VHP Valley Health Plan

2024 **Employer Group**

Combined Evidence of Coverage and Disclosure Form

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Welcome to Valley Health Plan!

Dear Member,

Thank you for choosing Valley Health Plan (VHP) to manage your health care needs. We look forward to ensuring a positive experience and your continued satisfaction with the services we provide.

VHP is a State-licensed health care service plan owned and operated by the County of Santa Clara. We care about the health and well-being of you and your family. VHP's staff is committed to ensuring that you receive quality care and service at the right time, at the right place, and by the right provider. We believe that health care is highly personalized and that you receive the best health care when you make informed decisions about your treatment in partnership with your Primary Care Provider (PCP).

To help you understand your Coverage and responsibilities as a VHP Member, this Combined Evidence of Coverage and Disclosure Form (EOC) will provide you with a detailed explanation of VHP's services, Benefits, limitations, and exclusions. We encourage you to carefully read through the information in the EOC.

Even after you have read the EOC, you may still have questions. Please remember you have someone you can count on, your Member Services Representative, who can help you manage the details of your health care - like paperwork, referrals and even selecting your Primary Care Provider (PCP).

Please note that this EOC constitutes only a summary of the plan. Updated Benefit changes, events, provider listings, and general information can be found at www.valleyhealthplan.org. Chapter 11 reflects defined terms used throughout the EOC. When you see a capitalized term in the EOC, refer to Chapter 11 to see a complete definition.

The staff at Valley Health Plan appreciate your membership and look forward to serving you.

Best wishes,

Valley Health Plan

VHP Nondiscrimination Policy

VHP complies with applicable federal and California civil rights Laws and does not discriminate based on race, disability, sex, religion, age, color, sexual orientation, creed, family history, marital status, veteran status, national origin, ancestry, gender, gender identity, handicap, or condition in accordance with applicable State and federal Law.

VHP provides free aids and services to people living with a disability to assist with effective communication with Plan, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

VHP provides free language services to people whose primary language is not English to assist with effective communication with Plan, such as:

- Qualified interpreters.
- Information written in other languages.

If you need these services, contact VHP Member Service Department.

If you believe that VHP has failed to provide these services, or discriminated in another way on the basis of race, color, national origin, ancestry, marital status, gender, age, religion, disability, sex, sexual orientation, gender identity, gender expression, or any other classification prohibited by State or federal Laws, you can file a Grievance with:

VHP Member Services
2480 North First Street, Ste 160,
San Jose, CA 95131
1.888.421.8444 (toll-free),
California Relay Service (CRS) 711 or the 800 CSR number from your modality

You may file a Grievance in person or by mail, fax, or email. If you need help filing a Grievance, Member Services Representatives are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 1.800.537.7697 (TDD)

Complaint forms are available at **https://www.hhs.gov/ocr/complaints/index.html**.

Language Assistance Program

Call VHP's Member Services Department at **1.888.421.8444 (toll-free)** if you would like to talk to us in your preferred language about any questions, comments, or concerns. VHP, in coordination with VHP's Plan Providers, offers over-the-telephone language assistance at no cost to you. You can also get an interpreter to talk to your Plan Provider by contacting VHP's Member Services Department. In addition, VHP can provide written translation of vital documents, such as applications, Grievance or consent forms, or other important membership materials. Language Assistance Program arranged by VHP is provided at no charge. If you have questions about language services, please call VHP's Member Services Department.

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call **1.888.421.8444** (California Relay Service (CRS) **711**).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1.888.421.8444** (California Relay Service (CRS) **711**).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1.888.421.8444** (California Relay Service (CRS) **711**).

Tagalog (Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1.888.421.8444** (California Relay Service (CRS) **711**).

한국어 (Korean)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1.888.421.8444 (California Relay Service (CRS) **711**)번으로 전화해 주십시오.

繁體中文(Chinese)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1.888.421.8444** (California Relay Service (CRS) **711**)。

Հ այ ե ր ե ն (Armenian)

ՈՒՇ ԱԴՐ ՈՒԹՅ ՈՒՆ՝ Եթ ե խո ս ո ւ մ եք հ այ ե ր ե ն, ապա ձեզ ան վ ճ ար

կ ար ո ղ ե ն տր ամ ադ ր վ ե լ լ ե զ վ ակ ան աջ ակ ց ո ւ թյ ան

ծ առ այ ո ւ թյ ո ւ ն ն ե ր ։ Զան գ ահ ար ե ք **1.888.421.8444** (California Relay Service (CRS) **711**)։

Р ус с ки й (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1.888.421.8444** (California Relay Service (CRS) **711**).

ف ارسي (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

(California Relay Service (CRS) 711) 1.888.421.8444 تماس بگیرید.

فراهم می باشد. با

日本語 (Japanese)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

1.888.421.8444 (California Relay Service (CRS) **711**) まで、お電話にてご連絡くだ。

Hmoob (Hmong)

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1.888.421.8444** (California Relay Service (CRS) **711**).

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1.888.421.8444 (California Relay Service (CRS) 711) 'ਤੇ ਕਾਲ ਕਰੋ।

لعبية (Arabic)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.888.421.8444 (رقم هاتف الصم والبكم: (California Relay Service (CRS) 711).

हिंदी (Hindi)

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.888.421.8444 (California Relay Service (CRS) 711) पर कॉल करें।

ภาษาไทย (Thai)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1.888.421.8444** (California Relay Service (CRS) **711**).

ខ្មែរ (Cambodian)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1.888.421.8444 (California Relay Service (CRS) 711).

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1.888.421.8444** (California Relay Service (CRS) **711**).

Helpful Contact Information

Telephone numbers listed in this document are subject to change as needed. Contact a VHP Member Services Representative at **1.888.421.8444 (toll-free)** to obtain revised telephone numbers or go to the VHP website at **www.valleyhealthplan.org**.

Valley Health Plan Main Office	2480 N. First Street, Suite 160, San Jose, CA 95131 Hours: M-F, 8:00 am - 5:00 pm (Pacific Time)
Valley Health Plan Website	**www.valleyhealthplan.org**
Member Services Department	**Phone**: **1.888.421.8444 (toll-free)** **TTY:** For the hearing and speech impaired, call the California Relay Service (CRS) by simply dialing 711 or the 800 CRS number from your mode of communication. **Fax**: **408.885.4425** **Email:** memberservices@vhp.sccgov.org **Hours:** M – F, 9:00 am – 5:00 pm (Pacific Time)
Health Education Department	**Phone**: **408.885.3490** **Fax**: **408.954.1023** **Email:** healtheducation@vhp.sccgov.org **Hours:** M – F, 9:00 am – 5:00 pm (Pacific Time)
Language Assistance (Interpretation, Translation & Disability Access)	**Phone**: **1.408.808.6150** or **1.888.421.8444** **TTY:** Contact CRS by dialing **711** and providing the number **1.800.735.2929**
Carenet - (Nurse Advice Line)	**Phone**: **1.866.682.9492 (toll-free)** **Hours:** 24 hours, seven days per week, including holidays
MDLive Care – Behavioral and	**Phone**: **1.888.467.4614** **TTY**: **1.800.770.5531** **Website**: **www.mdlive.com/VHP**

Urgent Care (Telehealth)	**Hours**: 24 hours, seven days per week, including holidays
Navitus - Pharmacy Customer Care	**Phone**: **1.866.333.2757 (toll-free)** **Hours:** 24 hours, seven days per week Call this telephone number when you need assistance with pharmacy/Prescription related issues.
Costco Pharmacy - Mail Order Prescriptions	**Phone**: **1.800.607.6861 (toll-free)** Call this telephone number when you need assistance with mail order pharmacy/Prescription related issues.
Select a Primary Care Provider (PCP)	Please use the Provider Search function on VHP's website at **www.valleyhealthplan.org** or call the Member Services Department at **1.888.421.8444 (toll-free)**. Note: if you elect not to select a PCP at the time of enrollment, VHP will select one for you. You may change your PCP at any time by calling VHP's Member Services Department.

Member Grievances

VHP takes pride in being a member-focused health plan. Please call our Member Services Department to assist you in resolving your concerns at **1.888.421.8444 (toll-free)**. For the hearing and speech impaired, call the CRS by simply dialing 711 or the 800 CRS number of your modality. You may also visit **www.valleyhealthplan.org** for recent updates, provider listings, and general information

You may request that a Grievance be filed verbally, or you may complete a Grievance Form and submit it to VHP. Grievance Forms are available through VHP, at your Plan Provider's office and on our website at **www.valleyhealthplan.org** under "Member Materials". Grievance Forms are available in English, Spanish, and Vietnamese at no cost to you. Grievance Forms, translated into other languages, are also available free of cost to you. For more information regarding these forms and VHP's Language Assistance Program, call Member Services at **1.888.421.8444 (toll-free).**

Send your Grievance Form to:

> **Valley Health Plan – Appeals and Grievance Department**
> **2480 N. First Street, Suite 160**
> **San Jose, CA 95131**

You may also submit your Grievance online at **www.valleyhealthplan.org**.

You have 180 days from the date of the event, which caused a Grievance, to file the Grievance. As needed, the 180 days starts on the date the Plan provides you with a Grievance Form translated into the language of your choice.

Include all pertinent information from your VHP ID Card and the details and circumstances surrounding your concern or problem. Providing as much information as possible may eliminate the time required to collect such data. Pertinent information should include any medical records or physician opinions in support of your Grievance; otherwise your medical records may need to be obtained from your Plan Physician or you may need to obtain them from a Non-Plan Physician. Your Grievance will be acknowledged within 5 calendar days of receipt. VHP will notify you in writing of the outcome within 30 calendar days of receiving your Grievance.

If the Grievance involves an imminent and serious threat to your health or the health of your Dependents, including but not limited to, severe pain, psychological well-being, potential loss of life, limb or major bodily function, you will be entitled to an expedited review. The Grievance must state that you are requesting an expedited review. You will be notified of the outcome or status within 3 calendar days of receipt of the emergent Grievance.

If you are not satisfied with the Grievance decision, you may contact the California State Department of Managed Health Care (DMHC) by following the procedures outlined in this section under "Department of Managed Health Care Consumer Helpline".

Department of Managed Health Care Consumer Helpline

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1.888.421.8444** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's internet website **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Chapter 1: Introduction to Valley Health Plan

Differences in Employer Groups

VHP offers health insurance to Large and Small Employer Groups. The Large Employer Groups include the County of Santa Clara, In Home Support Services, Santa Clara County Superior Courts and the Santa Clara County Fairgrounds. The Small Employer Group includes the Valley Health Foundation.

There are certain items that apply to specific Employer Groups. If an item applies to a specific Employer Group, it will be identified by the name of the employer.

Grandfathered Health Plan Status – Valley Health Foundation Employer Group

This group health plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at **1.888.421.8444**.

How do I Get Health Care?

When you enroll in VHP, you must select a Primary Care Provider (PCP) from VHP's Network. You are expected to receive services from your Primary Network, which is the Network affiliated with your PCP. A PCP provides and coordinates your medical care. For children, a pediatrician may be designated as the PCP. Until you make this PCP designation, VHP designates one for you. Additional information can be found under Chapter 3: Choice of Physicians and Providers.

To find a PCP, visit VHP's website at **www.valleyhealthplan.org** and use the Provider Search function, or call VHP's Member Services Department at **1.888.421.8444 (toll-free)**. For the hearing and speech impaired, call the CRS by simply dialing 711 or the 800 CRS number of your mode of communication.

Selecting and Changing a PCP:

You may change your PCP at any time by calling VHP's Member Services Department at **1.888.421.8444 (toll-free)**. The effective date of the change will be first of the next month after your request is received, provided you are not receiving hospital or other institutional care at the time of your request. In the event you are institutionalized, discuss your effective date with Member Services. If needed, a new VHP identification card (VHP ID Card) will be mailed to you. In the event your PCP terminates his/her relationship with VHP, you will be notified by VHP and will be assigned a new PCP.

Sometimes, you may need care that your PCP cannot provide. At such times, your PCP will refer you to a specialist affiliated with your Primary Network or other Plan Provider for that care.

The continued participation of any one physician, hospital or other provider cannot be guaranteed. The fact that a physician or other provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary, or make it a Covered Service.

Transition of Care for New Members

You may request continued care from a provider, including a hospital that does not contract with VHP, if at the time of enrollment with VHP, you were receiving care from such a provider for any of the following conditions:

- For an Acute Condition shall be provided for the duration of the Acute Condition.
- For a Serious Chronic Condition shall be provided for a period necessary to complete the course of treatment and to arrange for a safe transfer to a Plan Provider. Completion of Covered Services shall not exceed 12 months.
- For a Pregnancy shall be provided for the duration of the Pregnancy.
- For a Maternal Mental Health Condition that impacts a person during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, completion of maternal mental Covered Services shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.
- For a Terminal Illness shall be provided for the duration of the Terminal Illness. Terminal Illness for continuity of care is defined as an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Services shall be provided for the duration of a Terminal Illness, which may exceed 12 months from the Plan Provider contract termination date or 12 months from the Effective Date of Coverage for a new Member.
- For the care of a newborn child between birth and age 36 months, completion of Covered Services shall not exceed 12 months.
- For the performance of a surgery or other procedure that is Authorized by VHP as part of a documented course of treatment and has been recommended and documented by the current provider at the time of enrollment or Plan Provider termination, completion of such surgical Covered Services must occur within 180 days.
- For new Members transitioning from one health plan to another because of a health plan’s withdrawal from the marketplace or ceased offering the applicable product in the Member’s service area.

Please refer to “Continuity of Care” section in Chapter 4 for additional detail.

Emergency Services

In an emergency, call **911** for assistance, go to the nearest emergency room.

Emergency Services are covered when furnished either by Plan Providers or by Non-Plan Providers worldwide when the time required to reach your Plan Facility or Hospital is such that a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, Active Labor, and psychiatric condition) such that the absence of immediate medical attention could reasonably expect the delay to result in serious impairment to your bodily functions, serious dysfunction of any bodily organ or part, or placing your health or psychological well-being in serious jeopardy.

Emergency Services also includes additional screening, examination, and evaluation by a physician, or other personnel to the extent, permitted by applicable Law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition, within the capability of the facility.

Emergency Services do not require Prior Authorization, however, should it be necessary to receive Emergency Services from a Non-Plan Provider, present your VHP ID Card. Refer to “Follow-Up Care after Emergency at a Hospital that is not contracted with VHP (Post-Stabilization)” in this section.

Emergency Services are only covered by Plan until your condition has stabilized sufficiently to permit discharge or transfer to Plan Facility.

Emergency Services are available within, or outside, your Service Area 24 hours a day, seven (7) days a week. Urgently Needed Services are available through plan or Non-Plan Providers while inside or outside of the Service Area.

Although all necessary care is available from and should be obtained through Plan Providers, VHP also covers all Emergency Services and Urgently Needed Services received from Non-Plan Providers.

Be sure to carry your VHP ID Card with you at all times to access care.

Members are not financially responsible for payment of emergency care services, beyond the enrollee's Copayments, coinsurance, and Deductibles as provided in the "Summary of Benefits and Coverage."

Urgently Needed Services

Urgently Needed Services is care you need within 24 to 48 hours. If you need Urgently Needed Services, call the 24-hour Nurse Advice Line at **1.866.682.9492 (toll-free)**, schedule an appointment, or go to any Urgent Care clinic. In the event you are out of the Service Area and cannot safely go to a Plan Provider, go to the closest Urgent Care provider. If you are unsure where to go or the Emergency Services or Urgently Needed Service is not available nearby, call Member Services at **1.888.421.8444 (toll-free)** or the 24/7 Nurse Advice Line at **1.866.862.9492 (toll-free)** for guidance. Alternately, you can access 24-hour Telehealth services for non-emergency medical conditions or non-Psychiatric Emergency Medical Condition at **1.888.467.4614** or TTY **1.800.770.5531**. All care following the Urgent Care visit is considered Follow-Up Care and must be received through your PCP or Authorized by VHP.

If you seek routine or Elective Medical Services that are not Urgently Needed Services from Non-Plan Providers without a Prior Authorization, VHP will not pay for your care, and you will be required to pay for the full cost of such services.

Inside the Service Area

VHP offers extended hours at several Urgent Care clinics, some require an appointment, and some are walk-in clinics. Call the 24/7 Nurse Advice Line at **1.866.682.9492 (toll-free)** for medical advice. A nurse will assess your condition and direct you to the appropriate care. For a complete list of your Primary Network Urgent Care clinics, including the walk-in clinic locations, visit website at **www.valleyhealthplan.org** or call Member Services at **1.888.421.8444 (toll-free)**. For the hearing and speech impaired, call the CRS by simply dialing 711 or 800 CRS number of your modality for assistance. Present a form of ID and your VHP ID Card when seeking services.

Outside of the Service Area

Should it be necessary to receive Urgently Needed Services outside the Service Area and you need assistance finding a provider, call Member Services at **1.888.421.8444 (toll-free)** to answer any questions you may have. If you are unable to reach VHP, you can call the 24/7 Nurse Advice Line at **1.866.682.9492 (toll-free)**, explain the situation, and follow their instructions. As needed, contact the closest provider to receive treatment or go directly to the nearest Urgent Care center. As necessary, Member Services can help coordinate your care.

If you are temporarily outside our Service Area and the care you receive from a Non-Plan Provider is not an Urgently Needed Service, you may be financially responsible for all charges.

If you are outside of California and need a service on an emergency or urgent basis, but that service is not available in the area or state where you are physically located (such as abortion services which is a basic health care service under California Law) and you are unable to access the Emergency Services/Urgent Care in a timely manner, VHP will pay for your travel or will reimburse you, including travel to another state, so you can access the care in a timely manner.

Follow-Up Care

Follow-Up Care services must be performed within your Primary Network. If Authorization is required (see Chapter 6 for those services that require Prior Authorization from VHP), your PCP must obtain the Prior Authorization for those services. Follow-Up Care after any Emergency or Urgently Needed Service should be obtained through your PCP. Should it be necessary to obtain Follow-Up Care after an Emergency or Urgently Needed Service from a Non-Plan Provider, request that your PCP call VHP to receive Prior Authorization before you access care.

If you seek Follow-Up Care after an Emergency or Urgently Needed Services from Non-Plan Providers without an Authorization, VHP will not pay for your care, and you will be required to pay for the full cost of such services.

Follow-Up Care after Emergency at a Hospital that is not contracted with VHP (Post-Stabilization)

If, once your Emergency Medical Condition is stabilized, and your treating health care provider at the Hospital believes that you require additional Medically Necessary Hospital Services prior to your being safely discharged, the non-contracted hospital must contact VHP to obtain timely Prior Authorization for these post-stabilization services.

If VHP determines that you may be safely transferred to a Plan Hospital in your Primary Network, and you refuse to consent to the transfer, the non-contracted hospital must provide you written notice that you will be financially responsible for one hundred percent (100%) of the cost for services provided to you once your Emergency Medical Condition is stable.

If the non-contracted hospital is unable to determine your name and contact information at VHP to request Prior Authorization for services once you are stable, the non-contracted hospital may bill you for such services. If you feel that you were improperly billed for Emergency Services that you received from a non-contracted provider, please contact VHP at **1.888.421.8444 (toll-free).**

How Do I Get Help?

Member Services Representative

VHP's top priority is to provide quality service and health care to its Members. Everyone at VHP shares responsibility for assuring your satisfaction. Our Member Services Representatives will be happy to assist you with your questions, complaints or to hear how VHP and its Plan Providers are doing.

Member Services is available to assist you over the phone Monday through Friday from 9:00am to 5:00pm at **1.888.421.8444 (toll-free)** or by email at MemberServices@vhp.sccgov.org. For the hearing and speech impaired, call the California Relay Service (CRS) by simply dialing 711 or the 800 CRS number from your mode of communication. If you need language assistance, VHP's Member Services Department offers over-the-telephone language assistance at no cost to you. VHP's walk-in office hours are Monday through Friday 8:00am – 5:00pm. VHP is located at **2480 N. First Street, Suite 160, San Jose, CA 95131**.

You can ask Member Services representatives how to obtain medical care, how to interpret your covered health Benefits, what to do if you move, how to add dependents, obtain a new VHP ID Card, submit Member Claims, file Grievances, or to help you with any other service issue. You can also request VHP materials, including an updated EOC or VHP PCP list, which includes clinic addresses and telephone numbers.

If a representative is not available, please leave a message, a representative will return your call on the next business day. Call VHP at **1.888.421.8444 (toll-free)**, to leave a message 24 hours a day.

If you need to notify VHP of an emergency or Urgent Care situation, please leave a telephone number where you can be reached.

Language Assistance Program:

Call VHP's Member Services Department at **1.888.421.8444 (toll-free)** if you would like to talk to us in your preferred language about any questions, comments, or concerns. VHP, in coordination with VHP's Plan Providers, offers over-the-telephone language assistance at no cost to you. You can also get an interpreter to talk to your Plan Provider by contacting VHP's Member Services Department. In addition, as required by DMHC, VHP can provide written translation of vital documents, such as applications, Grievance or consent forms, or other important membership materials. Language Assistance Program arranged by VHP is provided at no charge. If you have questions about language services, please call VHP's Member Services Department.

24/7 Nurse Advice Line:

Call **1.866.682.9492 (toll-free)** to speak with an advice nurse. Advice nurses are available 24 hours a day, seven days a week. They can give you medical advice and direct you to the care you need.

Telehealth Services:

Telehealth services are covered Benefits. Your cost share for Telehealth services shall not exceed the cost share charged for the same services delivered in-person. Telehealth services will be subject to the same Deductible and annual or lifetime dollar maximum as equivalent in-person services.

Telehealth services are covered on the same basis and to the same extent that the health care service plan is responsible for Coverage for the same service through in-person diagnosis, consultation, or treatment. Members can receive Telehealth services at any preferred location through their owned equipment, such as a telephone, computer/tablet-based, web browser, or smartphone.

VHP contracts with MDLive for both medical and behavioral health services. Members are encouraged to register to MDLive services via MDLive application, web browser and phone. Members may also receive the services on an in-person basis or via Telehealth, if available, from the Member's Primary Care Providers, treating specialists, or another contracting individual health professional, contracting clinic, or contracting health facility consistent with the service and existing timeliness and geographic access standards. Please see the "Timely Access to Care" section to know your waiting time for an appointment. To access MDLive Care, call **1.888.467.4614**, TTY **1.800.770.5531** or online **www.mdlive.com/vhp**.

Refer to **https://www.valleyhealthplan.org/members/mdlivetelehealth-medical-and-behavioral-health-care** for additional information on Telehealth services from MDLive.

You have the right to access your medical records. The record of any services provided by MDLive shall be shared with your Primary Care Provider, unless you object. All services received through MDLive are available at in-network cost sharing and out-of-pocket costs shall accrue to any applicable Deductible or Out-of-Pocket Maximum.

Timely Access to Care

VHP provides and arranges for the provision of Covered Services in a timely manner appropriate for the nature of the Member's condition and consistent with professionally recognized standards of practice.

Appointment Scheduling	Waiting Time
Emergency Services	Immediately
Urgent Care appointments that do not require Prior Authorization	48 hours of request

Urgent Care Appointments that require Prior Authorization	96 hours of request
Non-urgent appointments with a PCP	10 business days of request
Non-urgent appointments with a Specialty Care Physician (SCP) including obstetrical care	15 business days of request
Non-urgent appointments for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	15 business days of request
Office/clinic wait time (from appointment registration time to when seen by the practitioner/doctor)	30 minutes (VHP standard)

Appointment Scheduling for Mental Health and Substance Use Disorder Providers	Waiting Time
Life-Threatening emergency	Immediately
Urgent Care appointments that do not require Prior Authorization	48 hours of request
Urgent Care Appointments that require Prior Authorization	96 hours of request
Non-urgent care appointments with a psychiatrist	15 business days of request
Non-urgent appointments with a non-physician Mental Health or Substance Use Disorder provider	10 business days
Non-urgent follow-up appointments with a non-physician mental health care or Substance Use Disorder provider	10 business days of the prior appointment

Non-urgent appointments for ancillary services related to Mental Health and Substance Use Disorders	15 business days
Office/clinic wait time (from appointment registration time to when seen by the practitioner/doctor)	30 minutes (VHP standard)

VHP Timely Access to Care standards include:

- A "24/7 Nurse Advice Line" for telephone screening that Members can call at any time to obtain triage or screening for the purpose of determining the urgency of the Member's need for care.
- An Authorization system in place that allows for Members to self-refer through direct access to OB/GYN or through obtaining standing referrals to Plan Specialists. This Authorization system includes timely referrals for other Medically Necessary Covered Services through the Plan Provider Network.
- A process to schedule or reschedule health care appointments. Visit **www.valleyhealthplan.org** to find Plan Providers, including emergency and Urgent Care. The website details provider telephone numbers and gives you the Urgent Care clinic's hours of operation. Many of our Urgent Care clinics offer self- referral/walk-in same day Urgent Care services. Appointments are not necessary, but it may save you time if you call ahead.
- A Member Services Department, with English, Vietnamese, and Spanish speaking representatives, who offer assistance in obtaining covered health care services and resolving Members health care issues. Additional interpreter services are available, as needed, at the time of the appointment or in the interpretation of critical documents, such as needed during the Plan's Grievance process.
- Professionally recognized standards of practice used to determine wait times when scheduling appointments that meet legislative requirements. Such standards do not prohibit the Plan or the Plan Providers from accommodating a Member's preference to wait for a later appointment from a specific Plan Provider.

- VHP will arrange Medically Necessary services Out-of-Network for you if the services are not available in-network within the timely access standards as outlined in this section. VHP will ensure the delivery of Medically Necessary Out-of-Network services and any Medically Necessary follow-up services that, to the maximum extent possible, meet the timely access standards. Arranging services may mean contacting non-contracted providers with the appropriate expertise on your behalf and assisting you with scheduling, and the provider with engaging with VHP. VHP may not delay your care beyond the applicable timely access standards due to lack of a single case agreement or other arrangement with a non-contracted provider. Member costs for Medically Necessary referrals to Out-of-Network providers shall not exceed applicable in-network providers Copayments, Coinsurance, and Deductibles.

For more information on timely access to care, including the Language Assistance Program, contact Member Services at **1.888.421.8444 (toll-free)**.

Chapter 2: Eligibility and Enrollment

For County of Santa Clara, Santa Clara County Superior Courts, Santa Clara County Fairgrounds and Valley Health Foundation Members, Dependents and Retirees

Becoming a VHP Member and Using your ID Card

Before applying for VHP membership, you and/or your Eligible Dependent(s) must meet certain eligibility and enrollment requirements. After you have enrolled in VHP, you must continue to meet the same requirements.

This section outlines who is eligible to enroll, how to enroll, how to renew and retain membership, and when Coverage begins. If you have any questions regarding eligibility, enrollment, or changes to your enrollment, contact your employer.

After enrollment, VHP provides you with a new Member Welcome Letter and your membership card, also called a Member Identification card (VHP ID Card). The card includes important contact information, and you should always present it when you seek medical care. If you do not present your ID card each time you receive services, your provider may fail to obtain Prior Authorization when needed and you may be responsible for the resulting cost.

If you need a new Member VHP ID Card, you may request a replacement from VHP Member Services.

Please note: Your VHP ID Card is for identification purposes only. To receive Covered Services, you must meet the eligibility requirements set forth herein as either an Eligible Dependent, Eligible Employee or Eligible Retiree. Anyone who is not a VHP Member will be charged for any services received. If you let someone else use your VHP ID Card, your membership may be terminated.

Eligibility for Active Employees and Dependents

You are eligible to apply for Coverage under the Benefit Plan if you meet the definition of Eligible Employee or Eligible Dependent as described in the "Definitions" section, and you:

- Live or work in Santa Clara County,
- Satisfy the Group's waiting period requirements, and
- Meet the Group's eligibility requirements.

If a Member chooses a Primary Network based on its proximity to the Subscriber's work address, the Member will need to travel to Primary Network locations for any non-emergency or non-urgent care that the Member receives.

All Members who are eligible for Benefits and who reside outside the Service Area will only be covered for Emergency or Urgently Needed Services when outside the Service Area. All follow-up or Routine Care must be received in the Service Area through the Member's PCP or the Member's Primary Network.

Members who are terminated, retired, or separated from employment with the Group may be eligible for continued Coverage. (Please refer to the "Individual Continuation of Coverage" section for details.)

VHP may verify eligibility, employee status and dependent status. Services are not covered prior to the Member's Effective Date of Coverage or after the Member's Coverage termination date.

If you or your Dependent(s) are subsequently found to be ineligible, VHP will not provide Benefits during the period of ineligibility and will be entitled to reimbursement from you for any services rendered and claims paid during such period you were not eligible for membership.

If you and your Dependent(s) are otherwise eligible to enroll, VHP will not refuse to enroll you or your Eligible Dependent(s) because of a pre-existing health condition.

Enrollment for Active Employees and Dependents

VHP must receive a completed and signed enrollment form from the Group for you and/or your Eligible Dependent(s) to apply for Coverage. Your employer will

distribute an application form and other VHP materials for enrollment and reference. Upon your request, your employer will provide a copy of the VHP Combined Evidence of Coverage and Disclosure Form. Your employer is responsible for submitting a properly completed membership application and applicable premiums to VHP. Following receipt, VHP will process all eligible enrollments and distribute a Welcome Letter and VHP ID Card(s) to the current address(es) in VHP's records. As part of the application process, you will be asked to provide personal information, including name, address, race, ethnicity, and language written and spoken.

At the time you enroll, you may be eligible to continue receiving treatment from your non-VHP provider. Please refer to the "Transition of Care for New Members" and "Continuity of Care" sections for additional information.

Initial Enrollment

You must apply for membership for you and your Eligible Dependents by submitting an application to your Group within the Initial Eligibility Period. Contact your employer for information about the application process when you are eligible to enroll and your Effective Date of Coverage.

Enrolling Late or During Open Enrollment

Late enrollment occurs when you or your Eligible Dependent(s) do not enroll when you first become eligible. If you do not enroll when you first become eligible, you may enroll only during the next Open Enrollment Period. Your employer will announce the dates of the Open Enrollment Period.

If you decline enrollment for you or your Eligible Dependent(s) because of other health insurance coverage but that insurance ceases, you may enroll yourself or your Eligible Dependent(s) within 30 days after such coverage ends or within 60 days of Medi-Cal or AIM Program or California Health Benefit Exchange coverage ending. If you do not enroll when you first become eligible, the late enrollment rule will not apply if:

- You submitted the enrollment form, but the form is incomplete.
- You never received a form from your employer.

For County of Santa Clara, Santa Clara County Superior Courts and the Santa Clara County Fairgrounds Employer Groups, Late Members who lose coverage are eligible for late enrollment which is the 30-day period following the date on which the Late Member loses coverage. The criteria to be eligible for late enrollment includes one of the following reasons:

- The termination of the employment of the Eligible Employee or of a person through whom the Eligible Employee or his/her Eligible Dependent(s) was covered as a dependent;
- A change in the employment status of the Eligible Employee or a person through whom the Eligible Employee or his/her Eligible Dependent(s) was covered as a dependent;
- Termination of health benefits coverage from another employer or no share-of-cost Medi-Cal coverage;
- Reduction or cessation of an employer's contribution toward an employee, retiree, or Dependent's Coverage;
- Death of the Eligible Employee/Retiree or person through whom the Eligible Employee/ Retiree or Eligible Dependent was covered as a Dependent; or

Divorce from the person through whom the Eligible Employee/Retiree or Eligible Dependent was covered as a Dependent.

For Valley Health Foundation Employer Group, the following also applies:

"Late enrollee" means an Eligible Employee, or Dependent, who has declined enrollment at the time of the initial enrollment period provided under the terms of the Group Agreement and who subsequently requests enrollment, provided that the initial enrollment period shall be a period of at least 30 days. However, an Eligible Employee, or an Eligible Dependent, shall not be considered a late enrollee and is eligible to enroll if any of the following is applicable:

(1) The individual meets all of the following requirements:

(A) They were covered under another employer health benefit plan, the Access for Infants and Mothers (AIM) Program, the Medi-Cal program, or coverage through the California Health Benefit Exchange at the time the individual was eligible to enroll.

(B) They certified at the time of the initial enrollment that coverage under another employer health benefit plan, the AIM Program, the Medi-Cal program, or coverage

through the California Health Benefit Exchange was the reason for declining enrollment, provided that, if the individual was covered under another employer health benefit plan, including a plan offered through the California Health Benefit Exchange, the individual was given the opportunity to make the certification required by this subdivision and was notified that failure to do so could result in later treatment as a late enrollee.

(C) They have lost or will lose coverage under another employer health benefit plan as a result of termination of employment of the individual or of a person through whom the individual was covered as a dependent, change in employment status of the individual or of a person through whom the individual was covered as a dependent, termination of the other plan's coverage, cessation of an employer's contribution toward an employee's or dependent's coverage, death of the person through whom the individual was covered as a dependent, legal separation, or divorce; or they have lost or will lose coverage under the Healthy Families Program, the AIM Program, the Medi-Cal program, or coverage through the California Health Benefit Exchange.

(D) They request enrollment within 30 days after termination of coverage or employer contribution toward coverage provided under another employer health benefit plan, or requests enrollment within 60 days after termination of Medi-Cal program coverage, AIM Program coverage, or coverage through the California Health Benefit Exchange.

(2) The employer offers multiple health benefit plans, and the employee elects a different plan during an open enrollment period.

(3) A court has ordered that coverage be provided for a spouse or minor child under a covered employee's health benefit plan.

(4) In the case of an Eligible Employee, VHP cannot produce a written statement from the Group stating that the individual or the person through whom the individual was eligible to be covered as a dependent, prior to declining coverage, was provided with, and signed, acknowledgment of an explicit written notice in boldface type specifying that failure to elect coverage during the initial enrollment period permits the plan to impose, at the time of the individual's later decision to elect coverage, an exclusion from eligibility for coverage until the next Open Enrollment Period, unless the individual meets the criteria specified in Section 1, 2 or 3 above.

(5) The individual is an employee or dependent who was under a COBRA continuation provision and the coverage under that provision has been exhausted.

For purposes of this section, the definition of "COBRA" set forth in subdivision (e) of Section 1373.621 shall apply.

(6) The individual is a dependent of an enrolled Eligible Employee who has lost or will lose their coverage under the Healthy Families Program, the AIM Program, the Medi-Cal program, or a health benefit plan offered through the California Health Benefit Exchange and requests enrollment within 60 days after termination of that coverage.

(7) The individual is an Eligible Employee who previously declined coverage under an employer health benefit plan, including a plan offered through the California Health Benefit Exchange, and who has subsequently acquired a dependent who would be eligible for coverage as a dependent of the employee through marriage, domestic partnership, birth, adoption, or placement for adoption, and who enrolls for coverage under that employer health benefit plan on their behalf and on behalf of their dependent within 30 days following the date of marriage, domestic partnership, birth, adoption, or placement for adoption, in which case the Effective Date of Coverage shall be the first day of the month following the date the completed request for enrollment is received in the case of marriage or domestic partnership, or the date of birth, or the date of adoption or placement for adoption, whichever applies. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(8) The individual is an Eligible Employee who has declined coverage for themself or their dependents during a previous enrollment period because their dependents were covered by another employer health benefit plan, including a plan offered through the California Health Benefit Exchange, at the time of the previous enrollment period. That individual may enroll themself or their dependents for plan coverage during a special open enrollment opportunity if their dependents have lost or will lose coverage under that other employer health benefit plan. The special open enrollment opportunity shall be requested by the employee not more than 30 days after the date that the other health coverage is exhausted or terminated. Upon enrollment, coverage shall be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

Adding Dependents

You must submit an enrollment or status change request to your employer to add a new spouse or dependent(s). VHP must receive the request within 31 days after they became your Eligible Dependent(s). You must provide proof of dependent status (e.g., birth or marriage certificate) when you add Eligible Dependents to your Coverage.

If you must provide coverage for a non-custodial child due to a court order for medical support, you must provide proof of legal status or court order.

You must notify your employer and VHP of any changes in status that affect your own or your enrolled Dependent's eligibility. If you do not enroll your Eligible Dependents when they are first eligible, you will not be able to enroll them until the next Open Enrollment Period unless they qualify for late enrollment. See "Enrolling Late or During Open Enrollment" section for circumstances where a dependent may be enrolled outside of the initial eligibility and Open Enrollment Periods.

Continuing Coverage for Dependents

Health Coverage may continue for an Eligible Dependent, if the Eligible Dependent is:

- An Eligible Dependent who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition which started before age 26, and who is chiefly dependent upon you for support and maintenance. VHP will notify you at least 90 days prior to the date your Dependent child turns 26. You must furnish proof of such incapacity and dependency to VHP within 60 days of receipt of notification to prevent a lapse in Coverage. Verification of disability and dependency may be required as often as deemed necessary by VHP. However, VHP will not request verification more often than once a year after the first 2 years the child has reached age 26.
- An Eligible Dependent who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition which started after age 26, and who is chiefly dependent upon you for support and maintenance.

- A newborn, newly adopted, or new legal ward. Coverage continues after the first 31 days provided Dependent is enrolled within the first 60 days following the child's birth, adoption, or guardianship. After this period, you will not be able to enroll your child.
- You, or your spouse's, natural child, stepchild, legally adopted child, or a child under your court ordered legal guardianship, is residing with you or with your present or former spouse. Coverage can be continued under VHP until the end of the benefit year for Dependents that reach the age 26. An enrolled Dependent child who reaches age 26 during a benefit year may remain enrolled as a Dependent until the end of that benefit year. The Dependent Coverage shall end on the last day of the benefit year during which the Dependent child becomes ineligible. Verification of dependent status may be requested by VHP.

Retirees Eligibility and Enrollment

Becoming a VHP Retiree Member

Before applying for VHP retiree membership, you and your Eligible Dependent(s) must meet certain eligibility and enrollment requirements as defined by your employer. After you have enrolled in VHP as a retiree, you must continue to meet these requirements.

To enroll in VHP as an Eligible Retiree, contact your employer. Your employer will give you the necessary paperwork, including the VHP application form. Your employer will advise you of your responsibility for any portion of VHP monthly membership fees or premiums.

Once enrolled, you and your Eligible Dependent(s) will receive new VHP Identification Card(s). Coverage will begin on the Effective Date of Coverage established by your employer. Group Coverage is available to Eligible Retirees, and Eligible Dependents. If you are eligible for Medicare, you must enroll in Medicare and contact your employer and VHP Member Services.

You must report any changes that would affect your eligibility or the eligibility of your Dependents to your employer within 30 days of the change in status.

For more information concerning your continuation of Coverage as an Eligible Retiree, call VHP Member Services at 1.888.421.8444 (toll-free) or contact your employer.

Retiree Eligibility

You and your Eligible Dependent(s) may be eligible for Valley Health Plan Group Coverage if you are retired. To continue or obtain Coverage as a retired Subscriber:

- You must be an Eligible Retiree from a Group that offers VHP as a benefit to its retired employees;
- You and your Eligible Dependent(s) must be enrolled in VHP and VHP must receive prepayment fees or premiums from the Group; and
- You must meet the Group's eligibility criteria and the Group's applicable waiting period requirements.

If you or your Eligible Dependents are eligible for Medicare, you must enroll in Medicare. You must also contact your employer and VHP. If you are on Medicare and receive your services from Plan Providers, VHP provides services for covered Benefits and coordinates payment with Medicare. Refer to the "Coordination of Benefits Reimbursement" section.

If you are enrolled in Medicare and you choose to receive services from a Non-Plan Provider without Prior Authorization from VHP, you can file your claim directly with Medicare. You may be responsible for all charges not reimbursed by Medicare.

If you are an Eligible Retiree and you elect to enroll, you will receive the same Benefit Plan that VHP is offering to the Group. As required, you will pay the Group membership premiums on a monthly prepayment basis the first (1st) of each month. VHP may decline, cancel, or terminate your Coverage if you fail to pay the membership premium, or for reasons as stated in the applicable Laws, rules, and regulations.

If you are an enrolled Eligible Retiree, you and your Eligible Dependent(s) must receive all routine, non-emergent, or non-Urgent Care Covered Services from VHP Plan Providers.

When Coverage Begins

Covered Services begin on the Effective Date of Coverage as described in the "Enrolling Late or During Open Enrollment" section or as established by your employer if you enroll:

- When you or your Eligible Dependent(s) first became eligible; or

- During an Open Enrollment Period; or
- Within 30 days of a late enrollment or 60 days after termination from certain programs. Refer to the "Enrolling Late or During Open Enrollment" section for details.

Covered Services begin for your Dependent according to the following timelines. Please note:

Newborn natural child - a newborn child is automatically covered from the moment of birth through 31 days after birth, or the birthing parent's hospitalization if they are a Member, whichever is later.

Adopted child - on the date you obtain adoptive custody or when you receive the legal right to control the adopted Eligible Dependent child's health care.

Renewal Provisions

Your Coverage renews automatically if premiums have been properly paid. You do not need to reapply at the time of Open Enrollment or renewal unless changes are needed. Monthly premiums may change upon Open Enrollment or at the time of renewal. If Coverage for you or your Dependent(s) is terminated, you must submit a new application for membership to be reinstated.

Medicare Late Enrollment Penalties

If you become eligible for Medicare Part B and do not enroll, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B. However, if you delay enrollment in Part B because you or your spouse are still working and have coverage through an employer group health plan, you may not have to pay the penalty.

Also, if you are (or become) eligible for Medicare and go without creditable prescription drug coverage (drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage), you may have to pay a late enrollment penalty if you later sign up for Medicare prescription drug coverage. For more information, call Member Services at **1.888.421.8444 (toll-free)**.

Contract Period of This Evidence of Coverage

The Agreement is revised when the contract between your Group and VHP is changed. Any future changes to the Agreement may affect this Combined Evidence of Coverage and Disclosure Form (EOC). If you would like copies of the EOC or of recent Member communications such as the VHP Member newsletter "Perspectives", visit **www.valleyhealthplan.org** or call the VHP Member Services Department at **1.888.421.8444 (toll-free)**. A copy of the Plan contract will be furnished on request.

Chapter 3: Eligibility and Enrollment for In Home Support Service Members

Becoming a VHP Member and Using your ID Card

Before applying for VHP membership, you must meet certain eligibility and enrollment requirements. After you have enrolled in VHP, you must continue to meet the same requirements.

This section outlines who is eligible to enroll, how to enroll, how to renew and retain membership, and when Coverage begins. If you have any questions regarding eligibility, enrollment, or changes to your enrollment, contact your employer.

After enrollment, VHP provides you with a new Member Welcome Letter and your membership card, also called a Member Identification card (VHP ID Card). The card includes important contact information, and you should always present it when you seek medical care. If you do not present your ID card each time you receive services, your provider may fail to obtain Prior Authorization when needed and you may be responsible for the resulting cost.

If you need a new Member VHP ID Card, you may request a replacement from VHP Member Services.

Please note: Your VHP ID Card is for identification purposes only. To receive Covered Services, you must meet the eligibility requirements set forth as an Eligible Employee. Anyone who is not a VHP Member will be charged for any services received. If you let someone else use your VHP ID Card, your membership may be terminated.

Eligibility for Active Employees

You are eligible to apply for Coverage under the Benefit Plan if you meet the definition of Eligible Employee as described in the "Definitions" section, and you:

- Live or work in Santa Clara County,
- Satisfy the Group's waiting period requirements, and
- Meet the Group's eligibility requirements.

If a Member chooses a Primary Network based on its proximity to the Subscriber's work address, the Member will need to travel to Primary Network locations for any non-emergency or non-urgent care that the Member receives.

Members who are terminated, retired, or separated from employment with the Group may be eligible for continued Coverage. (Please refer to the "Individual Continuation of Coverage" section for details.)

VHP may verify eligibility and employee status with your employer. Services are not covered prior to the Member's Effective Date of Coverage or after the Member's Coverage termination date.

If you are subsequently found to be ineligible, VHP will not provide Benefits during the period of ineligibility and will be entitled to reimbursement from you for any services rendered and claims paid during such period you were not eligible for membership.

If you are otherwise eligible to enroll, VHP will not refuse to enroll you because of a pre-existing health condition.

Enrollment for Active Employees

VHP must receive a completed and signed enrollment form from the Group for you to apply for Coverage. Your employer will distribute an application form and other VHP materials for enrollment and reference. Upon your request, your employer will provide a copy of the VHP Combined Evidence of Coverage and Disclosure Form. Your employer is responsible for submitting a properly completed membership application and applicable premiums to VHP. Following receipt, VHP will process all eligible enrollments and distribute a Welcome Letter and VHP ID Card to the current address in VHP's records. As part of the application process, you will be asked to

provide personal information, including name, address, race, ethnicity, and language written and spoken.

At the time you enroll, you may be eligible to continue receiving treatment from your non-VHP provider. Please refer to the "Transition of Care for New Members" and "Continuity of Care" sections for additional information.

Initial Enrollment

You must submit an application to your Group within the Initial Eligibility Period to apply for membership. Contact your employer for information about the application process when you are eligible to enroll and your Effective Date of Coverage.

Enrolling Late or During Open Enrollment

Late enrollment occurs when you do not enroll when you first become eligible. If you do not enroll when you first become eligible, you may enroll only during the next Open Enrollment Period. Your employer will announce the dates of the Open Enrollment Period.

If you decline enrollment for you because of other health insurance coverage but that insurance ceases, you may enroll yourself within 30 days after such coverage ends. If you do not enroll when you first become eligible, the late enrollment rule will not apply if:

- You submitted the enrollment form, but the form is incomplete.
- You never received a form from your employer.
- Late Members who lose coverage are eligible for late enrollment which is the 30-day period following the date on which the Late Member loses coverage. The criteria to be eligible for late enrollment includes one of the following reasons:
- The termination of the employment of the Eligible Employee or of a person through whom the Eligible Employee was covered as a Dependent;
- A change in the employment status of the Eligible Employee or a person through whom the Eligible Employee was covered as a Dependent;

- Termination of health benefits coverage from another employer or no share-of-cost Medi-Cal coverage;
- Reduction or cessation of an employer's contribution toward an employee;
- Death of the Eligible Employee or person through whom the Eligible Employee was covered as a Dependent; or
- Divorce from the person through whom the Eligible Employee was covered as a Dependent.

When Coverage Begins

Covered Services begin on the Effective Date of Coverage as described in the "Enrolling Late or During Open Enrollment" section or as established by your employer if you enroll:

- When you first became eligible; or
- During an Open Enrollment Period; or
- Within 30 days of a late enrollment. Refer to the "Enrolling Late or During Open Enrollment" section for details.

Renewal Provisions

Your Coverage renews automatically if premiums have been properly paid. You do not need to reapply at the time of Open Enrollment or renewal unless changes are needed. Monthly premiums may change upon Open Enrollment or at the time of renewal. If Coverage is terminated, you must submit a new application for membership to be reinstated.

Medicare Late Enrollment Penalties

If you become eligible for Medicare Part B and do not enroll, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B. However,

if you delay enrollment in Part B because you are still working and have coverage through an employer group health plan, you may not have to pay the penalty.

Also, if you are (or become) eligible for Medicare and go without creditable prescription drug coverage (drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage), you may have to pay a late enrollment penalty if you later sign up for Medicare prescription drug coverage. For more information, call Member Services at **1.888.421.8444 (toll-free)**.

Contract Period of This Evidence of Coverage

The Agreement is revised when the contract between your Group and VHP is changed. Any future changes to the Agreement may affect this Combined Evidence of Coverage and Disclosure Form (EOC). If you would like copies of the EOC or of recent Member communications such as the VHP Member newsletter "Perspectives", visit **www.valleyhealthplan.org** or call the VHP Member Services Department at **1.888.421.8444 (toll-free)**. A copy of the Plan contract will be furnished on request.

Chapter 4: Termination of Benefits

For County of Santa Clara, Santa Clara County Superior Courts, Santa Clara County Fairgrounds and Valley Health Foundation Members, Dependents and Retirees

Once enrolled, your Coverage may be canceled only for the Disenrollment and Termination of Benefits reasons identified below. To voluntarily disenroll, contact your employer and complete and sign the appropriate paperwork. Your employer will notify you of your effective date of Termination. If you or your Dependent(s) Coverage is terminated involuntarily, you will receive notice of the date of Termination. Until the effective date of your Disenrollment or Termination, you will remain a VHP Member and are responsible to:

- Continue to receive all Covered Services from Plan Providers within your Primary Network (except in the event of an Emergency or Urgently Needed Services);
- Pay for all applicable membership premiums; and
- Continue to adhere to all requirements of your VHP membership.

Once your Disenrollment or Termination from the Benefit Plan becomes effective, your VHP ID Card will no longer be valid. You may not be reinstated automatically if Coverage is canceled or terminated.

Fraudulent use of your VHP ID Card, the services or facilities of VHP or its Plan Providers, and/or Fraud or misrepresentation on the enrollment application form will result in an investigation and appropriate legal action.

If you have additional questions about the Disenrollment or Termination process, please review the following sections and/or call your employer or a VHP Member Services Representative at **1.888.421.8444 (toll-free)**.

Loss of Eligibility

VHP and its Groups are required to continue to offer Coverage to Dependent children until the child turns 26 years of age (through age 25). For more information regarding Dependent Coverage, contact your employer or VHP Member Services at **1.888.421.8444 (toll-free)**.

If you cease to meet VHP and/or your Group eligibility requirements, then you and your Dependent's Coverage will involuntarily terminate subject to the provisions for continuation of coverage or conversion of benefits. You and your employer must notify VHP immediately if you or your Dependent(s) cease to meet the eligibility requirements. Refer to the "Eligibility and Enrollment" chapter.

You lose eligibility if:

- You no longer work or reside within Santa Clara County (retirees are not required to live in Santa Clara County).

Your legal spouse/domestic partner (as defined by the Group Service Agreement or in accordance with State and federal requirements) loses eligibility:

- Upon dissolution of the marriage or domestic partnership as certified by your employer, Coverage for a Subscriber's spouse or domestic partner and all of the spouse's/domestic partner's Dependent(s) who are not also Eligible Dependents of the Subscriber, will terminate.
- Coverage will terminate on the last day of the month for Small Employer Group or the last day of the pay period for Large Employer Group.

Your Eligible Dependent child loses eligibility and Coverage automatically terminates when they:

- Reaches age 26 and is not eligible to be a disabled Dependent as described (contact your employer regarding your disabled Dependent's extension of Coverage); or

For an Eligible Dependent child who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition, prior to age

26 and are chiefly dependent on you for support and maintenance, Coverage will discontinue:

- At age 26 if the child is no longer disabled; or
- If the child is older than 26, the earlier of the date the child recovers from the handicap or the date the child is no longer chiefly dependent on you for support and maintenance.

Your Dependent(s) may also lose eligibility in the event of the Subscriber's death. If the Subscriber dies, Dependents must contact the Group for details on Disenrollment or continued Coverage.

Loss of eligibility does not affect any rights to continue Group Coverage under COBRA, as described in the "Individual Continuation of Coverage" section.

Disenrollment by Member

If you or your Dependent(s) elect coverage under another health benefits plan offered by or through your employer, then your Coverage terminates automatically at the time and date the alternate coverage becomes effective. You and your employer agree to notify VHP immediately that you or your Dependent(s) have elected coverage elsewhere. You or your Dependent(s) may voluntarily disenroll from VHP at any time and for any reason. You may disenroll by notifying your employer in writing of your intent to cancel your Coverage. Your Coverage terminates at midnight on the last day of the pay period for which premiums have been received for active employees of the County of Santa Clara, Santa Clara County Superior Courts and the Santa Clara County Fairgrounds. Your Coverage terminates at midnight on the effective date as determined by your employer for Valley Health Foundation, County of Santa Clara retirees, Santa Clara County Superior Courts retirees, and Santa Clara County Fairgrounds retirees.

Cancellation of Group Service Agreement

Your employer may terminate your Coverage upon written notice to VHP. If your employer terminates or does not renew the Group Service Agreement for any reason, or if VHP terminates the Agreement, your Coverage will cease on the date the Agreement terminates.

If your employer Group fails to pay the premiums, your health care Coverage can be cancelled. VHP will send the "Notice of Start of Grace Period" to the Subscriber and the employer Group if the employer Group has failed to make a premium payment by the due date. This notice will begin a 30-day grace period.

Your Coverage will be terminated on the day after the 30-day grace period ends if payment from your employer Group was not received on or before the last day of the grace period. VHP will send the Subscriber a "Notice of End of Coverage" within 5 calendar days after the Coverage ended. If you are undergoing treatment for a medical condition, services provided beyond the date of Termination will be your financial responsibility unless you are covered by continuation Coverage through VHP. Refer to the "Individual Continuation of Coverage" section.

Retiree Termination

Under this Coverage, you will receive the same Benefits as your Group, but you may be required to pay the full health premium, on a monthly prepayment basis, to your employer. Call your employer for more information about Eligible Retiree Coverage.

The "Cancellation of Members for Cause" section outlines termination reasons. You may also be terminated if you fail to pay your premiums. The Subscriber will receive a "Notice of Start of Grace Period" from their employer Group notifying them of their delinquency of payment and this will begin a 30-day grace period to complete the payment of their premiums. Coverage will be terminated on the day after the 30-day grace period ends if payment to the employer Group was not received on or before the last day of the grace period. The employer Group will send the Subscriber a "Notice of End of Coverage" within 5 calendar days after the Coverage ended.

Your Coverage as a retiree Member will terminate on one of the following dates:

- On the last day of the month in which you lose Retiree Eligibility; or
- On the day after your 30-day grace period ends if payment was not received on or before the last day of the grace period; or
- On the Termination date of the Agreement.

If VHP terminates your Coverage, VHP will notify the Group of the cause and effective date of your Termination. Your Coverage will cease as of the date of Termination or cancellation. If you are undergoing treatment for a medical condition, services provided beyond the date of Termination will be your financial responsibility

unless you are covered by continuation Coverage through COBRA or CAL-COBRA or other circumstances outlined in the "Cessation of Coverage" section.

Cancellation of Members for Cause

VHP may terminate your membership and the membership of your Dependent(s) with 30 days' notice if:

You or your Dependent(s) commit Fraud in connection with membership, Plan, or a Plan Provider. Some examples of Fraud include:

- Intentional failure to furnish material information required in connection with the enrollment under the Agreement, such as knowingly misrepresenting material eligibility or enrollment information, or intentionally giving incorrect or incomplete material enrollment information in any document, or if you fail to intentionally notify us of material changes in your family status (e.g., Dependent changes).
- Engage in an intentional misrepresentation of material fact in the use of the services or facilities of VHP, Plan Providers, or Non-Plan Providers.
- Unauthorized use of a VHP ID Card by permitting a non-Member to use a Member's VHP ID Card to obtain Benefits.

Cancellation of a Dependent for cause will solely apply to the Dependent involved and will not affect the enrollment of the Subscriber or any other Dependent(s).

You may use the Grievance procedure to contest an involuntary Disenrollment or Termination for cause. Refer to "Member Grievances" section.

State Review of Termination

If you believe your membership was terminated because of your ill health or your need for health care, you may request a review by the California Department of Managed Health Care by calling **1.888.466.2219 (toll-free)**. Please refer to the section "Department of Managed Health Care Consumer Helpline" for more details.

Cessation of Coverage

VHP will not cover any services or supplies provided after the effective date of Termination regardless of whether you were seeing a physician or other provider for a condition or course of treatment. The only exceptions are when you may be eligible for continuation Coverage, where applicable, and:

- You are or your Dependent is a registered bed patient in a hospital at the date of Termination of the Agreement by VHP. You or your Dependent may receive all the Benefits of your VHP Coverage for the condition confining you to the hospital, subject to your payment of the premium and applicable Copayments, until those Benefits expire, or you are discharged from the hospital, whichever occurs first;
- You are or your Dependent is receiving inpatient obstetrical care in a Plan Hospital at the date of Termination, and there has been no default in premiums. You will continue to receive Coverage for inpatient obstetrical care only through the date of discharge; or
- You or your Dependent is Totally Disabled, as determined by VHP, by a condition for which you or your Dependent was receiving services before your employer terminated Coverage. You or your Dependent will continue to receive Coverage only for services related to the disabling condition, subject to all limitations and restrictions, including applicable Copayments and premiums. Coverage will end:
- Twelve months after the Termination date;
- When you or your Dependent are no longer Totally Disabled as determined by VHP's Medical Director or designee; or
- When you or your Dependent are covered under any replacement contract or policy without limitation as to the disabling condition, whichever occurs first.

Effective Date of Termination

Your Coverage as a Member will terminate on one of the following dates subject to the grace period as described above in the "Cancellation for Group Service Agreement" section:

- For County of Santa Clara, Santa Clara County Superior Courts and the Santa Clara County Fairgrounds:
  - At midnight on the last day of the pay period of the month in which you were eligible; or
  - 30 days after the notice of the start of the grace period is dated and if payment has not been received by VHP from your employer Group.
- For Valley Health Foundation:
  - At midnight on the last day of the month in which you were eligible; or
  - 30 days after the notice of the start of the grace period is dated and payment has not been received by VHP from your Employer Group.
- For retirees:
  - 30 days after the notice of the start of the grace period is dated and payment has not been received by VHP from your employer Group.
- For COBRA and Cal-COBRA:
  - 30 days after the notice of the start of the grace period is dated and payment has not been received by VHP from your employer Group for COBRA or you for Cal-COBRA.

Grievance for Termination

You have the right to submit a Grievance regarding cancellation, rescission, or nonrenewal of VHP enrollment, subscription or Group Service Agreement.

If you believe your Coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a Grievance with VHP and/or the Department of Managed Health Care for at least 180 days from the date of the notice that you believe is improper.

If you file a Grievance before the effective date of cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, VHP shall continue to

provide Coverage to you pursuant to terms of the VHP Group Service Agreement while the Grievance is pending with VHP and/or the DMHC Director.

OPTION (1) - YOU MAY SUBMIT A GRIEVANCE TO VHP.

- You may submit a grievance to VHP by calling **1.888.421.8444 (toll-free)**, online at **www.valleyhealthplan.org**, or by mailing your written grievance to:

  Valley Health Plan
  Attention: Grievance Department
  2480 N. First Street, Suite 160
  San Jose, CA 95131

- You may want to submit your grievance to VHP first if you believe your cancellation, rescission, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.
- VHP will resolve your grievance or provide a pending status within 3 calendar days. If you do not receive a response from VHP within 3 calendar days, or if you are not satisfied in any way with VHP's response, you may submit a Grievance to the Department of Managed Health Care as detailed under Option 2 below.

OPTION (2) - YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DEPARTMENT OF MANAGED HEALTH CARE.

- You may submit a Grievance to the Department of Managed Health Care without first submitting it to VHP or after you have received VHP's decision on your Grievance.
- You may submit a Grievance to the Department of Managed Health Care online at: **www.healthhelp.ca.gov.**
- You may submit a grievance to the Department of Managed Health Care by mailing your written grievance to:

  Help Center
  Department of Managed Health Care
  980 Ninth Street, Suite 500
  Sacramento, California 95814-2725

- You may contact the Department of Managed Health Care for more information on filing a grievance at:

PHONE: 1.888.466.2219

TDD: 1.877.688.9891

FAX: 1.916.255.5241

Refunds in the Event of Cancellation

If your Coverage terminates, payment of premiums for any period after the Termination date and any other amounts due to you will be processed within 30 days and refunded to your employer. Refunds are minus any amounts due to VHP. If your Coverage terminates due to Fraud in the use of health services or facilities or you knowingly permitted such Fraud by another, refunds will not be made.

Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act (HIPAA) require employers or health plans to issue “Certificates of Creditable Coverage” to terminated Group Members. The certificate documents health care membership and is used to prove prior creditable coverage when a terminated Member seeks new coverage. When you terminate, you or your employer may request a certificate from VHP at any time by contacting VHP’s Member Services Department at **1.888.421.8444 (toll-free)**. VHP will mail the certificate to the Subscriber.

Individual Continuation of Coverage

US and California Laws protect your right and your Dependent(s) right to continue group health coverage under certain circumstances or qualifying events. This is called individual continuation of health care Benefits or individual continuation of coverage.

There are 3 kinds of individual continuation of coverage, which are:

1. COBRA
2. Cal-COBRA
3. HIPAA & other individual plans

California Law requires that every health plan that offers group continuation coverage must include the following statement about continuation health coverage:

Continuing Group Coverage Under COBRA and Cal-COBRA

You and your Eligible Dependent(s) may be eligible for continuation of coverage under COBRA and/or Cal-COBRA for up to 36 months. Contact your employer to see if you are eligible. The federal COBRA (Consolidated Omnibus Budget Reconciliation Act) and Cal-COBRA (the California Continuation Benefits Replacement Act) allows employees and/or their family members to temporarily continue their coverage, at group rates, when coverage would otherwise end.

COBRA applies to most employees (and most of your Eligible Dependents) of most employers with 20 or more employees.

Cal-COBRA applies to most employees (and Eligible Dependents) of most employers with less than 20 employees, and in certain cases, if you would otherwise lose COBRA coverage.

Understanding Your Choices

You or your Dependent(s) have 60 days to elect to continue COBRA or Cal-COBRA. Once elected, the Subscriber is required by Law to pay any required first premium within 45 days from when you requested continuation Coverage. If you or your Dependent(s) do not elect or do not pay for continuation Coverage within the required timelines, you or your Dependent(s) may be disqualified from receiving such continuation Coverage. Contact VHP, your employer, or your Group's COBRA administrator for more information.

If you or your Dependent(s) elect to purchase COBRA or Cal-COBRA coverage (as applicable) following the qualifying events more fully described below in the section entitled "Qualifying Events", you will receive the same Benefit Plan that VHP is offering to the Group. Following election and initial payment, you will pay the COBRA or Cal-COBRA membership premiums on a monthly prepayment basis by the first (1st) of each month. VHP may decline, cancel, or terminate your Coverage if you fail to pay the membership premium, or for reasons as stated in the applicable Laws, rules, and regulations. In addition, you must live or work in Santa Clara County and not be covered under any other health insurance, including Medicare. All rights to this

Coverage will cease on the Termination date of the Agreement. If the VHP Agreement is terminated through your Group, you may be eligible for other extended coverage under another group benefit plan offered by the employer. Call your employer or Group COBRA administrator for more information about COBRA coverage. VHP for more information about Cal-COBRA coverage.

Administratively, eligible persons will be terminated from Coverage upon a qualifying event but will be enrolled retroactively to the qualifying event upon timely election of continuation coverage under COBRA or Cal-COBRA. If an eligible person requires services before election, the eligible person must either:

(1) elect and pay for the Coverage, or (2) pay reasonable charges (i.e., reasonable and customary charges) for the services subject to reimbursement by VHP within 30 days of such person's timely election of continuation coverage under COBRA or Cal-COBRA.

COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Member's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends. Your Group or Group COBRA administrator will notify you of your eligibility to continue coverage under Cal-COBRA. You have 60 days from that notification to contact VHP to continue Group Coverage under Cal-COBRA. Refer to the "Cal-COBRA After Exhausting COBRA" section.

Note: COBRA enrollees must exhaust all the COBRA coverage to which you are entitled before you can become eligible to continue coverage under Cal-COBRA.

In no event will continuation of Group Coverage under COBRA, Cal-COBRA, or a combination of both be extended for more than three (3) years or 36 months from the date such Coverage began.

If Social Security Administration determined that you were disabled at any time during the first 60 days of COBRA or Cal-COBRA coverage, you must notify your Group within 60 days of receiving the determination from Social Security Administration. Also, if Social Security Administration issues a final determination that you are no longer disabled in the 35th or 36th month of Group continuation coverage, your Cal-COBRA coverage will end the latter of: (1) expiration of 36 months after your original COBRA effective date, or (2) the first day of the first month following 31 days after Social Security Administration's final determination that you are no longer disabled.

Cal-COBRA After Exhausting COBRA

If you elect to purchase Cal-COBRA after you lose COBRA coverage, you may be able to continue uninterrupted Group coverage, provided:

- Your effective date of COBRA coverage was on or after January 1, 2003;
- You have exhausted the time limit for COBRA coverage;
- You are not entitled to Medicare or covered under any other health or group health plan; and
- You pay VHP the monthly dues by the billing due date as described below.

COBRA or Cal-COBRA Enrollment Responsibility

To determine if you are eligible to enroll in COBRA or Cal-COBRA refer to the "Continuing Group Coverage Under COBRA and Cal-COBRA" section under "Qualifying Events".

Whether you are enrolling in COBRA or Cal-COBRA you must return your completed written enrollment application to your employer/Group COBRA administrator or to VHP or within 60 days following the later of: (1) the date your Coverage terminates or will be terminated by reason of a qualifying event; or (2) the date that you were sent notification that you may continue Coverage under the Group's Benefit Plan. If you or your Dependent(s) do not complete and return the application within the timelines, you or your Dependent(s) will be disqualified from receiving continuation Coverage.

1. **To request a COBRA enrollment application**, please contact your employer. Your employer or your employer's COBRA administrator will ensure you receive information regarding your COBRA rights. In order for you or your Dependent(s) to continue group coverage through COBRA, a completed written enrollment application and applicable premiums must be received by VHP based on the federal COBRA Law.
2. **To request a Cal-COBRA enrollment application**, if you are a Member of a Group with fewer than 20 employees, please contact VHP. VHP will ensure you or your Dependent(s) receive information regarding your Cal-COBRA rights. In order for a Member to continue group Coverage through Cal-

COBRA, a completed written enrollment application and applicable premiums must be received by VHP in accordance with the State Cal-COBRA Law.

3. **To request a Cal-COBRA enrollment application** after exhausting COBRA, please call a VHP Member Services Representative. Within ten days of your request, VHP will send you an enrollment application, which will include premium dues and billing information.

COBRA or Cal-COBRA Payment Responsibility

Once your VHP COBRA or Cal-COBRA enrollment application is approved, a bill will be sent to you within 30 days after receipt of your application. COBRA payments must be sent directly to your employer or Group COBRA administrator. Cal-COBRA payments must be sent directly to VHP.

You must pay the initial COBRA or Cal-COBRA bill within 45 days of election. The first premium payment will include dues for Coverage from when you terminated employment, or you exhausted COBRA Coverage through your employer Group, to the current billing cycle.

Thereafter, monthly premium payments are due on or before the last day of the month preceding the month of coverage (e.g. prepaid by June 30th for July 1st). The premiums will not exceed 110 percent of the applicable dues charged to a similarly situated individual under the Group Benefit Plan except that the premium for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent.

For more information regarding COBRA payment responsibilities, contact your employer or Group COBRA administrator. For more information regarding Cal-COBRA payment responsibilities, contact the VHP Member Services Department at **1.888.421.8444 (toll-free)**.

COBRA or Cal-COBRA Termination

COBRA continuation coverage terminates if payment of the appropriate monthly dues is not received by VHP as mandated by federal COBRA Law. Contact your employer or Group COBRA administrator regarding COBRA termination and/or your COBRA termination date.

Cal-COBRA continuation coverage terminates if payment of the appropriate monthly dues is not received by VHP at the time VHP specifies, or on the earliest of:

- The date your Group's Agreement with VHP terminates;
- The date you become eligible for Medicare;
- The date your coverage begins under any other health plan or group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have (or that does contain such an exclusion or limitation, but it has been satisfied);
- Expiration of 36 months after your original COBRA effective date (under this or any other plan); or
- The date your membership is terminated for nonpayment of premiums.

Qualifying Events

You or your Dependent(s) may be eligible to continue Group Coverage based on the following qualifying events:

- You or your Dependent(s) may be eligible to continue Group continuation Coverage if cancellation of your Coverage occurs because:
  - Your employment was terminated for any reason, except gross misconduct; or
  - Your hours of employment are reduced.
- Your Dependent(s) may be eligible to continue Group continuation Coverage if cancellation of their Coverage occurs because of:
  - Your death; or
  - Your divorce or separation from your spouse/domestic partner; or
  - Your entitlement to receive benefits under Medicare; or
  - Your Dependent child loses eligibility.

Important Notice Regarding Continuation of Coverage

For you to continue Group Coverage on COBRA or Cal-COBRA (as applicable) with no break in Coverage, VHP must be advised in writing within 60 days of the date of your qualifying event, otherwise you may not be eligible to continue Coverage on this Benefit Plan. If you or your Dependent(s) elect to continue coverage, by Law you have 45 days from the election date to pay the initial premium billing. Thereafter, you must prepay your monthly premiums by the end of the month prior to the month of coverage (e.g., pay July1st premium by June 30th).

Open Enrollment Period or Termination of Another Health Plan

If you previously elected COBRA or Cal-COBRA coverage through another health plan available through your Group, you may be eligible to enroll in VHP:

- During your Group's annual Open Enrollment Period, or
- If your Group terminated its agreement with the health plan in which you were enrolled.

You will be entitled to COBRA and/or Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by COBRA and/or Cal-COBRA.

If during your Group Open Enrollment Period or if your Group terminates another health plan and you want to elect to continue your COBRA or Cal-COBRA coverage through VHP, VHP must receive:

- Your written enrollment application, and
- Premiums in a timely fashion as required by Law.

If you want to change to VHP during the Open Enrollment Period, contact your employer or VHP at **1.888.421.8444 (toll-free)** for more information.

To elect VHP to continue your COBRA or Cal-COBRA coverage, VHP must receive your enrollment application during your Group's Open Enrollment Period, or within 30 days of receiving the termination notice from your Group as described in the "Group Responsibilities" section. To request an application, please call VHP's

Member Services Department at **1.888.421.8444 (toll-free)**. Payment must be received as required by State and federal guidelines.

Refer to the "Important Notice Regarding Continuation of Coverage" section.

Group Responsibilities

Your Group is required to give VHP written notice within 30 days after a Subscriber is no longer eligible for Coverage due to termination of employment or reduction of hours. If your Group advises VHP to not offer COBRA or Cal-COBRA (as applicable) coverage because Group terminated a Subscriber's employment for gross misconduct, the Group must notify VHP, within ten days after the Subscriber's employment terminates, by writing to:

Valley Health Plan
Attention: Member Services Department
2480 N. First Street, Suite 160
San Jose, CA 95131

Your Group is required to notify VHP in writing within 30 days if the Group becomes subject to COBRA under federal Law.

If your employer's agreement with a health plan is terminated, your Group is required to provide written notice at least 30 days before the termination date to the individuals whose COBRA or Cal-COBRA coverage is terminating or when all enrolled employees are notified, whichever is later. This notice must inform COBRA or Cal-COBRA beneficiaries that they can continue COBRA or Cal- COBRA coverage by enrolling in any health benefit plan offered by the Group. It must also include information about benefits, dues, payment instructions, and/or enrollment forms, or where to receive enrollment instructions on how to continue Group continuation coverage under the new health plan.

Eligible individuals will be entitled to continue Group coverage only for the remainder, if any, of the coverage period as prescribed by COBRA or Cal-COBRA. The Group is required to send this information to the person's last known address, as provided by the prior health plan.

If the Group fails to provide the appropriate notice to persons eligible to enroll in VHP or another health plan, neither plan(s) is obligated to provide continuation

coverage if the person did not enroll or pay premiums within the required timelines as required by Law.

HIPAA and Other Individual Plans

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health care coverage for workers and their families when they change or lose their jobs. If you lose group health care coverage and meet certain criteria, you are entitled to purchase individual (non-group) health care coverage from any health plan that sells individual health care coverage.

Every health plan that sells individual coverage must offer individual coverage to an eligible person under HIPAA. The health plan cannot reject your application if you are an eligible person under HIPAA, you agree to pay the required premiums, and you live or work inside the plan's service area.

VHP sells individual health care coverage. VHP also offers Group continuation coverage through COBRA and/or Cal-COBRA.

Continuation of Coverage for Totally Disabled Members

If you become Totally Disabled and your employer terminates Coverage, Coverage for your disabling condition will continue for 12 months, until you are no longer Totally Disabled, or until your employer obtains replacement coverage that does not limit coverage of the disabling conditions whichever occurs first. Coverage for your total disability is subject to the limitations and exclusions described in this Valley Health Plan Combined Evidence of Coverage and Disclosure Form.

Chapter 5: Termination of Benefits for In Home Support Service Members

Once enrolled, your Coverage may be canceled only for the Disenrollment and Termination of Benefits reasons identified below. To voluntarily disenroll, contact your employer and complete and sign the appropriate paperwork. Your employer will notify you of your effective date of Termination. If your Coverage is terminated involuntarily, you will receive notice of the date of Termination. Until the effective date of your Disenrollment or Termination, you will remain a VHP Member and are responsible to:

- Continue to receive all Covered Services from Plan Providers within your Primary Network (except in the event of an Emergency or Urgently Needed Services);
- Pay for all applicable membership premiums; and
- Continue to adhere to all requirements of your VHP membership.

Once your Disenrollment or Termination from the Benefit Plan becomes effective, your VHP ID Card will no longer be valid. You may not be reinstated automatically if Coverage is canceled or terminated.

Fraudulent use of your VHP ID Card, the services or facilities of VHP or its Plan Providers, and/or Fraud or misrepresentation on the enrollment application form will result in an investigation and appropriate legal action.

If you have additional questions about the Disenrollment or Termination process, please review the following sections and/or call your employer or a VHP Member Services Representative at **1.888.421.8444 (toll-free)**.

Loss of Eligibility

If you cease to meet VHP and/or your Group eligibility requirements, then your Coverage will involuntarily terminate subject to the provisions for continuation of coverage or conversion of benefits. You and your employer must notify VHP immediately if you cease to meet the eligibility requirements. Refer to the "Eligibility and Enrollment" chapter.

You lose eligibility if:

- You no longer work or reside within Santa Clara County.

Loss of eligibility does not affect any rights to continue Group Coverage under COBRA, as described in the "Individual Continuation of Coverage" section.

Disenrollment by Member

If you elect coverage under another health benefits plan offered by or through your employer, then your Coverage terminates automatically at the time and date the alternate coverage becomes effective. You and your employer agree to notify VHP immediately that you have elected coverage elsewhere. You may voluntarily disenroll from VHP at any time and for any reason. You may disenroll by notifying your employer in writing of your intent to cancel your Coverage. Your Coverage terminates at midnight on the effective date as determined by your employer.

Cancellation of Group Service Agreement

Your employer may terminate your Coverage upon written notice to VHP. If your employer terminates or does not renew the Group Service Agreement for any reason, or if VHP terminates the Agreement, your Coverage will cease on the date the Agreement terminates.

If your employer Group fails to pay the premiums, your health care Coverage can be cancelled. VHP will send the "Notice of Start of Grace Period" to the Subscriber and the employer Group if the employer Group has failed to make a premium payment by the due date. This notice will begin a 30-day grace period.

Your Coverage will be terminated on the day after the 30-day grace period ends if payment from your employer Group was not received on or before the last day of

the grace period. VHP will send the Subscriber a "Notice of End of Coverage" within 5 calendar days after the Coverage ended. If you are undergoing treatment for a medical condition, services provided beyond the date of Termination will be your financial responsibility unless you are covered by continuation Coverage through VHP. Refer to the "Individual Continuation of Coverage" section.

Cancellation of Members for Cause

VHP may terminate your membership with 30 days' notice if:

- You commit Fraud in connection with membership, Plan, or a Plan Provider. Some examples of Fraud include:
- Intentional failure to furnish material information required in connection with the enrollment under the Agreement, such as knowingly misrepresenting material eligibility or enrollment information, or intentionally giving incorrect or incomplete material enrollment information in any document.
- Engage in an intentional misrepresentation of material fact in the use of the services or facilities of VHP, Plan Providers, or Non-Plan Providers.
- Unauthorized use of a VHP ID Card by permitting a non-Member to use a Member's VHP ID Card to obtain Benefits.

You may use the Grievance procedure to contest an involuntary Disenrollment or Termination for cause. Refer to "Member Grievances" section.

State Review of Termination

If you believe your membership was terminated because of your ill health or your need for health care, you may request a review by the California Department of Managed Health Care by calling **1.888.466.2219 (toll-free)**. Please refer to the section "Department of Managed Health Care Consumer Helpline" for more details.

Cessation of Coverage

VHP will not cover any services or supplies provided after the effective date of Termination regardless of whether you were seeing a physician or other provider for a condition or course of treatment. The only exceptions are when you may be eligible for continuation Coverage, where applicable, and:

- You are a registered bed patient in a hospital at the date of Termination of the Agreement by VHP. You may receive all the Benefits of your VHP Coverage for the condition confining you to the hospital, subject to your payment of the premium and applicable Copayments, until those Benefits expire, or you are discharged from the hospital, whichever occurs first;
- You are receiving inpatient obstetrical care in a Plan Hospital at the date of Termination, and there has been no default in premiums. You will continue to receive Coverage for inpatient obstetrical care only through the date of discharge; or
- You are Totally Disabled, as determined by VHP, by a condition for which you were receiving services before your employer terminated Coverage. You will continue to receive Coverage only for services related to the disabling condition, subject to all limitations and restrictions, including applicable Copayments and premiums. Coverage will end:
    - Twelve months after the Termination date;
    - When you are no longer Totally Disabled as determined by VHP's Medical Director or designee; or
    - When you are covered under any replacement contract or policy without limitation as to the disabling condition, whichever occurs first.

Effective Date of Termination

Your Coverage as a Member will terminate on one of the following dates subject to the grace period as described above in the "Cancellation for Group Service Agreement" section:

- At midnight on the last day of the month in which you were eligible; or
- 30 days after the notice of the start of the grace period is dated and if payment has not been received by VHP from your employer Group.

Grievance for Termination

You have the right to submit a Grievance regarding cancellation, rescission, or nonrenewal of VHP enrollment, subscription or Group Service Agreement.

If you believe your Coverage has been, or will be, improperly cancelled, rescinded, or not renewed, you have the right to file a Grievance with VHP and/or the Department of Managed Health Care for at least 180 days from the date of the notice that you believe is improper.

If you file a Grievance before the effective date of cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, VHP shall continue to provide Coverage to you pursuant to terms of the VHP Group Service Agreement while the Grievance is pending with VHP and/or the DMHC Director.

OPTION (1) - YOU MAY SUBMIT A GRIEVANCE TO VHP.

- You may submit a grievance to VHP by calling **1.888.421.8444 (toll-free)**, online at **www.valleyhealthplan.org**, or by mailing your written grievance to:

  Valley Health Plan
  Attention: Grievance Department
  2480 N. First Street, Suite 160
  San Jose, CA 95131

- You may want to submit your grievance to VHP first if you believe your cancellation, rescission, or nonrenewal is the result of a mistake. Grievances should be submitted as soon as possible.
- VHP will resolve your grievance or provide a pending status within 3 calendar days. If you do not receive a response from VHP within 3 calendar days, or if you are not satisfied in any way with VHP's response, you may submit a Grievance to the Department of Managed Health Care as detailed under Option 2 below.

OPTION (2) - YOU MAY SUBMIT A GRIEVANCE DIRECTLY TO THE DEPARTMENT OF MANAGED HEALTH CARE.

- You may submit a Grievance to the Department of Managed Health Care without first submitting it to VHP or after you have received VHP's decision on your Grievance.
- You may submit a Grievance to the Department of Managed Health Care online at: **www.healthhelp.ca.gov**.
- You may submit a grievance to the Department of Managed Health Care by mailing your written grievance to:

  Help Center
  Department of Managed Health Care
  980 Ninth Street, Suite 500
  Sacramento, California 95814-2725

- You may contact the Department of Managed Health Care for more information on filing a grievance at:

  PHONE: 1.888.466.2219

  TDD: 1.877.688.9891

  FAX: 1.916.255.5241

Refunds in the Event of Cancellation

If your Coverage terminates, payment of premiums for any period after the Termination date and any other amounts due to you will be processed within 30 days and refunded to your employer. Refunds are minus any amounts due to VHP. If your Coverage terminates due to Fraud in the use of health services or facilities or you knowingly permitted such Fraud by another, refunds will not be made.

Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act (HIPAA) require employers or health plans to issue “Certificates of Creditable Coverage” to terminated Group Members. The certificate documents health care membership and is used to prove prior creditable coverage when a terminated Member seeks new coverage. When

you terminate, you or your employer may request a certificate from VHP at any time by contacting VHP's Member Services Department at **1.888.421.8444 (toll-free)**. VHP will mail the certificate to the Subscriber.

Individual Continuation of Coverage

US and California Laws protect your right to continue group health coverage under certain circumstances or qualifying events. This is called individual continuation of health care Benefits or individual continuation of coverage.

There are 3 kinds of individual continuation of coverage, which are:

1. COBRA
2. Cal-COBRA
3. HIPAA & other individual plans

California Law requires that every health plan that offers group continuation coverage must include the following statement about continuation health coverage:

Continuing Group Coverage Under COBRA and Cal-COBRA

You may be eligible for continuation of coverage under COBRA and/or Cal-COBRA for up to 36 months. Contact your employer to see if you are eligible. The federal COBRA (Consolidated Omnibus Budget Reconciliation Act) and Cal-COBRA (the California Continuation Benefits Replacement Act) allows employees to temporarily continue their coverage, at group rates, when coverage would otherwise end.

COBRA applies to most employees of most employers with 20 or more employees.

Cal-COBRA applies to most employees of most employers with less than 20 employees, and in certain cases, if you would otherwise lose COBRA coverage.

Understanding Your Choices

You have 60 days to elect to continue COBRA or Cal-COBRA. Once elected, the Subscriber is required by Law to pay any required first premium within 45 days from

when you requested continuation Coverage. If you do not elect or do not pay for continuation Coverage within the required timelines, you may be disqualified from receiving such continuation Coverage. Contact VHP, your employer, or your Group's COBRA administrator for more information.

If you elect to purchase COBRA or Cal-COBRA coverage (as applicable) following the qualifying events more fully described below in the section entitled "Qualifying Events", you will receive the same Benefit Plan that VHP is offering to the Group. Following election and initial payment, you will pay the COBRA or Cal-COBRA membership premiums on a monthly prepayment basis by the first (1st) of each month. VHP may decline, cancel, or terminate your Coverage if you fail to pay the membership premium, or for reasons as stated in the applicable Laws, rules, and regulations. In addition, you must live or work in Santa Clara County and not be covered under any other health insurance, including Medicare. All rights to this Coverage will cease on the Termination date of the Agreement. If the VHP Agreement is terminated through your Group, you may be eligible for other extended coverage under another group benefit plan offered by the employer. Call your employer or Group COBRA administrator for more information about COBRA coverage. VHP for more information about Cal-COBRA coverage.

Administratively, eligible persons will be terminated from Coverage upon a qualifying event but will be enrolled retroactively to the qualifying event upon timely election of continuation coverage under COBRA or Cal-COBRA. If an eligible person requires services before election, the eligible person must either:

(1) elect and pay for the Coverage, or (2) pay reasonable charges (i.e., reasonable and customary charges) for the services subject to reimbursement by VHP within 30 days of such person's timely election of continuation coverage under COBRA or Cal-COBRA.

COBRA enrollees who reach the 18-month or 29-month maximum available under COBRA may elect to continue coverage under Cal-COBRA for a maximum period of 36 months from the date the Member's continuation coverage began under COBRA. If elected, the Cal-COBRA coverage will begin after the COBRA coverage ends. Your Group or Group COBRA administrator will notify you of your eligibility to continue coverage under Cal-COBRA. You have 60 days from that notification to contact VHP to continue Group Coverage under Cal-COBRA. Refer to the "Cal-COBRA After Exhausting COBRA" section.

Note: COBRA enrollees must exhaust all the COBRA coverage to which you are entitled before you can become eligible to continue coverage under Cal-COBRA.

In no event will continuation of Group Coverage under COBRA, Cal-COBRA, or a combination of both be extended for more than three (3) years or 36 months from the date such Coverage began.

If Social Security Administration determined that you were disabled at any time during the first 60 days of COBRA or Cal-COBRA coverage, you must notify your Group within 60 days of receiving the determination from Social Security Administration. Also, if Social Security Administration issues a final determination that you are no longer disabled in the 35th or 36th month of Group continuation coverage, your Cal-COBRA coverage will end the latter of: (1) expiration of 36 months after your original COBRA effective date, or (2) the first day of the first month following 31 days after Social Security Administration's final determination that you are no longer disabled.

Cal-COBRA After Exhausting COBRA

If you elect to purchase Cal-COBRA after you lose COBRA coverage, you may be able to continue uninterrupted Group coverage, provided:

- Your effective date of COBRA coverage was on or after January 1, 2003;
- You have exhausted the time limit for COBRA coverage;
- You are not entitled to Medicare or covered under any other health or group health plan; and
- You pay VHP the monthly dues by the billing due date as described below.

COBRA or Cal-COBRA Enrollment Responsibility

To determine if you are eligible to enroll in COBRA or Cal-COBRA refer to the "Continuing Group Coverage Under COBRA and Cal-COBRA" section under "Qualifying Events".

Whether you are enrolling in COBRA or Cal-COBRA you must return your completed written enrollment application to your employer/Group COBRA administrator or to VHP or within 60 days following the later of: (1) the date your Coverage terminates or will be terminated by reason of a qualifying event; or (2) the date that you were sent notification that you may continue Coverage under the Group's Benefit Plan. If

you do not complete and return the application within the timelines, you will be disqualified from receiving continuation Coverage.

1. **To request a COBRA enrollment application**, please contact your employer. Your employer or your employer's COBRA administrator will ensure you receive information regarding your COBRA rights. In order for you to continue group coverage through COBRA, a completed written enrollment application and applicable premiums must be received by VHP based on the federal COBRA Law.

2. **To request a Cal-COBRA enrollment application**, if you are a Member of a Group with fewer than 20 employees, please contact VHP. VHP will ensure you receive information regarding your Cal-COBRA rights. In order for a Member to continue group Coverage through Cal-COBRA, a completed written enrollment application and applicable premiums must be received by VHP in accordance with the State Cal-COBRA Law.

3. **To request a Cal-COBRA enrollment application** after exhausting COBRA, please call a VHP Member Services Representative. Within ten days of your request, VHP will send you an enrollment application, which will include premium dues and billing information.

COBRA or Cal-COBRA Payment Responsibility

Once your VHP COBRA or Cal-COBRA enrollment application is approved, a bill will be sent to you within 30 days after receipt of your application. COBRA payments must be sent directly to your employer or Group COBRA administrator. Cal-COBRA payments must be sent directly to VHP.

You must pay the initial COBRA or Cal-COBRA bill within 45 days of election. The first premium payment will include dues for Coverage from when you terminated employment, or you exhausted COBRA Coverage through your employer Group, to the current billing cycle.

Thereafter, monthly premium payments are due on or before the last day of the month preceding the month of coverage (e.g. prepaid by June 30th for July 1st). The premiums will not exceed 110 percent of the applicable dues charged to a similarly situated individual under the Group Benefit Plan except that the premium for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent.

For more information regarding COBRA payment responsibilities, contact your employer or Group COBRA administrator. For more information regarding Cal-COBRA payment responsibilities, contact the VHP Member Services Department at **1.888.421.8444 (toll-free)**.

COBRA or Cal-COBRA Termination

COBRA continuation coverage terminates if payment of the appropriate monthly dues is not received by VHP as mandated by federal COBRA Law. Contact your employer or Group COBRA administrator regarding COBRA termination and/or your COBRA termination date.

Cal-COBRA continuation coverage terminates if payment of the appropriate monthly dues is not received by VHP at the time VHP specifies, or on the earliest of:

- The date your Group's Agreement with VHP terminates;
- The date you become eligible for Medicare;
- The date your coverage begins under any other health plan or group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have (or that does contain such an exclusion or limitation, but it has been satisfied);
- Expiration of 36 months after your original COBRA effective date (under this or any other plan); or
- The date your membership is terminated for nonpayment of premiums.

Qualifying Events

You may be eligible to continue Group continuation Coverage if cancellation of your Coverage occurs because:

- Your employment was terminated for any reason, except gross misconduct; or
- Your hours of employment are reduced.

Important Notice Regarding Continuation of Coverage

For you to continue Group Coverage on COBRA or Cal-COBRA (as applicable) with no break in Coverage, VHP must be advised in writing within 60 days of the date of your qualifying event, otherwise you may not be eligible to continue Coverage on this Benefit Plan. If you elect to continue coverage, by Law you have 45 days from the election date to pay the initial premium billing. Thereafter, you must prepay your monthly premiums by the end of the month prior to the month of coverage (e.g., pay July1st premium by June 30th).

Open Enrollment Period or Termination of Another Health Plan

If you previously elected COBRA or Cal-COBRA coverage through another health plan available through your Group, you may be eligible to enroll in VHP:

- During your Group's annual Open Enrollment Period, or
- If your Group terminated its agreement with the health plan in which you were enrolled.

You will be entitled to COBRA and/or Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by COBRA and/or Cal-COBRA.

- If during your Group Open Enrollment Period or if your Group terminates another health plan and you want to elect to continue your COBRA or Cal-COBRA coverage through VHP, VHP must receive:
- Your written enrollment application, and
- Premiums in a timely fashion as required by Law.

If you want to change to VHP during the Open Enrollment Period, contact your employer or VHP at **1.888.421.8444 (toll-free)** for more information.

To elect VHP to continue your COBRA or Cal-COBRA coverage, VHP must receive your enrollment application during your Group's Open Enrollment Period, or within 30 days of receiving the termination notice from your Group as described in the "Group Responsibilities" section. To request an application, please call VHP's Member Services Department at **1.888.421.8444 (toll-free)**. Payment must be received as required by State and federal guidelines.

Refer to the "Important Notice Regarding Continuation of Coverage" section.

Group Responsibilities

Your Group is required to give VHP written notice within 30 days after a Subscriber is no longer eligible for Coverage due to termination of employment or reduction of hours. If your Group advises VHP to not offer COBRA or Cal-COBRA (as applicable) coverage because Group terminated a Subscriber's employment for gross misconduct, the Group must notify VHP, within ten days after the Subscriber's employment terminates, by writing to:

Valley Health Plan
Attention: Member Services Department
2480 N. First Street, Suite 160
San Jose, CA 95131

Your Group is required to notify VHP in writing within 30 days if the Group becomes subject to COBRA under federal Law.

If your employer's agreement with a health plan is terminated, your Group is required to provide written notice at least 30 days before the termination date to the individuals whose COBRA or Cal-COBRA coverage is terminating or when all enrolled employees are notified, whichever is later. This notice must inform COBRA or Cal-COBRA beneficiaries that they can continue COBRA or Cal- COBRA coverage by enrolling in any health benefit plan offered by the Group. It must also include information about benefits, dues, payment instructions, and/or enrollment forms, or where to receive enrollment instructions on how to continue Group continuation coverage under the new health plan.

Eligible individuals will be entitled to continue Group coverage only for the remainder, if any, of the coverage period as prescribed by COBRA or Cal-COBRA. The Group is required to send this information to the person's last known address, as provided by the prior health plan.

If the Group fails to provide the appropriate notice to persons eligible to enroll in VHP or another health plan, neither plan(s) is obligated to provide continuation coverage if the person did not enroll or pay premiums within the required timelines as required by Law.

HIPAA and Other Individual Plans

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health care coverage for workers and their families when they change or lose their jobs. If you lose group health care coverage and meet certain criteria, you are entitled to purchase individual (non-group) health care coverage from any health plan that sells individual health care coverage.

Every health plan that sells individual coverage must offer individual coverage to an eligible person under HIPAA. The health plan cannot reject your application if you are an eligible person under HIPAA, you agree to pay the required premiums, and you live or work inside the plan's service area.

VHP sells individual health care coverage. VHP also offers Group continuation coverage through COBRA and/or Cal-COBRA.

Continuation of Coverage for Totally Disabled Members

If you become Totally Disabled and your employer terminates Coverage, Coverage for your disabling condition will continue for 12 months, until you are no longer Totally Disabled, or until your employer obtains replacemsssent coverage that does not limit coverage of the disabling conditions whichever occurs first. Coverage for your total disability is subject to the limitations and exclusions described in this Valley Health Plan Combined Evidence of Coverage and Disclosure Form.

Chapter 6: Choice of Physicians & Providers

Please read the following information so you will know from whom or what group of providers health care may be obtained.

Primary Care Provider Network Selection

VHP is a non-profit health plan operating as a Health Maintenance Organization (HMO). VHP contracts with a comprehensive network of Plan Providers, including by way of example, PCPs, specialists, hospitals, Skilled Nursing Facilities and Durable Medical Equipment providers to serve the commercial employer Group Members. In an HMO, PCPs provide and coordinate all Covered Services for their assigned Members. As you consider the selection of a PCP for you or your Dependents, it is important to note that your Primary Network (i.e., the physicians, hospitals, and other physical and behavioral care providers) is based upon the PCP you choose. For example, if you select a PCP affiliated with Santa Clara Valley Medical Center (SCVMC) your Primary Network encompasses the providers affiliated with SCVMC. Once a PCP and Primary Network is selected, or you are assigned a PCP and Primary Network by VHP, you must receive all your Covered Services from the Plan Providers affiliated with your Primary Network except in the event of an Emergency, Urgently Needed Services or if VHP has pre-Authorized the services. Except in an Emergency or in the event Urgently Needed Services are required, if you are referred to a Plan Provider not affiliated with your Primary Network or to a provider not contracted by VHP, Prior Authorization must be obtained by the referring provider from VHP. If VHP determines that your physical or behavioral needs can be met within your Primary Network, VHP may deny the request for services outside your Primary Network and authorize services with Plan Providers affiliated with your Primary Network.

In order to select your PCP and the PCP's affiliated Primary Network please use the "Provider Search" located on VHP's website. The "Provider Search" function will show you all the providers within the Primary Networks associated with your

Benefits Once you select the correct Benefit Plan you will then see the different Primary Networks. This search will display all the PCPs, specialists, behavioral health providers, hospitals, and other ancillary provider associated with each of the Primary Networks. You are also able to print or save a PDF of the providers within the Primary Networks from the "Provider Search" function. If you have any questions on how to use the "Provider Search" function, or any questions about the different Primary Networks, please contact Member Services at **1.888.421.8444 (toll-free)**.

In summary, each Member must select a PCP upon enrollment. If a PCP is not selected, VHP will assign you a PCP. The PCP and the PCP's network affiliation dictate the Primary Network where you will receive your physical and behavioral health care services. Your PCP provides all basic medical care and coordinates with VHP to obtain Prior Authorization for Medically Necessary specialty and elective Hospital Services, including those services at a Quaternary Referral Hospital. PCP services include visits, examinations, diagnostic, and surgical procedures performed in the office of a Plan PCP. Refer to the section "Choosing Your Primary Care Provider" to understand how to change your PCP.

To understand the meaning of important definitions, such as Plan Providers, Primary Network and Service Area, refer to the "Definitions" section of this EOC.

As a Member of VHP, you are selecting VHP to provide you and/or your family access to health care. You must receive all Covered Services from Plan Providers inside our Service Area, except as described in the "Emergency Services" and "Urgently Needed Services" sections. Through VHP, you have convenient access to all of the Covered Services you may need such as Routine Care with your PCP, hospital care, mental health, laboratory and pharmacy services and other Benefits listed in the "Medical Benefits and Prior Authorizations" chapter.

Choosing Your Primary Care Provider

You have the right to choose a PCP from VHP's list of Plan Providers. If you do not select a PCP, VHP will assign one to you and your enrolled Dependent(s). For updated Plan Provider information, visit **www.valleyhealthplan.org** or call a Member Services Representative at **1.888.421.8444 (toll-free)**.

On your VHP enrollment form, include the name of the PCP and their affiliated provider group. You may choose a different PCP for each Dependent.

VHP will make every effort to assign you to the PCP of your choice. However, if this is not possible, VHP will designate a PCP for you based on your geographic location, language preferences, and other factors.

If you need any assistance in selecting a PCP or changing a PCP assigned by VHP, please call a Member Services Representative at **1.888.421.8444 (toll-free)** or go to **www.valleyhealthplan.org** and use the Provider Search function. You may also download a hard copy of VHP's Provider Directory from VHP's website.

Finding a Behavioral Health Provider

Mental health and substance use outpatient treatment services with Plan Providers licensed as psychiatrists (MD), psychologist (PsyD), licensed clinical social worker (LCSW), or a licensed marriage and family therapist (LMFT), are available to you without the need for any referral or Authorization from VHP. In other words, you may contact any in-network Plan behavioral health counselor contracted with VHP directly to schedule an appointment.

For a list of VHP's behavioral health providers, consult VHP's Provider Directory or call VHP's Member Services Department at **1.888.421.8444 (toll-free)** or by visiting the VHP website at **www.valleyhealthplan.org**.

You may also seek mental health and substance use services with MDLive. Treatment can be provided via secure online video, phone or **MDLive** application 24 hours a day, seven days a week. MDLive providers can diagnose symptoms, prescribe non-narcotic medication (if needed), and send e-Prescriptions to the Member's VHP pharmacy of choice.

Members may register for access to the MDLive Benefit by visiting **www.mdlive.com/VHP** or by calling **1.888.467.4614** or TTY **1.800.770.5531**. Language assistance is available. For additional information, visit VHP's website at **https://www.valleyhealthplan.org/members/mdlive-telehealth-medical-and-behavioral-health-care**

Finding a PCP for your Newborn Baby

You may select a PCP (pediatrician) for your newborn baby at any time after you learn you are pregnant. For a list of VHP's network pediatricians, please consult

VHP's Provider Directory. You may also obtain a list of VHP's pediatricians by calling VHP's Member Services Department at **1.888.421.8444 (toll-free)** or by visiting the VHP website at **www.valleyhealthplan.org**.

Although you can select your baby's pediatrician at any time during your pregnancy, **please make sure to select a provider before your baby is born**. When your baby is born, VHP will ask you to list your preferred pediatrician on your baby's enrollment application so VHP can assign your baby to the pediatrician of your choice.

Changing Your Primary Care Provider

You can change your PCP at any time by calling VHP's Member Services Department or by requesting the change in writing. The effective date of the change will be first of the next month after your request is received, provided you are not receiving hospital or other institutional care at the time of your request. A new VHP ID Card will be mailed to you. Temporary VHP ID Cards can be obtained online at **www.valleyhealthplan.org** in "Members" under the section entitled "Forms and Resources".

In the event your PCP terminates his/her relationship with VHP, you will be notified in writing by VHP and will be assigned a new PCP.

Scheduling Appointments

VHP offers a wide selection of PCPs throughout the Service Area. To schedule an appointment with your PCP, call your PCP's appointment line. For your PCP's appointment line, go to **www.valleyhealthplan.org** or call VHP's Member Services Department at **1.888.421.8444 (toll-free)** for assistance.

VHP provides a free 24/7 Nurse Advice Line at **1.866.628.9492 (toll-free)**. VHP also offers free Telehealth services through MDLive Care. Members can access medical consultations and behavioral health providers for a wide range of Urgently Needed Services and non-emergency medical conditions 24/7 including holidays. Visit **www.mdlive.com/VHP**, call **1.888.467.4614 (toll-free)** or TTY **1.800.770.5531** to activate your account or schedule an appointment.

Language services are available to you at no cost through your Plan Provider or VHP's Language Assistance Program.

Receiving Self-Referral Services

VHP contracts with its Plan Providers. Based on a Primary Care Provider's network, you may self-refer to some select specialists. Please contact your PCP's office directly or visit **www.valleyhealthplan.org** for more information.

Any Member may self-refer to an obstetrician and gynecologist (OB/GYN) within your Primary Network. For services, call an OB/GYN within your Primary Network. Find an OB/GYN by using the "Provider Search" function at **www.valleyhealthplan.org** or by calling Member Services at **1.888.421.8444 (toll-free)**.

Members may also call Member Services at **1.888.421.8444 (toll-free)** to receive information on how to receive an Authorization for direct access for mental health services with a Plan Provider.

Lock-In Provision

You should be aware that the Lock-In provision of your Benefit Plan requires you to obtain all Covered Services from Plan Providers in your Primary Network. Lock-In means that Covered Services are available only through Plan Providers in the Primary Network affiliated with the Primary Care Provider you select. You may change your Primary Care Provider at any time by calling Member Services or by requesting the change in writing. The effective date of the change will be the 1st of the next month after your request is received. Please see "Changing Your Primary Care Provider" section.

Any care that is rendered as Emergency Services and Urgently Needed Services including during travel outside of the United States, or is Prior Authorized are excluded from this Lock-In provision. If you seek Routine Care, Durable Medical Equipment or Elective Medical Services, from Out-of-Network providers without a VHP-approved referral and/or Prior Authorization, VHP will not pay for your care, and you will be required to pay for the full cost of such services.

Receiving Hospital or Other Facilities Care

VHP is contracted with hospitals throughout its Service Area. Except in the case of Emergency Services or Urgently Needed Services, Hospital Services must be Authorized by VHP.

To receive any Medically Necessary hospital or facility Covered Services, your PCP will arrange for all Covered Services in a Plan Hospital or Plan Facility within your Primary Network. Such services include for example, inpatient, transitional, and/or care provided in a sub-acute or Skilled Nursing Facility. Authorization is required for all hospital and facility care. VHP should be notified of any such care either prior to admission or, as in the event of an emergency, as soon as possible thereafter.

In the rare event Covered Services are not available at a Plan Hospital or Plan Facility within your Primary Network, your PCP will arrange with VHP for a Prior Authorized referral. If you receive services without a Prior Authorization, or if you receive services outside of your Primary Network, you may be financially responsible for the charges.

In the event of an emergency and you cannot safely go to a Plan Hospital, you should **call 911** or seek care at the closest hospital. Please refer to the "Emergency Services" section of this EOC.

In order to determine the contracted hospitals and other facilities, please refer to VHP "Provider Search" at **https://vhpservices.sccgov.org/**.

Receiving Care While Out-of-Network/Service Area

Before leaving the Service Area, it is important that you obtain any care (such as Routine Care or foreseeable care for Serious Chronic Conditions) that you know will be needed before you return. For example, if you require routine dialysis or oxygen therapy and know that you will require a treatment during your absence, you should either arrange to obtain the necessary therapy prior to leaving the Service Area or work with your PCP and VHP to obtain Prior Authorization for this care from a Non-Plan Provider while you are Out-of-Network/Service Area.

Services that you receive while Out-of-Network/Service Area that can be foreseen and have not been Prior Authorized, are not considered Urgently Needed Services

or Emergency Services. If you delay receiving or arranging for this care until you are Out-of-Network/Service Area, VHP will not pay for your care, and you will be financially responsible for the full cost of such services.

In the event of Urgently Needed Services, call the 24/7 Nurse Advice Line at **1.866.682.9492 (toll-free).** The advice nurse will assess your condition and direct you to the appropriate care. The Nurse Advice Line telephone number is printed on your VHP ID Card. You should also notify VHP at **1.888.421.8444 (toll-free)** and as needed, leave a message. Refer to the "Emergency Services" and "Urgently Needed Services" sections. In the event of an Emergency, **call 911** or go to the nearest emergency room.

Receiving Health Care at an In-Network Facility by an Out-of-Network Provider

In some cases, a Non-Plan Provider may provide Covered Services at an in-network facility where we have Authorized you to receive care. You are not responsible for any amounts beyond your cost share for the Covered Services you receive at Plan Facilities where we have Authorized you to receive care.

Second Medical Opinions

Second opinions are available with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, a Non-Plan Physician may be Prior Authorized to provide a second opinion. For purposes of "Second Medical Opinions", an "appropriately qualified medical professional" is a physician who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion. Second opinions with Non-Plan Physicians, when Authorized by VHP, are *approved for a single consultation only*. Ongoing treatment for your medical condition must be completed by a Plan Physician.

Here are some examples of when a second medical opinion may be Authorized:

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or Medically Necessary.
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions.
- The clinical indications are not clear or are complex and confusing.
- A diagnosis is in doubt due to conflicting test results.
- The Plan Physician is unable to diagnose the condition.
- The current treatment plan is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care.
- You have concerns about the diagnosis or plan of care.

If you want to request a second medical opinion, your VHP PCP, your VHP Provider, or VHP Member Services Representative can help you make the necessary arrangements. As needed, they can help you select any provider of your choice within the Plan Physician Network of the same or equivalent specialty. Decisions regarding second medical opinions requests will be determined and notification to the Member and provider will be given within the following time limits:

Emergency Services Request	Within two to six hours
Urgently Needed Services Request	Within 24 hours
Routine Request	Within five business days

If you are seeking an Emergency Services second medical opinion after normal business hours, call VHP's 24/7 Nurse Advice Line at **1.866.682.9492 (toll-free)**. On the next business day, call VHP's Member Services Department at **1.888.421.8444 (toll-free).** The Member Services Department will help resolve your concern or if necessary, assist you in filing a Grievance as outlined in the "Member Services Representative" section under "How Do I Get Help?" section. In addition, you may also contact the California Department of Managed Health Care's Health Plan Division. Refer to the section "Department of Managed Health Care Consumer Helpline" for more details.

Continuity of Care

If a Member have an Acute Condition, a Serious Chronic Condition, a Pregnancy, a Terminal Illness, a Maternal Mental Health Condition, or your newborn child between birth and 36 months is under medical care, you may be eligible to continue to receive treatment from your provider (e.g., physician or hospital) if:

- Your treating Plan Provider terminates as a VHP Plan Provider.
- You are receiving care from a non-participating provider at the time of your enrollment in VHP.

You have the right to request a copy of VHP's continuity of care policy. To request a copy of this policy, call VHP's Member Services Department at **1.888.421.8444 (toll-free).**

Continuity of care Covered Services will be provided to qualified Members from their provider. Treatment will be provided in a timely and appropriate basis as determined by the Plan Physician. In the case that the Member is pregnant, continuity of care Covered Services will be provided until postpartum services related to the delivery are complete or until such time as it is deemed appropriate. Plan Providers will consult with the Member's provider to determine when it is safe to transfer.

Completion of Covered Services following termination of a Plan Provider or enrollment in the Plan:

- For an Acute Condition shall be provided for the duration of the Acute Condition.
- For a Serious Chronic Condition shall be provided for a period necessary to complete the course of treatment and to arrange for a safe transfer to a Plan Provider. Completion of Covered Services shall not exceed 12 months.
- For a Pregnancy shall be provided for the duration of the Pregnancy.
- For a Maternal Mental Health Condition that impacts a person during pregnancy, peri or postpartum, or that arises during pregnancy, in the peri or postpartum period, completion of Maternal Mental Health Covered Services shall not exceed 12 months from the diagnosis or from the end of pregnancy, whichever occurs later.

- For a Terminal Illness Covered Services shall be provided for the duration of the Terminal Illness. Terminal Illness for continuity of care purposes is defined as an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of Covered Services shall be provided for the duration of a Terminal Illness, which may exceed 12 months from the Plan Provider contract termination date or 12 months from the Effective Date of Coverage for a new Member.
- For the care of a newborn child between birth and age 36 months, completion of Covered Services shall not exceed 12 months.
- For the performance of a surgery or other procedure that is Authorized by VHP as part of a documented course of treatment and has been recommended and documented by the current provider at the time of enrollment or Plan Provider termination. Completion of such surgical Covered Services must occur within 180 days.

Continuity of care is only provided if you are a new Member or your provider is a terminated VHP Provider, when:

- The delay in the provision of services will result in loss of continuity of care.
- The services for the condition are otherwise Medically Necessary covered Benefits under the terms of your Coverage with VHP when provided by Plan Providers.
- The services are provided within the Service Area.
- Your Coverage with VHP is in effect.
- The terminated Provider or Out-of-Network provider signs a new temporary contract with VHP, and the terminated Provider was not terminated by VHP for reasons other than medical disciplinary cause, criminal activity, or the provider’s voluntary termination.

Your Coverage with VHP does not include an Out-of-Network option.

To apply for continuity of care Covered Services, call VHP’s Member Services Department at **1.888.421.8444 (toll-free)** to inform VHP that your Plan Provider has terminated or when your Plan Provider notifies you that they are terminating from VHP. For the hearing and speech impaired, **call the California Relay Service (CRS) by simply dialing 711 or the 800 CRS number of your modality**.

Independent Medical Review

One of VHP's principal exclusions is health care services that are not Medically Necessary. The determination whether a service or supply is Medically Necessary is made by VHP's Medical Director or designee based on an objective review. All decisions are subject to the Department of Managed Health Care's (DMHC) Grievance procedures. If VHP denies your health care services because such care was determined not to be Medically Necessary, you, your designee, or your doctor may request an Independent Medical Review (IMR). Before initiating an IMR, you must have completed the VHP Grievance or have participated in the VHP Grievance process regarding a Disputed Covered Service for at least 30 days. In the case of a Grievance that requires expedited review, you will not be required to participate in the VHP Grievance process for more than three days. See the section entitled "Member Grievances" for more detailed information about VHP's Grievance process.

The DMHC Help Center operates the Independent Medical Review Program, which is a review process conducted by health care professionals who are not associated with VHP. These doctors and other health care professionals outside VHP make an independent decision about your health care.

You must submit a request for an IMR to the DMHC within six months of receiving a written resolution response from VHP on your Grievance. You may only request a review for a service that is a Covered Service. You can obtain more information about the IMR process on DMHC's website at **www.dmhc.ca.gov** in the section entitled "Frequently Asked Questions" or by calling a VHP Member Services Representative at **1.888.421.8444 (toll-free).**

If services are denied because they are considered Experimental or Investigational Treatment, which are a non-covered Benefit, you have the right to request an IMR from the DMHC without first participating in the VHP's Grievance process. The IMR request for review of Experimental or Investigational Treatment must meet all the following criteria:

- You have a Life-Threatening or Seriously Debilitating condition;
- Your physician certifies that you have a Life-Threatening or Seriously Debilitating condition, for which standard therapies have not been effective in improving your condition, for which standard therapies would not be medically appropriate for you, or for which there is no more beneficial standard therapy covered by VHP than the proposed therapy in the following bullet point;

- Your physician, who is under contract with or employed by VHP, has recommended a drug, device, procedure, or other therapy that the physician certifies in writing is likely to be more beneficial to you than any available standard therapies, OR you, or a physician who is a licensed, board-certified or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two medical and scientific evidence documents, is likely to be more beneficial for you than any available standard therapy. The physician certification shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation. Nothing in this subdivision shall be construed to require VHP to pay for the services of a nonparticipating physician provided pursuant to this subdivision, that are not otherwise covered pursuant to the VHP contract;
- You have been denied Coverage by VHP for a drug, device, procedure, or other therapy recommended or requested pursuant to the above bullet point;
- The specific drug, device, procedure, or other therapy recommended would be a Covered Service, except for VHP's determination that the therapy is experimental or investigational.

Nothing in this section shall preclude a Member from seeking assistance directly from the DMHC in cases involving imminent or serious threat to the health of the Member or where the DMHC determines an earlier review is warranted. In such cases, the DMHC may require VHP and Plan Providers to expedite the delivery of information.

Chapter 7: Prescription Drugs, Medications and Pharmacy Services

VHP Formulary

VHP's Plan Providers use a comprehensive drug Employer Drug Formulary that includes FDA-Approved Drugs (Brand Name Drugs and Generic Drugs). Your PCP and other Plan Physicians coordinate your health care to determine when you need medication and the proper dosage. Although a drug may be on the Employer Drug Formulary, it does not guarantee that your Plan Prescribing Provider will prescribe the drug. If the Prescribing Provider specifies "Do Not Substitute" and a generic equivalent drug is available, the Prescription is subject to the Prior Authorization process. Upon review by VHP's Medical Director or designee, the generic equivalent drug may be dispensed by a Plan Pharmacy. Refer to "Generic Equivalents to Brand Name Drugs" section of this EOC.

The VHP Employer Drug Formulary is used as a reference for all health professionals who share the responsibility for the management of patient care, including VHP Members. VHP delegates the Employer Drug Formulary drug selection process to its Pharmacy and Therapeutics (P&T) Committee. The P&T Committee usually consists of healthcare providers involved in prescribing, dispensing, and administering medications, as well as administrators who evaluate medication use. The P&T Committee utilizes an evidence-based approach bringing up-to-date research to support medical decision-making. The goals of the P&T Committee are to ensure and promote Medically Necessary, clinically appropriate, safe, and cost-effective drug therapy. Decisions emanating from the P&T Committee are communicated to Members and Plan Providers involved in health care decisions for VHP Members.

Medically Necessary Prescription Drugs are limited to:

- Drugs approved by the FDA,

- Generic equivalents approved as substitutable by the FDA,
- Biosimilars approved by the FDA,
- Drugs approved by the FDA as Treatment Investigational New Drugs, or drugs classified as group C cancer drugs by the National Cancer Institute to be used only for the purposes approved by the FDA or the National Cancer Institute are excluded from the Benefit Plan.

VHP's Employer Drug Formulary is prepared for publication by VHP's Pharmacy Benefits Manager (PBM) under the direction of the P&T Committee. Additions and deletions to the Employer Drug Formulary, which occur throughout the year by action of the P&T Committee, are conveyed to the PBM. The PBM serves as the customer service center to address Plan Provider and Member pharmacy questions as appropriate.

To identify whether a specific drug is on VHP's Employer Drug Formulary or to obtain a copy of the Employer Drug Formulary, or request information on the appropriate Coverage, call VHP's PBM at **1.866.333.2757 (toll-free).** For additional information go to **https://www.valleyhealthplan.org/providers/pharmacy** or call VHP's Member Services Department at **1.888.421.8444 (toll-free)**. You are entitled to receive information about your Prescription Drug Coverage upon request. This information includes your eligibility for a Prescription, a copy of the current Employer Group Formulary, any applicable cost sharing for the Prescription, Employer Group Formulary alternatives and any variance in cost sharing based on the provider and your preferred retail or mail order pharmacy.

At the Time of Your Enrollment

If you are taking Prescription Drugs at the time you enroll with VHP, please make an appointment with your PCP for evaluation of your current medication(s) and your continuing care. If your Plan Provider determines that you need a Prescription, you will receive either a Prescription for your current medication or a new Prescription for a drug from the Employer Drug Formulary that is equally effective.

Prescription Drugs

Prescription Drugs must be written and dispensed by a Plan Pharmacy for a condition, illness, or injury covered by VHP's Plan Benefits. Drugs listed in the VHP

Employer Drug Formulary are covered when dispensed by Plan Pharmacies and prescribed by a Plan Provider or a provider rendering Emergency Services or Urgently Needed Services. Employer Drug Formulary drugs may require Prior Authorization from VHP to be covered. The fact that a drug is listed in the Employer Drug Formulary does not guarantee that your Plan Provider will prescribe it for you for a particular medical condition.

Tier 0: Healthcare Reform Drugs

Refer to the "Preventive Drugs (Healthcare Reform Drugs) and Contraceptive" section.

Tier 1: Generic Drugs, low-cost Preferred Brand Drugs

Tier 2: Brand Drugs

When you receive a Prescription from your Plan Provider you must have it filled at a Plan Pharmacy. Your Plan Provider will follow VHP's Employer Drug Formulary and coordinate your health care to determine when you need medication and the proper dosage. Visit VHP's website at **www.valleyhealthplan.org** for the detail of the Employer Drug Formulary.

Generic Equivalents to Brand Name Drugs

A Generic Drug will be dispensed in place of a Brand Name Drug when a Generic Drug equivalent is available. If the Plan Physician specifies "Do Not Substitute" and a generic equivalent drug is available, the Prescription is subject to the Authorization process. Upon review by the Medical Director, the generic equivalent drug may be dispensed by the Plan Pharmacies.

Off-Label Drugs

When a Prescription Drug is prescribed for a use that has not been approved by the Food and Drug Administration, your Plan Provider must submit documentation addressing this off-label use for your condition. The Prescription Drug may be covered only if the drug meets all of the following:

- The drug is approved by the Food and Drug Administration.
- The drug is prescribed by a participating licensed health care professional for the treatment of a Life-Threatening condition; or the drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is Medically Necessary to treat that condition, and the drug is on the formulary. If the drug is not on the formulary, the participating subscriber's request shall be considered pursuant to the process required by Health and Safety Code 1367.24.
- The drug has been recognized for treatment of that condition by any of the following:
  - The American Hospital Formulary Service's Drug Information.
  - One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen: The Elsevier Gold Standard's Clinical Pharmacology, the National Comprehensive Cancer Network Drug and Biologics Compendium, or the Thomson Micromedex DrugDex.
  - Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

For purposes of this section, "chronic and seriously debilitating" means diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

The provision of drugs and services when required by this section shall not, in itself, give rise to liability on the part of VHP. Nothing in this section shall be construed to prohibit the use of a formulary, Copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Food and Drug Administration.

If VHP denies coverage pursuant to this section on the basis that its use is experimental or investigational, you can request a Member Grievance (see "Member Grievances" section) or external exception requests.

External Exception Requests

The external exception request review process applies to a denial of a Prior Authorization or Step Therapy exception request. You have a right to request a review from an independent medical review organization. Please submit a copy of your denial notice and a brief explanation of your situation, and other relevant information to your health plan. Please indicate that you are requesting an external exception request. You will receive a determination within 24 hours upon receipt of your request for a request based on Exigent Circumstances and 72 hours for standard external exception requests.

Diabetic Drugs and Supplies

Prescription Drugs for the treatment of diabetes are covered as stated in the Employer Drug Formulary, which include insulin, prescriptive medications for the treatment of diabetes, and glucagon. Selected brands of diabetic supplies are also covered under the Prescription Drug Employer Drug Formulary including, but not limited to, blood glucose monitors (including those designed to assist the visually impaired), blood glucose and ketone testing strips, lancets and lancet puncture devices, pen delivery systems for injecting insulin and insulin needles and syringes. Insulin pumps and related supplies (such as infusion sets, syringe with needle) are covered under the medical Benefit. For diabetics who are visually impaired, Medically Necessary visual aids (excluding eyewear) to assist with proper dosing of insulin are covered. See “Vision Therapy, Eyeglasses and Contact Lenses” section.

Over-the-counter (OTC) drugs, medications, and supplies are not Covered Services, except as specified in the Employer Drug Formulary.

Drugs and Equipment for the Treatment of Asthma

Prescription Drugs for the treatment of asthma are covered as stated in the Employer Drug Formulary. Spacer and peak flow meters are covered when Medically Necessary through your Plan Pharmacy. Continuous positive airway pressure (CPAP), nebulizers, and respiratory therapy supplies, are covered under the medical Benefit. Refer to the “DME for Home Use” section of this EOC.

Smoking Cessation Coverage

Drugs for treatment of smoking cessation are a Covered Service. A Prescription is required from the treating Prescribing Provider. There is no annual limit on number of days for the course of treatment for all FDA-Approved Drugs, including smoking and tobacco cessation medications. Refer to the Employer Drug Formulary for a list of covered products. For information on smoking cessation support programs available through VHP, contact VHP's Member Service Department at **1.888.421.8444 (toll-free).**

Compounded Drugs

Compounding is a process of combining, mixing, or altering two or more drugs by a pharmacist to create a medication tailored to the needs of an individual when no FDA-Approved Drug is available that meets Medical Necessity. Compounded drugs can be in the form of cream/ointment, capsule, tablet, solution, suppository, or other form. Compounded drugs are not FDA approved, but compound drugs that use FDA-Approved Drugs for an FDA indication are covered when no FDA approved product is commercially available. Refer to the "Off-Label Drugs" section of this EOC.

Sexual Dysfunction Drugs

Prescription Drugs prescribed for sexual dysfunction to establish, maintain or enhance sexual function are covered when Medically Necessary. The Prescription Drugs are covered as specified in the Employer Drug Formulary. For information about the Employer Drug Formulary, visit **www.valleyhealthplan.org** or call VHP's Member Services Department at **1.888.421.8444 (toll-free).**

Infertility Drugs

Prescription Drugs for the treatment of infertility are covered when a Plan Provider prescribes them for a Covered Service and the Member meets the Prior Authorization criteria for the Prescription Drugs. Refer to "Infertility Diagnosis and

Treatment" section of this EOC. For a list of covered drugs, refer to the Employer Drug Formulary.

Preventive Drugs (Healthcare Reform Drugs) and Contraceptives

Preventive drugs include but not limited to the following: prenatal vitamins, fluoride preparations, iron preparations generic immediate release single ingredient products, tobacco cessation products, tamoxifine/raloxifine, statins (lower Strengths), bowel preparation, and medications recommended by the United States Preventive Services Task Force grade A or B. Refer to the Employer Drug Formulary for a complete list of covered products.

VHP covers all FDA-approved contraceptive drugs, devices, and other products, including all FDA-approved contraceptive drugs, devices, and products available over-the-counter and they must be obtained at a Plan Pharmacy. Covered products include vaginal, oral, transdermal, and emergency contraceptives, which are FDA-Approved Drugs taken after sexual intercourse to prevent pregnancy. For a complete list of covered products, refer to the Employer Drug Formulary. Intrauterine devices (IUDs), injectable, and implantable contraceptives are covered under the medical Benefit when administered by a Plan Provider. Refer to "Family Planning Services" section of this EOC.

Over-the-Counter Drugs, Equipment and Supplies

Any over-the counter drug, medical equipment or supply that can be purchased without a Prescription is not covered, even if a Plan Physician writes a Prescription for such drug, equipment or supply unless listed in the Employer Drug Formulary. However, if a higher Dosage Form of an over-the-counter drug is only available by Prescription, that higher dosage drug may be covered when Medically Necessary.

Over-the-counter drugs, medical equipment and supplies (including insulin), that are available without a Prescription, are covered when prescribed by a Prescribing Provider for the management and treatment of diabetes, for preventive purposes in accordance with the U.S. Preventive Services Task Force A and B recommendations, as approved by the FDA. Refer to the Employer Drug Formulary.

For over-the counter Food and Drug Administration approved contraceptive drugs, devices and products, a Prescription shall not be required for over-the-counter Food and Drug Administration approved contraceptive drugs, devices, and products and will be covered at point-of-sale when provided at in-network pharmacy without cost sharing or medical management restrictions. For Coverage of self-administered hormonal contraceptives, VHP allows for dispensing up to 12-month supply at one time for a Member at an in-network pharmacy.

At Home COVID-19 Tests

Members are eligible for at home over-the-counter COVID-19 tests. Over-the-counter COVID-19 tests can be obtained at no cost through retail pharmacies and health centers approved by VHP, and purchased by you through pharmacies, stores, or online retailers, with your actual cost of test or $12 per test (whichever is lower) reimbursed by VHP after you submit a claim for reimbursement. We encourage Members to take advantage of our zero out-of-pocket cost over-the-counter COVID-19 tests available through approved retail pharmacies and approved health centers, as this option does not require Members to submit claims for reimbursement. You are entitled to eight individual over-the-counter COVID-19 tests per 30-day period. Additional tests are only payable by VHP if they are ordered by a provider.

For questions about zero-cost or reimbursed over-the-counter COVID-19 tests, please contact Member Services at **1.888.421.8444** or by emailing **MemberServices@vhp.sccgov.org**.

Appetite Suppressants or Drugs for Weight Reduction

Prescription Drugs for the treatment of obesity are covered when Medically Necessary or when you meet VHP's Prior Authorization requirements. Your Plan Provider must obtain Prior Authorization for Coverage consideration. Refer to the Employer Drug Formulary for covered products.

Surgically Implanted Drugs

Medically Necessary surgically implanted drugs are covered under the medical Benefit Plan and may be provided in an inpatient or outpatient setting.

Step Therapy

Step Therapy is a process specifying the sequence in which different Prescription Drugs for a given medical condition and medically appropriate for a particular patient are prescribed. VHP may require you to try one or more drugs to treat your medical condition before VHP will cover a particular drug for the condition pursuant to a Step Therapy request. If your provider submits a request for Step Therapy exception, VHP shall make exceptions to Step Therapy when the criteria is met.

Prior Authorization, Step Therapy Exception and Non-Formulary Process for Prescription Drugs

Prior Authorization may be required for a Prescription on VHP's Employer Drug Formulary. Prescription Drugs requiring Prior Authorization are identified in VHP's Employer Drug Formulary. VHP delegates the administrative processing of the Prior Authorizations to our PBM. The PBM evaluates the submitted information upon receiving your Plan Provider's request for Prior Authorization or Non-Formulary Drug and makes a determination based on established clinical criteria or off-label drug criteria for the medication being requested. The criteria used for Prior Authorization are approved by VHP's P&T. Your Plan Provider may contact VHP's PBM to obtain the usage guidelines for specific medications. Refer to the "Off-Label Drugs" section of this EOC.

Your Plan Provider must get approval from VHP's PBM before prescribing for a Prescription Drug that is indicated on the Employer Drug Formulary as requiring a Prior Authorization. A list of drugs requiring Prior Authorization is available in the Employer Drug Formulary and can be obtained by contacting VHP's Member Service Department at **1.888.421.8444 (toll-free)** or visiting **www.valleyhealthplan.org**.

Medically Necessary Non-Formulary Drugs may be covered if your Plan Provider obtains Authorization from VHP's PBM. Your Plan Provider must get approval from VHP's PBM before prescribing a medication that is not listed on the Employer Drug Formulary.

Requests for drugs with Prior Authorization, Step Therapy exception, or Non-Formulary may be submitted electronically or by facsimile, must be completely filled out by the prescriber on the "Prescription Drug Prior Authorization or Step Therapy Exception Request Form" with information that supports the request, then

submitted electronically or by facsimile to the PBM. The form will be reviewed and approved based on established Medical Criteria and/or Medical Necessity and the Member and provider will receive communication with the decision. There may be situation where it may be Medically Necessary for you to receive certain medications without first trying an alternative drug. VHP will grant a Step Therapy exception if your provider submits justification and clinical documentation supporting the provider's determination that the required Prescription Drug is inconsistent with good professional practice for provision of Medically Necessary Covered Services to you, taking into consideration your needs and medical history, along with the professional judgment of your provider. If the provider bases its determination of the criteria listed below, VHP will grant the request.

The basis of your provider's determination may include, but is not limited to, any of the following criteria:

- The required Prescription Drug is contraindicated or is likely, or expected, to cause an adverse reaction or physical or mental harm to you in comparison to the requested Prescription Drug, based on the known clinical characteristics of you and the known characteristics and history of your Prescription Drug regimen.
- The required Prescription Drug is expected to be ineffective based on the known clinical characteristics of you and the known characteristics and history of your Prescription Drug regimen.
- You have tried the required Prescription Drug while covered by VHP or your previous health coverage or Medicaid, and that Prescription Drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse reaction. VHP may require the submission of documentation demonstrating that you tried the required Prescription Drug before it was discontinued.
- The required Prescription Drug is not clinically appropriate for you because the required drug is expected to do any of the following, as determined by your Prescribing Provider:
    - Worsen a comorbid condition.
    - Decrease the capacity to maintain a reasonable functional ability in performing daily activities.
    - Pose a significant barrier to adherence to, or compliance with, your drug regimen or plan of care.

- You are stable on a Prescription Drug selected by your Prescribing Provider for the medical condition under consideration while covered by VHP or your previous health coverage or Medicaid.

Once the PBM receives a completed "Prior Authorization and Step Therapy Exception Request" form, the PBM must follow the timeline below:

- The "Prescription Drug Prior Authorization or Step Therapy Exception Request Form" request will be turned around within 72 hours for nonurgent requests, and within 24 hours if Exigent Circumstances exist, upon receipt of a completed Prior Authorization request from a Prescribing Provider.
- If the Plan fails to respond to a completed "Prescription Drug Prior Authorization or Step Therapy Exception Request Form" within 72 hours of receiving of a nonurgent request and 24 hours of receiving an Exigent Request, the request shall be granted for the duration of the Prescription including refills.
- Exigent Circumstances exist when you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function or when you are undergoing a current course of treatment using a Non-Formulary Drug.

Once a medication is approved, its Authorization becomes effective immediately.

All "Limitations and Exclusions" for Prescription Drugs and the requirements of the Employer Drug Formulary also apply to drugs filled at an Out-of-Network pharmacy.

Plan Pharmacies

VHP is contracted with major pharmacies, supermarket-based pharmacies, and independent pharmacies throughout California. Major pharmacies and supermarket-based pharmacies are also available throughout the United States. For a pharmacy location near you, visit VHP's website at **www.valleyhealthplan.org** or call VHP's Member Service Department at **1.888.421.8444 (toll-free).**

When filling a Prescription at a Plan Pharmacy, present your VHP ID Card and the Prescription to the pharmacist. The Plan Pharmacy will dispense up to, but no more than, a 90-day supply for Serious Chronic Conditions. For Brand Name Drugs, if your Plan Provider prescribes the Brand Name Drug and you have not obtained the

Brand Name Drug from VHP on your first fill with VHP, you will receive a 30-day supply. Subsequent refills can be more than a 30-day supply. If your Prescription stipulates a 30-day supply for the original order and subsequent refills, your Plan Pharmacy may dispense the 30-day supply at the appropriate time intervals. You may be required to pay a Copayment. The Pharmacy will advise you of all charges which are your responsibility to pay.

All Prescriptions must be filled by Plan Pharmacies. Your pharmacy Benefit is limited to Prescriptions filled at a Plan Pharmacy. Only Prescriptions from emergency or Urgent Care services will be covered at an outside pharmacy when a Plan Pharmacy is not available. Should you need to obtain a Prescription associated with Emergency Services or Urgently Needed Services, take your Prescription to a Plan Pharmacy. If a Plan Pharmacy is not available or in close proximity, VHP will cover the Prescription filled at an Out-of-Network pharmacy. You must submit your manual claim with receipt to the Pharmacy Benefit Manager or VHP for payment.

Maintenance Drugs

A maintenance drug is prescribed for a Serious Chronic Condition or illness. The Plan Pharmacy can dispense up to a 90-day supply for Employer Drug Formulary medications that are listed on the Maintenance Drug List. For Members starting a new brand maintenance drug, the Member can receive a 30-day supply for the first fill. Not all drugs on the Maintenance Drug list are covered on the Employer Drug Formulary. Refer to the Employer Drug Formulary for further information.

Prescription Drugs Dispensed via Mail Order

You may choose to have your maintenance Prescription Drug mailed to your home through VHP's Mail Service Pharmacy. You will not be charged for delivery through VHP's designated mail order administrator. If your request for mail order cannot be filled through the Mail Service Pharmacy, the mail order administrator may contact you. It is important that your telephone numbers and mailing address are up to date at the Mail Service Pharmacy. If you need to change the mailing address for your Prescription, call the Mail Service Pharmacy at **Phone: 1.800.607.6861 (toll-free)**. Once a Prescription is filled by the Mail Service Pharmacy, the Prescription cannot be transferred to another Plan Pharmacy. Contact VHP's PBM at **1.866.333.2757 (toll- free).** For additional information go to

www.valleyhealthplan.org or contact VHP's Member Services Department at **1.888.421.8444 (toll-free).**

The mail order administrator may dispense up to a 90-consecutive calendar day supply of a covered maintenance drug and each refill allowed by that Prescription. In some cases, a 90-consecutive calendar day supply of medication may not be an appropriate drug treatment plan according to the FDA or VHP's usage guidelines. If this is the case, the Mail Services Pharmacy may dispense less than a 90-consecutive calendar day supply.

Schedule II narcotic drugs are not covered through the Mail Services Pharmacy. For more information go to VHP's website at **www.valleyhealthplan.org** or call VHP's Member Services Department at **1.888.421.8444 (toll-free).**

Prescription Fill Options Plan Pharmacies

You have the option to contact your Plan Pharmacy to have your Prescription refilled. Information regarding your Prescription is on your Prescription label.

Mandatory Specialty Pharmacy Drugs

Certain Employer Drug Formulary medications, brand or generic, are classified as mandatory specialty pharmacy (MSP) drugs by VHP's P&T Committee and are provided exclusively through VHP's designated mandatory specialty pharmacies. MSP drugs may require specialized delivery and administration on an ongoing basis. MSPs are often for chronic conditions and involve complex care issues that need to be monitored and managed. The specialty pharmacies have a dedicated team of pharmacists, specialty technicians, patient care coordinators and/or nurses available to address your therapy and drug support needs. Specialty drugs are available for a maximum of a 30-day supply.

Outpatient Infusion Therapy

Outpatient infusion therapy used to administer covered drugs and other substances by injection or aerosol is covered when Medically Necessary for your illness, injury or condition and will be covered for the number of days determined Medically Necessary to treat the illness, injury or condition.

Infusion therapy can include:

- Total parenteral nutrition (TPN) (nutrition delivered through the vein);
- Injected or intravenous antibiotic therapy;
- Chemotherapy;
- Injected or intravenous pain management;
- Intravenous hydration (substances given through the vein to maintain the patient's fluid and electrolyte balance, or to provide access to the vein), and other therapeutic injected or intravenous drugs;
- Aerosol therapy (delivery of drugs or other Medically Necessary substances through an aerosol mist); and
- Tocolytic therapy to stop premature labor.

Covered Services include professional services (including clinical pharmaceutical support) to order, prepare, compound, dispense, deliver, administer, or monitor covered drugs or other covered substances used in infusion therapy.

Covered supplies include injectable Prescription Drugs or other substances which are approved by the California Department of Health or the FDA for general use by the public. Other Medically Necessary supplies and Durable Medical Equipment (DME) necessary for infusion of covered drugs or substances are covered.

All services must be billed and performed by a Plan Provider licensed by the State. Only a 30-day supply will be dispensed per delivery.

Infusion therapy Benefits will not be covered in connection with the following:

- Infusion medication administered in an outpatient hospital setting that can be safely administered in the home or a non-hospital infusion suite;
- Non-Prescription Drugs or medications;
- Any drug labeled "Caution, limited by Federal Law to Investigational Use" or Experimental or Investigational Treatment, including drug therapy not approved by the FDA;
- Drugs or other substances obtained outside of the United States;
- Homeopathic or other herbal medications not approved by the FDA;

- FDA-Approved Drugs or medications prescribed for indications that are not approved by the FDA, or which do not meet Generally Accepted Standards of Medical Practice (except for non-investigational FDA-Approved Drugs used for off-label indications); or
- Payment of Benefits will be reduced as set forth in this EOC if Prior Authorization is not obtained for outpatient infusion therapy.

Immunizations and Injections

Immunizations and injections that are administered by a Plan Provider in the office setting are Covered Services.

Self-injectable drugs (other than insulin) and needles and syringes used with these self-injectable drugs considered MSPs are subject to Prior Authorization and must be obtained through VHP's mandatory specialty pharmacy. Self-injectables drugs may be limited to a 30-day supply or less. Your Plan Provider will coordinate the Authorization and upon approval, the mandatory specialty pharmacy will arrange for the dispensing of the drugs, needles, and syringes.

Immunizations for travel purposes are covered. Refer to the "Travel Services" section in this EOC.

Lost or Misplaced Medications

You may be financially responsible for lost or misplaced medications. The Pharmacy Benefits Manager or pharmacist will advise you of all charges. For more pharmacy
information, visit **www.valleyhealthplan.org/members/pharmacy** or call VHP Member Services at **1.888.421.8444 (toll-free).**

Chapter 8: Medical Benefits and Prior Authorizations

VHP offers Members a comprehensive range of Benefits. This section describes the Covered Services that are available through your Benefit Plan and a summary of when Covered Services require Prior Authorization.

Prior Authorization Grid for VHP Members

This table below reflects services that require Prior Authorization and is not intended to be a comprehensive list of Covered Services.

Those services will require a Prior Authorization if the services are listed in the grid below. For a complete list of covered Benefits, you should refer to the appropriate descriptions below:

Category of Service	Service Requiring Prior Authorization
Behavioral Health	• All admissions for: ○ Acute inpatient psychiatric ○ Partial hospital psychiatric ○ Residential mental health ○ Substance Use Disorder, including detoxification • Applied Behavior Analysis (ABA) Services • Electroconvulsive Therapy (ECT) • Intensive Outpatient Program (IOP) • Psychological testing • Office-based opioid treatment and withdrawal management
Durable Medical Equipment (DME)	• Bone stimulators • Breast pump – Hospital grade only

	• Baclofen pump, insulin pump, Continuous Glucose Monitoring Device (CGM) and supplies • Customized DME (e.g., diabetic shoes, compression sleeves) • DME repair services • Formula and enteral therapy • Hospital beds and mattress • Medical equipment and supplies over $500 (e.g., IV pole, syringes, catheters, wound care supplies, etc.) • Mobility devices and accessories (e.g., power wheelchairs, scooters, manual wheelchairs, motorized wheelchairs, cushion, foot and head rests) • Negative pressure wound therapy system or wound vac • Other specialty devices over $500 (e.g., Speech Generating Device) • Prosthetics and Orthotics over $500 • Respiratory equipment and supplies (e.g., oxygen, Bilevel Positive Airway Pressure (BiPAP), ventilators, airway clearance vest • Vision aids as treatment for aniridia and aphakia
Experimental/Investigational Treatment, Procedures, and Drugs	• Clinical trials • Investigational and experimental drug therapies • Investigational and experimental procedures • New technologies that are not FDA approved for use Non-FDA approved and/or off-label use drugs
Home Health/Hospice	• All home health services (registered nurse, physical, speech and occupational therapists, home health aide, etc.) • Home Intravenous (IV) Infusions

	• Hospice services
Inpatient Admissions	• All elective inpatient admissions and admissions via ED to: ○ Acute care hospitals ○ Long Term Acute Care Hospital (LTACH) • Rehabilitation and therapy Services: ○ Acute Inpatient Rehabilitation or Acute Rehabilitation Unit (AIR/ARU) ○ Skilled Nursing Facilities (SNF) ○ Subacute nursing facilities
Medications	• Infusion services • Injections (excluding immunizations) • Non-formulary Prescription Drugs
Non-Contracted Providers, Tertiary Providers, and/or Quaternary Providers	• All non-urgent/non-emergent medical or behavioral health services rendered by non-contracted providers, tertiary providers and/or quaternary providers such as Lucile Packard Children's Hospital, Stanford Children's Health, Stanford Health Care, and Stanford Hospital & Clinics
Outpatient Services and Procedures	• Acupuncture and chiropractic services after the initial 24 visits per Calendar Year • All outpatient procedures performed outside of a physician's office (e.g., amniocentesis, nerve conduction studies, varicose vein treatment) • All outpatient surgery (e.g., cataract surgery, tonsillectomy, abdominoplasty, panniculectomy, breast reduction and augmentation surgery) • Automated External Defibrillator (AED), holter, mobile cardiac telemetry monitoring services • CAR T-cell therapy

	• Cardiac and pulmonary rehabilitation • Chemotherapy and radiation treatment (e.g., brachytherapy, neutron beam therapy, proton beam therapy, Intensity-Modulated Radiation Therapy (IMRT), Stereotactic Body Radiation Therapy (SBRT), Stereotactic Radiosurgery (SRS), gamma-ray and cyberknife) • Dental surgery, dental anesthesiology service, jaw surgery and orthognathic procedures • Diagnostic imaging: ○ Bone density (DEXA scan) ○ Computerized Tomography Scans (CT) ○ Magnetic Resonance Angiography (MRA) ○ Magnetic Resonance Imaging (MRI) ○ Nuclear cardiology procedures (stress tests/treadmill) ○ Positron-Emission Tomography (PET/PET-CT) ○ Single-Photon Emission Computerized Tomography (SPECT) • Dialysis: all hemodialysis and peritoneal, Continuous Ambulatory Peritoneal Dialysis (CAPD), Automated Peritoneal Dialysis (APD), Continuous Cycling Peritoneal Dialysis (CCPD) • Gender affirming therapy and surgery • Genetic testing and counseling • Hyperbaric oxygen therapy • Infertility services • Neuropsychological testing • Non-routine laboratory, ultrasound and radiology services • Outpatient therapies (Physical Therapy (PT), Occupational Therapy (OT), Speech

	Therapy (ST)) after the initial 24 visits per each discipline per Calendar Year • Palliative Care services • Reconstructive procedures • Second opinions • Sleep studies • Spinal procedures, including all injections • Surgical implants (e.g., pacemaker, baclofen pump, neuro and spinal cord stimulators, cochlear auditory implant) • Temporomandibular Disorder (TMJ) Treatment • Unclassified procedures • Ventricular assist device
Transplants	• All transplants and related services
Non-Emergency Medical Transportation: Non-Interfacility	• Non-Emergency Medical Transport (NEMT) (including fixed-wing air transport)
Other	• All non-urgent/non-emergent services performed out-of-area • All Non-Covered Services • All services not covered by the Member's primary insurance and VHP is the secondary insurance • Any services that exceed the Benefit limit

Benefit Description Section

Acupuncture Services

Medically Necessary acupuncture services are covered through Plan Providers when referred by your PCP or VHP. No Prior Authorization required for the first 24 visits provided by the Plan Providers. Prior Authorization is required at 25th visit. If you seek care beyond the first 24 visits without Prior Authorization from VHP, you may

be financially responsible for all charges. Services that are not acupuncture related, such as herbal medicines, will be your financial responsibility.

Applicable Copayments apply. Visit the VHP website www.valleyhealthplan.org or call VHP's Member Services Department at **1.888.421.8444 (toll-free)** for a list of Plan Providers. For acupuncture services there is a $10/visit copay when referred by your Primary Care Provider. For additional Covered Services or Copayments information, refer to the "Summary of Benefits and Coverage" And "Schedule of Benefits and Coverage Matrix."

Acute Inpatient Rehabilitation Services

Acute Inpatient Rehabilitation Services provided in a Plan Facility that offers a physician-directed plan of rehabilitation care including physical therapy (PT), occupational therapy (OT), speech therapy (ST) and DME are covered by VHP. Benefits include a semi-private bed and board, nursing, social services, drugs, and medications dispensed for use during the rehabilitation center stay, x-rays, laboratory testing, supplies, blood, blood derivatives, and transfusions (Blood Bank), and DME ordinarily furnished by the rehabilitation center. Rehabilitation Services are provided in the amount, frequency, or duration, as the Plan Physician deems Medically Necessary. Coverage is limited to care that is not Custodial Care and as a practical matter, can only be provided on an inpatient basis. To obtain care, you must receive a written referral from your VHP Plan Provider to a Plan Facility and Prior Authorization from VHP.

Arrangements for a private room are excluded from your Benefit Plan unless Medically Necessary and ordered by your Plan Physician. If you request a private room, you must pay the difference between the Plan Facility's charge for a private room and a semi-private room.

Rehabilitation Services are provided as Medically Necessary. Limits on habilitative and rehabilitative services and devices shall not be combined.

Adult Periodic Health Examinations

Adult periodic health examinations include immunizations, diagnostic services, Pap Smears, Prostate Specific Antigen (PSA) tests, all medically accepted cancer screening tests and all preventive services recommended by the US Preventive

Services Task Force, A and B including preventive care and screenings supported by Health Resources and Services Administration, and immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. There is no cost sharing for preventive services.

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. The Plan will also provide Coverage without cost sharing for the required colonoscopy for a positive result on a test or procedure, other than a colonoscopy, that is a colorectal cancer screening examination or laboratory test identified assigned either a grade of A or B by the United States Preventive Services Task Force.

Allergy Testing and Treatment

Allergy testing and treatment, including allergy serum and injection services. Treatment requires a written referral and a Prior Authorization from VHP.

Ambulance Services

In the event of an Emergency Medical Condition that requires an emergency response, you are encouraged to use the “911” emergency response system in areas where the system is established and operating for emergency transportation. In the event of an emergency where no “911” response service is available, go to the nearest hospital by the most appropriate means available to you. Ambulance services, including air ambulance, are Covered Services when used in accordance with the services as outlined in the “Emergency Services” and “Urgently Needed Services” sections.

You shall not pay more than the in-network cost sharing amount for Out-of-Network air ambulance services.

Biofeedback

Coverage for biofeedback therapy is limited to Medically Necessary treatment of certain physical disorders, such as incontinence and chronic pain, and as otherwise Prior Authorized by VHP. Biofeedback is also covered as Medically Necessary Treatment of a Mental Health or Substance Use Disorder.

Blood

Blood transfusions, including blood processing, the cost of blood, unreplaced blood and blood products, are Covered Services. Self-donated (autologous) blood transfusions are covered only for a surgery that has been Authorized and scheduled. VHP does not cover treatments which use umbilical cord blood, cord blood stem cells or adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be Experimental or Investigational in nature.

Chiropractic Services

Chiropractic services are covered through the Plan Providers when referred by your PCP or VHP. No prior authorization is required for the first 24 visits provided by the Plan Providers. Prior Authorization is required at the 25th visit. If you seek care beyond the first 24 visits without Prior Authorization from VHP, you may be financially responsible for all charges. Services that are not chiropractic related, such as nutritional counseling will be your financial responsibility.

Applicable Copayments apply. Visit the VHP website **www.valleyhealthplan.org** or call VHP's Member Services Department at **1.888.421.8444 (toll-free)** for Plan Providers. For chiropractic services there is a $10/visit copay when referred by your Primary Care Provider. For additional Covered Services or Copayments information, refer to the "Summary of Benefits and Coverage" and "Schedule of Benefits and Coverage Matrix."

Clinical Trial Services

Qualified Members may participate in an approved clinical trial conducted by a Plan Provider. An approved clinical trial means a phase I, phase II, phase III, or phase

IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another life-threatening disease or condition that meets at least one of the following:

(A) The study or investigation is approved or funded by one or more of the following:

(i) The National Institutes of Health

(ii) The Centers for Disease Control and Prevention

(iii) The Agency for Healthcare Research and Quality

(iv) The Centers for Medicare and Medicaid Services

(v) A cooperative group or center of any of the entities described in clauses (i) to (iv), inclusive, the Department of Defense, or the United States Department of Veterans Affairs

(vi) A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants

(vii) One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health, and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

(I) The United States Department of Veterans Affairs;

(II) The United States Department of Defense; or

(III) The United States Department of Energy.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.

(C) The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration.

“Life-threatening disease or condition” means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Qualified Member" means an enrollee who meets both of the following conditions:

(A) The Member is eligible to participate in an approved clinical trial, according to the clinical trial protocol, for the treatment of cancer or another life-threatening disease or condition.

(B) Either of the following applies:

(i) The referring health care professional is a participating provider and has concluded that the Member's participation in the clinical trial would be appropriate because the Member meets the conditions of subparagraph (A).

(ii) The Member provides medical and scientific information establishing that the Member's participation in the clinical trial would be appropriate because the Member meets the conditions of subparagraph (A).

Your Plan Physician or VHP will order or arrange for Prior Authorization of Covered Services. The cost sharing for routine patient care costs shall be the same as that applied to the same services not delivered in a clinical trial, except that the in-network and Out-of-Pocket Maximum shall apply if the clinical trial is not offered or available through a Plan Provider. Coverage is limited to routine patient care costs in accordance with State and federal Law. Participation is limited to approved clinical trials in California, unless the clinical trial is not offered or available through a participating provider in California.

COVID-19 Testing and Therapeutics

COVID-19 testing, vaccines and therapeutics are Covered Services. There is zero cost sharing for these services. No Prior Authorization is required for COVID-19 diagnostic and screening testing and for related health care services for granted emergency use authorization by the federal Food and Drug Administration.

Covered testing includes Members who:

- have symptoms of COVID-19
- have recent known or suspected exposure to SARS-CoV-2
- are asymptomatic and do not have recent known or suspected exposure to SARS-CoV-2 if the COVID-19 test reflects an individualized clinical assessment

In addition, no Prior Authorization is required for COVID-19 therapeutics if you test positive.

Dental Services

Dental services are limited to Medically Necessary Covered Services. Services must be Prior Authorized by VHP at a Plan Provider.

VHP does not provide dental insurance services for routine dental services covered through your employer's dental plan or as purchased through a dental plan carrier.

Outpatient Dental Services

Dental services include Prior Authorized Covered Services rendered in an outpatient setting by a Plan Provider for:

- Treatment or removal of tumors;
- Services or x-ray examinations (not in a dentist office) for the treatment of accidental injury to natural teeth;
- Services in connection with accidental fracture of the jaw; or
- Prescribed drugs for pain and antibiotics incidental to the dental procedure when obtained at a Plan Pharmacy.

Limitations and Exclusions apply. Routine, general dental services are not covered. Charges for the dental procedure itself, including, but not limited to, the professional fee of the dentist, items and services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth are Non-Covered Services.

Dental Services - Plan Facility or Plan Hospital

For dental procedures conducted at a Plan Facility or Plan Hospital, VHP covers general anesthesia and the Plan Facility's or Plan Hospital's services associated with the anesthesia if your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient center and the dental procedure would not ordinarily require general anesthesia. General anesthesia and associated facility charges are only covered for the following Members:

- Members who are under seven years of age.

- Members who are developmentally disabled, regardless of age.
- Members whose health is compromised and for whom general anesthesia is Medically Necessary, regardless of age.

Your Plan Physician or VHP will make Prior Authorized arrangements when Medically Necessary in a Plan Hospital or Plan surgery center. VHP does not cover any other services related to the dental procedure, such as the dentist's professional services.

VHP DOES NOT OFFER DENTAL INSURANCE. Charges for the dental procedures that are not related to the treatment of a Medically Necessary condition are excluded from your Benefit Plan. Covered Services are only available if you are under seven years of age, you are developmentally disabled (regardless of age) or your health is compromised, and general anesthesia is Medically Necessary (regardless of age). Prior Authorization is required from VHP for Medically Necessary Covered Services in a Plan Hospital or Plan Facility.

Drugs Prescribed by a Dentist

Prescription Drugs prescribed by a dentist for the management of pain and infection which are incidental to a dental procedure are Covered Services. Prescription Drugs prescribed by your dentist must be on VHP's Employer Drug Formulary and filled by a Plan Pharmacy. Other drugs prescribed by your dentist for purposes other than pain management and infection are not covered by VHP. Refer to the VHP Employer Drug Formulary for additional information.

Dermatology Services

Dermatology Services are Covered Services from a Plan Physician (dermatologist), including Routine Care and diagnostic, laboratory, and dermatological preparations.

Diagnostic Laboratory Services

Laboratory services are covered under your Benefit Plan when Medically Necessary. Diagnostic laboratory services including outpatient diagnostic X-ray, nuclear medicine, and laboratory services (including tests performed on an outpatient basis at your Plan Facility or hospital) are Covered Services.

Prior Authorization will not be required for biomarker testing for a Member with advanced or metastatic stage 3 or 4 cancer. Prior Authorization will also not be required for biomarker testing for cancer progression or recurrence in a Member with advanced or metastatic stage 3 or 4 cancer. Prior Authorization is required for the biomarker testing that is not FDA-approved therapy for advanced or metastatic stage 3 or 4 cancer.

Durable Medical Equipment - Medical Supplies and Equipment

Medical supplies and equipment are covered under your Benefit Plan through DME Plan Providers. Coverage is limited to the basic Medically Necessary item of equipment that adequately meets your medical needs.

Medically Necessary DME must be prescribed by a VHP Plan Provider. If Prior Authorization is required (e.g., DME and Prosthetic Devices) your PCP or Plan Provider will arrange for the provision of it. Covered Services include:

- DME;
- Corrective appliances;
- Prosthetic Devices;
- Prescription Orthotic Devices; and
- Oxygen and oxygen equipment.

Medical supplies are limited to equipment and devices which:

- Are ordered by a Plan Provider,
- Are intended for repeated use over a prolonged period,
- Are not considered disposable, with the exception of ostomy bags and diabetic supplies,
- Do not duplicate the function of another piece of equipment or device covered by VHP, and
- Are generally not useful to you in the absence of illness or injury.

Medically Necessary repair or replacement of medical supplies or equipment must be prescribed by your Plan Physician. VHP does not cover repair or replacement of

any covered items if the items are damaged or destroyed by Member misuse or lost. Any purchase or customization of your living environment or automobile (e.g., home ramps, swimming pools/ hot tubs, doorway enlargements, air conditioners, waterbeds, or any other equipment which could be used in the absence of an injury or illness) are excluded from your Benefit Plan. Braces or other devices primarily for use in athletic competition or recreational activities are excluded from your Benefit Plan.

Prescribed hearing aid Benefits are limited to once every 36 months and up to a Coverage maximum of $1,000, regardless of the number of hearing aids, ear molds or devices prescribed. Shoe inserts and over-the-counter medical supplies and equipment are excluded from your Benefit Plan. Over-the-counter items include but are not limited to garter belts and similar devices, and experimental or research equipment and devices not Medically Necessary.

DME for Home Use

Within the applicable Service Area, VHP covers DME for use in your home (or another location used as your home) in accordance with VHP's DME Formulary guidelines. DME for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home. Member cost sharing may apply.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered DME (including repair or replacement of covered equipment) must be supplied by a Plan Provider. VHP in its sole discretion decides whether to rent or purchase the equipment, and VHP selects the supplier. You must return rental equipment when VHP no longer covers it.

Within the applicable Service Area, VHP covers the following Medically Necessary DME for home use:

- Bone stimulator.
- Cervical traction (over door).
- Enteral pump and supplies.
- Hospital bed, mattress, and related accessories.
- Infusion therapy equipment and supplies such as intravenous pole, insulin pumps and supplies to operate the pump (but not including

insulin or any other drugs, or supplies used by a health care provider that are incidental to the administration of infusion therapy, including but not limited to cotton swabs, bandages, tubing, syringes, medications, and solutions).

- Mobility devices such as a standard cane, crutches, walker, or wheelchair.
- Phototherapy blankets for treatment of jaundice in newborns.
- Respiratory therapy equipment such as CPAP, positive air pressure machine (Bi-PAP), nebulizer and supplies, and tracheostomy tube and supplies.
- Speech generating device.

VHP or your Plan Provider will determine whether to repair or to replace the prosthetic DME or Prosthetic Device. Any customization of your living environment or automobile are excluded from your Benefit Plan.

Enteral Formula

Enteral formula is a Covered Service if you require tube feeding in accordance with Medicare review guidelines. Formulas and special food products for the treatment of phenylketonuria (PKU) are Covered Services provided that such items are part of a diet prescribed by a Plan Provider who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function because of PKU. Prior Authorization is required.

Evaluation of New and Existing Technologies

VHP continuously looks for changes and advances in health care that may improve your care. We review new treatments, medicines, procedures, and devices. We refer to this as “new technology”. For VHP to consider the use of any new technology, we look at related scientific reports and other information from the government and medical specialists. We will also review the value, effectiveness, and safety standards before making the decision whether the new technology

should be covered as a health benefit. Your health care provider may submit a referral to VHP’s Utilization Department to review new technology services.

Experimental or Investigational Treatment Services

Experimental or Investigational Treatment including drugs, devices, procedures or other therapies are only covered when:

- Independent review deems them appropriate. Refer to the "Independent Medical Review" portion of the "Choice of Physicians & Providers" chapter of this EOC for more information; or
- Clinical trials for Qualified Members with cancer or other Life-Threatening diseases or conditions if deemed appropriate according to the “Clinical Trial Services” provision in the "Benefit Description Section" portion of the "Medical Benefits and Prior Authorizations" chapter of this EOC.

In addition, Benefits will also be provided for services and supplies to treat medical complications caused by Experimental or Investigational Treatment services or supplies.

Hospitals - Inpatient Services

Inpatient Hospital Service Benefits include:

- Semi-private room and board, intensive care, operating room, inpatient drugs, x-ray lab, supplies, acute rehabilitation, dialysis, and Medically Necessary blood, blood derivatives, and transfusions (blood bank).
- Ancillary services, such as laboratory, pathology, radiology, radiation therapy, cathode ray scanning, inhalation and respiratory therapy, physical therapy, occupational therapy, and speech therapy.
- Diagnostic and therapeutic services.
- Discharge planning services and the coordination and planning of such continuing care.

- Surgical and anesthetic supplies furnished by the hospital as a regular service.
- Physician and surgeon care.
- Inpatient skilled nursing care.

Rehabilitation Services are provided in the amount, frequency, or duration, as deems Medically Necessary. Limits on habilitative and rehabilitative services and devices shall not be combined. There is no limit to the number of inpatient days, when provided at a Plan Hospital by Plan Providers in your Primary Network when your care is deemed Medically Necessary.

Arrangements for a private room are excluded from your Benefit Plan unless Medically Necessary and ordered by your Plan Physician. If you request a private room, you must pay the difference between the Plan Hospital's charge for a private room and a semi-private room.

All non-emergent scheduled admissions at hospitals must be Prior Authorized by VHP or you may be financially responsible for all charges.

If you are admitted to a Non-Plan Hospital or a hospital that is not affiliated with your Primary Network due to Emergency Services or Urgently Needed Services, VHP's Utilization Management Department may work with the Non-Plan Hospital or the hospital not included in your Primary Network to facilitate a transfer for post-stabilization services as medically appropriate to a Plan Hospital affiliated with your Primary Network. Refusal to accept a transfer for post-stabilization services to a Plan Hospital may result in additional costs to you for your hospitalization at the Non-Plan Hospital or hospital not included in your Primary Network.

Concurrent Review and Discharge Planning

VHP performs ongoing concurrent review for inpatient admissions through electronic medical record, on-site or telephonic methods, through contact with the hospital's utilization and discharge planning departments and with your attending physician when necessary. When determining ongoing Medical Necessity and appropriate level of care, Utilization Management reviews your status, treatment plan, and any results of diagnostic testing or procedures. Urgent concurrent review decisions are made within 24 hours of receipt of the request.

Retrospective Review

Retrospective review is an initial review of services already rendered to you, but for which Authorization was not obtained. Retrospective review for inpatient services is conducted when you have been discharged following an inpatient admission prior to notifying VHP. Notification to VHP may have untimely due to extenuating circumstances. Retrospective review may also be conducted for outpatient services when Authorization was not obtained due to extenuating circumstances. Requests for retrospective review must be submitted promptly. A decision is made within 30 calendar days following receipt of the request for retrospective review.

If a provider is unable to obtain Authorization before providing a service or medical item, VHP will respond to a retrospective/post-service authorization request received within 30 calendar days of initiation of the service or provision of the medical item. A retrospective authorization request will be denied for untimely submission if VHP receives it after 30 calendar days. Post-service authorization requests must be accompanied by documentation explaining why the authorization was not requested prior to the provision of services. VHP's response will inform the provider of the decision to approve, modify or deny the retrospective authorization request.

Family Planning Services

Your Benefit Plan offers a wide selection of family planning services through your Plan Provider.

- Family planning Benefits include family planning services, genetic counseling services, and some Authorized artificial insemination services.
- All FDA-approved contraceptives drugs, devices and other products, including all FDA-approved contraceptive drugs, devices, and products available over-the-counter obtained at a Plan Pharmacy.
- Clinical services related to obtaining or using contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling.
- Family planning counseling, pre-abortion counseling, post-abortion counseling, and information on birth control.

- Procedures for prenatal diagnosis of fetal genetic disorders including tests for specific genetic disorders for which genetic counseling is available when such testing is determined Medically Necessary and Prior Authorized by VHP.
- Sterilization services including voluntary tubal ligation and other similar sterilization procedures with Prior Authorization and vasectomy services without Authorization.
- Abortion services including pre-abortion and follow-up services and abortion without a referral or Authorization.

Refer to the Employer Drug Formulary for a complete list of covered contraceptive products.

Vasectomies or abortion and abortion related services are available to you at no cost.

No Prior Authorization is required for all abortion and abortion related services. Abortion services includes examination, counseling, and procedure.

Some hospitals and other providers do not provide one or more of the following services that may be covered under your Plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health Plan at 1.888.421.8444 (toll-free) to ensure that you can obtain the health care services that you need.

Fertility Preservation Coverage

VHP covers standard fertility preservation services when a covered treatment may directly or indirectly cause Iatrogenic Infertility and are not within the scope of Coverage for treatment of infertility. Iatrogenic Infertility means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. Standard fertility preservation services mean procedures consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

Self-Referral for Obstetrical and Gynecological Physician Services

You may obtain obstetrical and gynecological (OB/GYN) physician services within your Primary Network without first contacting your PCP or securing a referral from your PCP. Obstetrical and gynecological services include but are not limited to:

- Routine gynecological examinations;
- Pregnancy services, including contraceptives and treatment;
- Diagnosis and treatment of sexually transmitted infections;
- Medical care due to rape or sexual assault, including collection of medical evidence; and
- HIV testing.

If you need obstetrical and gynecological services, you may go directly to an obstetrician and gynecologist or a physician who provides such services in your Primary Network. If such services are not available in your Primary Network, you may go to one of the Plan Physicians who provide obstetrical and gynecological services, and no referral/Authorization is required. The obstetrical and gynecological physician will consult with the Member's PCP regarding the Member's condition, treatment, and any need for Follow-Up Care.

For services, call a Plan OB/GYN. Find an OB/GYN by using the provider search function at **www.valleyhealthplan.org** or by calling VHP's Member Services Department at **1.888.421.8444 (toll-free).**

Gender Affirming Therapy and Surgery

Medically Necessary gender affirming therapy and surgery services, including, but not limited to, mental health evaluation and treatment, pre-surgical and post-surgical hormone therapy, fertility preservation, speech therapy, and surgical services (such as hysterectomy, ovariectomy, orchiectomy, genital surgery, breast surgery, mastectomy, and other Reconstructive Surgery) for the treatment of gender dysphoria is covered. Surgical services must be performed by a qualified

Plan Provider. Medical Necessity determinations are based on the guidelines established by the World Professional Organization for Transgender Health (WPATH).

Genetic Counseling Services

Genetic counseling services include Medically Necessary risk assessments for family planning and diagnosis. Genetic tests are not covered if performed primarily for the medical management of other family members who are not covered under VHP's Benefit Plan, performed in the absence of symptoms or high-risk factors for an inheritable disease, or when knowledge of genetic status will not affect a treatment decision. Genetic tests performed by a provider without Clinical Laboratory Improvement Amendments (CLIA) certificate and State license or registration are not covered by VHP.

Health Education Services

VHP is committed to supporting and improving the health of Members. The primary purpose of providing health education and health promotion is to help you live a healthy lifestyle. Health promotion services are designed to improve your health as well as to prevent illness. Health education programs and materials related to disease management are available. Contact your PCP or the VHP Health Education Department at **408.885.3490** to discuss your needs for this service.

Topics include smoking cessation, fitness, diabetes prevention, weight management and more.

Heath education and promotion classes are offered to Members at low or no cost. VHP maintains an updated list of health education classes available throughout Santa Clara County. To register and obtain class availability, schedule(s), and fees, visit VHP's website at www.valleyhealthplan.org for a list of VHP offered health education classes. There is no reimbursement for fees incurred for health education Benefits.

These classes are sponsored by VHP, Santa Clara County Health and Hospital System, partnerships with various community organizations, hospitals, health centers, health programs and agencies.

Youth Diabetes Summer Camp

The YMCA offers one-week summer camp sessions for youth who are at risk of developing Type II diabetes. The program focuses on nutrition education and practicing a healthy eating lifestyle. The program is free for VHP Members ages 6-16.

Youth Asthma Camp

A free one-week asthma camp is offered for children ages 6-12 and their families. The camp addresses asthma problems through asthma self-management and offers unique opportunities for children to socialize with their peers who have the same chronic illness. The camp is organized with the goal of providing an entertaining and educational summer camp experience. In addition to asthma self-management, campers are provided with opportunities to try new activities at their own (often reduced) level of participation. Camp fellowships and informal social interactions in a variety of settings (sports, picnic, nature study, hiking, boating, fishing, swimming, crafting, etc.) are offered as part of the program.

Diabetes Prevention Program

VHP partners with the YMCA to offer Members a free Adult Diabetes Prevention Program, which includes a four month YMCA membership. The YMCA's adult Diabetes Prevention Program helps Members learn and adopt healthy eating and physical activity habits with the goal of reducing the risk of developing Type II diabetes. Members will receive support and encouragement from both a trained lifestyle coach and fellow classmates as they develop a plan for improving and maintaining their overall well-being.

Nutrition

VHP offers free nutrition classes to its Members through the YMCA. The one-hour classes are hosted and conducted by a Registered Dietician and provided quarterly every year. Topics vary and include "Tips for Healthy Weight Loss," "Tips for Traveling," "Eating Out in a Restaurant," "Smart Snacking," "The Amazing Benefit of Omega 3," "Holiday Survival Guide," and "How to Cook with Whole Grain".

Fitness & Wellness Classes

VHP offers group fitness classes free of charge to Members. Classes vary and include Pilates, Yoga, Zumba, and Sports Conditioning. All instructors are certified and meet

industry standards. Since the County of Santa Clara has reopened after the height of the COVID-19 pandemic, we have returned to in-person classes. VHP will continue to offer virtual fitness classes (until further notice) free of charge to Members.

WW (Formerly Weight Watchers)

VHP is committed to helping Members reach their wellness goals, whether to achieve a healthy weight, learn better eating habits, move more, or develop a more positive mindset. VHP offers WW (Weight Watchers reimagined) to Members. Members can join the program through several membership options. WW has moved from in-person workshop meetings to a virtual platform due to COVID-19. VHP continues t to subsidize 50 percent (50%) of the cost for Members. Fees apply. Member is responsible for other half (50% portion of WW fee). Price will vary depending on Members choice of participation and program options.

Member Outreach

In collaboration with VHP's Case Management and Member Services Department, VHP's Health Education Department conducts outreach to Members through one-on-one phone calls. These calls serve as an opportunity to provide education to Members on prevention campaigns, as well as promote a vital and free of charge online resource, MDLive Care.

Collaboration with other County of Santa Clara Departments

Health Education collaborates with various County departments to carry out initiatives led by the Board of Supervisors, such as:

- County Diabetes Prevention Initiative (DPI) to ensure that residents with pre-diabetes are identified and connected to prevention education and active living resources;
- County Employee Wellness Division to improve the health and well-being of the workforce through campaigns such as "#CampWell2020" and "Know Your Health, Keep Your Health"; and
- County Tobacco-Free Communities (TFC) to reduce illness and premature death attributed to the use of tobacco products.

Health Education Materials

VHP has contracted with Krames Staywell to make health education materials available to its Members. Members may request materials free of charge. These materials have been reviewed for cultural and linguistic standards and are available in English, Spanish and Vietnamese.

Topics include:

- Allergies
- Asthma
- Behavioral Health
- Breast Health
- Cancer
- Children's Health
- Colon Cancer
- Diabetes
- Eating Healthy
- Exercise for Busy People
- Healthy Aging
- High Blood Pressure
- Men's Health
- Post-partum mental health
- Pain Management
- Self-Care for Adults
- Smoking Cessation
- Sexually Transmitted Diseases
- Stress Management
- Weight Management
- Women's Health

To request an order form, packet of sample materials or materials on a specific topic, contact the Health Education Department at **1.408.885.3490** or e-mail: **healtheducation@vhp.sccgov.org**.

HIV, AIDS, or Other Infectious Disease Testing, Prevention and Treatment

Medically Necessary treatment includes HIV testing regardless if related to your primary diagnosis or diagnoses.

Home Test Kits for Sexually Transmitted Infections

When ordered by an in-Network Provider, the Plan will provide Coverage for home test kits for sexually transmitted infections, 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 needs.

Home Birth

A birth which takes place at home will be covered only when the criteria for Emergency Services, as defined in this EOC, have been met.

Home Health

Home Health Care

VHP covers Home Health Care Services from Plan Providers when you are confined to your home for medical reasons. Home health Care Services will be provided under the direct care and supervision of a Plan Provider and administered by visiting Plan Provider health care professionals. Home Health Care Services Medically Necessary health care services and supplies provided in your home. Services include

- Drugs;
- Medicines, and supplies administered by a visiting health care professional;

- Rehabilitation, and laboratory services; and
- Medically Necessary intermittent skilled nursing and home health aide services.

VHP covers only part-time or intermittent Home Health Care Services, as follows:

- Up to two hours per visit by a nurse, or physical, occupational, or speech therapist. If a visit lasts longer than two hours, then each additional increment of two hours count as a separate visit.
- Up to three visits per day (combining all home health visits).
- Up to 100 visits in a benefit year.

Your Plan Physician will prescribe or make Prior Authorized arrangements when Medically Necessary.

If, at the time of enrollment, you are receiving on-going Home Health Care Services from a Non-Plan Provider, please contact Member Services so they can assist in coordinating your care Contact Member Services at **1.888.421.8444 (toll-free)** for assistance.

Coverage is limited to services that may not be appropriately provided in a Plan Provider's office, Plan Hospital or Skilled Nursing Facility and is limited to homebound Members under a doctor's supervision. Custodial Care and private duty nursing are excluded from your Benefit Plan. Your Plan Physician will determine the amount, frequency, or duration of Medically Necessary in-home physical, occupational, and speech therapies, and/or other rehabilitative services.

Dialysis Services

Dialysis services for acute renal failure and chronic renal disease, including all hemodialysis and peritoneal, continuous ambulatory peritoneal dialysis (CAPD), automated peritoneal dialysis (APD), continuous cycling peritoneal dialysis (CCPD), equipment, training and medical supplies required for home dialysis are covered under your Benefit Plan. Plan Providers must render Covered Services. Prior Authorization must be received before evaluation and treatment.

Hospice Care

Should you be diagnosed with a Terminal Illness and have a life expectancy of 12 months or less, you may elect home-based Hospice care. Such care will be arranged

through a licensed Hospice agency or a licensed home health agency with a federal Medicare certification with Prior Authorization from VHP and an order from your Plan Provider. Hospice care must be provided by a Plan Provider.

You may change your decision to elect or revoke Hospice care at any time. However, once you have elected Hospice care, you are not entitled to any curative treatments for the Terminal Illness while enrolled in Hospice except Covered Services that are not related to the Terminal Illness.

When qualified for Hospice Benefit, the following services are considered available through your contracted licensed provider:

- An interdisciplinary team care with development and maintenance of an appropriate plan of care
- Physician services
- Skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse
- Bereavement Services
- Medical social services/counseling
- Dietary counseling
- Volunteer services
- Short-term inpatient care arrangements.
- Pharmaceuticals, medical equipment and supplies for the palliation and management of Terminal Illness and related conditions:
- Physical therapy, occupational therapy, and speech-language pathology service

Covered Services are to be made available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of Terminal Illness and related conditions.

Special Coverage Requirements.

- The following care during periods of crisis is covered when you need continuous care to achieve palliation or management of acute medical symptoms:

  - Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home.
  - Short-term inpatient care required at a level that cannot be provided at home.
- Respite Care:
  - Respite care is short-term inpatient care provided to the enrollee only when necessary to relieve the family members or other persons caring for the Member. Coverage of respite care may be limited to an occasional basis and to no more than five consecutive days at a time.

Immunizations and Injections

Immunizations and injections including flu shots, tetanus and diphtheria boosters, AIDS vaccines, hepatitis A and B vaccines, pneumococcal pneumonia vaccines, COVID-19 vaccines, mpox vaccines, and immunizations as required by Immigration and Naturalization Services Department or as recommended by the United States Preventive Services Task Force or Health Resources and Services Administration, or as recommended from the Advisory Committee on Immunizations Practices of the Centers for Disease Control (CDC), including travel immunizations are covered outpatient services.

Travel Immunizations

Travel immunizations are covered when recommended by the U.S. Preventive Services Task Force. Call **1.888.421.8844** for information on a Plan Pharmacy that offers travel immunizations. Travel health Immunizations consultations are not a covered Benefit.

Infertility Diagnosis and Treatment

Infertility evaluation, diagnostic operative procedures, and treatment are covered when determined Medically Necessary and when Authorized in accordance with the Member's Benefit Plan. Diagnostic evaluation and treatment should be completed within six months or six cycles. The VHP or Medical Group Medical Director may authorize repeat procedures on a case by case basis. Infertility evaluation,

diagnosis, and treatment are covered at 100% under the medical Benefit. Limitations apply and are listed at the end of this section under "Exclusion" and in the "Limitations and Exclusions" chapter.

Covered Services include the following when medically indicated and Authorized:

Infertility Evaluation

- Initial screening evaluations including, but not limited to hysterosalpingogram, semen analysis, antibody testing. Semen analysis is covered for the partner of a Plan Member, even if the partner is not a Plan Member.
- Initial diagnostic operative procedures such as laparoscopy, dye injections, and dilation and curettage (D&C).

Infertility Treatment:

- Operative procedures to surgically correct infertility are covered when Medically Necessary and Authorized by a VHP Medical Director. This including but not limited to infertility caused by the treatment of tumors (e.g., Myomectomy - abdominal or vaginal approach or laparoscopy with fulguration or excision of lesions), endometriosis, pelvic adhesions, varicocele, or tubal obstruction from infection.
- Artificial insemination (intrauterine insemination) is covered when determined Medically Necessary. This Coverage is subject to Prior Authorization, which must be obtained before the procedure is performed. Artificial Insemination services include family planning counseling, pre-abortion and post-abortion counseling, and information on birth control.
- If the Plan Member is a person seeking to become pregnant, the Member must provide the sperm (e.g., from a partner, donor, or sperm bank). The Plan will cover sperm washing as part of the artificial insemination procedure irrespective of the source of the sperm but does not cover any costs associated with obtaining or preparation of sperm from a donor or sperm bank.
    - Artificial Insemination is the actual basic insemination procedure.

    - Sperm washing only in connection with the Artificial Insemination procedures.
    - Two (2) semen analyses are covered in conjunction with the artificial insemination procedures. Semen analysis for conception procedures will be covered only in conjunction with artificial insemination procedures.

- Prescription Drugs for the treatment of infertility are covered if listed on VHP's Employer Drug Formulary, when a Plan Provider prescribes them for a Covered Service. Some drugs used in the treatment of infertility require Prior Authorization. Your Plan Provider must get Prior Authorization before prescribing.
    - Ovulation induction with Clomid (Clomiphene), FSH (follicle-stimulating hormone), and HCG (Human Chorionic Gonadotropin) injections are covered under the Pharmacy Benefit as appropriate for your reproductive system and determined by Plan Physician and as Prior Authorized by the Medical Director/designee. Combination ovulation induction drugs are not covered.

- For a list of covered infertility drugs, refer to VHP's Employer Drug Formulary.
- Procedures such as laboratory test, at time of ovulation, ultrasound, endometrial biopsies, sperm washing, and semen analysis are covered under the medical Benefit.

Exclusion:

- Reversal of Sterilization (Tubal ligation, vasectomy).
- Infertility resulting from voluntary sterilization. Includes sterilization procedures such as tubal ligation, tubal re-anastomosis, or vasectomy.
- Gamete Intrafallopian Transfer (GIFT).
- Zygote Intrafallopian Transfer (ZIFT).
- In-Vitro Fertilization (IVF).

- Embryo, Egg, Sperm storage unless due to Iatrogenic Infertility.
- Intracytoplasmic Sperm Injection (ICSI).
- Coverage is limited to Plan Members only. Coverage is not provided to a Member's partner who is not a Plan Member, except as specified above with regard to semen analysis and sperm washing.
- Coverage is limited to the actual basic insemination procedure.
- Services at Non-Plan Providers.
- Services not Prior Authorized.
- Egg Harvesting

Mammography Screening

VHP covers mammogram screenings for routine and diagnostic purposes. Mammogram screenings including radiological procedures and interpretation of the results will be when ordered through your Plan Provider when referred by a participating nurse practitioner, participating certified nurse-midwife, participating physician assistant, or participating physician for Medically Necessary care. Frequency is based on Medical Necessity, age, and demographic characteristics. Coverage for mammography screening is limited to once every Calendar Year. Diagnostic mammograms will be covered as a diagnostic laboratory services Benefit.

Maternity Services

Maternity Care

Maternity care is provided through your Plan Physician. Maternity services include maternity care and newborn circumcision. After confirmation of pregnancy, the normal series of regularly scheduled preventive prenatal care exams and the first postpartum follow-up consultation and exam are available to you at no cost.

Keeping your prenatal appointments, making healthy lifestyle changes, and following the advice of your physician are important to assure the good health of you and your baby. You are entitled to Alpha Feto Protein (AFP) testing and as desired, can participate in the California Prenatal Screening Program, which is a

statewide prenatal testing program administered by the California Department of Public Health. Procedures for the prenatal diagnosis of fetal genetic disorders including tests for specific genetic disorders for which genetic counseling is available will be covered if medical necessary and prior Authorized by VHP.

Prior Authorization must be obtained by your Plan Provider from VHP for a scheduled cesarean section. You and your newborn child are entitled to at least 48 hours of inpatient hospital care following a normal vaginal delivery or 96 hours following a cesarean section. An earlier discharge may be arranged when the decision is made jointly by you and your attending physician. Inpatient Hospital Services for your baby after you are discharged are considered a separate hospital admission.

If you are released from the hospital early, you and your baby are entitled to a follow-up visit within 48 hours of discharge. You and your Plan Physician will determine whether the visit will occur at your Plan Facility, your Plan Physician's office, or at home. The visit will include, at a minimum, parent education, assistance and training in feeding, and the performance of any necessary maternal or neonatal physical assessments.

If you travel outside of the Service Area to obtain Medical Services related to the care and/or delivery of the newborn, you may be financially responsible for all charges, except for those expenses related to Emergency or Urgently Needed Services.

Amniocentesis, ultrasounds, or any other procedure performed solely for the purpose of sex determination are excluded from your Benefit Plan.

VHP has a maternal mental health program called VHP Pregnancy and Postpartum Wellness Program that is targeted to Members to help improve screening treatment and referral to maternal mental health services. The program offers support, education, and referrals. To learn more about the program or if you want to get started right away, please call us at **669.220.5235**, and press 2 for Case Management.

Should you give birth while a Member and your newborn meets the definition of an Eligible Dependent, they are automatically covered under the Benefit Plan for the first 31 days after the birth. Except in the event of an Emergency or Urgently Needed Services, during this grace period, your Plan Physician must provide care.

For County of Santa Clara, Santa Clara County Superior Courts, Santa Clara County Fairgrounds and the Valley Health Foundation, the Subscriber must complete and submit the appropriate paperwork to enroll your newborn as an Eligible Dependent within 31 days of the birth for continuous Coverage of your newborn beyond 31

days. Enrollment materials must be submitted to your employer's Human Resources office. The appropriate membership premium will be charged from the date of enrollment.

If you are enrolled as an Eligible Dependent child when you give birth, newborn care is excluded from your Benefit Plan. (Please refer to the "Eligible Dependent" definition for details.)

If you are enrolled as a Subscriber to as part of the In Home Support Services Group that does not offer dependent coverage, Coverage of your newborn child will be excluded 31 days after the birth.*

* Note: For information on continuous health coverage for your newborn, contact the Children's Health Initiative (CHI) at **1.833.912.2447 (toll-free)**. A CHI representative can give you information about free or low-cost health insurance.

Circumcision Services

Circumcisions are performed on an outpatient basis through the hospital discharge instructions or through the pediatrician only if the newborn meets the definition of an Eligible Dependent. To ensure Coverage of this service, you must make your appointment within the time limits written on this notice, usually two weeks from the date of birth. Medically Necessary circumcisions for non-newborns requires Prior Authorization by VHP.

Medical Transportation Services

Medically Necessary non-emergency medical and psychiatric inter-facilities transport is covered and will be arranged by your PCP and VHP. Prior Authorization is required. Non-emergency medical and psychiatric transport is limited to inter-facility transfer only.

Mental Health Services

Mental health services include outpatient mental health counseling, outpatient mental health services provided by a psychiatrist, inpatient mental health services, and any other Medically Necessary Treatment of a Mental Health or Substance Use Disorder. VHP will not limit Benefits or Coverage for Mental Health and Substance Use Disorders to short-term or acute treatment. No Prior Authorization is required

for outpatient mental health provided by non-physician mental health provider or via MDLive (Telehealth service).

VHP provides the Mental Health or Substance Use Disorder Coverage in its entire Service Area and in emergency situations or Urgently Needed Services including but not limited to services provided by 988 crisis centers and mobile crisis teams. No Prior Authorization is required for these services.

VHP will arrange Medically Necessary services Out-of-Network for you if the services for the Medically Necessary Treatment of a Mental Health or Substance Use Disorder are not available in Network within the timely access standards as outlined in "Timely Access to Care". VHP will ensure the delivery of Medically Necessary Out-of-Network services and any Medically Necessarily follow up services that, to the maximum extent possible, meet the timely access standards. Arranging services may mean contacting non-contracted providers with the appropriate expertise on your behalf and assisting you with scheduling, and the provider with engaging with VHP. VHP may not delay your care beyond the applicable timely access standards due to lack of a single case agreement or other arrangement with a non-contracted provider. Member costs for Medically Necessary referrals to Out-of-Network providers shall not exceed applicable in-network providers Copayments, coinsurance, and Deductibles.

VHP has a maternal mental health program called VHP Pregnancy and Postpartum Wellness Program that is targeted to Members to help improve screening treatment and referral to maternal mental health services. The program offers support, education, and referrals. To learn more about the program or if you want to get started right away, please call us at **669.220.5235**, and press 2 for Case Management.

To obtain a list of mental health Plan Providers go to **www.valleyhealthplan.org** and use the "Provider Search" or call VHP Member Services **at 1.888.421.8444 (toll-free)**.

To obtain the clinical review criteria, education program and training materials for determining Medically Necessary Treatment of a Mental Health or Substance Use Disorder, call VHP Member Services at **1.888.421.8444 (toll-free).**

Outpatient Mental Health and Behavioral Health Treatment Provided by Non-Physician Providers

Outpatient mental health provided by non-physician providers includes, but are not limited to:

- Assessment, diagnosis, individual and group psychotherapy.
- Psychological testing when necessary to evaluate a Mental Health or Substance Use Disorder.
- Outpatient Covered Services for the purpose of monitoring drug therapy.

Behavioral Health Treatment is covered by the Plan and includes professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with autism spectrum disorder. These services are provided by psychologists, marriage and family counselors and licensed clinical social workers, or other health professionals permitted by California Law. In some instances, your PCP may be able to provide mental health services that are within the PCP's scope of practice. Prior Authorization from VHP is not required for counseling services provided by contracted non-physician providers.

Outpatient Mental Health and Behavioral Health Services Provided by a Psychiatrist

Outpatient Mental Health and Behavioral Health Treatment services provided by a psychiatrist are available through VHP Mental Health Plan Providers. Coverage includes evaluation and treatment, prescribed psychological and neuropsychological testing, crisis intervention, hospital-based outpatient care (partial hospitalization) and multidisciplinary treatment in an outpatient psychiatric treatment program. Behavioral Health Treatment is covered by the Plan and includes professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with autism spectrum disorder. In some instances, your PCP may be able to provide Mental Health Services. Services include Prescription Drugs/medications, and pharmacy services; Prescription Drugs must be written by an authorized psychiatrist or PCP. Services are limited to Medically Necessary treatment in the amount, frequency, or duration up to the point in which you are no longer clinically determined to require treatment. No Prior

Authorization is required for outpatient mental health and behavioral health services provided by a psychiatrist. If you seek outpatient mental health services from an Out-of-Network mental health provider without Prior Authorization, you may be financially responsible for all charges.

Inpatient Mental Health and Behavioral Health Treatment Services

Covered Services for inpatient mental health and Behavioral Health Treatment services are available when Authorized to Plan Provider. Hospital alternative treatment services are available if a Member would benefit from treatment in a structured multidisciplinary mental health program as an alternative to inpatient hospitalization. Post-hospitalization outpatient mental health services treatment(s) only as authorized by a Plan Provider at a Plan Facility.

VHP covers inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license.

VHP covers the following psychiatric treatment programs at a Plan Facility:

- Inpatient mental health residential treatment.
- Crisis residential treatment.
- Treatment in a crisis residential program in licensed psychiatric treatment facility with 24 hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis.
- Psychiatric observation for an acute psychiatric crisis.

Inpatient mental health services that are court ordered, or as a condition of parole or probation are excluded from your Benefit Plan, unless determined Medically Necessary by the Medical Director or part of a Community Assistance, Recovery and Empowerment Court Program agreement or plan. Community Assistance, Recovery and Empowerment Court Program services do not require Prior Authorization, have zero cost share and can be provided by in-network providers or Out-of-Network providers.

Substance Use Disorder Services

Outpatient evaluation and treatment for Substance Use Disorder and medical treatment as well as education and counseling services for withdrawal symptoms are Covered Services when Authorized by VHP and arranged through a Plan Provider.

Contact Member Services at **1.888.421.8444 (toll-free)** for assistance. Prior Authorized inpatient detoxification services for Substance Use Disorders are available for confinement when provided in a Plan Facility.

Hospitalization for overdose and residential rehabilitation as Medically Necessary per American Society of Addiction Medicine (ASAM) guidelines are covered when provided in a Plan Facility.

Substance Use Disorder/behavioral health services that are court ordered, or as a condition of parole or probation or when incarcerated are excluded from your Benefit Plan, unless determined Medically Necessary by the Medical Director or part of a Community Assistance, Recovery and Empowerment Court Program agreement or plan. Community Assistance, Recovery and Empowerment Court Program services do not require Prior Authorization, have zero cost share and can be provided by in-network providers or Out-of-Network providers.

Inpatient Detoxification

VHP covers hospitalization in a Plan Hospital for medical management of withdrawal symptoms, including room and board, Plan Physician Covered Services, drugs, Substance Use Disorder services, education, and counseling.

Residential Substance Use Disorder Treatment

Residential Substance Use Disorder treatment includes non-hospital based detoxification services, and transitional Substance Use Disorder residential treatment for Substance Use Disorders that are Medically Necessary.

Outpatient Substance Use Disorder Care

Covered Services for treatment of Substance Use Disorder are:

- Intensive outpatient programs, including but not limited to partial hospital program.
- Individual and group Substance Use Disorder counseling.
- Medical treatment for withdrawal symptoms.

Medically Necessary methadone maintenance services are included in outpatient Substance Use Disorder care.

Prosthetic and Orthotic Devices

Orthotic Devices and Prosthetic Devices or appliances are considered Medically Necessary devices to restore bodily functions essential to activities of daily living, prevent significant physical disability or serious deterioration of health, or alleviate severe pain. Covered Services also includes Prosthetic Devices to restore and achieve symmetry.

VHP covers Prosthetic Devices and Orthotic Devices if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes;
- The device is the standard device that adequately meets your medical needs; and
- The device is prescribed and provided by a Plan Provider.

VHP covers the following external Prosthetic Devices and Orthotic Devices:

- Compression burn garments and lymphedema wraps and garments.
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Provider or by a podiatrist contracted by VHP.
- Prostheses needed after a Medically Necessary mastectomy, including:
- Custom-made prostheses when Medically Necessary; and
- Up to three brassieres required to hold a prosthesis every 12 months.
- Prostheses to replace all or part of an external facial body part that has been removed or impaired because of disease, injury, or congenital defect.
- Voice prostheses and accessories, the Prosthetic Devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this Coverage does not include electronic voice-producing machines, which are not Prosthetic Devices).
- Artificial limbs and eyes.
- Supplies necessary for the operation of prostheses.

- Initial fitting and replacement after the expected life of the prothesis.

Ophthalmology Services

Ophthalmology services are provided by a Plan Specialist and include visits, examinations, outpatient surgery at a Plan Hospital or Plan Facility. To obtain outpatient surgery care, you must receive a Prior Authorization from VHP.

Ostomy and Urological Supplies

Coverage includes ostomy and urological supplies as prescribed in accordance with VHP's Employer Drug Formulary guidelines. VHP selects the Plan Provider best able to meet your requirements. Coverage is limited to the standard supply that adequately meets your medical needs.

Ostomy and urological supplies used for comfort, convenience, or luxury equipment or features are excluded from your Benefit Plan.

VHP's formulary guidelines allow you to obtain non-formulary ostomy and urological supplies (those not listed on our soft goods formulary for your condition) if they would otherwise be covered and the Plan Provider determines that they are Medically Necessary.

Note: VHP's soft goods formulary lists ostomy and urological supplies in a variety of types and materials. Generic categories for those supplies are as follows:

- Adhesives – liquid, brush, tube, disc or pad
- Adhesive removers
- Belts – ostomy
- Belts – hernia
- Catheters
- Catheter insertion trays
- Cleaners
- Drainage bags/bottles – bedside and leg
- Dressing supplies

- Irrigation supplies
- Incontinence supplies
- Lubricants
- Miscellaneous supplies – urinary connectors; gas filters; ostomy deodorants; drain tube attachment devices; soma caps tape; colostomy plugs; ostomy inserts; irrigation syringes, bulbs, and pistons; tubing; catheter clamps; leg straps and anchoring devices; penile or urethral clamps; and compression devices
- Pouches – urinary, drainable, ostomy
- Rings – ostomy rings
- Skin barriers
- Tape – all sizes, waterproof and non-waterproof

Outpatient Hospital or Surgical Center Services

VHP covers Outpatient Hospital Services or surgical center services including outpatient surgery and procedures in a hospital or outpatient ambulatory care centers such as, but not limited to, angiograms and bronchoscopies; IV infusion; chemotherapy; anesthesia services; drugs, X-ray, lab, supplies and blood, blood derivatives.

Outpatient Services

Your Benefit Plan covers Outpatient Care by Plan Providers. Routine Care or Urgent Care is arranged or provided through your PCP or Plan Provider within your Primary Network and includes many of the common preventive and diagnostic services you will need, such as evidence-based preventive services rated A or B by the United States Preventive Services Task Force, recommended immunizations by the Centers of Disease Control, preventive care for children, adolescents, and adults, plus additional preventive care and screenings for men and women. There is no limit to the number of visits (except for defined limitations and exclusions). You may self-refer directly to an OB/GYN Plan Provider who has access to a Plan Hospital or Plan Facility.

Outpatient services also includes screening for adverse childhood experiences. These experiences can relate to an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

VHP believes that screening and preventive services are important to maintain our Members health. Outpatient Covered Services include but are not limited to:

- Pediatric/well-childcare
- Adult periodic health examinations
- Colorectal cancer screening
- Physical examinations for Routine Care
- Vision and hearing screening examinations provided by PCP to determine the need for vision or hearing correction
- Chest and cervical cancer screening and pelvic examinations (previously known as well-woman examinations)
- Mammography screenings
- Allergy testing and treatment
- Dermatology services
- Diagnostic laboratory services
- HIV, AIDS, or other infectious diseases testing and treatment; HIV testing is covered regardless if related to a primary diagnosis
- Immunizations and injections
- Medication management
- Drug therapy monitoring
- Travel immunizations
- Optometry services (for special contact lenses to treat aphakia or aniridia);
- Ophthalmology services
- Podiatry services

- Prescription Drugs
- Therapy services
- Outpatient Hospital Services or surgical center services
- Urgently Needed Services
- Adverse childhood experiences screenings

Pediatric/Well-Child Care

Pediatric/well-childcare visits as well as adverse childhood experiences screenings, periodic office visits, diagnostic laboratory services, immunizations, pediatric asthma services and the testing and treatment of phenylketonuria (PKU) are Covered Services. The age, health status, and medical needs of the child determine the frequency of these examinations.

Vision and hearing screening physical examinations provided by your child's PCP to determine the need for vision or hearing correction is a covered outpatient service.

Podiatry Services

Podiatry services are referred by your PCP to a Plan Specialist and include treatment for injuries and diseases of the feet, such as diabetes, systemic foot disease, trauma, or accidental injury to the foot. To obtain care, you must receive a written referral from your PCP and a Prior Authorization from VHP.

VHP covers podiatric devices to prevent or treat diabetes-related complications.

Orthotic appliances must be Medically Necessary devices to restore bodily functions essential to activities of daily living, prevent significant physical disability or serious deterioration of health or alleviate severe pain. Orthotic appliances are limited to one per year, unless determined to be Medically Necessary and Prior Authorized by VHP. Refer to the "Durable Medical Equipment - Medical Supplies and Equipment" section.

Podiatric surgery is limited to Reconstructive Surgery.

Routine foot care such, as corn removal/cosmetic foot care and Cosmetic Surgery is excluded from your Benefit Plan.

Preventive Services

All preventive services recommended by the United States Preventive Services Task Force, A and B, preventive care and screenings supported by Health Resources and Services Administration, and immunizations recommended by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention are Covered Services when received from your Network Providers without limit to number of visits. You may self-refer directly to a Plan Physician for obstetrical and gynecological (OB/GYN) services.

Professional Services

Medically Necessary professional physician services are covered under your Benefit Plan when rendered by Plan Physicians within your Primary Network. Covered Services include:

- PCP services
- Specialist care
- Inpatient hospital physician services
- Outpatient physician care
- Outpatient hospital physician services

Specialist care includes visits, examinations, and outpatient surgery at a Plan Hospital, Plan outpatient facility or Plan Specialist office. Prior Authorization is required for Plan Specialist Covered Services. Refer to "Prior Authorization Grid for VHP Members" section describing those Covered Services requiring Authorization.

Radiologic Services

VHP covers diagnostic and therapeutic radiologic services when rendered by Plan Providers within your Primary Network. Refer to "Prior Authorization Grid for VHP

Members" section describing those Covered Services requiring Authorization.

Reconstructive, Cosmetic, & Bariatric (Weight Loss) Surgery Services

Reconstructive Surgery

Reconstructive Surgery includes plastic surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Provider determines that it is necessary to improve function, or create a normal or uniform appearance, to the extent possible when Medically Necessary.

Cosmetic Surgery

Cosmetic Surgery is not a Covered Service under the VHP Benefit Plan. Reconstructive Surgery that, in the judgment of a Plan Provider specializing in Reconstructive Surgery, offers only a minimal improvement in appearance is excluded as it is Cosmetic Surgery. Surgery that is performed to alter or reshape normal structures of the body to improve appearance is also considered Cosmetic Surgery. Cosmetic Surgery that is intended primarily to change or maintain your appearance, except for Covered Services determined to be Reconstructive Surgery, is also excluded from Coverage under your Benefit Plan.

Mastectomies & Lymph Node Dissections

Following Medically Necessary removal of all or part of a breast due to mastectomy surgery (due to disease, illness, or injury), reconstruction of the breast, surgery and reconstruction of the other breast to achieve symmetry, and treatment of physical complications and Prosthetic Devices are covered Benefits. Covered Services include Prosthetic Devices and Reconstructive Surgery, including devices or surgery to restore and achieve symmetry incident to the mastectomy. When necessary, your Plan Provider will arrange for you to receive Covered Services.

Bariatric (Weight Loss) Surgery

Bariatric surgery provided for the treatment of morbid obesity is a covered Benefit when Medically Necessary, is Prior Authorized by VHP, and performed by a Plan Provider. Reconstructive Surgery deemed Medically Necessary under the

Reconstructive Surgery Benefit and approved by VHP, other than Cosmetic Surgery to improve appearance, is a covered Benefit.

Refractive Eye Surgery

VHP does not cover eye surgery performed to correct refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) or astigmatism, unless Medically Necessary, recommended by a Plan Provider and Authorized by VHP.

Rehabilitation Therapy

Coverage for rehabilitation therapy is limited to Medically Necessary services provided by a physician, licensed physical, speech or occupational therapist or other Plan Provider, acting within the scope of his or her license, to treat physical and mental health conditions, or a qualified autism service (QAS) provider, QAS professional or QAS paraprofessional to treat autism spectrum disorder. Coverage is subject to any required Authorization from VHP. The services must be based on a treatment plan Authorized by VHP or its designee.

Rehabilitation therapy for physical impairments in Members with mental health conditions, including autism spectrum disorder, that develops or restores, to the maximum extent practicable, the functioning of an individual, is considered Medically Necessary when criteria for rehabilitation therapy are met.

Outpatient physical, occupational, and speech therapies and/or other rehabilitative services are limited to treatment provided in the amount, frequency, or duration as the Plan Provider deems Medically Necessary. To obtain care, you must receive a written referral from your Network Provider and Prior Authorization from VHP after the initial 24 visits per each discipline per Calendar Year.

Habilitation services shall be covered as Medically Necessary. Habilitation services include physical and occupational therapy, speech-language pathology, and other services for people with disabilities. Habilitative services and devices shall be covered under the same terms and conditions applied to rehabilitative services and devices. Limits on habilitative and rehabilitative services and devices shall not be combined.

Residential Treatment Center

Admission to a residential treatment center that is not Medically Necessary is excluded from your Benefit Plan. Admissions that are not considered Medically Necessary and are not covered include, but are not limited to, admissions for Custodial Care or Domiciliary Care, for a situational or environmental change only, or as an alternative to placement in a foster home or halfway house.

Services Not Related To Covered Condition, Illness Or Injury

Any services not related to the diagnosis or treatment of a covered condition, illness or injury is not covered under the Benefit Plan. However, VHP does cover Medically Necessary services for medical conditions directly related to Non-Covered Services when complications exceed routine Follow-Up Care (such as Life-Threatening complications of Cosmetic Surgery).

Skilled Nursing Services

Skilled Nursing Facilities (SNF) care is provided to you when referred by a Plan Physician. VHP provides up to 100 days per benefit period (see definition below) of Authorized skilled nursing services in a Plan Facility.

- Skilled nursing care (inpatient) provided in a SNF or a skilled nursing bed in a Plan Facility, including:
- Physician and nursing services
- Semi-private room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Facility in accordance with VHP's Employer Drug Formulary guidelines if they are administered to you in the Plan Facility by medical personnel
- Durable Medical Equipment in accordance with VHP's Durable Medical Equipment formulary if Skilled Nursing Facilities ordinarily furnish the equipment

- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Blood, blood products, and their administration
- Medical supplies
- Physical, occupational, and speech therapy
- Medically Necessary Treatment of a Mental Health or Substance Use Disorder
- Respiratory therapy
- Rehabilitation Services

SNF care is limited to Medically Necessary Covered Services, which is (1) at the skilled level of care and is required on a daily basis (2) is not Custodial Care; and (3) as a practical matter, can only be provided on an inpatient basis in a Plan Facility. Coverage excludes durable medical equipment for home use that is for comfort, convenience, or luxury equipment or features.

Skilled nursing care is limited to conditions which are not long term or chronic in nature. SNF care that requires ongoing inpatient skilled nursing care are excluded from your Benefit Plan after you receive 100 days of care for each benefit period (see definition below). Rehabilitation Services are limited to treatment provided in the amount, frequency, or duration, as the Plan Physician deems medically appropriate shall be covered as Medically Necessary. Rehabilitative services and devices shall be covered under the same terms and conditions applied to habilitative services and devices. Limits on habilitative and rehabilitative services and devices shall not be combined.

A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility receiving a skilled level of care, for sixty (60) consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required. Day and visit treatment limitations do not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder.

If you request a private room, you must pay the difference between the Plan Facility or hospital's charge for a private room and a semi-private room.

Sterilizations

Sterilization services include voluntary tubal ligation and other similar sterilization procedures with Prior Authorization and vasectomy services without Authorization. Any expenses for vasectomy or tubal ligation reversal is not covered under your Benefit Plan.

Surrogate Pregnancy

Surrogate pregnancy is when someone carries another person's fetus until birth. VHP covers services for a surrogate pregnancy only when the surrogate is a VHP Member. VHP will not seek to recover any of its direct medical expenses when compensation is obtained for the surrogacy.

Temporomandibular Joint Disorder Services

Temporomandibular Joint (TMJ) disorder services include the evaluation and treatment of TMJ dysfunction, including the provision of intra-oral appliances. Prior Authorization is required for all services including consultations, diagnosis, and medical or surgical treatment for disorders of TMJ.

VHP will authorize TMJ Covered Services if:

- Diagnosis of the TMJ Syndrome is made by a Plan Provider or specialist.
- You have completed a three to six month trial of continuous conservative management; and
- The intra-oral appliance was placed prior to surgery.

Surgical Coverage is limited to:

- Services for treatment or removal of tumors;
- Plan Physician services;

- X-ray examinations or other radiology services for the treatment of accidental injury to natural teeth;
- Surgery on the maxilla or mandible that is Medically Necessary to correct TMJ or other medical disorders; and
- Services in connection with accidental fracture of the jaw.

Upon Prior Authorization, you may elect to seek care at VHP's dental consultant's office.

Exclusions include routine dental services and dental treatment, hypnosis or biofeedback, and bruxism appliances. Submit your request for reimbursement for intra-oral devices and related services to VHP within 90 days of the date of service. Please contact Member Services for additional information.

Transplant Services

Human Organ, Tissue, and Bone Marrow Transplantation Services

VHP covers tissue and human organ transplantation for non-experimental procedures and donation-related services for actual or potential donors, including but not limited to:

- Preoperative evaluation
- Outpatient imaging and laboratory
- Outpatient Prescription Drugs and physician administered drugs
- Medically Necessary ambulance services
- Harvesting the organ, tissue, or bone marrow and for treatment of complications
- Surgery
- Follow-up care

Services for organ, tissue, and bone marrow transplants are subject to the limitations and exclusions as outlined in the "Limitations and Exclusions" chapter of this EOC. Plan Provider(s) must:

- Determine that you meet the Medical Necessity criteria developed for individuals needing transplants.

- Submit a referral to VHP for approval and requesting an evaluation by a Referral Specialist at a transplant Plan Hospital selected by VHP.

If the Plan Hospital or Referral Specialist to which you were referred by VHP determines that you do not satisfy its criteria for the transplant, VHP will only provide Coverage for the services you receive before that determination is made.

More than one evaluation (including tests) by a Referral Specialist at more than one transplant Plan Hospital will not be Authorized unless it is Medically Necessary. Travel expenses and hotel accommodations associated with organ, tissue and stem cell transplants are not covered by VHP.

The patient-selection committee of the VHP designated transplant center will select recipients. If Plan Physicians or the Referral Specialist or Plan Facility determines that you do not satisfy the patient selection criteria for the transplant, tissue and organ transplant procedures, services will be excluded from Coverage under your Benefit Plan. VHP will pay only for the services you received before that decision is made.

Applicable pharmacy Plan Benefit applies for immunosuppressive drugs prescribed after a covered transplant. Prescriptions are covered when obtained from a Plan Pharmacy.

Donor Services

Donor services include donation-related Covered Services for a donor, or an individual identified by the Authorized transplant Plan Hospital to be a potential donor, even if the donor is not a VHP Member. These Covered Services must be directly related to a covered transplant and are covered up to 12 months from the date of the transplant surgery. Benefits are reduced by any amounts paid or payable by the donor's own coverage. Only Medically Necessary services related to the organ donation are covered.

Travel Services

VHP covers worldwide Emergency Services and Urgently Needed Services. When out of the Service Area, all Covered Services must be Authorized by VHP except for Emergency Services and Urgently Needed Services. Refer to the "Receiving Care While Out-of-Network/Service Area" section of this EOC.

Travel immunizations as recommended by the U.S. Preventive Services Task Force are covered by your Benefit Plan. Travel health immunization consultations are not a covered Benefit. To obtain travel immunizations, you may contact your Plan Provider, Plan Pharmacy or VHP's Member Services Department at **1.888.421.8444 (toll-free)** for information on travel immunizations services.

Treatment Related to Judicial or Administrative Proceedings

Medical, mental health care or substance use services as a condition of parole or probation, and court-ordered treatment and testing are limited to Medically Necessary Covered Services.

Vision Therapy, Eyeglasses and Contact Lenses

VHP covers optometry services for vision screening, including a wide range of diagnostic testing, which include diabetes and glaucoma. As needed you will be referred to ophthalmology. If you have vision coverage through another plan offered by your employer, and you receive services provided by that plan, VHP will not cover any Copayments or costs for those services or items provided through your employer's vision plan.

VHP covers Eyeglass lenses, frames and contact lenses, including fitting and dispensing, non-implant low vision aides, and correction of visual acuity of refractive errors for those with a diagnosis of aphakia or aniridia and implanted lens to replace organic eye lens due to conditions such as cataracts. VHP does not cover vision therapy, eyeglasses or contact lenses without such diagnosis.

Call your Plan Network office to schedule Covered Services from a VHP Network optometrist.

For treatment of aniridia (missing iris), Coverage is limited to up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period, whether provided by the Plan during the current or a previous 12-month contract period.

For treatment of aphakia (absence of crystalline lens of the eye), Coverage is limited to up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per Calendar Year for Members, whether provided by the Plan during the current or a previous contract in the same Calendar Year.

In addition to the above Benefits, Medically Necessary visual aids (excluding eyewear unless otherwise covered above) are covered for diabetics who are visually impaired to assist with proper dosing insulin.

If your employer offers a vision benefit, refer to that carrier's provider list and coverage detail.

Chest and Cervical Cancer Screening and Pelvic Examinations (Previously Known as Well-Woman Examinations)

VHP covers diagnostic services, pelvic and breast examinations, Pap Smear, and other simple diagnostic services.

Annual cervical screenings include PAP tests, human papillomavirus screening that is approved by the FDA, and the option of any cervical cancer screen test approved by the FDA (i.e., liquid based prep test).

You may self-refer to an OB/GYN contracted by VHP for an examination once every Calendar Year.

Chapter 9: Limitations and Exclusions

This section describes the limitations and exclusions to your Benefit Plan.

VHP is not financially responsible for services that exceed the limitation or are excluded. Service refers to any item, drug (unless listed in the VHP Employer Drug Formulary and a Prescription is written by a Plan Provider), supply, equipment, device, service, treatment, benefit, or therapeutic or diagnostic procedure. When a particular service is excluded, any service necessary (or incidental) to that excluded service is also excluded, even if it would otherwise be covered.

The fact that a Plan Physician or other Plan Provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary, or make it a Covered Service.

It is extremely important to read this section before you obtain services in order to know what VHP will and will not cover.

Principal Limitations

This section describes the limitations and exclusions generally affecting services that are not available through the Benefit Plan. For specific Benefit limitations and exclusions, also refer to the “Medical Benefits and Prior Authorizations” chapter.

VHP will not be financially responsible for such limited or excluded services. Service refers to any item, drug (unless listed in the VHP Employer Drug Formulary and a Prescription is written by a Plan Provider), supply, equipment, device, treatment, benefit, or therapeutic or diagnostic procedure. When a particular service is excluded, any services necessary to that excluded service is also excluded, even if they would otherwise be covered. These exclusions or limitations do not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder.

The following items, procedures, Benefits, services, drugs, supplies, and equipment are limited under your Benefit Plan:

1. Covered Services are available only from Plan Providers in your Primary Network (unless such care is rendered as worldwide Emergency Services, Urgently Needed Services, or if Prior Authorized).
2. Covered Services provided by Non-Plan Providers are limited to those services rendered as worldwide Emergency Services or Urgently Needed Services, or for which you have obtained Prior Authorization before services are rendered.
3. If you seek Routine Care, Elective Medical Services, or follow-up from Non-Plan Providers without Authorization, VHP will not pay for your care, and you will be required to pay for the full cost of such services.
4. In the event of major disasters, epidemic, labor disputes, war, and other circumstances beyond VHP’s control, Plan Providers will provide Benefits to the extent practical, according to their best judgment within the limitations of available facilities and personnel. VHP will have no liability to you for delay or failure to provide services under such conditions. VHP will use its best efforts to provide Covered Services, however if Plan Providers are unable to provide services in the above noted circumstances, Member(s) should seek Emergency Services from the nearest facility, and the Plan will later provide reimbursement for Covered Services.
5. Non-emergency medical and psychiatric transport is limited to Medically Necessary vehicle transports to and from Covered Services inside the Service Area if your condition requires the use of services only a licensed ambulance or psychiatric transport van can provide and other means of transportation would endanger your health.
6. You may refuse, for personal reasons, to accept procedures or treatment recommended by your Plan Physician. If you refuse to follow a recommended treatment or procedure, your Plan Physician will inform you whether they believe there is no acceptable alternative treatment. You may seek a second medical opinion from any Plan Provider of your choice from the same or equivalent specialty. If you still refuse the recommended treatment or procedure, as required by Law, VHP will still be responsible to arrange for the provision and payment of all Medically Necessary Covered Services not refused by you.
7. Refraction eye examinations are limited to one per year.
8. VHP reserves the right to apply Coordination of Benefits (COB) as outlined in the Agreement. Your Benefits are limited by the application of COB. As a

Member, you have an obligation to cooperate and assist VHP to coordinate Benefits by providing information to all health service providers on any other coverage you and your Dependent(s) have that pays for health care services.

9. VHP reserves the right to seek third party liability (TPL) reimbursement as outlined in the Agreement. Your Benefits are limited by recoveries from third parties. As a Member, you have the obligation to cooperate fully in our efforts by signing any forms necessary to assist VHP in obtaining TPL recoveries.

10. VHP will pay for Medically Necessary, custom-fabricated mandibular advancement oral devices or appliances to treat Obstructive Sleep Apnea (OSA) and other medical conditions for which the oral device or appliance has proven efficacy. These are not simple "mouth guards" or "night guards," which are not a covered Benefit. The appliance or device must be FDA-approved for the condition. Benefit is for all aspects related to producing and fitting the device, including, but not limited to, the taking of impressions, modeling, fabricating, and fitting and readjustment of the device or appliance for up to 90 days after the initial fitting. VHP's Coverage is secondary to any dental insurance coverage you may have that provides coverage for any part of the production, fitting, and adjusting of the device. Explanation of benefits or denials from your dental insurance carrier must accompany receipts for which you seek reimbursement.

11. Phenylketonuria formula and special food product reimbursement is limited to the amount and duration that the Plan Physician deems Medically Necessary. Special formulas for allergy, for example cow's milk, soy, or lactose intolerance milk are not a Covered Service under your Benefit Plan.

Principal Exclusions

The following items, procedures, Benefits, services, drugs, supplies, and equipment are excluded (i.e., not covered) under your Benefit Plan, except for certain Medically Necessary provision of services. These exclusions or limitations do not apply to Medically Necessary Treatment of a Mental Health or Substance Use Disorder. Further exceptions can be found under the "Medical Benefits and Prior Authorizations" chapter:

1. Services furnished by a facility which is primarily a place for rest, a place for the aged, a nursing home or any facility of like character, except as specifically provided as Covered Services.

2. Services not Medically Necessary as determined by the treating physician, except Reconstructive Surgery.
3. Services rendered by Non-Plan Providers except in an Emergency, or Urgently Needed Services, or upon Prior Authorization by the Medical Director or designee.
4. Services rendered when not an Eligible Member, prior to the Member's Effective Date of Coverage, or after the time Coverage ends.
5. Services that are court ordered or as a condition of incarceration, parole, or probation, unless determined Medically Necessary by the Medical Director or part of a Community Assistance, Recovery and Empowerment Court Program agreement or plan. Community Assistance, Recovery and Empowerment Court Program services do not require Prior Authorization, have zero cost share and can be provided by in-network providers or Out-of-Network providers, however Prescription drugs that are part of this treatment program are subject to standard cost sharing and Authorization requirements for Non-Formulary Drugs.
6. Services which exceed the limitations or fail to meet the conditions of Covered Services contained in this EOC or as required by State and federal Law.
7. Services and treatment not approved by the Food and Drug Administration.
8. Charges for services which the Member would not be obligated to pay in the absence of the Agreement or which are provided to the Member at no cost.
9. Acupuncture services except as specifically listed as a Covered Service in the "Acupuncture Services" section.
10. Anorectics or any other drug used for the purpose of weight control, unless Medically Necessary.
11. Aquatic therapy and other water therapy, except aquatic therapy and other water therapy services that are part of a physical therapy treatment plan and covered in the "Medical Benefits and Prior Authorizations" chapter under "Outpatient Services," "Hospitals - Inpatient Services," "Home Health Care," and "Hospice Care." This exclusion does not apply to services deemed Medically Necessary for Treatment of a Mental Health or Substance Use Disorder.
12. Prescription Drugs for treatment of infertility that not on Employer Drug Formulary, donor sperm, and sperm preservation, except standard fertility

preservation services when a covered treatment may directly or indirectly cause Iatrogenic Infertility.

13. Clinical trial services except as specifically listed as a Covered Service in the "Medical Benefits and Prior Authorizations" chapter under "Clinical Trial Services" section of this EOC.
14. Chiropractic services except as specifically listed as a Covered Service in the "Chiropractic Services" section of this EOC.
15. Classes and equipment that are solely for exercise, recreation, self-help, hygiene, and beautification, except as specifically listed as a Covered Service.
16. Conception by artificial means, such as in-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), and gamete intrafallopian transfer (GIFT) or any other process that involves the harvesting or manipulation (physical, chemical, or by any other means) of the human ovum to treat infertility, unless the Iatrogenic Infertility is caused directly or indirectly by a covered treatment.
17. Cosmetic Surgery or plastic surgery except as specified as a Covered Service in the "Definitions" and "Medical Benefits and Prior Authorizations" chapters of this EOC under "Mastectomies & Lymph Node Dissections".
18. Cosmetics, herbal products and treatments, dietary supplements, health, or beauty aids.
19. Custodial or Domiciliary Care, except as required under hospice care.
20. Dental services except as specified as Covered Services in the "Medical Benefits and Prior Authorizations" chapter of this EOC.
21. Devices or appliances except Medically Necessary diabetic, Prosthetic Devices, and Orthotic Devices. Specifically excluded devices include, but are not limited to, the following: garter belts, and similar devices, experimental or research equipment, devices not medical in nature, modifications to a home or automobile, deluxe equipment, non-standard equipment, more than one piece of equipment that serves the same function, more than one (1) device for the same part of the body, electronic voice producing machines. Unless Medically Necessary, with Prior Authorization, Orthotic Devices are limited to one device per year.
22. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressing, ACE-type bandages, and diapers, underpads, and other incontinent supplies. This exclusion does not apply to supplies or devices under the

"Ostomy and Urological Supplies" in the "Medical Benefits and Prior Authorizations" chapter of this EOC.

23. Educational services, which a Member might be eligible under State Law, including Lanterman Developmental Disabilities Services Act, California Early Intervention Services Act, and services delivered as part of an individualized education program for individuals with exceptional needs, except as expressly provided as covered Benefits. Refer to the "Medical Benefits and Prior Authorizations" chapter under "Health Education Services." This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
24. Emergency room services for non-emergency care.
25. Experimental or Investigational Treatment except as expressly provided as a Covered Service. Independent Medical Review of a Denial of Coverage by VHP for Experimental and Investigational Treatment is available. Refer to the "Medical Benefits and Prior Authorizations" chapter under "Clinical Trial Services," and in the "Choice of Physicians & Providers" chapter under "Independent Medical Review."
26. Gastric bubble, gastroplasty, gastric bypass, bariatric surgery, Laparoscopic Gastric Band (lap-band) surgery, and gastric stapling except when determined to be Medically Necessary by the Plan Provider.
27. Hair loss or growth treatment for the promotion, prevention, or other treatment of hair loss or hair growth. This exclusion does not apply to services deemed Medically Necessary Treatment of a Mental Health or Substance Use Disorder.
28. Hearing aid batteries
29. Human Chorionic Gonadotropin (HCG) Injections, unless Medically Necessary with the appropriate VHP Prior Authorization.
30. Human Growth Hormone (HGH), except for Members with confirmed HGH deficiency, and Covered Services are recommended by a Plan Specialist as Medically Necessary with the appropriate VHP Prior Authorization.
31. Services related to the diagnosis and treatment of infertility as identified in this "Principal Exclusions" section, except for fertility preservation for treatment of Iatrogenic Infertility.
32. Liposuction.

33. Massage therapy, except massage therapy services that are part of a physical therapy treatment plan and covered in the "Medical Benefits and Prior Authorizations" chapter under "Outpatient Services," "Hospitals - Inpatient Services," "Home Health Care," and "Hospice Care."
34. Medical and Hospital Services of a donor or prospective donor where the recipient of an organ, tissue or bone marrow transplant is not a Member. Covered Services for a non-member donor must be directly related to a covered transplant of a Member. Independent Medical Review of a Denial of Coverage by VHP for Experimental and Investigational Treatment is available. Refer to the "Choice of Physicians & Providers" chapter under "Independent Medical Review."
35. Mental Health and Substance Use Disorder services that are court ordered, or as a condition of incarceration, parole or probation, except if a Plan Physician determines that the services are Medically Necessary Covered Services in the "Medical Benefits and Prior Authorizations" chapter or part of a Community Assistance, Recovery and Empowerment Court Program agreement or plan. Community Assistance, Recovery and Empowerment Court Program services do not require Prior Authorization, have zero cost share and can be provided by in-network providers or Out-of-Network providers, however Prescription drugs that are part of this treatment program are subject to standard cost sharing and Authorization requirements for Non-Formulary Drugs.
36. Military service-connected disability care for which a Member is covered or is eligible for such care through another group, whether insured or self-insured.
37. Non-health care services including but not limit to:
    a. Teaching manners and etiquette
    b. Teaching how to read regardless of dyslexia
    c. Teaching and support services to develop planning skills such as daily activity planning and project or task planning, or to increase intelligence
    d. Items or services for the purpose of increasing academic knowledge or skills
    e. Teaching art, dance, horse riding, music, play or swimming except services that are part of a behavioral health therapy treatment plan and covered under "Outpatient Mental Health and Behavioral Health

Treatment Provided by a Psychiatrist" in the "Medical Benefits and Prior Authorizations" chapter.

f. Vocational training or teaching vocational skills

g. Professional growth courses, academic coaching or tutoring for skills such as grammar, math, financial and time management

h. Training for a specific job or employment counseling.

This exclusion does not apply to the Members who determined to be Medically Necessary Treatment of a Mental Health or Substance Use Disorder.

38. Oral nutrition, such as dietary supplements, herbal supplements, weigh loss aids, formulas, and food. This exclusion does not apply to Members where oral nutrition is determined to be Medically Necessary Treatment of a Mental Health or Substance Use Disorder.

39. Organ, tissue, and bone marrow transplants considered Experimental or Investigational Treatment.

40. Organ, tissue, and bone marrow transplants treatment, including medical and Hospital Services for a Member who is a donor or prospective donor when the recipient of an organ, tissue or bone marrow transplant is not a Member. Covered Services for a non-member donor must be directly related to a covered transplant of a Member.

41. Organ donor searches and recipient or donor transportation costs to the transplantation center.

42. Out-of-Network opinions, except as a covered Benefit. Independent Medical Review of a Denial of Coverage by a Plan Provider for Experimental and Investigational Treatment is available. Refer to the "Choice of Physicians & Providers" chapter under "Independent Medical Review."

43. OTC drugs, shoe inserts, medications, and supplies are not a covered Benefit, except as specified in this membership Agreement and EOC.

44. Penile implants and services related to the implantation of penile prostheses, except as Medically Necessary for direct physical trauma, tumor, or physical disease to the circulatory system or the nerve supply. Refer to the "Medical Benefits and Prior Authorizations" chapter of this EOC.

45. Personal lodging, meals, travel expenses and all other non-medical expenses.

46. Personal or comfort items which are non-medical, environmental enhancements and environmental adaptations, modifications to dwellings, property or motor vehicles, adaptive equipment and training in the operation and use of vehicles.
47. Physical exams (including psychological examinations or drug screening), evaluations and reports for the purpose of employment, insurance, licensing, school, sports, camp, or recreation.
48. Prescription Drugs and accessories not Medically Necessary or in accordance with professionally recognized standards of care. Non-prescription drugs or medications, including over-the-counter drugs. Non-FDA approved drugs. Generic equivalents not approved as substitutable by the FDA. Non-FDA approved treatment using investigational new drugs. Independent Medical Review of a Denial of Coverage by VHP for Experimental and Investigational Treatment is available. Refer to the "Choice of Physicians & Providers" chapter under "Independent Medical Review."
49. Prescriptions from non-plan pharmacies, except in connection with Emergency Services, Urgently Needed Services, or upon Prior Authorization. Refer to the "Medical Benefits and Prior Authorizations" chapter and "Emergency Services" and Urgently Needed Services" sections of this EOC.
50. Private duty nursing means continuous nursing services provided by a licensed nurse (registered nurse, licensed vocational nurse or licensed practical nurse) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a hospital or Skilled Nursing Facility. Private duty nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private duty nursing may be provided in an inpatient or outpatient setting, or in a noninstitutional setting, such as at home or at school. Private duty nursing may also be referred to as shift care and includes any portion of shift care services. VHP will cover special duty nursing services as Medically Necessary.
51. Radial keratotomy (laser-assisted in situ keratomileusis surgery) unless Medically Necessary intervention for the treatment of certain eye conditions.
52. Reversal of voluntary sterilization or of voluntary induced infertility.
53. Routine/cosmetic foot care, including trimming of corns, calluses, and nails, massage of any type and treatment for fallen arches, flat or pronated feet

unless Medically Necessary for a diabetic condition or peripheral vascular disease. Additionally, treatment for cramping of the feet, bunions and muscle trauma are not covered, unless Medically Necessary.

54. Services for anyone in connection with a surrogacy arrangement, except for otherwise -Covered Services provided to a Member who is a surrogate.
55. Sports activities and costs associated, including, but not limited to, yoga, rock climbing, hiking, and swimming.
56. Temporomandibular joint (TMJ) disorder services that are not Medically Necessary.
57. Vision care, including items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia or astigmatism, except as provided in the Agreement in the "Medical Benefits and Prior Authorizations" chapter of this EOC.
58. Vocational Rehabilitation.
59. Weight control, weight loss treatments, weight loss surgery, or related supplies unless Medically Necessary or except as specifically provided as Covered Benefits in the "Medical Benefits and Prior Authorizations" chapter of this EOC.
60. Personal or comfort items.

Chapter 10: Payment and Reimbursement Responsibility

Prepayment Fees (Premiums)

Your employer is responsible for paying your membership premiums. Your employer will notify you if you are responsible for any portion of these charges. If you have questions regarding information about the method, amount, or frequency of your contribution (if any), please contact your employer.

If the Group no longer employs you and you wish to continue receiving VHP Benefits, VHP must receive your premiums. Continued Coverage is only available for the period when premiums are received and if you are covered under:

- COBRA or the Consolidated Omnibus Budget Reconciliation Act - you will be required to make monthly prepayment premiums directly to the Group. The Group will be responsible for distributing these fees to VHP (Note: Group may designate a Group COBRA Administrator to administrate and submit premiums directly to VHP).
- Cal-COBRA or the California Continuation Benefits Replacement Act - you will be required to make monthly prepayment premiums directly to VHP (Note: VHP may designate a Cal-COBRA administrator or Group to administrate and submit premiums directly to VHP).
- Continuation of Coverage for Totally Disabled Members - you will be required to make payments directly to the Group. The Group will be responsible for distributing these fees to VHP.

Changes in Fees, Benefits, and Charges

VHP may change the premiums and Benefits, to the extent permitted by Law, during the term of the Agreement. If there are changes or modification to your Benefits, to other charges, such as Copayments, or to the cost of contribution to your membership premiums, your employer will notify you of the change in writing and reason(s) why.

Other Charges

When you receive medical care, you may be responsible for paying certain Copayments. A Copayment is a charge made at the time-of-service payable to the Medical Service provider. For your information and convenience, a schedule of the Covered Services and applicable Copayment, refer to the "Summary of Benefits and Coverage" and "Schedule of Benefits and Coverage Matrix."

Annual Copayment Maximum

There is a limit to the Copayments and other charges that you must pay in any Calendar Year. The Copayment limit per Calendar Year is:

- $1,000.00 for an individual, or
- $2,000.00 for a family. (not applicable to In Home Support Services Group Members)

Once you have reached the limit, you will not be required to pay any additional Copayments or other charges for the remainder of the Calendar Year.

VHP is required to provide Members with a report of your most up-to-date accrual balances towards your annual Deductible and Out-of-Pocket Maximum expenses at any time. You can contact VHP by one of the following methods to request this report:

VHP Member Services
2480 N. First Street, Suite 160
San Jose, CA 95131

1.888.421.8444 (toll-free)
MemberServices@vhp.sccgov.org

Upon request, VHP will mail you this report to the mailing address on file. You may also request the report of your most up-to-date accrual balances towards your annual Deductible and annual Out-of-Pocket Maximum be emailed to you at any time.

You will soon begin receiving a monthly report that includes your annual Deductible accrual balance and your annual Out-of-Pocket Maximum accrual balance for every month in which benefits were used until the Deductible and Out-of-Pocket Maximum are both met. Accrual balance information will be mailed to you unless you elect to opt out of mailed notices. Accrual balance information will be sent electronically to you if you opt to receive electronic notices. You will be able to view your most up-to-date balance accrual information and change your communication preferences at any time through a Member portal that will soon be available at **www.valleyhealthplan.org** .

Maximum Lifetime Benefit

There is no maximum lifetime Benefit (on essential Benefits) that applies to the Covered Services described in this booklet. The only maximum Benefit limits are those specifically mentioned in this booklet.

Provider Payments

VHP contracts with its Plan Providers to provide Covered Services to its Members. Plan Providers include clinics, hospitals, SNFs, Urgent Care and surgery centers, community clinics, a Pharmacy Benefits Manager (PBM), and a 24/7 Nurse Advice Line - to name just a few. Under the terms and conditions of your membership with VHP, you must obtain services from these Plan Providers unless you are Authorized to receive services elsewhere or in the event of an Emergency or Urgently Needed Services.

VHP's financial arrangements with Plan Providers are reviewed and approved by the DMHC. No financial incentives are utilized for any provider.

Providers are paid based on the terms and conditions of their agreements with VHP. Plan Providers are paid in accordance with those contractual agreements. Members are responsible for payment of Copayments (including Deductible and co-insurance, if applicable) and for Non-Covered Services.

Reimbursement Provisions (Claims)

VHP has designed Coverage in a way to minimize the need for you to file a Member Claim for medical or pharmacy services. If for some reason you are billed or have paid for services, submit the itemized bill and/or your original receipt showing proof of payment with your request for reimbursement within 90 days of the service date (or as soon as possible thereafter) you receive those Covered Services.

Medical Claim Reimbursement

The "Medical Claim Reimbursement Form" should be completed in its entirety and signed by the Subscriber. VHP will process the request for reimbursement within 45 working days of receiving a "Medical Claim Reimbursement Form" that is complete and ready for processing.

Submit your "Medical Claim Reimbursement Form" and supporting documents to:

By Mail:
Valley Health Plan Attention: Member Services Department
2480 N. First Street, Suite 160
San Jose, CA 95131

By Email: **MemberServices@vhp.sccgov.org**

Be sure Member name, Member identification number, date and type of service, the PCP's name, and any other pertinent information (such as original receipts, doctor notes, etc.) are included in your request. You must fill out the reimbursement claim form completely.

To obtain additional information or for a "Medical Claim Reimbursement" Form contact VHP's Member Services Department at 1.888.421.8444 (toll-free) or go online to VHP's website at www.valleyhealthplan.org in "Forms and Resources" under "Members".

Pharmacy Claim Reimbursement

For pharmacy claims, submit your claim to:

Navitus Health Solutions Operations Division – Claims
P.O. Box 999
Appleton, WI 54912-0999

To obtain a "Prescription Reimbursement Form" go online to VHP's website at **www.valleyhealthplan.org** in "Forms and Resources" under "Members". You may also obtain a "Prescription Reimbursement Form" at **www.navitus.com**or by calling Navitus Customer Care, 24 hours a day/7 days per week, at **1.866.333.2757 (toll-free)**.

To submit a "Prescription Reimbursement Form" for reimbursement, you must provide specific information about the Prescription, the reason you are requesting reimbursement, and any payments made by you or on your behalf. Be sure the Member's name, the Member's identification number, date and type of service, the PCP's name, and any other pertinent information (such as original receipts, doctor notes, etc.) are included in your request. You must fill out the reimbursement claim form completely. VHP will process the request for reimbursement within 45 days of receiving complete information.

Other Important Considerations for Member Reimbursement of Claims

VHP may reimburse you or the Plan Provider, less any applicable Copayment, for Covered Services. If a request for reimbursement is denied or partially denied, you and the Plan Provider will receive written notice specifying the reason for the Denial.

VHP's Utilization Management Department reviews all services performed by Non-Plan Providers or Plan Providers outside the Member's Primary Network to assess Medical Necessity and appropriateness of care. If you receive Covered Services from a Non-Plan Provider for either an Emergency, Urgently Needed Services, or for Authorized services, VHP will reimburse you or the Non-Plan Provider for those Covered Services, less any applicable Copayment(s). If the services from the Non-

Plan Provider are Non-Covered Services or you have exceeded the Benefit limits, VHP will deny your request for reimbursement.

Members are financially responsible to pay Plan Providers for applicable Member Copayments and charges for Non-Covered Services. If VHP fails to pay a Plan Provider for Covered Services, you will not be liable to the Plan Provider for any sums owed by VHP. As required by California Law, every contract between VHP and a Plan Provider contains a provision to this effect. However, if VHP fails to pay a Non-Plan Provider or a Plan Provider outside your Primary Network, you may be liable to the Non-Plan Provider or Plan Provider for the cost of the Covered Service.

Liability of Subscriber or Member for Payment

VHP Members are not liable for charges for Covered Services Authorized by VHP or VHP's designee. A Copayment may be required for some services. The specific Copayment or other charges for your Benefit Plan can be found in the "Summary of Benefits and Coverage" and "Schedule of Benefits and Coverage Matrix."

If you receive care that is not performed by your PCP or Authorized by VHP, you will be financially responsible for the cost of care provided. This does not apply if you receive Emergency Services or Urgently Needed Services that are Covered Services.

If you receive care that is a Non-covered service or if you receive services from a Non-Plan Provider that have not been Authorized by VHP, you will be financially liable for such services. Non-Covered Services are listed in the "Limitations and Exclusions" chapter and the "Benefit Description Section".

Coordination of Benefits Reimbursement

The Covered Services under this EOC are subject to Coordination of Benefits rules. Coordination of Benefits (COB) is a process, regulated by Law, that determines financial responsibility for payment of allowable expenses between two or more group insurance plans.

Members must notify VHP if they are covered under another health insurance plan.

Third Party Reimbursement / Liability

In cases of injuries caused by any act or omission of a third party (including, without limitation, motor vehicle accidents and injuries, and illnesses covered by workers' compensation) and complications incident thereto, VHP will furnish Covered Services. However, you must inform VHP or your Provider when services performed are covered through Workers' Compensation Laws, automobile, accident, or other liability coverage.

VHP will not duplicate Coverage for such services. When a legitimate dispute exists as to third party liability, VHP will furnish Covered Services until the dispute is resolved. You must agree to supply all information and sign the appropriate documents necessary to carry out VHP's right to recover its costs for the services provided or for VHP to obtain a lien. Otherwise, VHP may deny Coverage for such reimbursement. As necessary, VHP and/or its Plan Providers will seek reimbursement up to the amount VHP has paid for any services which are ultimately determined to be the responsibility of another insurer. In the case of a monetary award, VHP or its Plan Providers or Non-Plan Providers Authorized by VHP to render services to you must be reimbursed immediately after the award is received. You are responsible for notifying VHP of any payment made for such services. VHP also has the option to be subrogated to your rights to the extent of the cost of Benefits provided by VHP; meaning that VHP has the right to collect directly from any third party who is responsible for such liability when payment has been made by VHP for services.

Chapter 11: Your Rights and Responsibilities

As a Member, you have the right to:

1. Exercise these rights without regard to race, color, national origin, age, religion, disability, sex, sexual orientation, gender identity, gender expression, creed, family history, marital status, veteran status, national origin, handicap, or condition, without regard to your cultural, economic, or educational background, or source(s) of payment for your care, or any other classification prohibited by State or federal Laws.
2. Be treated with dignity, respect, consideration, and your right to privacy.
3. Expect health care providers (doctors, medical professionals, and their staff) to be sensitive to your needs.
4. Be provided with information about VHP, its services, and Plan Providers and Member rights and responsibilities;
5. Know the name of the Primary Care Provider who has primary responsibility for coordinating your health care and the names and professional relationships of other Plan Providers you see.
6. Actively participate in your own health care, which to the extent permitted by Law, includes the right to receive information so that you can accept or refuse recommended treatment.
7. Receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse this course of treatment or procedure. Except for Emergency Services this information will include a description of the procedure or treatment, the medically significant risks involved, alternative courses of action and the risks involved in each, and the name of the Plan Provider who will carry out the treatment or procedure.

8. Full consideration of privacy concerning your course of treatment. Case discussions, consultations, examinations, and treatments are confidential and should be conducted discreetly. You have the right to know the reason should any person be present or involved during these procedures or treatments.
9. Confidential treatment of information in compliance with State and federal Law including HIPAA (including all communications and medical records) pertaining to your care. Except as is necessary in connection with administering the Agreement and fulfilling State and federal requirements (including review programs to achieve quality and cost-effective medical care), such information will not be disclosed without first obtaining written permission from you or your authorized representative.
10. Receive complete information about your medical condition, any proposed course of treatment, and your prospects for recovery in terms that you can understand.
11. Give informed consent unless medically inadvisable, before the start of any procedure or treatment.
12. Refuse health care services to the extent permitted by Law and to be informed of the medical consequences of that treatment, unless medically inadvisable.
13. Readily accessible and ready referral to Medically Necessary Covered Services.
14. A candid discussion of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit Coverage
15. A second medical opinion, when medically appropriate, from another Plan Physician within your VHP Provider Network.
16. Be able to schedule appointments in a timely manner.
17. Reasonable continuity of care and advance knowledge of the time and location of your appointment(s).
18. Reasonable responses to any reasonable requests for Covered Services.
19. Have all lab reports, X-rays, specialist’s reports, and other medical records completed and placed in your files as promptly as possible so that your Primary Care Provider can make informed decisions about your treatment.

20. Change your Primary Care Provider.
21. Request and expedited change of a provider due to Medical Necessity.
22. Review your medical records, unless medically inadvisable.
23. Be informed of any charges (Co-payments) associated with Covered Services.
24. Be advised if a Plan Provider proposes to engage in or perform care or treatment involving experimental medical procedures, and the right to refuse to participate in such procedures.
25. Leave a Plan Facility or Hospital, even against the advice of Plan Providers.
26. Be informed of continuing health care requirements following your discharge from Plan Facilities or Hospitals.
27. Be informed of, and if necessary, given assistance in making a medical Advance Health Care Directive.
28. Have rights extended to any person who legally may make decisions regarding medical care on your behalf.
29. Know when Plan Providers are no longer under a contractual arrangement with VHP.
30. Examine and receive an explanation of any bill(s) for Non-Covered Services, regardless of the source(s) of payment.
31. File a Grievance without discrimination through VHP or appropriate State or federal agencies.
32. Know the rules and policies that apply to your conduct as a Member.
33. Make recommendations regarding the organization’s Member rights and responsibilities policy.
34. Participate with practitioners in making decisions about your health.
35. Know Provider credentials are available by request or through the provider directory.
36. Receive information regarding malpractice insurance on providers upon request.

A Member has the responsibility to:

1. Provide complete & accurate information (to extent possible) that VHP and its practitioners/providers need in order to provide care. Inform practitioner/provider about any health issues, medications, and allergies. This information should also include living will, medical power of attorney, or other directive that could affect care.
2. Follow plans and instructions for care that you have agreed to with your practitioner.
3. Accept fiscal responsibility for any cost of share, such as Premiums, Deductibles, Coinsurance, or Copayments.
4. Accept fiscal responsibility associated with Non-Covered Services. Covered Services are available only through Plan Providers in your VHP Network (unless such care is rendered as worldwide Emergency Services or is Prior Authorized).
5. Adhere to behavior that is reasonably supportive of therapeutic goals and professional supervision as specified.
6. Treat healthcare providers, staff, and others with respect to prevent any interference with your Plan Provider or their ability to provide care.
7. Cooperate with VHP or a Plan Provider's third-party recovery efforts or Coordination of Benefits
8. Safeguard the confidentiality of your own personal health care as well as that of other Members.
9. Participate in your health care by scheduling and keeping appointments with Plan Providers. If you cannot keep your appointment, call in advance and reschedule or cancel.
10. Report any changes in your name, address, telephone number, or your family's status to your employer, and a VHP Member Services Representative.
11. Inform your provider if you have a living will, medical power of attorney, or other directives affecting care.
12. Understand your health problems and participate in developing mutually agreed upon treatment goals, to the degree possible

Chapter 12: General Information

This Combined Evidence of Coverage and Disclosure Form constitutes only a summary of the health Plan. The health Plan contract must be consulted to determine the exact terms and conditions of Coverage.

Governing Law

VHP is subject to State and federal Laws, including the Knox-Keene Health Care Service Plan Act, and the regulations issued by the DMHC. The terms and provisions of the Agreement may be amended or modified if the Law requires such amendments or modifications. Any provisions required in this EOC by the above regulators will bind you and VHP whether or not expressly provided for in this document.

Suspension of Services

In the event of an Emergency or circumstances not within the control of VHP, suspension of services may occur. Suspension of services may result in the facilities, personnel, or resources of VHP or its Plan Providers becoming unavailable to provide or arrange for health care services pursuant to the Agreement. Taking into account the nature of the event, VHP's obligation will be limited to the requirement that it makes a good-faith effort to provide or arrange for Covered Services.

Privacy Practices & Protected Health Information

VHP will protect the privacy of your Protected Health Information (PHI). VHP also requires contracting providers to protect your PHI. Your Protected Health Information is individually identifiable information (oral, written, or electronic) about your health, health care services you receive or payment for your health

care. You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means.

We may use or disclose your Protected Health Information for treatment, health research information for treatment, health research, payment, and health care operations purposes such as measuring the quality of services. We are sometimes required by Law to give Protected Health Information to others, such as government agencies or in judicial actions.

We will not use or disclose your Protected Health Information for any other purpose without your (or your representative's) written authorization, except as described in our Notice of Privacy Practices.

You may view the Notice of Privacy Practices at **www.valleyhealthplan.org**. To request a copy, contact VHP's Member Services Department at **1.888.421.8444 (toll-free)**.

A STATEMENT DESCRIBING VALLEY HEALTH PLAN'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Privacy Practices Regarding Confidential Information or Sensitive Services

A Member may also call Member Services at **1.888.421.8444 (toll free)** to request, and VHP will accommodate request for, confidential communications in the form and format requested by the Member, if it is readily producible in the requested form and format, or at alternative locations. The confidential communication request shall apply to all communications that disclose medical information or provider name and address related to receipt of medical services by the individual requesting the confidential communication. The confidential communication request will be valid until the Member submits a revocation of the request or a new confidential communication request is submitted.

If a protected individual has designated an alternative mailing address, email address, or telephone number to receive confidential communications, VHP will direct all communications regarding Sensitive Services to that alternative mailing address, email address, or telephone number.

If a protected individual **has not** designated an alternative mailing address, email address, or telephone number to receive confidential communications, VHP will direct all communications regarding Sensitive Services in the name of the protected individual at the address or telephone number on file.

A "protected individual" means any adult covered by the Subscriber's health care service plan or a minor who can consent to a health care service without the consent of a parent or legal guardian, pursuant to State or federal Law. "Protected individual" does not include an individual that lacks the capacity to give informed consent for health care. Communications regarding a protected individual's receipt of Sensitive Services include:

- Bills and attempts to collect payment.
- A notice of adverse benefits determinations.
- An explanation of benefits notice.
- A health care service plan's request for additional information regarding a claim.
- A notice of a contested claim.
- The name and address of a provider, description of services provided, and other information related to a visit.
- Any written, oral, or electronic communication from the Plan that contains Protected Health Information.

VHP will not release medical information related to a person or entity allowing a child to receive gender affirming health care or mental health care in response to any civil action, including a foreign subpoena, based on another state's Law that authorizes a person to bring a civil action against a person or entity that allows a child to receive gender affirming health care or mental health care.

Membership Records/Information

VHP membership record contains eligibility and other information about each of its Members. This information is important because it identifies you as a Member and determines where Members can receive services. Incorrect records can delay medical care, create problems in Coverage, and possibly cost you money.

It is important to keep your Member records updated with current information. It is your responsibility to keep your membership records updated. Contact your employer and call the VHP Member Services office at **1.888.421.8444 (toll-free).**

Membership Records – Employer Responsibilities

Your employer provides VHP with updated eligibility/enrollment information; including the Effective Date of Coverage, name, address, telephone numbers, dependent status, and other carrier benefits information. Your employer is also responsible for notifying VHP of status changes including marriage, death, termination of employment, reduction in hours, or entitlement to Medicare. Therefore, it is necessary for you to notify your employer or employer's human resources department of any changes you may have to your eligibility and membership information.

Public Policy Committee

You may assist VHP to establish public policy through VHP's Public Policy Committee, the VHP Member Advisory Board. The findings and recommendations of this Advisory Board are regularly reported to VHP's governing body. A minimum of 51% of the committee must be Members of VHP. "Public policy" means acts performed by VHP and its employees to assure the comfort, dignity, and convenience of Members who rely on Plan Providers to provide services. Contact a VHP Member Services Representative at **1.888.421.8444 (toll-free)** if you are interested in becoming an Advisory Board member or would like more information.

Advance Health Care Directive - Your Health Care Choices

An Advance Health Care Directive is a formal document, signed by you in advance of a severe illness or injury, which will guide your physician(s) when providing treatment. Notwithstanding this document, you still have the right to make medical and other health care decisions for yourself so long as you can give informed consent regarding the particular decision. As long as you can speak for yourself, Plan Providers will honor your wishes. But, if you become so incapacitated that you

cannot make an informed decision, this directive will guide your health care treatment based on the directions you set out in the Advance Health Care Directive.

There are two (2) basic types of Advance Health Care Directives in California that provide guidance to your physicians if there is a disagreement results about your wishes. They are:

- Durable Power of Attorney for Health Care Decisions (DPAHCD), and
- Natural Death Act Declaration.

The most common method is the DPAHCD which requires the completion of a California Advanced Health Care Directive Form. You can find a copy of this form online at **www.valleyhealthplan.org** under Forms & Resources, Advanced Health Care Directive or by visiting the California Attorney General's offices website at **https://oag.ca.gov/**.

The policies involving your right to make medical treatment decisions may vary from facility to facility. For example, operating rooms typically suspend Advance Health Care Directives and provide all appropriate resuscitative and life-prolonging treatment during surgery and recovery.

It is your responsibility to inquire about and comply with the policies of your hospital or other health care facility about Advance Health Care Directives. Give copies of your completed Advance Health Care Directive to your physician, your representative (if designated), and your family. Be sure to keep a copy for yourself and take one with you when you are hospitalized.

You are not required to have an Advance Health Care Directive. If you do not have an Advance Health Care Directive, you can and will still be treated.

If you have any questions regarding your health care choices or need help obtaining forms, please contact your Primary Care Provider or a Member Services Representative at **1.888.421.8444 (toll- free).**

Chapter 13: Definitions

Active Labor means a labor at a time at which either of the following would occur:

1. There is inadequate time for safe transfer to another hospital prior to delivery; or
2. A transfer may pose a threat to the health and safety of the patient or the unborn child.

Acute Condition means a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration.

Advance Health Care Directive means a formal document, signed by you in advance of a severe illness or injury, which will guide your care if you become so incapacitated that you cannot make an informed decision.

Agreement means the Group Service Agreement, including but not limited to this Combined Evidence of Coverage and Disclosure Form, any and all applications and information submitted by the Group and Members in applying for Coverage, attachments, addenda, and any amendments that may be added in the future. The Agreement contains the exact terms and conditions of your Coverage. It incorporates all of the contracts, promises, and agreements exchanged by the Group and VHP. It replaces any and all prior or concurrent negotiations, agreements, or communications, whether written or oral, between both parties with respect to the contents of the Agreement.

Authorized, Authorization, Prior Authorized, or Prior Authorization is VHP's formal process requiring a Plan Provider to obtain advance approval from VHP Utilization Management Department or VHP's designee before a Member can receive certain Medically Necessary Covered Services, including without limitation Elective Medical Services, treatments, Prescriptions, or procedures.

Behavioral Health Treatment means professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of an individual with autism spectrum disorder and that meet all of the following criteria:

1. Treatment is prescribed by a Plan Provider or a psychologist, licensed pursuant to California Law.
2. Treatment is provided under a treatment plan prescribed by a qualified autism service (QAS) Plan Provider and administered by a QAS provider, a QAS professional supervised by the QAS provider, or a QAS paraprofessional supervised by a QAS provider or QAS professional;
3. The treatment plan has measurable goals developed and approved by the QAS provider that is reviewed every six months and modified where appropriate; and
4. The treatment plan is not used to provide or reimburse for respite, day care, educational service, or participation in the treatment program.

Benefit(s) means the Covered Services provided for under the Benefit Plan.

Benefit Plan means the Covered Services contained in this Combined Evidence of Coverage and Disclosure Form. Any date referenced in this Benefit Plan begins at 12:01am, Pacific Standard Time.

Brand Name Drug means a drug that is marketed under a proprietary, trademark protected name. The Brand Name Drug will be listed in all CAPITAL letters in VHP's Formulary.

Cal-COBRA (California Continuation Benefits Replacement Act) means the California legislation that requires insurance carriers and HMOs to offer continued access to group health care coverage provided to employees, and their Dependents, of employers with 2 to 19 Eligible Employees who are not currently offered continuation coverage under COBRA and whose coverage would end due to termination layoff, or other change in employment status. Cal-COBRA also means you may have the opportunity of group continuation coverage when coverage would otherwise cease due to the termination of COBRA.

Calendar Year means a 12-month period that begins on January 1 and ends 12 consecutive months later on December 31.

Case Management means a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet the member's health and human service needs.

COBRA (Consolidated Omnibus Budget Reconciliation Act) is the federal legislation that extends your group health plan benefits at group rates for a specified period. The Law requires employers to offer continued health insurance

coverage to employees who have had their health insurance coverage terminated because of a change in employment.

Coordination of Benefits means when you are covered by two or more insurance plans and payment rules apply. Coordination of Benefits is important as it 1) eliminates duplicate payments; 2) specifies the order in which coverage will be paid (the primary plan, the secondary plan, etc.); and 3) ensures that the benefits paid under both plans do not total over 100% of the allowable charges. It is your responsibility to notify VHP when other coverage is available to pay for your physical and behavioral health care services.

Copayment as defined herein includes, but not limited to the fixed amount for a Covered Service paid by a Member to the provider of service before receiving the service in addition to coinsurance and the Deductible. Coinsurance is the percentage of the allowable amount for a service the Member is obligated to pay. The Deductible is the amount of money that the Member must pay in health care costs before VHP will begin to cover the cost of any Provider Claims. Copayments are defined in VHP's Benefit Plan and payment by the Member may be required each time a Medical Service is accessed.

Copayment Maximum or Out-of-Pocket Maximum is the maximum Copayment amount you are required to pay for Covered Services during a Calendar Year.

Cosmetic Surgery means surgery that is not Medically Necessary and is performed to alter or reshape normal structures of the body to improve appearance.

Coverage means the Covered Services contained in this Combined Evidence of Coverage and Disclosure Form.

Coverage Decision means the Authorization or Denial of Covered Services by VHP or VHP's designee. A Coverage Decision does not include a Disputed Covered Service(s).

Covered Service(s) means the Medically Necessary health care services, supplies, Prescriptions, and products to which you are entitled as a Member under your Group Service Agreement as described in this Combined Evidence of Coverage and Disclosure Form.

Custodial Care or Domiciliary Care means care that can be provided by a layperson, which does not require the continuing attention of trained medical or paramedical personnel, and which has no significant relation to the treatment of a medical condition. This definition does not refer to BHT prescribed for autism

spectrum disorder. Custodial Care includes but is not limited to activities of daily living such as walking, getting in and out of bed, bathing, dressing, feeding, toileting and taking medication; or care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification, or the presence of a supervising licensed nurse.

Deductible means the amount you must pay in a Calendar Year for certain Covered Services before we will cover those services at the applicable Copayment or Coinsurance in that time period. Employer Group does not currently have Deductibles.

Denial means a refusal to comply with or satisfy a request for services or payment of services rendered. Denial of services are made exclusively by VHP's Medical Director or physician designee.

Department of Managed Health Care (DMHC) or Department is the State's administrative agency responsible for the licensing, regulation or oversight of health care service plans in California.

Disenrollment is the voluntary process of ending your membership in the Benefit Plan.

Disputed Covered Service(s) means any Covered Service that has been Denied, modified, or delayed by a decision of VHP, or by one of VHP's designees, in whole or in part due to a finding that the Benefit is not Medically Necessary. A decision regarding disputed health care services relates to the practice of medicine and is not a Coverage Decision.

Dosage Form is the physical form in which a Prescription Drug is produced and dispensed, such as a tablet, a capsule, or injectable.

Drug Prior Authorization or Drug Utilization Review is VHP's requirement that the Member or the Member's Plan Provider obtain VHP's or VHP's designee's Authorization for a service before the health Plan will cover the drug. VHP or VHP's designee shall grant Prior Authorization when it is Medically Necessary for the Member to obtain the drug.

Drug Tier means a group of Prescription Drugs that corresponds to a specified cost sharing tier in VHP's Prescription Drug Coverage. The tier in which a Prescription Drug is placed determines the Member's portion of the cost for the drug.

Durable Medical Equipment or DME means the Medically Necessary medical supplies, equipment, and devices which:

- Are intended for repeated use over a prolonged period;

- Are not considered disposable, with the exception of ostomy bags and diabetic supplies;
- Are ordered by your Plan Provider,
- Do not duplicate the function of another piece of equipment or device covered by VHP;
- Are generally not useful to you in the absence of illness or injury;
- Primarily serve a medical purpose; and
- Are appropriate for use in the home.

Effective Date of Coverage means the date that your Coverage under the Benefit Plan begins. Your precise Effective Date of Coverage may be obtained from your employer.

Elective Medical Services means Medically Necessary non-Urgently Needed Services and non-Emergency Services.

Eligible Dependent or Dependent is a person who is:

1) A Subscriber’s lawful spouse; or
2) A Subscriber’s domestic partner as eligible and as defined in the Subscriber’s Group Service Agreement or in accordance with State and federal requirements; or
3) The child of a Subscriber or the Subscriber’s spouse/domestic partner who is defined as:
    a) Under the age of 26; or
    b) Age 26 or older, but incapable of holding a self-sustaining job by reason of mental disorder or physical handicap which commenced prior to age 26.
    c) When the Eligible Dependent reaches age 26 Coverage will not be terminated while the child is and continues to meet both of the following criteria:
    - Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition.
    - Chiefly dependent upon the Subscriber for support and maintenance.

d) An enrolled Dependent child who reaches age 26 during a benefit year may remain enrolled as a Dependent. When the child becomes an Eligible Dependent after the age of 26, the Eligible Dependent will be allowed to enroll while the child is and continues to meet both of the following criteria:

- Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition.
- Chiefly dependent upon the Subscriber for support and maintenance.

e) A natural child or stepchild; or

f) A child placed in the physical custody of the Subscriber or the Subscriber's spouse/domestic partner for adoption, and who is covered from and after the date on which there exists evidence of the Subscriber or Subscriber's spouse's or domestic partner's right to control the health care of the child placed for adoption (documentation of placement by an adoption agency and/or court will be required); or

g) A legally adopted child (documentation by an adoption agency and/or court will be required); or

h) A ward or child under the guardianship of the Subscriber or the Subscriber's enrolled spouse pursuant to a valid court order (proof of legal guardianship will be required).

The Subscriber must furnish proof of incapacity and dependency to VHP within 60 calendar days following the date of the request. VHP has the right to require such proof of eligibility status as may be required. Such proof will be without cost to VHP.

All Eligible Dependents who are eligible for Benefits and who reside outside the Service Area will only be covered for Emergency or Urgently Needed Services when provided by Out-of-Network providers. All follow-up or Routine Care must be received in the Service Area through the Member's PCP or the Member's Primary Network.

Eligible Employee means any permanent employee employed as defined by Group and who:

- Has met any Group applicable waiting period requirements established by your employer, and the Group's eligibility criteria; and
- Works or resides continuously within the Service Area.

For Small Groups, Eligible Employee also means permanent employees who work at least 20 hours but not more than 29 hours if the following apply:

- The employee otherwise meets the definition of an Eligible Employee except for the number of hours worked,
- The employer offers the employees' health Coverage under a health Benefit Plan,
- All similarly situated individuals are offered Coverage under the Benefit Plan, and the employee must have worked at least 20 hours per normal workweek for at least 50 percent of the weeks in the previous calendar quarter.

Eligible Retiree means any employee who has retired from a Group and that Group offers the Group Plan Coverage as a benefit to its retired employees and who:

- has met the Group's eligibility criteria,
- has met any statutorily authorized or Group applicable waiting period requirements, and

Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Medical Transportation means transportation in an ambulance or emergency vehicle to an emergency room to receive emergency medical care.

Emergency Services means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable Law, by other appropriate licensed persons under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or Active Labor exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility.

Emergency Services also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable Law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition or detoxification, within the capability of the facility.

VHP is permitted to deny payment of emergency services to a provider only when the enrollee did not require emergency care and reasonably should have known that an emergency did not exist.

EOC or Combined Evidence of Coverage and Disclosure Form means this *C*ombined Evidence of Coverage and Disclosure Form or this Valley Health Plan Benefits and Coverage handbook.

Exigent Circumstances exist when a Member is suffering from a health condition that may seriously jeopardize the Member's life, health, or ability to regain maximum function or when a Member is undergoing a current course of treatment using a Non-Formulary Drug.

Experimental or Investigational Treatment means services, tests, treatments, supplies, devices, or drugs which VHP determines are not generally accepted by informed medical professionals in the United States, at the time services, tests, treatments, supplies, devices or drugs are rendered, as safe and effective in treating or diagnosing the condition for which their use is proposed, unless approved by one of the following:

- The Diagnostic and Therapeutic Technology Assessment Project of the American Medical Association;
- The Office of Technology Assessment of the U.S. Congress;
- The National Institutes of Health;
- The Food and Drug Administration (FDA); or
- The specialty board and the academy it represents as recognized by the American Board of Medical Specialties (ABMS).
- Approved drug usage will not be excluded as an Experimental or Investigational Treatment.

FDA-Approved Drug means drugs, medications and biologicals approved by the Food and Drug Administration and listed in the United States Pharmacopeia, the AMA Drug Evaluations and/or the American Hospital Formulary.

Employer Drug Formulary means the complete list of drugs preferred for use and eligible for Coverage by VHP, and includes all drugs covered under the outpatient Prescription Drug Benefit. Formulary is also known as a Prescription Drug list. The Employer Drug Formulary includes both brand and generic equivalent drugs, all of which are approved by the Food and Drug Administration.

Fraud means an intentional act to deceive or misrepresent by a person who knows the deception could result in some unauthorized benefit for the person or someone else.

Follow-Up Care is the care provided after Emergency Services or Urgently Needed Services when the Member's condition, illness or injury has been stabilized and no longer requires Emergency Services or Urgently Needed Services.

Generic Drug means the same drug as its Brand Name Drug equivalent in dosage, safety, Strength, how it is taken, quality, performance, and intended use. A Generic Drug is listed in bold and italicized lowercase letters on VHP's Employer Drug Formulary.

Grievance means a written or oral expression of dissatisfaction regarding VHP and/or provider, including quality of care concerns, Denial of a service or payment of a Provider Claim (in whole or part) made by a Member or the Member's representative.

Group means the Large employer or Small Employer that has entered into the Agreement with VHP.

Group Service Agreement means the Group Medical and Hospital Service Agreement between your employer and VHP.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, which is a federal Law enacted to create national standards to protect sensitive PHI from being improperly disclosed without the Member's consent or knowledge.

Home Health Care Services mean Covered Services rendered by Plan Providers using an interdisciplinary team to meet the needs of Members being cared for in out-of-hospital settings such as private homes, boarding homes, Hospices, shelters, etc.

Hospice means a public agency or private organization that is a Plan Provider and is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital Services means all services provided by the hospital on either an inpatient or outpatient basis within the capability of the facility.

Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome (HIV or AIDS) is a condition or disease that is medically interpreted broadly as a condition or disease that requires specialized medical care over a prolonged period of time and is Life-Threatening, degenerative or disabling.

Iatrogenic Infertility means infertility caused by a medical intervention, including, but not limited to, reactions from prescribed drugs or from medical and surgical procedures.

Infertility Diagnosis and Treatment means procedures consistent with established medical practices by licensed physicians and surgeons including, but not limited to, diagnosis, diagnostic tests, medications, and Medically Necessary surgery.

Initial Eligibility Period means the period during which Eligible Employees or Eligible Retirees, and their Eligible Dependent(s) may initially enroll in VHP, and is further defined as follows:

1) For Group's employees or retirees who are or will be Eligible Employees or Eligible Retirees on the initial Effective Date of Coverage under the Agreement, the Initial Eligibility Period is the 31-day period prior to the Effective Date of Coverage.
2) For future employees of Group who were not Eligible Employees on the Effective Date of Coverage, the Initial Eligibility Period is the applicable Group Waiting Period.
3) For future retirees of Group who were not Eligible Retirees on the Effective Date of Coverage, the Initial Eligibility Period is the 31-day period prior to the first day of the month after becoming a retiree.

Inpatient Hospital Services means those Covered Services, which are provided on an inpatient basis by a hospital, excluding long term, non-acute care.

Language Assistance Program means the Language Assistance Program established by VHP in compliance with the requirements of the Health Care Language Assistance Act. This program offers free language services to a Member who has an inability or a limited ability to speak, read, write, or understand the English language at a level that permits that individual to interact effectively with health care providers or plan employees. This program includes qualified interpreters and documents written in other languages.

Large Employer Group means the County of Santa Clara, Santa Clara County Superior Courts, In Home Support Service workers and Santa Clara County Fairgrounds.

Late Member means an Eligible Employee/Retiree or his or her Eligible Dependent(s) who declined to enroll in VHP during the Eligible Employee's or Eligible Retiree's Initial Eligibility Period or any subsequent Open Enrollment Period.

Law means any and all Laws and regulations of the State of California or of the United States and all orders, instructions, regulations, manuals, guidance documents, and other requirements of any government agency which are applicable to the Agreement.

Life-Threatening means either or both of the following:

- Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes.

Lock-In means that Covered Services are available only through Plan Providers in the Primary Network affiliated with the Primary Care Provider you select (unless such care is rendered as Emergency Services, Urgently Needed Services, or is Prior Authorized).

If you seek Routine Care, Durable Medical Equipment or Elective Medical Services from Out-of-Network providers without an authorized referral and/or VHP's Prior Authorization, VHP will not pay for your care, and you will be required to pay for the full cost of such services.

Mail Service Pharmacy means a VHP pharmacy that only provides mail order services. A Mail Service Pharmacy does not have walk-in pharmacy services.

Maternal Mental Health Condition means a mental health condition that impacts a person during Pregnancy, peripartum or postpartum periods, or that arises during Pregnancy, in the peripartum or postpartum period, up to one year after delivery.

Medical Criteria means the predetermined rules or guidelines for medical care, developed by medical professionals relying on professional expertise, prior experience, and the professional literature, with which aspects of actual instances of medical care may be compared.

Medical Director means the VHP physician or physician designee with responsibility for implementing VHP Utilization Management and quality of care review systems. The Medical Director is the VHP physician or physician designee who determines appropriate Authorization or Prior Authorization of Covered Services.

Medical Services means those professional services of physicians and other health care professionals, which are performed, prescribed or directed by a licensed physician or specialist.

Medically Necessary or Medical Necessity means the services which are:

- Appropriate and necessary for the symptoms, diagnosis, or treatment of a medical condition.
- Within recognized standards of medical practice.
- Not primarily for the convenience of you, your family, caretaker, or any provider.
- The most appropriate supply or level of service which can safely be provided.

Medically Necessary Treatment of a Mental Health or Substance Use Disorder means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

i. In accordance with the generally accepted standards of Mental Health and Substance Use Disorder care.

ii. Clinically appropriate in terms of type, frequency, extent, site, and duration.

iii. Not primarily for the economic benefit of the health care service plan and Subscribers or for the convenience of the patient, treating physician, or other health care provider.

Member is any Subscriber or Eligible Dependent who is enrolled in the Benefit Plan in accordance with the applicable eligibility requirements.

Member Claim means a statement listing services rendered, the dates of services, and itemization of costs including a statement signed by the Subscriber that services have been rendered and any supporting documentation from the treating provider. The completed Member Claim Reimbursement Form serves as the basis for reimbursement for payment of covered Benefits.

Member Services Representative means a VHP employee who is available to answer Member's questions about Coverage, help Members with any service issues, and assist Members with special situations relating to Covered Services.

Mental Health and Substance Use Disorders means a mental health condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the "International Classification of Diseases (ICD)" or that is listed in the most recent version of the "Diagnostic and Statistical Manual (DSM) of Mental Disorders."

Network is the doctors, hospitals, pharmacies, and mental health services contracted with VHP to provide covered health care services for Members.

Plan Facility means a facility (other than a Plan Hospital), such as Ambulatory Surgery Centers, Skilled Nursing Facility that have contracted with VHP to provide Medical Services and/or supplies to Members.

Qualified Member means a Member who meets both of the following conditions:

a) The Qualified Member is eligible to participate in an approved clinical trial, according to the clinical trial protocol, for the treatment of cancer or another life-threatening disease or condition.

b) Either of the following applies:

    i. The referring health care professional is a Plan Provider and has concluded that the Member's participation in the clinical trial would be appropriate because the Member meets the conditions of subparagraph (A) above.

    ii. The Qualified Member provides VHP the medical and scientific information establishing that the Member's participation in the clinical trial would be appropriate because the Member meets the conditions of subparagraph (A).

Non-Covered Services mean services that VHP does not cover under the Member's Benefit Plan.

Non-Formulary Drug means a Prescription Drug that is not listed on VHP's Employer Drug Formulary. A Member may have a different Copayment or out-of-pocket costs for a Non-Formulary Drug than an Employer Drug Formulary Prescription Drug.

Non-Plan Hospital means a hospital other than a Plan Hospital.

Non-Plan Physician means a physician other than a Plan Physician.

Non-Plan Provider means a provider outside the Member's Primary Network.

Open Enrollment Period means a period of no less than 30 calendar days or as defined by the Group and agreed upon by VHP, and that occurs at least once annually. The Open Enrollment Period is the time during which all Eligible Employees are given the opportunity to select from the alternative health care plans offered by the Group, and when Subscribers may add or delete Eligible Dependent(s).

Orthotic Device means a Medically Necessary rigid or semi-rigid device used as a support or brace affixed to the body externally to support or correct a defect or function of an injured or diseased body part, excluding devices to enable the Member to continue ongoing athletic activity prior to medical recovery.

Out-of-Network means any Plan Provider or Non-Plan Provider that is not part of your Primary Network.

Outpatient Hospital Services or Outpatient Care means those Covered Services, which are provided to Members under the direction of a Plan Provider and do not require an overnight stay in the hospital.

Palliative Care means care to reduce physical, emotional, social, and spiritual discomforts for a Member with a serious illness.

Pharmacy Benefits Manager or PBM means the organization(s) designated to manage Prescription Drug Benefits on behalf of VHP.

Protected Health Information or PHI means any information about health status, provision of health care, or payment for health care that is created or collected by VHP and can be linked to a specific Member.

Plan or VHP means Valley Health Plan. The County of Santa Clara owns and operates VHP, which is licensed under the Knox-Keene Health Care Service Plan Act of 1975, as amended. VHP is a health maintenance organization (HMO).

Plan Hospital means a duly licensed hospital that, at the time care is provided, has a contract with VHP to provide Hospital Services to Members and is designated as part of the Member's Primary Network.

Plan Pharmacy means a pharmacy contracted with VHP or its PBM that delivers services and provides medication(s) prescribed by Plan Providers to Members.

Plan Physician means a licensed physician of medicine or osteopathy who is a partner or an employee of a Plan Hospital or medical group, or any licensed physician who contracts to provide Covered Services to Members (but not including physicians who contract only to provide Referral Services).

Plan Provider means a Plan Hospital, Plan Facility, Plan Physician, Plan Pharmacy, or any other health care provider that VHP designates as a Plan Provider.

Prescribing Provider means a Plan Provider who is licensed to write Prescriptions and is contracted by VHP to do so for VHP Members.

Plan Specialist means a Plan Physician who has additional training, qualifications, and experience in a medical or surgical specialty area and contracts with VHP to deliver Covered Services to VHP Members.

Pregnancy means the three trimesters of Pregnancy and the immediate postpartum period which includes pregnancy-related and postpartum care services that may last up to 12 months after birth.

Prescription means an oral, written, or electronic order by a Prescribing.

Prescription Drug means a drug that is prescribed by the Member's Prescribing Provider and requires a Prescription under applicable Law. A Prescription Drug is approved by the FDA for sale to consumers and requires a Prescription and is not provided for use on an inpatient basis.

Primary Care Provider (PCP) means a Plan Physician you choose who has contracted with VHP to deliver primary care services to Members.

PCPs practice in a wide range of medical disciplines and can be family or general practitioners, pediatricians, or internists. In addition, obstetricians/gynecologists (OB/GYNs) may serve as PCP within selected networks if they meet VHP criteria for the delivery of primary care.

A PCP is medically trained to take care of your routine health care needs and is primarily responsible for the coordination of your care. Coordinating your care includes responsibilities such as supervising continuity of care, record keeping, and initiating referrals for specialist Plan Physicians

Primary Network is the comprehensive Network of Plan Providers, including by way of example, Plan Specialists, Plan Hospitals, Plan Facilities, et cetera affiliated with the Primary Care Provider you choose. Except for Emergency Services or Urgently Needed Services, physical and behavioral health care Covered Services must be obtained in your Primary Network unless you have an Authorized in-network referral to a provider outside your Primary Network or if you change Primary Care Providers in order to change your Primary Network.

Referral Specialist means a specialist contracted by VHP to provide services pursuant to a VHP Authorization when a higher level of care or specialization is required. Referral Specialists are not part of a Member's Primary Care Network.

Prosthetic Device means an artificial device affixed to the body to replace a missing part of the body. Prosthetic Devices also means surgically implanted devices and supplies.

Provider Claim means a Complete Claim that serves as the basis for payment of Authorized Medically Necessary Covered Services directly to a provider.

Psychiatric Emergency Medical Condition means a mental disorder where there are acute symptoms of sufficient severity to render either an immediate danger to yourself or others, or you are immediately unable to provide for or use, food, shelter, or clothing due to the mental disorder.

Quantity Limit is a restriction on the number of doses or any other limitations on the quantity of a Prescription Drug VHP will cover during a specific time period.

Reconstructive Surgery means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease:

- To improve function; or
- To create a normal or uniform appearance, to the extent possible.

Reconstructive Surgery includes Prosthetic Devices needed after a mastectomy and original and replacement Prosthetic Devices to replace all or part of an external facial body part removed or impaired as a result of disease, injury, or congenital defect.

Rehabilitation Services means Covered Services that are provided in a prescribed, organized, multidisciplinary rehabilitation program, whether in a hospital, Skilled Nursing Facility, acute rehabilitation facility, physician's office or other facility.

Routine Care means the provision of Medically Necessary services, which are required for:

- Screening purposes and disease prevention;
- The diagnosis and treatment of new or ongoing illnesses or injuries; or
- The evaluation and treatment of signs or symptoms which a Member or physician might reasonably be concerned to represent a deterioration in health status.

Such Routine Care does not pose an immediate risk to the Member requiring either Urgently Needed Services or Emergency Services.

Sensitive Services means all health care services related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections, HIV/AIDS, Substance Use Disorder, sexual assault and abortions, gender affirming care, and intimate partner violence, and includes services described in Sections 6924, 6925, 6926, 6927, 6928, 6929, and 6930 of the Family Code, and Sections 121020 and 124260 of the Health and Safety Code, obtained by a patient at or above the minimum age specified for consenting to the service specified in the section.

Serious Chronic Condition means a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that does either of the following:

- Persists without full cure or worsens over an extended period of time; or
- Requires ongoing treatment to maintain remission or prevent deterioration.

Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

Service Area means Santa Clara County and the geographic area, established by VHP and approved by the Department of Managed Health Care (DMHC), where VHP provides health care services to Members.

Skilled Nursing Facility (SNF) means a facility where inpatient services are provided at a less intensive level than an acute care hospital but still requiring services by a licensed health care professional.

Small Employer means the small employer that has at least 1 but no more than 100 Eligible Employees, the majority of whom are employed within the State. The Small Employer can be any person, firm, proprietary or nonprofit corporation, partnership, public agency, or association that is actively engaged in business or services. For purposes of determining whether an employer has 1 employee, sole proprietors and their spouses, and partners of a partnership and their spouses, are not employees.

Small Employer Group means the Valley Health Foundation.

State means the State of California.

State Hospital means any hospital operated and maintained by the State system.

Step Therapy means a process specifying the sequence in which different Prescription Drugs for a given medical condition and medically appropriate for a particular patient are prescribed. VHP may require the Member to try one or more drugs to treat the Member's medical condition before VHP will cover a particular drug for the condition pursuant to a Step Therapy request. If the Member's Prescribing Provider submits a request for Step Therapy exception, VHP will make exceptions to Step Therapy when VHP's exception criteria are met.

Strength means the amount of active ingredient or ingredients present in each dose of a Prescription Drug.

Subscriber means the primary insured or the individual who is responsible for payment to VHP or whose employment or other status, except for family dependency, is the basis for eligibility for participation in VHP.

Telehealth means the mode of delivering health care services and public health information via electronic information and telecommunication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a Member's health care. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

Terminal Illness is a medical condition that cannot be reversed and will most likely cause death within one year or less if the disease follows its natural course.

Termination means the involuntary process of ending your membership in the Benefit Plan.

Quaternary Referral Hospital means a hospital that provides quaternary care, which are higher levels of care required to treat more severe conditions that require specialized knowledge, more intensive health monitoring, and medical or surgical intervention obtained from specialists affiliated with such hospital. Use of a Quaternary Referral Hospital and its affiliated specialists may be Authorized after an evaluation by VHP that the Medically Necessary Covered Services are unavailable in the Member's Primary Network. If health care services are requested at a Quaternary Referral Hospital and your care can appropriately be obtained within your Primary Network, VHP may redirect the Medically Necessary Covered Services to Plan Providers affiliated with your Primary Network.

Totally Disabled means that an individual is either (a) confined in a hospital as determined to be Medically Necessary, or (b) unable to engage in any employment or occupation for which the

individual is (or becomes) qualified by reason of education, training or experience and is not, in fact, engaged in any employment or occupation for wage or profit.

Utilization Management is a process that evaluates the efficiency, appropriateness and Medical Necessity of the treatment, services, procedures that are provided to patients on a case-by-case basis. These evaluations include but are not limited to inpatient admissions, skilled nursing admissions, home health services and outpatient services.

Urgent Care, Urgent Services or Urgently Needed Services are those services necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including Pregnancy, for which treatment cannot be delayed until the Member returns to the Plan's Service Area. Urgently Needed Services includes maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the Member's reasonable belief that they have a

Pregnancy-related condition for which treatment cannot be delayed until the Member returns to the Plan's Service Area.

VHP ID Card is an identification card (ID card) issued to Members by VHP to identify membership in VHP. You must be eligible for services when presenting your VHP ID Card. Your VHP ID Card must be presented whenever and wherever care is received. If you use your VHP ID Card and you are no longer eligible to receive services through VHP, you will be responsible to pay the provider for the cost of the services you received.

Vocational Rehabilitation means evaluation, counseling, and placement services designed or intended primarily to prepare an injured or disabled individual for employment.