who live or reside within the plan's service area. Members seeking to add their dependent parent or stepparent will be provided with written notice about the California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP).

For in-network providers, the plan will provide coverage for home test kits for sexually transmitted diseases, and the laboratory costs for processing those kits, that are deemed medically necessary or appropriate and ordered directly by a health care provider or furnished through a standing order for patient use based on clinical guidelines and individual patient health.

Endnotes:

1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network services include services provided by an out-of-network provider but are approved as in-network by the issuer.

2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.

3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.

4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.

5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2024 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.

6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the $45 copayment, the lesser amount is the applicable cost-sharing amount.

7) Where indicated, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, and/or outpatient Mental Health/Substance Use Disorder visits.
8) Member cost-share for oral anti-cancer drugs shall not exceed $250 for a script of up to 30 days per state law (Health and Safety Code § 1367.656; Insurance Code § 10123.206).
9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.
10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2024 Dental Copay Schedule.
13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Podiatrists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit category for a service provided by one of these practitioners. Services provided by other practitioners for the treatment of

mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.

19) The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.

20) The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility.

21) Covered California may approve deviations from the benefit plan designs for certain services on a case by case basis if necessary to comply with the California Mental Health Parity Act or federal Mental Health Parity and Addiction Equity Act (MHPAEA).

22) Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.

23) Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
2	1) Non-preferred generic drugs; 2) Preferred brand name drugs; and 3) Any other drugs recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or; 2) Drugs that are recommended by P&T committee based on drug safety, efficacy and cost or; 3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Drugs that are biologics and drugs that the Food and Drug Administration (FDA) or drug manufacturer requires to be distributed through specialty pharmacies; 2) Drugs that require the enrollee to have special training or clinical monitoring; 3) Drugs that cost the health plan (net of rebates) more than six hundred dollars ($600) net of rebates for a one-month supply.

- Some drugs may be subject to zero cost-sharing under the preventive services rules.

24) Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.

25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.

26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.

27) The cost sharing for hospice services applies regardless of the place of service.

28) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.

29) For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.

30) For any benefit plan design in which a designation of Individual-Only or CCSB-Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.

31) The out-of-pocket maximum in the Bronze HDHP shall not exceed the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2024 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of- pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For additional cost-share please refer to the Summary of Benefits and Coverage (SBC). For a complete benefit explanation, please refer to the "Limitations & Exclusions" section in your EOC.