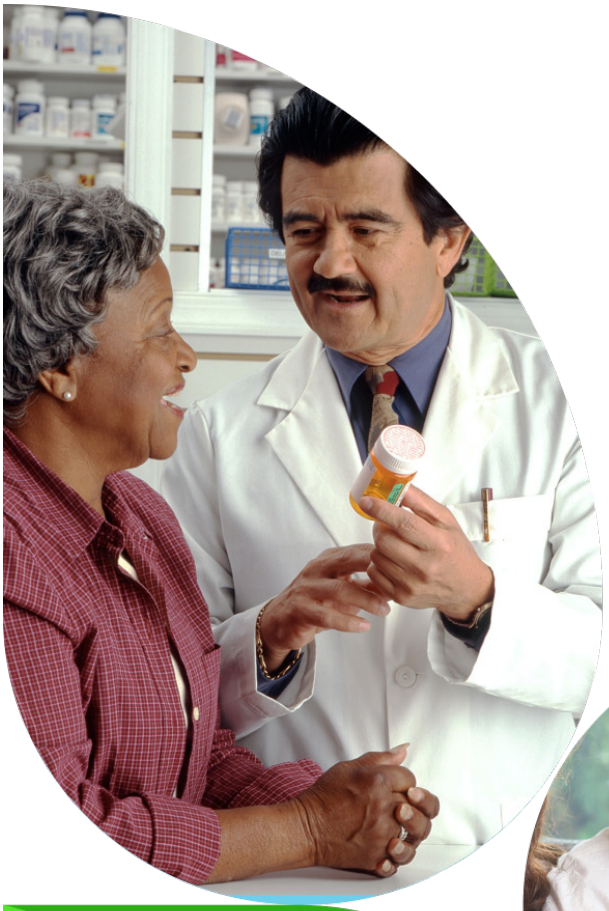
Valley Health Plan



2023 Plan

Covered California Plan and Individual & Family Plan Membership Agreement

Combined Evidence of Coverage (EOC) and Disclosure Form

Valley Health Plan Covered California and Individual & Family Plan

Combined Evidence of Coverage (EOC) and Disclosure Form

Please visit www.valleyhealthplan.org for Summary of Benefits Coverage Matrices for Deductible, Copayment, and Coinsurance costs.

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.

Where can I go to get Healthcare?

In the event of an Emergency, call 911 or seek care at the closest hospital. It is an emergency if waiting to get care could be dangerous to your life or a part of your body. Note: Members are not financially responsible in payment of emergency care services, in any amount the plan is obligated to pay, beyond the enrollee's copayments, coinsurance, and deductibles as provided in this EOC.

Primary Care Physician

Valley Health Plan (VHP) has a number of health centers and individual provider offices that provide the health care services you need. These doctors are located throughout the VHP Service Area. These visits are covered 100% through VHP. To obtain a Primary Care Physician (PCP) list, visit **www.valleyhealthplan.org** or call Member Services at **1.888.421.8444 (toll free)**. For the hearing and speech impaired, call the California Relay Service (CRS) by simply dialing 711 or the 800 CRS number of your modality.

Urgent Care Services

Urgent care is care you need within 24 to 48 hours. If you need Urgent Care Services, call the 24/7 Nurse Advice Line at 1.855.348.9119 (toll-free), schedule an appointment; or go to a VHP Network Walk-in Urgent Care

Clinic. In the event you are out of the Service Area and cannot safely go to your Plan Providers, go to the closest urgent care provider. All follow-up care must be received through Plan Network Providers or authorized by VHP.

VHP Network Hospitals

VHP is contracted with several hospitals throughout its Service Area. Except in an emergency, Hospital Services must have been authorized by the Plan.

Choosing a Primary Care Physician

Your Primary Care Physician

Your PCP or doctor plays a key role in your health care and will be your regular personal doctor. Your doctor may refer you to other doctors/ specialists when necessary.

Choosing Your Doctor

You may choose your own doctor from within the VHP Network. If you do not choose a doctor, you will be assigned one by VHP. To find a doctor, visit **www.valleyhealthplan.org** and use the Provider Search, or call Member Services at **1.888.421.8444 (toll free)**.

Changing Your Doctor

You can change your doctor at any time by calling Member Services at **1.888.421.8444 (toll free)**.

Who to Call?

Member Services

Call Member Services at **1.888.421.8444 (toll free)** if you have any questions about your health plan benefits or if you need help with any other health plan matter. For the hearing and speech impaired, call the California Relay Service (CRS) by simply dialing 711 or the 800 CRS number of your modality.

Member Services

Call Member Services at **1.888.421.8444 (toll free)** if you have any questions about your health plan benefits or if you need help with any other health plan matter. For the hearing and speech impaired, call the California Relay Service (CRS) by simply dialing 711 or the 800 CRS number of your modality.

Appointments

For an appointment with your PCP, call the appointment phone number listed for their office. For Provider office appointment phone numbers, visit **www.valleyhealthplan.org** and use the Provider Search function, or call Member Services at **1.888.421.8444 (toll-free)**.

24/7 Nurse Advice Line

Call **1.855.348.9119 (toll-free)** to speak with an Advice Nurse. Advice Nurses are available 24 hours a day, seven (7) days a week. They can give you medical advice and direct you to the care you need.

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Introduction

About this Agreement

This Membership Agreement and Evidence of Coverage & Disclosure Form describes the health care coverage of the "Valley Health Plan Covered California and Individual & Family Plan." This Membership Agreement and Evidence of Coverage and Disclosure Form, the Rate Sheet, and any amendments constitute the legally binding contract between the County of Santa Clara, DBA Valley Health Plan (Health Plan), and you (Subscriber). For benefits provided under any other Health Plan program, refer to that plan's Evidence of Coverage.

In this Agreement, Valley Health Plan, is sometimes referred to as "Health Plan," "VHP," "we," or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this Agreement; please see the "Definitions" section for terms you should know.

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

The Health Plan provides Services directly to our Members through an integrated medical care program, rather than reimbursing expenses on a fee-for-service basis. Please refer to the "Access to Care" section to obtain more information on access to care.

It is important to familiarize yourself with your coverage by reading this Agreement completely so that you can take full advantage of your health plan Benefits. Also, if you have special health care needs, please read the sections applicable to you carefully.

VHP offers this Covered California and Individual & Family Plan under the Patient Protection and Affordable Care Act Amended as of 2010 (PPACA). You or your dependents are eligible for the VHP Covered California and Individual & Family Plan Benefit Plan upon enrollment and meeting the eligibility criteria.

As explained in the “Eligibility and Enrollment” section, if you enroll in the VHP Covered California and Individual & Family Plan under PPACA there are two options for enrollment:

- If through Covered California, the Exchange will be responsible for managing all enrollment and eligibility, and the associated forms.
- If not through the Exchange, you must meet the eligibility rules for the VHP Individual & Family Plan and complete an enrollment form.

Payment is due prior to the effective date of coverage.
For more information not found in this booklet call Member Services at **1.888.421.8444 (toll-free)**.

Definitions

VHP is dedicated to making its services easily accessible and understandable; however, the language of health care and managed care organizations can sometimes be very confusing. Certain definitions of terms used to describe your Benefits can be found in the “Definitions” section. These defined terms will be Capitalized throughout the document. For example: Covered Services, Plan Physicians.

Active Labor means a labor at a time at which either of the following would occur:

- There is inadequate time for safe transfer to another hospital prior to delivery.
- 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 Member Agreement, including but not limited to this Combined Evidence of Coverage and Disclosure Form, any and all applications and information submitted by the Member 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 Member 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.

Authorization means a system whereby a written (or oral followed by a written) approval is given by the Medical Director or designee for a Member to receive and/or have VHP pay for certain Medically Necessary Covered Services.

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 physician or a psychologist, licensed pursuant to California law.
2. Treatment is provided under a treatment plan prescribed by a Qualified Autism Service (QAS) provider, and administered by a QAS provider, or a QAS professional or paraprofessional supervised and employed by the QAS provider, or a qualified entity or group.
3. The treatment plan has measurable goals developed and approved by the QAS provider that is reviewed every six (6) months and modified where appropriate.
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 as covered under the Benefit Plan.

Benefit Plan means the Covered Services contained in this Combined Evidence of Coverage and Disclosure Form or as required by State and Federal Law. Any date referenced in this Benefit Plan begins at 12:01am, Pacific Standard Time.

Cal-COBRA (California Continuation Benefits Replacement Act) means the California legislation that requires health plans to offer continued access to group health care coverage provided to employer, 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.

Coinsurance is the Member's share of cost of Covered Services, which are represented as percentages. The coinsurance will be calculated based on contracted rates, if any, between VHP and its Plan Providers.

Contract Health Service means any health service that is:

- Delivered based on a referral by, or at the expense of, an Indian health program.
- Provided by a public or private medical provider or hospital that is not a provider or hospital of the Indian Health Program.

Coordination of Benefits (COB) means when you are covered by two (2) or more insurance plans, COB:

- Eliminates duplicate payments.
- Specifies the order in which coverage will be paid (the primary plan, the secondary plan, etc.).
- Ensures that the benefits paid under both plans do not total over 100% of the charges.

Copayment is a fee, which you are required to pay in order to receive a Benefit. This is the Member's share of the cost of Covered Services. The dollar amount of the Copayment can be $0 (no charge). Copayments paid for eyeglasses, dental services, or any other supplementary benefit(s) that are not covered under this Benefit Plan are not counted against the Copayment Maximum.

Copayment Maximum is the maximum 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 in order to improve appearance.

Cost Sharing means the amount you are required to pay for a Covered Service or Benefits, for example: The Deductible, Copayment, or Coinsurance.

Coverage means the Covered Services contained in this Membership Agreement and Combined Evidence of Coverage and Disclosure Form.

Coverage Decision means the approval or Denial of Covered Services by Plan or Plan Providers. A Coverage Decision does not include a Disputed Covered Service(s).

Covered California is California's Health Benefit Exchange, where individuals, families and small businesses can find affordable health insurance.

Covered Service(s) means the Benefits as covered under the Benefit Plan.

Custodial Care or Domiciliary Care means care that can be provided by a lay person, 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 Behavioral Health Therapy (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.
- Taking medication.
- 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.

Denial means a refusal to comply with or satisfy a request for services or payment of services rendered.

Department of Managed Health Care (DMHC) is the State regulatory agency responsible for the regulation or oversight of health care plans in California.

Dependent means any member of a Subscriber's family who is an Eligible Dependent and meets the applicable eligibility requirements set forth in this Agreement, and who has enrolled in the Plan in accordance with its enrollment requirements.

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 the Plan, or by one of its Plan Providers, 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.

Durable Medical Equipment (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 Physician.
- Do not duplicate the function of another piece of equipment or device covered by VHP.
- Are generally not useful to the Member in the absence of illness or injury.
- Primarily serve a medical purpose.
- 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 by calling Member Services.

Elective Medical Services means non-urgent, or non-emergent, or non-essential treatment.

Eligible Dependent is a person who is:

1) A Subscriber's lawful spouse.
2) A Subscriber's registered domestic partner.
3) 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 the Subscriber's spouse/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) with a permanent residence within the Service Area.
4) A legally adopted child (documentation by an adoption agency and/or court will be required).

5) A ward or child under the guardianship of the Subscriber or the Subscriber's enrolled spouse/domestic partner pursuant to a valid court order (proof of legal guardianship will be required) and the child must be under the age of 26; or age 19 to age 26 and prior to March 23, 2010, they were not eligible for another employer- sponsored insurance plan; or 26 years of age or older, but incapable of holding a self-sustaining job by reason of mental retardation or physical handicap. The Subscriber must furnish proof of incapacity and dependency to VHP within 60 calendar days following the date of the request.

6) 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:

   i) Is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition.

   ii) Is chiefly dependent upon the subscriber for support and maintenance.

7) 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.

8) Eligible Dependent children may reside outside the Service Area but will only be covered for Emergency or Urgently Needed Services when Out-of-Network. All follow-up or Routine Care must be received in Network through the Member's PCP.

9) All other Eligible Dependents who are eligible for Benefits and who reside outside the Service Area will only be covered for Emergency or Prior Authorized Urgently Needed Services when Out-of-Network. All follow-up or Routine Care must be received in the VHP Network through the Member's PCP.

10) A parents or stepparents who meets the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code and who lives or resides within the Plan's service area. Members seeking to add their dependent parent or stepparent will be provided with written notice about the California Department of Aging's Health Insurance Counseling and Advocacy Program (HICAP).

Emergency Services are Covered Services unless the "enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist.

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. 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.

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 Membership Agreement and Combined Evidence of Coverage and Disclosure Form(s) or this booklet

Exchange means Covered California or the California Health Benefit Exchange.

Experimental or Investigational Treatment means services, tests, treatments, supplies, devices or drugs which Plan 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 Institute of Health.
- The Food and Drug Administration (FDA).
- 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 FDA and listed in the United States Pharmacopoeia, the AMA Drug Evaluations and/or the American Hospital Formulary.

Formulary is the broad list of prescription drugs that have been reviewed and selected by VHP Plan Providers on the VHP Pharmacy and Therapeutic Committee in accordance with professionally recognized medical standards for their medical and cost effectiveness. The Formulary includes both brand and generic equivalent drugs, all of which are approved by the FDA.

Grievance means a written or oral expression of dissatisfaction regarding the Plan and/or Provider, including quality of care concerns, Denial of a service or payment of a claim (in whole or part) made by a Member or the Member's representative.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Hospital Services means all services provided by the hospital while occupying a hospital bed or visiting a licensed facility provider for a procedure or treatment, 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 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.

Individual means VHP Coverage for an individual.

Initial Eligibility Period is the period that meets one of the following criteria:

- The period when the enrollment form is completed and being reviewed by Plan for approval (enrollment forms and payment must be received 15 days prior to the 1st day of the month of the effective date).

- The 60-day period after your dependent is no longer an Eligible Dependent under this Agreement and he/she may enroll in the Plan as a Subscriber.
- The 60-day period after your newborn or newly adopted child becomes an Eligible Dependent and may enroll in this Plan.

Inpatient Hospital Services are those services that are provided on an inpatient basis to Member while staying in the hospital over a 24-hour period, excluding long term non-Acute Care.

Late Enrollee means an individual or dependent who has declined enrollment in a health benefit plan offered by a Covered California or the Plan at the time of the initial enrollment period provided under the terms PPACA open enrollment periods and who subsequently requests enrollment in a health benefit plan due to status change in family or employment.

Legend Drug means a drug which is required by federal law to bear the following statement, "Caution: Federal law prohibits dispensing without prescription."

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, where the end point of clinical intervention is survival.

Lock-In means that Covered Services are available only through Plan Providers in the VHP Network you select (unless such care is rendered as worldwide Emergency Services, out-of-area Urgently Needed Services, or is Prior Authorized).

If you seek Routine Care, DME or Elective Medical Services, from Non-Plan Providers without a VHP-approved referral, VHP will not pay for your care, and you will be required to pay for the full cost of such services.

Maternal Mental Health Condition means a mental health condition that impacts a woman during pregnancy, peri or postpartum) or that arises during pregnancy, in the peri 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 Medical Director of VHP who a physician or designee with the responsibility for the medical administration of VHP and authorizing care is when required. The Plan Medical Director is a manager of the utilization and quality of health care.

Medical Services mean those professional services of physicians and other health care professionals, which are performed, prescribed, or directed by a Primary Care Physician or Specialist Physician.

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 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; includes a statement signed by the Subscriber that services have been rendered and any supporting documentation from the provider. The completed Member Claim Reimbursement Form serves as the basis for reimbursement for payment of Covered Benefits.

Member Services Representative means any VHP Member liaison who is available to answer your questions about Coverage, help you with any service issues, and assist you with special situations.

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.

Mid-Levels means health care professional supervised by a physician(s), who include medical attendants such as nurse practitioners.

Network is a health care delivery service system within the Service Area. A Plan Network is made up of Plan Physicians (such as Primary Care Physicians (PCP) and Plan Specialists), Plan Facilities, and Plan Hospitals.

Non-Experimental Procedures are those procedures for which the medical safety and efficacy have been demonstrated and are no longer investigational, as determined by VHP in accordance with generally accepted medical practice and professionally recognized standards in the medical community.

Non-Plan Provider is any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the appropriate regulatory agency to deliver or furnish health care services; and who is neither employed, owned, operated by, or under contract with VHP to deliver services to Members.

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 VHP Network.

Outpatient Care means medical treatment that does not require an overnight stay.

Outpatient Hospital Services or Outpatient Care means the medical services received by an individual under the direction of a Plan Physician and they are not staying in the hospital overnight.

Plan or VHP means the Valley Health Plan. VHP is the DBA (doing business as) name of the County of Santa Clara, a California corporation licensed under the Knox-Keene Health Care Service Plan Act.

Plan Facility means a facility (other than a Plan Hospital), such as a Skilled Nursing Facility, which has contracted with VHP to provide Medical Services and/or supplies to Members.

Plan Hospital means any duly licensed hospital that at the time care is provided to a Member has a contract with VHP to provide Hospital Services to Members.

Plan Pharmacy means a pharmacy that has contracted with VHP to provide you with medication(s) prescribed by your Plan Provider.

Plan Physician is a duly licensed PCP, physician, or physician group who at the time of care is provided, has contracted with VHP to deliver health care services to Members and is in the individual Member's primary care provider network. This is not including physicians who contract only to provide referral Services.

Plan Provider means any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the State or as otherwise authorized under California Law to deliver or furnish health care services. Such person or facility is located within the Service Area or which, at the time care is provided has a contract with VHP to deliver services to Members.

Plan Specialist means a physician whom practices in a medical specialty and has contracted with VHP to deliver health care services to Members.

Pregnancy means the three (3) 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.

Pre-existing Condition Provision means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the enrollee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage. No health care service plan shall limit or exclude coverage for any individual based on a pre-existing condition whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

Premium(s) mean the monthly payment amounts that you are responsible for paying for your membership under this Evidence of Coverage.

Prescription Unit means the maximum amount (quantity) of medication that may be dispensed per prescription. Most long-term oral medications are prescribed in 90-day units. A single container, inhaler unit, package, or course of therapy may be the Prescription Unit for other medications. For drugs that could be habit-forming, the Prescription Unit is set at a smaller quantity for your protection and safety.

Primary Care Physician (PCP) means a Plan Physician 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 means **the Plan Provider(s) in the Member's assigned Primary Care Network**

Prior Authorized or Prior Authorization means a system whereby an oral or written advance approval is given by the Medical Director or designee before a Member can receive certain Medically Necessary Covered Services.

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 statement listing services rendered, the dates of services, and itemization of costs; includes a statement signed by the member and treating professional that services have been rendered. The completed Provider Claim serves as the basis for payment of Covered Benefits 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.

Qualified Health Plan (QHP) Issuer means a health plan that has entered an agreement with the California Health Benefit Exchange, an independent entity established within the government of the State of California doing business as Covered California (the "Exchange").

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 do either of the following:

- To improve function.
- To create a normal or uniform appearance, to the extent possible.

Reconstructive Surgery includes prosthetic devices needed after a mastectomy and original and replacement prostheses 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 Benefits that are provided in a prescribed, organized, multidisciplinary rehabilitation program, whether in a hospital, Skilled Nursing Facility, physician's office or other facility.

Routine Care means the provision of Medically Necessary services which are required for:

- Screening purposes.
- The prevention of disease.
- The diagnosis and treatment of new or ongoing illnesses or injuries.
- The evaluation and treatment of signs or symptoms which a Member has reasonable belief of the existence of an emergency medical condition or reasonable belief of a deterioration in health status or significant disability.

Such Routine Care does not pose an immediate risk requiring either urgent or emergency care.

"Sensitive Services" means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, 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.
- Requires ongoing treatment to maintain remission or prevent deterioration.

Serious Emotional Disturbance(s) of a Child or Adolescent means minors under the age of 18 years who:

- Has one or more mental disorder(s), as identified in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, and which results in behavior inappropriate to the child's age according to expected developmental norms.
- Meets the criteria in paragraph (2) of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

Service Area means the geographic area, established by VHP and approved by the Department of Managed Health Care (DMHC), where VHP provides health care services to Members.

The location of facilities providing primary health care services are within reasonable proximity of the business or personal residences of members to ensure accessibility.

Severe Mental Illness means a mental disorder of a person of any age. Severe Mental Illness includes Schizophrenia, Schizoaffective Disorder, Bipolar Disorder (manic-depressive illness), Major Depressive Disorders, Panic Disorder, Obsessive-Compulsive Disorder, Autism Spectrum Disorder, Anorexia Nervosa, and Bulimia Nervosa.

Skilled Nursing Facility (SNF) means a facility where inpatient services provided at a less intensive level than an Acute Care hospital but still requiring services by a licensed health care professional.

Standing Referral means a referral by a PCP to a specialist for more than one visit to the specialist, as indicated in the treatment plan, if any, without the PCP having to provide a specific referral for each visit.

State means the state of California.

Subscriber means the person who is enrolled and responsible for payment to VHP or whose terminated employment or other status is the basis of eligibility for membership in the Benefit Plan.

Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

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 Care Provider Network, VHP may redirect the Medically Necessary Covered Services to Plan Providers affiliated with your Primary Network.

Urgently Needed Services means the Covered Services for an illness, injury, or Pregnancy which, treatment cannot be delayed until the Member returns to the Service Area and, member has reasonable belief of the existence of an Emergency Medical Condition or reasonable belief of a deterioration in health status or significant disability.

VHP ID Card is an identification card (ID card) issued to Members by VHP to identify membership in VHP. Your VHP ID Card must be presented whenever and wherever care is received.

Vocational Rehabilitation means evaluation, counseling, and placement services designed or intended primarily to assist an injured or disabled individual find appropriate employment.

Non-Discrimination and Language Policy

Discrimination is Against the Law

Valley Health Plan (VHP) does not discriminate, exclude people or treat them differently because of race, color, national origin, age, religion, disability, sex, sexual orientation, gender identity, gender expression, or any other classification prohibited by state or federal civil rights laws.

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, 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
MemberServices@vhp.sccgov.org

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, **800.537.7697 (TDD)**

Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html

Language Assistance

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)。

Հայերեն (Armenian)
ՈՒՇ ԱԴՐ ՈՒԹՅ ՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարողեն տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 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 ارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما تماس بگیرید. (California Relay Service (CRS) 711) 1.888.421.8444 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さい。

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: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรีโทร 1.888.421.8444 (California Relay Service (CRS) 711).

ខ្មែរ (Cambodian)
[illegible] បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, បសវាជំនួយខ្នកភាសា ជោយមិនគិតឈ្ន [illegible] គឺអាចមានសំរាប់បរីអ្នក។ ជួរ ទូរស័ព្ទ 1.888.421.8444 (California Relay Service (CRS) 711).

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.888.421.8444 (California Relay Service (CRS) 711).

Eligibility and Enrollment

Becoming a VHP Member

Before applying for VHP Plan membership through the VHP Covered California or the Individual & Family Plan you must be eligible to enroll. You or your Eligible Dependents must meet certain eligibility and enrollment requirements. After you have enrolled in the VHP Plan it will be necessary for you to continue to meet these requirements.

The following sections outline who is eligible to enroll, how enrollment is done, how to retain membership, and when coverage begins. If you have any questions regarding plan eligibility, enrollment, or changes to your enrollment, contact Member Services.

You must report any changes in status or any change that would affect your eligibility or the eligibility of your dependents to Covered California or the Plan within 60 days of the change in status.

Covered California Plan and Individual & Family Plan Eligibility

You are eligible to apply for Coverage under the Benefit Plan through Covered California or the Plan if you meet the definition of Subscriber or Eligible Dependent as described in the “Definitions” section, and you:

- Live in the VHP Service Area.
- Are not enrolled in any other health coverage, including Medicare.
- Submit a written application and first Premium payment at least 15 days prior to the effective date of coverage.

- Have completed an application for coverage, and the application has been approved by VHP for the effective date of coverage.

VHP may verify eligibility, other health plan eligibility (including Medicare) status and dependent status. Services are not covered prior to the Member's Effective Date of Coverage or after the Member's Coverage ends.

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

If a Subscriber works and resides outside the Service Area for more than 90 consecutive days (with no intention of returning) he/she is not eligible, or is no longer eligible, for Coverage under the Benefit Plan.

You, or any of your Dependents, may not be eligible to enroll, if you or your Dependents have ever had membership in VHP terminated for a reason stated in the section entitled "Termination of Coverage."

Children of your Dependent(s) are not eligible for enrollment.

If you, or your Dependents, 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 ineligible for membership.

If you, and your Dependents, are otherwise eligible to enroll, VHP will not refuse to enroll you, or your Eligible Dependents, because of you or your Dependent(s):

- Health status.
- Medical condition, including physical and mental illnesses.
- Claims experience.
- Receipt of health care.
- Medical history.
- Genetic information.
- Evidence of insurability, including conditions arising out of acts of domestic violence.
- Disability.

Enrollment: Commencement of Coverage

If you are applying for coverage through Covered California, Covered California shall:

- Notify VHP regarding each eligible Member who has completed an application for enrollment and designated VHP as the Certified Qualified Health Plan (QHP).
- Transmit information required for VHP to enroll the applicant.

VHP shall ensure a Coverage effective date for the Member as of:

- The first day of the next subsequent month for VHP's selection notice received by the Exchange between the first day and fifteenth (15) day of the month, or
- The first day of the second following month for VHP selections received by the Exchange from the sixteenth day through the last day of a month, or
- Such other applicable dates specified in State and Federal requirements for the Open Enrollment Period and for the Special Enrollment Period and/or as otherwise established in accordance with the Exchange's applicable laws, rules and regulations.

The Exchange shall require payment of 100% of the entire first month premium to be received by the Exchange on, or before, the fourth remaining business day of the month to commence coverage on first day of the following month.

VHP shall provide the Exchange with information necessary to confirm VHP's receipt of premium payment from Member that is required to commence coverage.

As part of the application process, you will be asked to provide personal information including name, address, race (optional), ethnicity, and language written and spoken.

If you are applying for coverage through VHP for Individual & Family Plan, the Plan shall:

- Receive completed application for enrollment.
- Inform the Member of acceptance of enrollment.

VHP shall ensure a Coverage effective date for the Member as of:

- The first day of the next month if application and premium is received between the first and the 15-day of the prior month, or
- The first day of the second month if the application and premium is received between the 16-day and the last day of a month, or
- Such other applicable dates specified in State and Federal requirements for the Open Enrollment Period, the Special Enrollment Period, and/or as other established in accordance with the Exchange.

The Plan shall require payment of 100% of the entire first month premium to be received by the Plan on or before the fifteenth day of the month to commence coverage as of the first day of the following month.

VHP shall provide the Member with information necessary to confirm VHP's receipt of premium payment from Member that is required to commence coverage.

As part of the application process, you will be asked to provide personal information including name, address, race (optional), ethnicity, and language written and spoken.

Open Enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting an enrollment application to Covered California during the open enrollment period as announced by Covered California. Covered California applications can be found at **www.coveredca.com**. Covered California will let you know when the open enrollment period begins and ends and the effective date of coverage.

To apply for Individual Family Plan, individuals may visit the VHP website at **https://www.valleyhealthplan.org/sites/m/shop/Pages/individual.aspx** or contact VHP at **1.888.421.8444** to request an application or apply over the phone.

Special Enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting an enrollment application to Covered California during the special enrollment period as announced by Covered California. Covered California applications can be found at **www.coveredca.com**. Covered California will let you know when the open enrollment period begins and ends and the effective date of coverage.

To apply for Individual & Family Plan, individuals may visit the VHP website at **https://www.valleyhealthplan.org/sites/m/shop/Pages/individual.aspx** or contact VHP at **1.888.421.8444** to request an application or apply over the phone.

Enrolling Initially

If you are applying for Coverage through the Covered California, you must apply for membership for you and your Eligible Dependents by submitting an enrollment application and premium to the Exchange.

If you are applying for Coverage to the Plan, you must apply for membership for you and your Eligible Dependents by submitting an enrollment application and premium to the Plan.

Changing Your Benefit Plan

To change your Benefit Plan, you must meet the Eligibility requirements of the Exchange or the Plan in which you would like to enroll. You must submit an enrollment or status change request to the Exchange or the Plan within 60 days after a status change. Proof of change of status or dependent status (e.g. birth certificate or adoption paperwork) must also be provided at the time that you add a Dependent to your Coverage. Call Member Services Department at **1.888.421.8444 (toll-free)** for more information.

It is your responsibility to notify the Exchange or the Plan of any changes in status that affect yours or your enrolled Dependent's ability to meet the eligibility criteria. If you do not enroll your Eligible Dependents when they are first eligible, you will not be able to enroll them.

The Plan shall allow an individual to enroll in, or to change, individual health benefit plans as a result of the following qualifying events or change of status events which include triggering events for the Special Open Enrollment period:

1. You or your dependents lose minimum essential coverage through Covered California. Loss of minimum essential coverage does not include loss of that coverage due to the individual's failure to pay premiums on a timely basis or situations allowing for a rescission.
2. You have a newborn or newly adopted dependent(s) or you become a dependent.
3. You have a new dependent who is mandated to be covered as a dependent pursuant to a valid State or Federal Court order.
4. You are released from incarceration.
5. You lose coverage through another health coverage issuer that substantially violated a material provision of the health coverage contract.
6. You move out of the Service Area or change permanent residency.
7. You gain access to new health benefit plans as a result of a permanent move.
8. Your Plan provider terminates as a provider through the Plan or another health benefit plan.
9. You enrolled in the Plan due to misinformation of eligibility under minimum essential coverage through Covered California.
10. You return from active duty service in either the United States military or the California National Guard.
11. You experience any other change of status events as defined by California Coverage or Federal Regulations.

Enrolling Late or During Open Enrollment

Late enrollment means you are a Late Enrollee. If you do not enroll yourself or your Dependents when they first become eligible, you can enroll during open enrollment or upon receipt of an enrollment form and premium. Call Member Services at **1.888.421.8444 (toll-free)** for more information.

You may enroll or change your plan during this time.

It is your responsibility to ensure your completed enrollment application for the VHP Covered California and Individual & Family Plan is received by the Exchange/Plan during the Initial Eligibility Period.

When Coverage Begins

Covered Services begin for you, the Subscriber, and your Dependents on January 1 at 12:00 A.M. when enrolling initially or on the Effective Date of Coverage established by the Exchange or the Plan. Coverage begins on the first of the month following enrollment and receipt of payment, which is delivered or postmarked within the first 15 days of the month prior to the effective date. When enrollment and payment is delivered or postmarked after the 15th day of any month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

Covered Services begin for:

- A Dependent Newborn Natural Child at the moment of birth.
- A Dependent 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.
- A Dependent Ward that is an Eligible Dependent child on the commencement date of legal guardianship.
- A Dependent child in court-ordered guardianship with the subscriber.

This coverage lasts for 31 days. For coverage to continue beyond 31 days, the Subscriber must enroll the child through Covered California or the Plan within 60 days of birth, adoption or placement for adoption, other date of court-ordered guardianship.

Continuing Coverage for Dependents

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

1. A physically or mentally handicapped Eligible Dependent who is incapable of self-sustaining employment and is dependent upon

you for support and maintenance can continue Coverage providing the child was handicapped on the day before reaching age 26 and proof of such incapacity and dependency is furnished to VHP within 60 days of the child reaching that age. Verification of disability and dependency may be required as often as deemed necessary by VHP. However, the Plan will not request verification more often than once a year after the first two years the child has reached age 26.

2. 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.
3. You, or your spouse's, natural child, stepchild, legally adopted child, or a child under your court ordered legal guardianship, is residing with Subscriber or with Subscriber's present or former spouse. Coverage can be continued under the Plan 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.
4. An Eligible Dependent who reaches age 26 and meets the following criteria:
    a. The Dependent is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition.
    b. The Dependent is chiefly dependent upon the subscriber for support and maintenance.

Contract Period of this Evidence of Coverage

The Agreement is revised when the contract between you and VHP is changed. Any future changes to the Agreement will affect this Evidence of Coverage and Disclosure Form. The description of Benefits discussed in this booklet are applicable after January.

If you would like a copy of the EOC, or of recent Member communications, such as the VHP Member newsletter "Perspectives," visit **www.valleyhealthplan.org** or call the Member Services at **1.888.421.8444 (toll-free)**.

Choice of Physicians and Providers

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

VHP is a non-profit health plan that contracts with its Primary Care Physicians (PCPs) and other Plan Providers who are responsible for providing and coordinating Covered Services or Benefits for its Members. As a Member of VHP, you must receive all care for Covered Services from contracted Plan Providers. The use of Plan Providers is necessary except:

- In the event of an Emergency.
- In the event of Urgently Needed Services while out of the Service Area. (Urgent care from non-contracted Providers is covered if a reasonable person would believe that your health would seriously deteriorate if treatment was delayed).
- If VHP has pre-authorized the services.

At the time of enrollment, a PCP needs to be selected for each Member. The PCP is responsible for providing all basic medical care, for all specialty and hospital services referrals, and for coordinating any necessary Prior Authorization.

For updated Plan Provider information, visit **www.valleyhealthplan.org** or call Member Services at **1.888.421.8444 (toll-free)**.

To understand the meaning of important definitions, such as Plan Providers and Service Area, refer to the “Definitions” section. Additional important information regarding our Plan Network is located in the “Payment and Reimbursement Responsibility” section under “Provider Payments.”

Choosing Your Primary Care Physician

VHP encourages you, and your Dependent(s), to choose a VHP Primary Care Physician (PCP). If you do not select a PCP, VHP will assign one for you and your enrolled Dependent(s).

To choose a PCP:

- Include the name of the PCP of your choice on your Enrollment Application when initially enrolling.
- Select a PCP which is located near your home or work by using the Provider Search at **www.valleyhealthplan.org**. You may choose a different PCP for each Dependent.

VHP will make every effort to assign you with the PCP of your choice, however, if this is not possible, VHP will contact you with details on how to make another selection.

If you need any assistance in selecting a PCP, please call Member Services Representative at **1.888.421.8444 (toll-free)** or go to **www.valleyhealthplan.org** and use the Provider Search. You may also download a hard copy of the Provider directory on our website.

VHP encourages you to identify your newborn's PCP during the last few months of pregnancy. Please contact a Member Services Representative to help you with your selection.

Changing Your Primary Care Physician

You may change your PCP at any time by calling Member Services 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. 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.

Primary Care Provider Network Selection

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

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 vendors (DME) 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 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. Refer to the "*Where Can I Go To Get Health Care?*" section under "*General Information*" 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.

Access to Care

As a Member of VHP, you are selecting our health plan to provide you and/or your family health care. You must receive all Covered Services from Plan Providers inside our Service Area, except as described in the "Emergency and Urgent Care Services" section. Through our health plan, 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 "Benefits and Cost Sharing" section.

Scheduling Appointments

VHP offers a wide selection of PCPs throughout its Service Area. To schedule an appointment, call your PCP's office appointment line. You can view your PCP's telephone number at **www.valleyhealthplan.org**. If you need help finding your PCP's appointment number, you can call Member Services at **1.888.421.8444 (toll-free)**.

VHP also provides a free 24/7 Nurse Advice Line at **1.855.348.9119 (toll-free)**. Language services are also available to you for no cost through your Plan Providers.

Eligible Members may obtain Covered Services through direct access (self-refer) from a Plan OB/GYN and/or through direct access from a Plan family practice physician and surgeon (Plan Provider).

VHP recommends you call in advance when scheduling your doctor's appointments. Be prepared to provide information such as your name, the VHP ID number on your VHP ID Card, a daytime telephone number where you can be reached, and the reason for the visit (so that adequate time can be scheduled for your appointment). For more immediate or urgent care attention, tell the nurse of the urgency of your call and request the next available appointment.

If you need to cancel an appointment, be sure to contact the Plan Provider immediately so another patient can be scheduled. Whenever possible, you should give at least a 24-hour notice when canceling an appointment.

At the time of your doctor's appointment, you will be asked to show your VHP ID Card. VHP suggests that you bring your VHP ID Card and another form of identification at all times.

When making appointments, or if you need language services, call VHP Member Services at **1.888.421.8444 (toll-free)** for assistance in your preferred language or have questions, comments or concerns. VHP offers over-the-telephone language assistance at no cost to you. You can also get an interpreter to talk to your doctor by contacting Member Services. In addition, as required by the Department of Managed Health Care (DMHC), VHP will provide written translation of vital documents, such as applications, Grievance or consent forms, or other important membership materials. If you have questions about language services, call Member Services at 1.888.421.8444 (toll-free).

Receiving Primary Health Care

The PCP you or your Dependent(s) have chosen will provide or arrange for the majority of your general medical, pediatric, and OB/GYN Covered Services from VHP Plan Providers. To ensure quality health care, you should regularly schedule general checkups and office visits.

Receiving Self-Referral Services

VHP contracts with its Plan Providers. Based on a Primary Care Physician'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 female Member may self-refer to a Plan OB/GYN. For services, call a Plan OB/GYN. 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.

Receiving Specialty Care and Referrals

Your PCP will coordinate all specialty care or other Covered Services.

Except for self-refer services, before you receive specialty services from a Plan Physician, (such as general surgery, orthopedic surgery, or cardiology), you must receive a referral from your PCP.

Your PCP will obtain Authorization for specialty services. Your PCP will instruct you how to make an appointment to see the Plan Specialist. Making an appointment will be your responsibility. Services received by specialists with no Prior Authorization could result in your financial responsibility. Some specialty referrals may require additional review by the VHP Medical Director.

When all necessary referral information has been provided, VHP will inform you and the physician of its decision within five (5) business days.

If you have a Serious Chronic Condition, including HIV or AIDS, that may require a standing referral for more than two (2) visits, your PCP will involve your Plan Specialist and discuss the coordination of your care with you. The Prior Authorization process through VHP is needed to obtain these services. Your PCP is responsible for requesting and coordinating these services to ensure continuum of care. You will be advised of the decision by VHP within two (2) business days.

If you require mental health/behavioral health services, refer to the "Benefits and Cost Sharing" section under "Mental Health Services."

To receive more information about referrals and Authorizations simply call Member Service at **1.888.421.8444 (toll-free)** or refer to "Authorization and Denial of Services" in this section.

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 Care Provider's Network. Except in an Emergency or out-of-area urgent care situation, if you seek and receive services outside of your Primary Care Provider Network without an authorized referral and/or Prior Authorization you may be responsible for the charges.

Quaternary Referral Or Care

VHP offers a network of quaternary care providers inclusive of level one and level two trauma centers, neonatal intensive care units, perinatology services, comprehensive cancer services, comprehensive cardiac services, and pediatric subspecialists available 24 hours per day. In the event VHP is unable to provide the necessary quaternary care services required, VHP will facilitate timely and adequate coverage of these services through an out-of-network provider, until a network provider is contracted, and coordinate the authorization and payment in these circumstances. VHP has contracted with quaternary care hospitals which may only be utilized when services are not otherwise available in the primary network chosen by the member. For further information about referrals to these facilities or for assistance in making a referral to a non-contracted quaternary care hospital for a VHP member, contact VHP's Utilization Management team at 1.408.885.4647 (for TTY, contact California Relay by dialing 711 and provide the number 1.800.735.2929) and VHP will identify a provider for the necessary referral.

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

Appointment Scheduling	Waiting Time
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 reschedules 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 Members' preference to wait for a later appointment from a specific Plan Provider.

For more information on timely access to care, including language services, contact Member Services at **1.888.421.8444 (toll-free)**.

Receiving Hospital or Other Facilities Care

VHP is contracted with several hospitals throughout its Service Area. Except in an emergency, Hospital Services must have been authorized by the Plan.

24/7 Nurse Advice Line services are available 24 hours a day by calling **1.855.348.9119 (toll-free)**.

To receive any Medically Necessary hospital or facilities Covered Services your Primary Care Physician will arrange for all Covered Services in a Plan Hospital or Facility, including inpatient, transitional, and/or care provided in a sub-acute or Skilled Nursing Facility. Authorization is required for all facilities

care and 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 Plan Facilities, 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 the VHP Plan Provider Network, you may be responsible for the charges.

In the event of an Emergency and you cannot safely come to a Plan Hospital, you should call 911 or seek care at the closest hospital. Please refer to the "Emergency and Urgent Care Services" section.

Receiving Out-of-Network Care

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 make arrangements to obtain the necessary therapy prior to leaving your Network or work with your PCP 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 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, 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 **1.855.348.9119 (toll-free)**. The advice nurse will assess your condition and direct you to the appropriate care. The telephone number is also 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 and Urgent Care Services" section.

In the event of an Emergency, call 911 or go to the nearest emergency room. Refer to the "Emergency and Urgent Care Services" section.

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.

Authorization and Denial of Services

VHP contracts with its PCPs and Plan Providers who are responsible for providing and coordinating Covered Services or Benefits for its Members. Except in the event of an Emergency, Urgently Needed Services, or if VHP has authorized the services in advance, you must receive all of your care from these contracted providers. Services not received from the Member's PCP require a referral (unless such services are eligible for self-referral as defined in this EOC) or Prior Authorization. Timelines regarding Authorization and Denial of Services are outlined in this section under "Receiving Specialty Care and Referrals."

All Covered Services are provided, arranged for, or coordinated by your PCP. For Members to receive Covered Services that require a referral or Prior Authorization the conditions must be met:

- A VHP PCP must initiate such a referral to a specialist on behalf of the Member and submit for approval or Denial.
- For services that require Prior Authorization, Prior Authorization must be approved prior to a Member receiving services.

If you would like more details regarding the referral provision of your Benefit Plan or the Authorization process, you may contact Member Services at **1.888.421.8444 (toll-free)** or refer to this section under "Receiving Specialty Care and Referrals."

Members are notified of Authorizations and Denials in writing.

If you believe that your PCP or other VHP Provider has improperly denied a request for treatment or services, you may file a Grievance of that decision by calling Member Services at **1.888.421.8444 (toll-free)** within 180 days

of the initial Denial. If the service you requested is still denied; you may file a VHP Member Grievance as described in the “Member Services Assistance” section under “Member Grievances.”

Requests involving an imminent and serious threat to your health will receive an expedited review as may be required by the urgency of the situation.

In the event that you are dissatisfied with any action or adjustment by your Plan Provider or VHP, you should follow the “Member Grievances” procedures in the “Member Services Assistance” section under “Member Grievances.” In addition, you may also contact the California Department of Managed Health Care. Refer to the “Member Services Assistance” section under “DMHC Consumer Help-Line” for more details.

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 for a second opinion. For purposes of this "Second Opinions" provision, 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 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 opinion may be provided or authorized:

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or 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 treatment plan in progress 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 requests — within two (2) to six (6) hours.
- Urgently Needed Services requests — within 24 hours.
- Routine requests — within five (5) business days.

If you are seeking an Emergency Services second medical opinion after normal business hours, call our 24/7 Nurse Advice Line at **1.855.348.9119 (toll-free)**. On the next business day, please call Member Services **1.888.421.8444 (toll-free)**. Member Services will help resolve your concern or if necessary, assist you in filing a Grievance as outlined in the "Member Services Assistance" section under "Member Grievances." In addition, you may also contact the California Department of Managed Health Care's Health Plan Division; refer to the "Member Services Assistance" section under "DMHC Consumer Help-Line" for more details.

Continuity of Care

If you or your Dependent(s) 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.

This section describes the Covered Services of this continuity of care. You have the right to request a copy of the Plan's continuity of care policy. To

request a copy of this policy, call Member Services 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 woman 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 (1) 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 the Plan 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 enrollees 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 enrollee's service area.

To receive continuation of care from your provider or Plan Provider, you must obtain a written Prior Authorization from VHP. This authorization shall state the predetermined amount of time you will be able to continue to receive care from your current provider.

A written referral for Continuity of Care is only provided if you are a new Enrollee 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 Member Services at **1.888.421.8444 (toll-free)** to inform VHP that your Plan Provider has terminated or when your Plan Provider notifies you that he/she is 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 principal exclusions includes services that are not Medically Necessary. The determination whether a service or supply is Medically Necessary is made by the Plan Medical Director based on an objective review and subject to the Plan Grievance procedures. However, if VHP denies your health care services on the basis that the service is not

Medically Necessary, you, your designee, or your doctor can request an Independent Medical Review (IMR). Before initiating an IMR, you must have completed the VHP Grievance process or have participated in the Grievance process regarding a Disputed Covered Service for at least 30 days.

The Department of Managed Health Care's (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 (6) months of receiving a Denial from the Plan. You may only request a review for a service that is a Covered Benefit. You can obtain more information on the IMR process by accessing the Department of Managed Health Care's website at **www.dmhc.ca.gov** (Questions and Answers about IMR) or by calling Member Services at **1.888.421.8444 (toll-free)**.

If services are denied because they are Experimental or Investigational Treatment(s), which are non-covered Benefit(s), you have the right to request an IMR from the DMHC without first participating in the VHP's Grievances process. The IMR request for review of Experimental or Investigational Treatments must be based on the following requirements that the Member's Plan Physician certifies that the disease or condition is:

- Life-Threatening and Seriously Debilitating.
- Due to a terminal condition that has a high probability of causing death within two (2) years and that your Plan Physician certifies that standard therapies used have not been effective to improve the condition, would not be medically appropriate, or for which there is no other beneficial standard therapy covered by the Plan than the proposed drug, device, procedure or therapy.
- The specific drug, device, procedure, or other therapy recommended by the Plan Physician would be a Covered Benefit, except for the Plan's determination that the therapy is Experimental or Investigational.

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

For additional information on the DMHC Consumer Helpline or the Plan's Grievances process, refer to the "Member Services Assistance" section.

VHP Website: www.valleyhealthplan.org

VHP's website provides information such as Covered Services/Benefits, VHP Network Providers and their locations, and wellness information which includes prevention guidelines and recommended immunizations. There will also be a listing of phone numbers for you to call for appointments with your Primary Care Physician (PCP), to reach a VHP Network Pharmacy, to make appointments with a self-refer clinic (OB/GYN and some specialists based on your PCP Network) or how to reach VHP Member Services. Updates to this website will be made as needed.

VHP Newsletter – Perspectives

VHP publishes the Perspectives newsletter at least once a year. It includes articles and links to pages at **www.valleyhealthplan.org** that provide its Members with legislative changes, access to care advice, health tips, doctor profiles, and other information that is important to Members. For copies of VHP's most recent Perspectives newsletter, contact Member Services at **1.888.421.8444 (toll-free)** or visit **www.valleyhealthplan.org**.

Using Your VHP ID Card

After enrolling, you will receive a VHP Identification (ID) Card for yourself and one for each covered Dependent. Keep your VHP ID Card handy when you call to make an appointment or go to a medical facility for care.

Please note: Your VHP ID Card is for identification only. To receive Covered Services, you must be an eligible Member. Anyone who is not a VHP Member at the time of services will be charged for any services received. If you let someone else use your card, your membership may be terminated.

Benefits and Cost Sharing

Certain definitions of terms used to describe your Benefits can be found in the "Definitions" section of this booklet. These defined terms will be capitalized throughout the document. For example: Covered Services, Plan Physicians.

You and your Dependents are eligible to receive a comprehensive range of medical and hospital Benefits when you need them. This section describes the standard Covered Services that are available through your Benefit Plan.

Please take a few moments to read these descriptions, the "Emergency and Urgent Care Services" and the "Exclusions and Limitations" sections to fully understand the extent of your Benefits.

Your Member's Cost Sharing or share of cost (e.g. Deductibles, Coinsurance, and Copayments) responsibility and the particular costs due to exclusions and limitations that apply to a specific Benefit are your responsibility. None of the Cost Sharing shall exceed the Plan's actual cost of the service. For example, if laboratory tests cost less than the $45 Copayment, the lesser amount is the applicable Cost Sharing amount.

Note: The dollar amount of Deductibles, Coinsurance, and Copayments can be $0 (no charge). For Cost Sharing information, refer to the applicable "Summary of Benefits and Coverage" and "Schedule of Benefits and Coverage Matrix."

Except for Emergency Services, Urgently Needed Services, Prior Authorized, or Member Self-Referral Services, Covered Services must be:

- Provided, prescribed, arranged for, and/or directed for Authorization by your PCP or a Plan Physician.
- Obtained from Plan Provider(s) within the VHP Network, and

- Rendered to a Member for the treatment of illness or injury, (unless specifically covered as preventive or routine health services).

Mid-Level Practitioners and resident physicians may be involved in your care through VHP. These providers will participate in your care only under the direct supervision of an attending physician and all health care decisions will be made by consultation with the attending physician. You will be informed of the involvement of any Mid-Level Practitioners by the individuals at the Plan Provider site.

If you have additional questions about your Covered Services, please call Member Services at **1.888.421.8444 (toll-free)**.

Professional Services

Professional services include physician services that are covered under your Benefit Plan. Covered Services are received from your PCP or Plan Specialist (or other Plan Providers) and include:

- Primary Care Physician (PCP) services.
- Plan Specialist care.
- Inpatient Hospital Plan Physician services.
- Outpatient Plan Physician care.
- Outpatient Hospital Plan Physician services.

Outpatient Services

Outpatient Care is covered under your Benefit Plan when received from your Plan Providers. Routine Care or urgent care is arranged or provided through your PCP or Plan Physician and includes many of the common preventive and diagnostic services you will need. There is no limit to the number of visits (except for defined limitations).

You may self-refer directly to a Plan Physician for OB/GYN services.

Outpatient Covered Services include but are not limited to:

- 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). The age, health status, and medical needs of the child determine the frequency of these examinations.

- Screening for Adverse Childhood Experiences, which refers 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
- Periodic health examinations for Routine Care including immunizations, diagnostic laboratory services, Pap smears, Prostate Specific Antigen (PSA) tests, and all generally medically accepted cancer screening tests. Frequency is based on Medical Necessity, age, and demographic characteristics.
- The plan will provide coverage without any cost sharing for a colorectal cancer screening test assigned either a grade of A or B by the United States Preventive Services Task Force (USPSTF). 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 USPSTF.
- 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.
- All preventive services recommended by the US 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. These services shall not have any cost-sharing requirements.
- Physical examinations for Routine Care including diagnostic laboratory services and testing and treatment of PKU. Vision and hearing screening examinations to determine the need for vision or hearing correction as provided by your PCP.
- Well woman examinations including diagnostic laboratory services, a pelvic and breast examination, Pap smear, and other simple

diagnostic tests. Annual cervical screening includes PAP tests, a human papillomavirus screening that is approved by the federal 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 within the VHP Network for a Well-Woman Examination once every Calendar Year.

- Mammography screening for Routine Care including radiological procedures and interpretation of the results, frequency is determined based on Medical Necessity, age, and demographic characteristics.
- Allergy testing and treatment including serum and injection services.
- Dermatology services for Routine Care including diagnostic, laboratory, and dermatological preparations.
- 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).
- Habilitation services include physical and occupational therapy, speech-language pathology, and other services for people with disabilities. Habilitation services shall be covered as medically necessary. 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.
- HIV, AIDS, or other infectious diseases Testing and Treatment; HIV testing is covered regardless if related to a primary diagnosis.
- Immunizations and injections including flu shots, tetanus and diphtheria boosters, AIDS vaccines, Hepatitis A and B vaccines, pneumococcal pneumonia vaccines, and immunizations as required by Immigration and Naturalization Services Department or as recommended by the U.S. Preventative 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.
- Optometry services or vision screening, including a wide range of diagnostic testing, which includes screening for cataracts, diabetes, and Glaucoma. Exclusions include: Industrial frames; eyeglass lenses and frames; contact lenses, including fitting and dispensing; non-implant low aides; and correction of visual acuity or refractive errors, including eye surgery such as radial keratotomy are excluded for adults.
- Podiatry services for the treatment of injuries and diseases of the feet. Coverage is limited to a medical condition affecting the feet,

such as diabetes, systemic foot disease, trauma, or accidental injury to the foot, requiring care by a medical professional. Orthotic appliances are limited to one (1) per year, unless Medically Necessary with Prior Authorization.

- Physical, occupational, speech, and respiratory therapy services to maintain or prevent deterioration of a patient's chronic physical or mental condition, including Sever Mental Illness are limited to treatment provided in the amount, frequency, or duration, as the Plan Physician deems Medically Necessary. Occupational therapy is limited to care that will allow you to achieve and maintain improved self-care. Physical Therapy includes but is not limited to aquatic or other water therapy as Plan Physician deems Medically Necessary in the appropriate setting.
- Outpatient hospital services including outpatient surgery and procedures in a hospital or outpatient centers such as, but not limited to, angiograms and bronchoscopies, chemotherapy and medically appropriate materials. Outpatient services also include surgical assistant and anesthesiologist, drugs, X-ray, supplies and blood, and blood derivatives, and transfusions (blood bank).
- Urgently Needed Services when you are temporarily out of your Service Area Network. The provision of Medically Necessary services for an illness or injury, which treatment cannot be delayed until the Member returns to the Service Area and, is covered if a reasonable person would believe that your health would seriously deteriorate if you delayed treatment.
- Ambulance and transportation services including emergency ambulance transportation, air ambulance, and inter- facility medical transportation transfers, Non-Emergency medical and psychiatric transport is covered when determined to be Medically Necessary.

Inpatient Services

Hospitalization Services

When Medically Necessary, your Plan Physician will make arrangements for you to be admitted to your Plan Hospital. Inpatient Hospital Services are covered under your Benefit Plan when your Plan Physician has admitted you, or Prior Authorization has been obtained, or Emergency or Urgently Needed Services result in your hospitalization.

There is no limit to the number of inpatient days, when provided at a Plan

Hospital by Plan Providers.

You must notify VHP if you are confined in a facility, hospital, or Skilled Nursing Facility on your Effective Date of Coverage so that VHP can arrange for care to be provided in your Plan Facility or Plan Hospital as soon as your condition has stabilized sufficiently to permit transfer.

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.

Skilled Nursing Facility Services

Skilled Nursing Facilities (SNF) care is provided to you when authorized by a Plan Physician. VHP provides up to 100 days per benefit period of prescribed and 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.
- Room and board.
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug Formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by

medical personnel.

- Durable medical equipment in accord with our 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.
- Behavioral health treatment for autism spectrum disorder.
- Respiratory therapy.

Care is limited to Medically Necessary covered service, which is skilled and required on a daily basis, is not Custodial Care, and as a practical matter, can only be provided on an inpatient basis. 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 which requires ongoing inpatient skilled nursing care are excluded from your Benefit Plan after you receive 100 days of care for each benefit period. 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 Behavioral Health Treatment for autism spectrum disorder.

Ambulance and Transportation Services

If a Plan physician determines that your condition requires the use of services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you between facilities. Arrangements will be made and/or authorized by your PCP or Plan Medical Director for non-emergency medical and psychiatric and psychiatric transportation when Medically Necessary.

In the event of an emergency medical condition that requires an emergency response you are encouraged to use appropriately the “9-1-1” emergency response system in areas where the system is established and operating. In the event of an emergency where no “9-1-1” 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 with Prior Authorization or when used in accordance with the services as outlined in the “Emergency and Urgent Care Services” section.

Prescription Drugs

When you receive a prescription from your Plan Physician, have it filled at a Plan Pharmacy. Your Plan Physician coordinates your health care to determine when you need medication and the proper dosage from VHP’s Formulary. Medically Necessary medications (only medications for pain, antibiotics) prescribed by your dentist must be filled by your Plan Pharmacy. Routine Medically Necessary ophthalmic agents prescribed by your optometrist are a Covered Benefit only when authorized and filled at a Plan Pharmacy. Other prescriptions written by dentists or optometrists are not covered by VHP. Over the counter (OTC) drugs, medications, and supplies are not a Covered Benefit, except as specified in this Membership Agreement and Evidence of Coverage & Disclosure Form. Medications, not Medically Necessary, including travel patches, cosmetics, herbal products and treatments, dietary supplements, health, or beauty aids, are excluded from the Benefit Plan.

Outpatient Drugs, Supplies and Supplements

The following outpatient drugs, supplies and supplements are covered:

- Drugs for which a prescription is required by law. Also, certain drugs

that do not require a prescription by law if they are listed on our drug Formulary.

- Diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills) at no charge.
- All FDA-approved contraceptive drugs, devices and products available OTC when prescribed by your Plan Physician and filled at a Plan Pharmacy are provided at $0 (no charge).
- All drugs, devices and other products for women as approved by the FDA included within each of the following methods: barrier; hormonal; emergent; implanted and permanent.
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs.

Cost Sharing for Outpatient Drugs, Supplies and Supplements

The Cost Sharing for these items is as follows. For an explanation of the Drug Deductible, see “Drug Deductible” in this section.

Prescription Drugs are classified by Tiers. All Tiers may be subject to the Drug Deductible under the following conditions:

- Tier 1 drugs: Copayment applies for up to a 90-day supply.
- Tier 2 drugs: Copayment applies for up to a 90-day supply.
- Tier 3 drugs: Copayment applies for up to a 90-day supply.
- Tier 4 drugs: Coinsurance or Copayment applies for up to a 30-day supply.

For explanation of Tier drug categories, see applicable “Schedule of Benefits and Coverage Matrix.” None of the Cost Sharing shall exceed the Plan’s actual cost of the service. For example, if laboratory tests cost less than the $45 Copayment, the lesser amount is the applicable Cost Sharing amount.

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

Drug Deductible

In any Calendar Year, some benefit plans have a deductible that applies to covered prescription drugs. If your benefit plan includes a Deductible, you are responsible for paying all costs to meet the Deductible each Calendar Year before VHP will cover the prescription at the applicable Copayment. Coinsurance or Copayment for drugs that are non-Formulary but are authorized accumulate toward your out-of-pocket maximum.
The total amount of copayments and coinsurance an enrollee is required to pay shall not exceed $250 for an individual prescription of up to a thirty (30) day supply of a prescribed orally administered anticancer medication covered under the Plan's Formulary. Enrollee is not required to meet the drug deductible before the $250 maximum is applied to orally administered anticancer medications.
Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in a Plan Medical Office or during home visits; you do not need to meet the Drug Deductible for the following items:

- Amino acid-modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria).
- Cancer chemotherapy drugs and certain critical adjuncts following a diagnosis of cancer.
- Certain drugs for the treatment of life-threatening ventricular arrhythmias.
- Diaphragms and cervical caps.
- Drugs for the treatment of tuberculosis.
- Elemental dietary enteral formula when used as a primary therapy for regional enteritis.
- Emergency contraceptive pills.
- Hematopoietic agents for dialysis and for the treatment of anemia in chronic renal insufficiency.
- Human growth hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion.
- In connection with a transplant, immunosuppressants and ganciclovir and ganciclovir prodrugs for the treatment of cytomegalovirus.
- Low molecular weight heparin for acute therapy for life-threatening

thrombotic disorders.

- Phosphate binders for dialysis patients for the treatment of hyperphosphatemia in end-stage renal disease.

Any copayment or percentage coinsurance will not exceed 50% of the cost to the Plan.

Certain Intravenous Drugs, Supplies and Supplements

We cover certain self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an intravenous or intraspinal-infusion) for up to a 30-day supply and the supplies and equipment required for their administration. Injectable drugs and insulin are not covered under this section. Refer to the "Outpatient Drugs, Supplies and Supplements" section.

Diabetes Urine-Testing Supplies and Insulin-Administration Devices

VHP covers ketone urine test strips and sugar tablets for up to a 90-day supply. VHP covers the following insulin-administration devices for up to a 90-day supply: pen delivery devices, disposable insulin needles and syringes, and visual aids required to ensure proper dosage (except eyewear).

Day Supply Limit

The prescribing provider determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, the prescribing provider determines the amount of an item that constitutes a Medically Necessary up to a 30 or 90-day supply. Upon payment of the Cost Sharing specified in this "Outpatient Prescription Drugs, Supplies and Supplements" section, you will receive the supply prescribed up to the day supply limit also specified in this section. The day supply limit is either up to a 30-day supply for specialty drugs in a 30-day period or up to a 90-day

supply for non-specialty drugs in a 90-day period. If you wish to receive more than the covered day supply limit, then you must pay charges for any prescribed quantities that exceed the day supply limit.

Plan Pharmacies

When filling a prescription at a Plan Pharmacy, present your VHP ID Card and the prescription to the pharmacist. There are no limits on the number of prescriptions you may have filled as long as your Plan Physician prescribes them. However, the Pharmacy will dispense up to but no more than a 90-day supply for Serious Chronic medical conditions. You may be required to pay a Prescription Unit copayment. The Pharmacy will advise you of all charges.

All prescriptions must be filled by Plan Pharmacies. Your pharmacy Benefit is limited to prescriptions filled at a Plan Pharmacy. Only prescriptions for emergent or urgent care services will be covered at an outside pharmacy when a Plan Pharmacy is not available. Formulary drug prescriptions obtained from non-VHP providers and filled at non VHP pharmacies are subject to the Authorization process. Upon review by the Medical Director, reimbursement may be denied.

Routine Medically Necessary antibiotics and pain medications prescribed by your dentist are a Covered Benefit only when authorized and filled at a Plan Pharmacy. Routine Medically Necessary ophthalmic agents prescribed by your optometrist are a Covered Benefit only when authorized and filled at a Plan Pharmacy. Other prescriptions written by dentists or optometrists are not covered by VHP.

You may be financially responsible for lost or misplaced medications. The Pharmacy Benefits Manager (PBM) or pharmacist will advise you of all charges.

PKU formula and special food product reimbursement is limited to the amount and duration that the Plan Physician deems Medically Necessary. Special formulas for allergy, e.g. cow’s milk, soy, or lactose intolerance milk are not a Covered Service under your Benefit Plan.
Over the counter (OTC) drugs and supplies are not a Covered Benefit except for all FDA-approved contraceptive drugs, devices, and products available over the counter at no charge, when prescribed by your Plan Physician and filled at a Plan Pharmacy.

You may choose to have your prescription mailed to your home. You will not be charged for this mail order service, however if your request for mail services cannot be filled, the pharmacy may need to contact you. It is important that your phone numbers and mailing address are up to date at your Plan Pharmacy. For more information regarding mail order services, refer to the "Prescription Refill Options" section. For more information, call **1.888.421.8444 (toll-free)** or go to **www.valleyhealthplan.org**.

Prescription Refill 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.

Mail Service Pharmacy

You have the option of using the Mail Service Pharmacy, which only offers prescriptions to be mailed to your home. Once a prescription is filled by the Mail Service Pharmacy, the prescription cannot be transferred to another Plan Pharmacy. For additional information call **1.888.421.8444 (toll-free)** go to **www.valleyhealthplan.org**.

VHP

Plan Physicians use a comprehensive drug Formulary that includes both FDA-approved brand and generic equivalent drugs. Your Plan Physician coordinates your health care to determine when you need medication and the proper dosage. Although a drug may be on the Formulary, it does not guarantee that your Plan Physician will prescribe the drug. 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.

VHP delegates the Formulary drug selection process to its Pharmacy and Therapeutics Committee (P&T). The VHP Formulary has been prepared as

a reference for all health professionals who share the responsibility for the management of patient care, including VHP Members. The Formulary is prepared for publication by its pharmacy benefits management provider under the direction of VHP, the Medical Director, and Plan Providers. The Formulary is prepared for publication by VHP's PBM under the direction of the P&T. The Formulary is published online. Additions and deletions to the Formulary, which occur throughout the year by the action of the P&T conveyed to the PBM. The PBM advises the Plan Providers and Members as appropriate. Record of these changes are maintained in the P&T minutes.

To identify whether a specific drug(s) is on the Formulary or to obtain a copy of the formulary, call **1.866.333.2757 (toll-free)** or go to **www.valleyhealthplan.org.**

Non-Formulary, Urgent or Emergency Prescriptions

Medically Necessary non-Formulary drugs may be covered if your Plan Physician obtains Authorization from VHP or the PBM. New non-Formulary prescriptions will be authorized within five (5) business days. Urgent or emergency non-Formulary prescriptions will be authorized within 24 hours or one (1) business day. If you are completely out of your prescription, call your Plan Pharmacy, Plan Provider, or call Member Services at **1.888.421.8444 (toll-free).**

If the request for Authorization is denied, VHP will notify you and your Physician in writing, within two (2) working days, of the reason for the Denial. You will be referred back to your Plan Physician for alternative treatment and/or to contact VHP or PBM Customer Care for further assistance. The notice will also inform you of your right to dispute the Denial. If you have questions, speak with your Plan Pharmacist, Plan Provider, or call **1.888.421.8444 (toll-free)**.

In the event Member needs to file a Grievance with the Plan, the Member must contact VHP Member Services. If VHP denies the Member Grievance, VHP will notify the Member in writing of the reason for denial. The notice shall also inform the Member of their right to dispute the decision. Emergency prescription drugs are filled according to the provider's prescription. Should you need to obtain a prescription associated with Out-of-Network Emergency Services or Urgently Needed Services, take your prescription to a Plan Pharmacy. If a Plan Pharmacy is not available,

VHP will cover the prescription filled at an Out-of-Network Pharmacy. Call **1.888.421.8444 (toll free)** or go to **www.valleyhealthplan.org**. Refer to the "Payment and Reimbursement Responsibility" section under "Reimbursement Provisions (Claims)" for reimbursement procedures.

Drugs Prescribed at the Time of Enrollment

If you are taking prescription drugs at the time you enroll, please make an appointment with your Primary Care Physician for evaluation of your current medication 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(s) from the Formulary that is equally effective.

Inpatient Pharmacy Services

For inpatient care, Covered Services include drugs, supplies, and supplements. Inpatient hospital and other facility drugs and supplements are provided in accordance with your Plan Physician's prescription and Plan Formulary.

Durable Medical Equipment - Medical Supplies and Equipment

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

Your Plan Physician will prescribe when Medically Necessary. If Prior Authorization is required (e.g. DME and prosthetic devices) your PCP or Plan Physician will arrange it.
Covered Services include:

- Durable Medical Equipment.
- Corrective appliances.
- Prosthetic Devices.
- Prescription Orthotic devices.
- Oxygen and oxygen equipment.

VHP or your Plan Provider will determine whether to repair, rather than to replace prosthetic devices.

Durable Medical Equipment for Home Use

Inside the Service Area, VHP covers Durable Medical Equipment specified in this section for use in your home (or another location used as your home) in accord with Durable Medical Equipment formulary guidelines. Durable Medical Equipment 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.
Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered Durable Medical Equipment (including repair or replacement of covered equipment) is provided. VHP will decide whether to rent or purchase the equipment and will select the vendor. You must return the equipment to VHP or pay the fair market price of the equipment when VHP is no longer covering it.
Inside our Service Area, we cover the following Durable Medical Equipment for use in your home (or another location used as your home):

- Diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices).
- Infusion pumps (such as insulin pumps) and supplies to operate the pump (but not including insulin or any other drugs).
- Standard curved handle or quad cane and replacement supplies.
- Standard or forearm crutches and replacement supplies.
- Dry pressure pad for a mattress.
- Nebulizer and supplies.
- Peak flow meters.

- IV pole.
- Tracheostomy tube and supplies.
- Enteral pump and supplies.
- Bone stimulator.
- Cervical traction (over door).
- Phototherapy blankets for treatment of jaundice in newborns.

Prosthetic and Orthotic Devices

Prostheses incidental to surgery, include, but are not limited to the following:

- 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 item.

For surgically implanted and other Prosthetic Devices provided to restore and achieve symmetry incident to a mastectomy, see the “Reconstructive, Cosmetic, and Bariatric (weight loss) Surgery Services” section under “Reconstructive Surgery.” The Plan covers up to three brassieres, required to hold a prosthesis, every 12 months as required for Medically Necessary mastectomy.
VHP does not cover most prosthetic and orthotic devices, but we do cover devices as described in this “Prosthetic and Orthotic Devices” section 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.
- You receive the device from a Plan Provider.

Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and Services to determine

whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the Cost Sharing that you would pay for obtaining that device.

Medical Supplies, Equipment, and Other External Devices

Medical Supplies are limited to 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 Physician, 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.

VHP covers the following external prosthetic and orthotic devices:

- 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).
- Prostheses needed after a Medically Necessary mastectomy, including:

  - Custom-made prostheses when Medically Necessary.

  - Up to three brassieres required to hold a prosthesis every twelve (12) months.
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist.
- Compression burn garments and lymphedema wraps and garments.
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines.
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.

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 Plan Physician 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 as a consequence of PKU. **Prior Authorization is required.**

Any customization of living environment or automobile are excluded from your Benefit Plan. Coverage is limited to the basic Medically Necessary item of equipment that adequately meets your medical needs.

Home Test Kits for Sexually Transmitted Diseases

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

Ostomy and Urological Supplies

Coverage includes ostomy, urological supplies and incontinence supplies as prescribed in accordance with our Plan Formulary guidelines. VHP will select the Plan Provider, and 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.
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.
The Plan's soft goods Formulary lists ostomy and urological supplies in a variety of types and materials. Generic categories for those supplies are:

- 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.
- 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.

Mental Health Services

Mental health services include outpatient mental health counseling, outpatient mental health services provided by a Psychiatrist, and inpatient mental health services. Covered Services specified in this section are limited to services specified by the defined term “Mental Health and Substance Disorder” in the definitions section. VHP will not limit benefits or coverage for Mental Health and Substance Use Disorders to short-term or acute treatment.

Covered Services include but are not limited to Severe Mental Illness (SMI) and Serious Emotional Disturbances (SED) as defined in the “Definitions Section” of this EOC. SED of a child under age 18 also means a condition identified as a mental disorder, in the most recent edition of the DSM, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child’s age according to expected developmental norms, if the child also meets at least one of the following

three (3) criteria:

1. As a result of the mental disorder the child has substantial impairment in at least two (2) of the following areas:
   a) Self-care, school functioning, family relationships, or ability to function in the community; **and**

   b) Either:
   i) The child is at risk of removal from the home or has already been removed from the home, or

   ii) The mental disorder and impairments have been present for more than six (6) months or are likely to continue for more than one (1) year without treatment.
2. The child displays psychotic features, or risk of suicide or violence due to a mental disorder.
3. The child meets special education eligibility requirements under the Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code.

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)**. If the Plan Provider is not available within the geographic and timely access standards, a referral to an out of network provider can be requested for medically necessary services. This referral includes initial and follow up mental health and substance use services.

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.

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 your Plan Physician.

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 your Plan Physician.

Chemical Dependency Services (Alcohol & Drug Abuse)

Outpatient evaluation and treatment for alcohol or drug dependency 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. Prior Authorized inpatient detoxification services for alcohol and drug addictions are available for confinement when provided in a Plan Facility.

Hospitalization for overdose and residential rehabilitation as medically necessary per ASAM guidelines are covered when provided in a Plan Facility. Chemical dependency/behavioral health services that are court ordered, or as a condition of parole or probation or when incarcerated are excluded from your Benefit Plan.

Inpatient Detoxification

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

Outpatient Chemical Dependency Care

Covered Services for treatment of chemical dependency are:

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

Cost Sharing may apply to these Covered Services where Cost Sharing may apply include:

- Individual chemical dependency evaluation and treatment.
- Group chemical dependency treatment.

Medically Necessary methadone maintenance services are included in outpatient chemical dependency care.

Hearing Services

The Plan does not cover hearing aids (other than internally implanted devices as described in the “Prosthetic and Orthotic Devices” section). The Plan does cover, at no charge:

- Routine hearing screenings that are preventive care services.
- Hearing exams to determine the need for hearing correction.

Hearing Services that are excluded from the Plan are:

- Hearing aids, replacement parts and batteries, repair, and replacement of hearing aids.
- Internally implanted hearing aids such as Cochlear implants and Osseo integrated hearing devices. Refer to “Prosthetic and Orthotic Devices” in this section.

Home Health Services

When you are confined to your home for medical reasons, your Benefit Plan covers you for home health services from Plan Providers. Your Plan Physician must arrange Prior Authorization. Home health care will be provided under the direct care and supervision of a Plan Physician and administered by visiting Plan Provider health care professionals.

Home health services are only covered in the Service Area, only if you are substantially confined to your home, your condition requires the services of a nurse, physical therapist occupational therapist, or speech therapist, and only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home.

Coverage is limited to skilled care, which is not Custodial Care, and may not be appropriately provided in a Plan Provider’s office, hospital, or Skilled Nursing Facility. Coverage excludes meals, childcare, in-home day care, and housekeeping services. VHP covers only part-time or intermittent home health care, as follows:

- Up to two hours per visits for visits by a nurse, or physical, occupational, or speech therapist. If a visit lasts longer than two hours, then each additional increment of two (2) hours counts as a separate visit.
- Up to three (3) visits per day (combining of all home health visits)
- Up to 100 visits in a Benefit Year

Dialysis Services

Dialysis services for acute renal failure and chronic renal disease, including equipment, training and medical supplies required for dialysis are covered under your Benefit Plan. Plan Providers must render Covered Services. Prior Authorization must be received before evaluation and treatment.

Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It provides support to the primary caregiver and the Member's family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

VHP covers the hospice services listed below at no charge only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less.
- The Services are provided inside the Service Area.
- The Services are provided by a licensed hospice agency that is a Plan Provider.
- The Services are necessary for the palliation and management of your terminal illness and related conditions.

If all of the above requirements are met, VHP covers the following under coordination of benefit with hospice services, which are available on a 24-hour basis if necessary, for your hospice care:

- Plan Physician services.
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers.

- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living.
- Respiratory therapy.
- Medical social services.
- Home health aide and homemaker services.
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a ninety (90) day supply in accordance with our drug Formulary guidelines. You must obtain these drugs from Plan Pharmacies. Certain drugs are limited to a maximum thirty (30) day supply in any thirty (30) day period. For a current list of these drugs call **1.866.333.2757 (toll-free)** or go to **www.valleyhealthplan.org**.
- Durable Medical Equipment.
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five (5) consecutive days at a time.
- Counseling and bereavement services.
- Dietary counseling.

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.

Transplant Services

VHP covers Tissue and Human Organ Transplantation for Non-Experimental Procedures and donation-related services for actual or potential donors, including but not limit to:

- Outpatient imaging and laboratory
- Outpatient prescription drugs and administered drugs

- Medically Necessary ambulance services.
- Harvesting the organ, tissue, or bone marrow and for treatment of complications.

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

- Determine that you meet certain Medical Criteria developed for patients needing transplants.
- Refer you, in writing with the approval of the VHP Medical Director, to transplant facilities selected by VHP.

If the Plan referral facility determine that you do not satisfy its respective criteria for the transplant, VHP will only cover Services you receive before that determination is made.

Clinical Trial Services

Qualified enrollees may participate in an approved clinical trial conducted by a participating 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 federal Centers for Disease Control and Prevention.

(iii) The Agency for Healthcare Research and Quality.

(iv) The federal 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.

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

(A) The enrollee 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 enrollee's participation in the clinical trial would be appropriate because the enrollee meets the conditions of subparagraph (A).

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

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 participating provider. Participation is limited to approved clinical trials in California, unless the clinical trial is not offered or available through a participating provider in California.

Acupuncture Services

Acupuncture services are available through authorized Plan Providers and are obtained by PCP or VHP referral only. Covered Services are typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain. Coverage is limited to a maximum of 24 prescribed visits per Calendar Year. No prior authorization required for the first 12 visits provided by the Plan Providers. Prior authorization is required at 13th visit.

To find VHP Acupuncture Providers visit the VHP website at **www.valleyhealthplan.org** and use the Provider Search or call Member Services at **1.888.421.8444 (toll-free)**.

Dental Services

Plan Hospital or Surgery Center

For dental procedures at a Plan Facility, VHP covers general anesthesia and the facility'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 ordinary require general anesthesia. VHP does not cover any other Services related to the dental procedure, such as the dentist's Services

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

Outpatient Dental Services

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

- Treatment or removal of tumors.
- Plan Physicians' services or X-ray exams (not in a dentist office) for

the treatment of accidental injury to natural teeth.

- Surgery on the maxilla or mandible that is Medically Necessary to correct temporomandibular joint (TMJ) disease or other medical disorders.
- Services in connection with accidental fractures of the jaw.
- Prescribed drugs 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, are excluded. Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered.

Temporomandibular Joint (TMJ) Disorders Services

Temporomandibular Joint (TMJ) disorders services includes the evaluation and treatment of Medically Necessary TMJ dysfunction, including the provision of prescribed intra-oral appliances. Prior Authorization by VHP is required for all Covered Services including consultations, diagnosis, and medical or surgical treatment for disorders of the TMJ. A lifetime limitation of $800.00 applies to the cost of any intra-oral positioning devices and related services. You will be financially responsible for services and all costs over the lifetime $800 limits for intra-oral appliances and related services.

VHP will authorized TMJ Covered Services if:

- Diagnosis of the TMJ Syndrome is made by a Plan PCP and the Member has completed a three (3) to six (6) month trial of continuous conservative management.
- Intra-oral appliance has been placed prior to surgery.

Surgical Coverage is limited to:

- Services for treatment or removal of tumors.
- Physicians' services or X-ray exams for the treatment of accidental injury to natural teeth.
- Surgery on the maxilla or mandible that is Medically Necessary to correct temporomandibular joint disease or other medical disorders.
- Services in connection with accidental fractures of the jaw.

Upon Prior Authorization, Member may elect to seek care at VHP dentist consultant office. Exclusions include routine dental services and dental treatment; more than one (1) intra-oral positioning device or prosthesis (these are considered dental); 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.

Pediatric Dental Services

The Liberty Dental Plan of California Program (LDP) provides essential pediatric dental care through a convenient network of Contract Dentists in the service area. These Dentists are screened to ensure that our standards of quality, access and safety are maintained. The network is composed of established dental professionals. When you visit your assigned Contract Dentist, you pay only the applicable Copayment for Benefits up to the Out-of-Pocket Maximum.

Eligibility and Enrollment

Eligible Pediatric Enrollees are children from birth to age 19 who meet the eligibility requirements in the VHP Covered California and Individual & Family Plan Membership Agreement and Evidence of Coverage and Disclosure Form. LDP is included for Eligible Pediatric Enrollees who enroll in the medical plan provided by the VHP Covered California and Individual & Family Plan. Enrollment under this LDP for coverage begins on the date enrollment under the medical plan begins and terminates on the date that enrollment under the medical plan terminates. LDP will provide you with an Evidence of Coverage and Disclosure Form upon enrollment which will provide:

- The advantages of your Liberty Dental Plan and how to use your benefits.
- Details regarding Deductibles, Coinsurance and Copayments.
- How to select a provider.
- Continuity of Care.
- Answers to your frequently asked questions.

For pediatric dental services contact LDP, Customer Service Department

at **1.888.703.6999 (toll free)** or by submitting a written request to Customer Service, LDP, P.O. Box 26110, Santa Ana, CA, 92799- 6110. You can also go to LDP's website at **www.libertydentalplan.com** to obtain a copy of the latest LDP Network Doctor list, visit VHP's website at **www.valleyhealthplan.org** or call Member Services at **1.888.421.8444 (toll-free).**

If You Have a Complaint About LIBERTY Dental Plan

LIBERTY provides a Grievance resolution process. You can file a complaint with LIBERTY for any dissatisfaction you have with a claim determination, a benefit or coverage determination, your Dental Provider, or any aspect of your dental Benefit Plan. If you disagree with LIBERTY's decision about your complaint, you can get help from the State of California's DMHC Help Center at **1.888. 466.2219 (toll-free)** and at **1-877-688-9891 TDD Line** for the hearing and speech impaired. In some cases, the DMHC Help Center can help you apply for an Independent Medical Review (IMR) or file a complaint. IMR is a review of your case by doctors who are not part of your health plan. DMHC's internet website **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Coordination of Benefits

As a covered Member, you will always receive your dental benefits. LDP does not consider your Individual Plan secondary to any other dental coverage you might have. You are entitled to receive benefits as listed in the LDP Evidence of Coverage and Disclosure Form despite any other coverage you might have in addition.

Annual Out-of-Pocket Maximum

The yearly Out-of-Pocket maximum is the most money you would have to pay for Covered Services in a year. Any payment for dental services is subject to your Out-of-Pocket maximum, along with your medical costs. To verify your Out-of-Pocket maximum visit **www.valleyhealthplan.org** or call Member Services at **1.888.421.8444 (toll-free)**. After you have reached the yearly Out-of-Pocket maximum, LIBERTY will pay the rest of the cost of dental services for that year, as long as the service you receive is a covered benefit performed by your assigned contracted dental Provider or authorized dental Provider.

Family Services

Your Benefit Plan offers a wide selection of family services when provided, arranged, and coordinated through a Plan Physician. Family services Benefits include:

- Family planning services.
- Sterilization services including Prior Authorized sterilization procedures.
- Abortion services and abortion without a referral or authorization.

Some Plan Hospitals and Plan Providers do not provide one (1) or more of the following services that may be covered under your plan benefits and that you or your Eligible Dependent(s) 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 Plan Provider or call Member Services at 1.888.421.8444 (toll-free) to ensure that you can obtain the health care services that you need.

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. The postpartum care period for individuals receiving pregnancy-related and postpartum care services may extend up to 12 months after birth.

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 Expanded AFP program, which is a statewide prenatal testing program administered by the State Department of Health Services. Procedures for the prenatal diagnosis of fetal

genetic disorders including tests for specific genetic disorders for which genetic counseling is available will be covered.

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 delivery by 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. Enrollment of the newborn is required for continued coverage.

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 breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. In addition to prenatal and newborn support classes, VHP covers breastfeeding support, supplies, and counseling.

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

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

Circumcision Services

Circumcisions are performed on an outpatient basis. Upon discharge from the Hospital, you will be given a notice, which includes instructions on how to make an appointment for your newborn's circumcision or you can ask your Plan Pediatrician to arrange this service. To ensure coverage of this service, you must make your appointment within the time limits written on this notice, usually two (2) weeks from the date of birth.

Fertility Preservation Coverage

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.

Telehealth

Telehealth is 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.

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

Health Education and Health Promotion Services

VHP is committed to promoting and enriching the health of our Members. The primary purpose of providing health education and health promotion is to help Members live a healthy lifestyle. Health education programs and materials related to disease prevention and management are available. Coverage is limited to program design and class availability. Please contact the VHP Health Education Department at 1.408.885.3490 for information on class availability, schedules, fees, and reimbursement options. You may also visit www.valleyhealthplan.org for a list of Plan authorized health education classes.

VHP provides a "Tobacco Cessation" program. Consisting of two (2) classes with a duration of two (2) hours, the program teaches the Member how to understand and address their smoking history and routine. Members learn about the benefits of quitting smoking, different ways to quit, withdrawal symptoms, smoking "triggers", helpful medicines, and the importance of selecting a quit date. Members create a personal quit plan and review coping techniques in a small group setting.

After completing the Tobacco Cessation program, Members receive a Certification of Completion that allows them to request medicines such as Nicotine Replacement Therapy (including the nicotine patch, the nicotine gum or the nicotine lozenge) to help reduce withdrawal symptoms. The program and all FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a ninety (90) day treatment regimen when prescribed by a Plan Provider are preventive services offered at no cost to enrollees and without the need of prior authorization.

VHP Health Education Department contact information:

Telephone: **1.408.885.3490**

E-mail address: **healtheducation@vhp.sccgov.org**

Website: **www.valleyhealthplan.org**

Reconstructive, Cosmetic, and Bariatric (Weight loss) Surgery Services

Reconstructive Surgery

Reconstruction 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 Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible. See “Mastectomies and Lymph Node Dissections” and “Bariatric (Weight Loss) Surgery” in this section for additional information.

Cosmetic Surgery

Cosmetic Surgery is not a Covered Benefit. Reconstructive surgery that, in the judgment of a Plan Physician 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 in order to improve appearance is also considered Cosmetic Surgery. Cosmetic services that are intended primarily to change or maintain appearance, except for Covered Services covered under “Reconstructive Surgery” are excluded.

Mastectomies and Lymph Node Dissections

Following Medically Necessary removal of all or part of a breast mastectomy surgery (due to disease, illness, or injury), reconstruction of the breast, surgery and reconstruction of the other breast to achieve symmetry, treatment of physical complications and Prosthetic Devices is a Covered Benefit. Coverage includes Medically Necessary mastectomies and lymph node dissections including hospitalization, office visits, and physician and surgeon costs. When medically necessary, your Plan Physician will make arrangements to receive these 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, performed by a Plan Provider, and the Member has completed VHP requirements for Bariatric surgery. Reconstructive surgery deemed Medically Necessary under

the reconstructive surgery benefit and otherwise approved, other than cosmetic surgery to improve appearance, is a Covered Benefit.

Travel Services

VHP covers worldwide Emergency and Urgently Needed Services Refer to the "Access to Care" section under "Authorization and Denial of Services." Travel immunizations as recommended by the U.S. Preventative Services Task Force are covered. Travel health immunization consultations are not a covered benefit. To obtain travel immunizations, contact your VHP Plan Provider or Plan Pharmacy that offer travel immunizations. Call Member Services at **1.888.421.8444 (toll-free)** for more information.

Vision Services

VHP does not cover eyeglasses or contact lenses except for children under the age of 19. Coverage does include special contact lenses for aniridia and aphakia as described in this section.

Special Contact Lenses for Aniridia and Aphakia

Low vision exam	Comprehensive evaluation is Covered in Full	Once every calendar year	Pre-Authorization required
Low vision aids	Approved low vision aids are Covered in Full	Once every calendar year	Pre-Authorization required

There is no Copayment for the examination or materials payable by the Member to the VSP network doctor at the time services are rendered.

VHP covers the following special contact lenses when prescribed by a Plan Physician or Plan optometrist:

- Up to two (2) Medically Necessary contact lenses per eye (including

fitting and dispensing) in any 12-month period to treat aniridia, whether provided by the plan during the current or previous 12-month contract period. No charge.

- Up to six (6) Medically Necessary aphakia contact lenses per eye (including fitting and dispensing) per calendar year to treat aphakia (absence of the crystalline lens of the eye), whether provided by the plan under the current or a previous contract in the same calendar year. No charge.

Pediatric Vision Care Services

VHP covers the following vision care services for children under age 19 via VSP network.

- Vision Examination. Covered in Full.
- Vision Care Materials. Covered in Full.
- Lenses (Coverage includes lenses in polycarbonate, plastic or glass, scratch resistant or UV coatings also covered).
    - o Single Vision lenses. Covered in Full.
    - o Bifocal lenses. Covered in Full.
    - o Trifocal lenses: Covered in Full.
    - o Lenticular lenses. Covered in Full.
- Frames from Pediatric Exchange Collection. Covered in Full.
- Contact lenses
    - o Medically Necessary contact lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by Member's VSP network doctor or Out-of-Network Provider.
    - o Medically Necessary professional fees and materials are Covered in Full.
    - o Elective contact lenses may be obtained in leu of glasses.
- Professional Fees: Covered in Full.
- Materials: Covered in Full with the following service limitations:
    - o Standard: One (1) pair annually = One (1) contact lens per eye (total two (2) lenses).
    - o Monthly: Six (6) month supply = Six (6) lenses per eye (total 12

lenses).

- o Bi-weekly: Three (3) month supply = Six (6) lenses per eye (total 12 lenses).
- o Dailies: One (1) month supply = 30 lenses per eye (total 60 lenses).

Obtaining Services from VSP Network Doctors

When obtaining Covered Services, you must select a VSP network doctor, schedule an appointment and inform the doctor's office that you are covered under VSP to enable the network doctor to obtain a VSP benefit authorization. A VSP benefit authorization must be obtained before you can obtain Covered Services from a VSP network doctor. If you receive Covered Services from a VSP network doctor without a VSP benefit authorization, the VSP network doctor will be considered an Out-of-Network Provider and services may be limited to those for an Out-of-Network Provider, if available under the Plan's Vision Services program.

Out-of-Network Provider Benefits

If you receive Covered Services from an Out-of-Network Provider under the Vision Services Program you or the Out-of-Network Providers may submit requests for reimbursement to VSP. VSP will pay available Covered Services to you or directly to the Out-of-Network Providers when claims include a prior authorization. VSP may deny any claims received after 180 calendar days from the date services are rendered and/or materials provided.

For pediatric vision services contact Vision Services Plan (VSP), Customer Service Department at **1.800.877.7195 (toll free)** or by submitting a written request to:

Customer Service, VSP
P.O. Box 997100
Sacramento, CA 95899-7100

Visit www.vsp.com to obtain a copy of the latest VSP network doctor list. You may also visit **www.valleyhealthplan.org** or call VHP Member Services at **1.888.421.8444 (toll-free)**.

If You Have a Complaint About VSP

If you have a grievance against your vision service plan, you should first telephone VSP at **1.800.877.7195** and use VSP's Grievance process before

contacting DMHC. 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 VSP or a Grievance that has remained unresolved for more than 30 days, you may call the DMHC 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 vision service 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. DMHC also has a toll-free telephone number **1.888.466.2219** and a TDD line **1.877.688.9891** for the hearing and speech impaired. You may obtain complaint forms, IMR application forms and instructions at the DMHC website **http://www.dmhc.ca.gov**.

Cost Sharing

General Rules, Examples, and Exceptions

Your Cost Sharing for Covered Services will be in effect on the date you receive the Services, except as follows:

- If you are receiving covered inpatient hospital or Skilled Nursing Facility services on the effective date of this Membership Agreement and Evidence of Coverage, you pay the Cost Sharing in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Sharing in effect on the date you receive the Services.
- For items ordered in advance, you pay the Cost Sharing in effect on the order date (although we will not cover the item unless you still have Coverage for it on the date you receive it) and you may be required to pay the Cost Sharing when the item is ordered.
- For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription Cost Sharing for Covered Services received by newborns. During the 31 days of automatic coverage

for newborn children described in the "Eligibility and Enrollment" section under "When Coverage Begins," the parent or guardian of the baby must pay the Cost Sharing indicated in this "Benefits and Cost Sharing" section for any Covered Services that the baby receives, whether or not the baby is enrolled.

Receiving a Bill

In most cases, your provider will ask you to make a payment toward your Cost Sharing at the time you receive Covered Services. Keep in mind that this payment may cover only a portion of the total Cost Sharing for the Covered Services you receive, and you will be billed for any additional Cost Sharing amounts that are due. In some cases, your provider will not ask you to make a payment at the time you receive services, and you will be billed for any Cost Sharing amounts that are due. For example, some laboratories do not collect Cost Sharing, you will be billed for any Cost Sharing amounts that are due. The following are examples of when you may receive a bill:

- You receive services during your visit that were not scheduled when you made your payment at check-in. For example, if you are scheduled to receive treatment for an existing condition, at check-in you will be asked to pay the Cost Sharing that applies to these Covered Services. If during your visit your provider finds another problem with your health, your provider may perform or order additional unscheduled services to diagnose your problem. You will be billed for any Cost Sharing that applies for each of these additional unscheduled Covered Services, in addition to the Cost Sharing amount you paid at check-in for the treatment of your existing condition.
- You receive services from a second provider during your visit that were not scheduled when you made your payment at check-in. For example, if you are scheduled to receive a diagnostic exam, at check-in you will be asked to pay the Cost Sharing that applies to these Covered Services. If during your diagnostic exam your provider confirms a problem with your health, your provider may request the assistance of another provider to perform additional unscheduled services (such as an outpatient procedure). You will be billed for any Cost Sharing that applies for the unscheduled services of the second provider, in addition to the Cost Sharing amount you paid at check-in for your diagnostic exam.
- You go in for preventive care services and receive non-preventive services during your visit that were not scheduled when you made your payment at check-in. For example, if you go in for a routine physical maintenance exam, at check-in you will be asked to pay the

Cost Sharing that applies to these Covered Services (the Cost Sharing may be "no charge"). If during your routine physical maintenance exam your provider finds a problem with your health; your provider may order non-preventive services to diagnose your problem (such as laboratory tests). You will be billed for any Cost Sharing that applies for the non-preventive services performed to diagnose your problem, in addition to the Cost Sharing amount you paid at check-in for your routine physical maintenance exam.

- At check-in, you ask to be billed for some or all of the Cost Sharing for the Covered Services you will receive, and the provider agrees to bill you.
- Plan Provider authorizes a referral to a Non–Plan Provider and that provider does not collect Cost Sharing at the time you receive services.

For more information about Cost Sharing, refer to the applicable "Summary of Benefits and Coverage" and "Schedule of Benefits and Coverage Matrix." If you have questions about Cost Sharing for specific services that you are scheduled to receive or that your provider orders during a visit or procedure, please call the VHP Member Services Department at **1.888.421.8444** (toll-free).

Non-Covered Services

If you receive services that are not covered under this Membership Agreement and Evidence of Coverage & Disclosure Form, you may be responsible for the full price of those services. Payments you make for non-covered services are not Cost Sharing. In any calendar year, you must pay charges for Covered Services subject to the Deductible until you meet the Deductible. After you meet the Deductible and for the remainder of the calendar year, you pay the applicable Copayment or Coinsurance subject to the limits described in the "Payment and Reimbursement Responsibility" section under "Other Charges" and "Annual Out-of-Pocket Maximum."

Services Subject to the Deductible

The Cost Sharing that you must pay for Covered Services is in this "Benefits and Cost Sharing" section. Then the Cost Sharing is described as "subject to the Deductible," and you have not met the Deductible, you must pay charges for those services.

Example: When Plan covers services at "no charge" subject to the Deductible, and you have not met your Deductible, you must pay

charges for the Covered Services.

If you would like an estimate of the charges for a Service before you schedule an appointment or procedure, please call Member Services at **1.888.421.8444** (toll-free). If you pay a Deductible amount for a service that has a visit limit, the services count toward reaching the limit.

After you receive the services, VHP will send you a bill that lists charges for the services you received, payments and credits applied to your account, and any amounts you still owe. You may receive more than one bill for a single outpatient visit or hospital stay.

Example: You are admitted to the hospital for an acute illness. You may receive a bill for physician services and a separate bill for hospital services. In addition, it may take more than one bill to reflect all of the Covered Services you received.

If it is determined that you overpaid and are due a refund, a refund will be sent to you within four (4) weeks after that determination.

When you pay an amount toward your Deductible, you will receive a report that will include the total amount you have paid toward your Deductible and toward your annual out-of-pocket maximum. You may also call to obtain a copy of the report from Member Services at **1.888.421.8444** (toll-free). Any overpayments will be refunded to you.

Copayments and Coinsurance

Refer to the applicable "Summary of Benefits and Coverage" for the Copayment or Coinsurance you must pay for each Covered Services, after you meet any applicable Deductible.

Cost-Sharing for Alaskan Native and American Indian

There is no cost sharing for Alaskan Native and American Indian enrolled in Covered California who are under 300% of the Federal Poverty Limit (FPL) regardless where or how they receive their care. This is also applicable to an Alaskan Native or American Indian enrolled in Covered California who is, "furnished an item or service directly by the Indian Health Service, an Indian Trip, Tribal Organization, or Urban Indian Organization or through referral under Contract Health Services."

Annual Maximum Out-of-Pocket

There is a limit to the total amount of Cost Sharing you must pay under this Membership Agreement and Evidence of Coverage in a calendar year for all Covered Services that the Plan has designated as counting toward your annual Maximum Out-of-Pocket.

Any amounts that you pay for Covered Services subject to the Deductible, as described in the Summary of Benefits and Coverage under "Deductibles," apply toward your annual Maximum Out-of-Pocket expense. The following Copayments and Coinsurance apply toward your annual Maximum Out-of-Pocket expenditure:

- Administered drugs.
- All Chemical dependency services.
- All Mental health services.
- Ambulance services.
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria).
- Behavioral health treatment for autism spectrum disorder.
- Diabetic testing supplies and equipment and insulin administration devices.
- Emergency department visits.
- Home health care.
- Hospice care.
- Hospital care.
- Imaging, laboratory, and special procedures.
- Psychiatric treatment programs.
- Mental Health and Substance Use Disorders.
- Outpatient surgery.
- Prosthetic and orthotic devices.
- Serious Emotional Disturbances care.
- Skilled Nursing Facility care.

As discussed below in the section titled "Annual Deductible and Annual Out-of-Pocket Maximum Balances," when you pay Cost Sharing that applies

toward the annual out-of-pocket maximum, we will send you a report that will include the total amounts you have paid toward your Deductible and toward your annual out-of-pocket maximum. You may also obtain a copy of this report from our Member Services Department by calling **1.888.421.8444** (toll-free).

Annual Deductible and Annual Out-of-Pocket Maximum Balances

VHP will monitor each Member's accrual toward their annual deductible, if any, and annual out-of-pocket maximums. VHP will automatically provide Members with their up-to-date accruals (based on the information available to VHP at the time of publishing) toward their annual deductible and out-of-pocket maximum for every month in which benefits were used until the accrual balance equals the full deductible and/or out-of-pocket maximum amount.

VHP will mail the report to the mailing address on file unless you opt out of mailed notices and instead elect electronic accrual notifications. You may opt back into mailed notices at any time. You can opt in or out of electronic accrual notification by calling Member Services at **1.888.421.8444** (toll-free)

At any time, you can also get a report of up-to-date accrual balances towards your annual deductible and maximum out-of-pocket expenses by contacting VHP by one of the following methods:

Mail: VHP Member Services, 2480 N. First Street, Suite 160, San Jose, CA 95131

Phone: **1.888.421.8444** (toll-free)

Email: **MemberServices@vhp.sccgov.org**

Limitations and Exclusions

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 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 “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 Providers within the Service Area or through Non-Plan Providers while 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:

- When your condition is so emergent that you cannot safely travel to a Plan Hospital.
- When you are out of the Service Area and require Urgent Medical Care and cannot safely go to a Plan Provider.

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

Urgent care services are covered by VHP if your condition meets the definition of Urgently Needed Services, and:

- You may contact the 24/7 Nurse Advice Line at **1.855.348.9119 (toll-free)**.
- You obtain urgent care services through your VHP Network Provider.
- You obtain Urgent Needed Services while outside the Service Area and the medical care could not be delayed until you return to the Service Area.

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 **1.855.348.9119 (toll-free)** for medical advice. A nurse will assess your condition and direct you to the appropriate care. For a complete list of Plan 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 California Relay Service (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, call Member Services at **1.888.421.8444 (toll-free)** to answer any questions you may have. If you are unable to reach VHP, call the 24/7 Nurse Advice Line at **1.855.348.9119 (toll-free)**, explain the situation, and follow their instructions. As needed, contact the closest provider to receive treatment. Present your VHP ID Card and call a VHP representative at **1.888.421.8444 (toll-free)** within 48 hours to advise them of your urgent care visit. As necessary, they can help coordinate your care. Failure to notify VHP within this time frame may result in the Denial of your claim.

Follow-Up Care After Emergency or Urgently Needed Services

Your Coverage includes Medically Necessary follow-up care, after Emergency and Urgently Needed Services, if that care cannot be delayed and you need timely access to health care services.

Follow-up care after any Emergency Service or Urgently Needed Service should be obtained through your Primary Care Physician. Should it be necessary to receive follow-up care after an Emergency or Urgently Needed Services from a Non-Plan Provider, 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 a Prior Authorization, VHP will not pay for your care and you will be required to pay for the full cost of such services.

Post-Stabilization

Once your emergency medical condition is stabilized your treating health care provider may request additional Medically Necessary Services prior to your being safely discharged. If the hospital is not part of VHP's contracted network, the hospital will contact your PCP or the Plan to obtain timely Prior Authorization for these post-stabilization services. If VHP determines that you may be safely transferred to a Plan Hospital, and you refuse to consent to the transfer, the non-Plan hospital must provide you written notice that you will be financially responsible for 100% of the cost for services provided to you once your Emergency condition is stable. If the non-Plan hospital is unable to determine your name and contact information for VHP in order to request Prior Authorization for services once you are stable, the non-Plan hospital may bill you for such services.

If you feel that you were improperly billed for services that you received from a non-contracted provider, please contact VHP at 1.888.421.8444 (toll-free).

This section describes the limitations and exclusions generally affecting services that are not available through the Benefit Plan. For specific Benefit limitations and exclusions please also refer to the "Benefits and Cost Sharing" section.

VHP will not be financially responsible for such limited or excluded services. Service refers to any item, drug (unless listed in the VHP Formulary and a prescription is written by a VHP 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 mental health and substance disorders.

Principal Limitations

The following items, procedures, benefits, services, drugs, supplies, and equipment are limited under your Benefit Plan:

1. Covered Services are available only through Plan Providers in the

Network (unless such care is rendered as worldwide Emergency Services, Out-of-Network Urgently Needed Services, or is Prior Authorized).

2. Covered Services provided by Non-Plan Providers are limited to those services rendered as worldwide Emergency Services or Out-of-Network 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 a VHP approved referral, 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 our control. VHP Plan Providers will provide benefits to the extent practical, according to their best judgment within the limitations of available facilities and personnel. We will have no liability to you for delay or failure to provide services under such conditions. The Plan will use its best efforts to provide Covered Services, however if Plan Providers are unable to provide services in these, the above note circumstances, Member(s) should seek Emergency Services from the nearest facility, and the Plan will later provide reimbursement for Covered Services.
5. 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 he or she believes there is no acceptable alternative treatment. You may seek a second medical opinion from another VHP Plan Provider. If you still refuse the recommended treatment or procedure, as required by law, VHP will still be responsible to provide all Medically Necessary Covered Services not refused by you.
6. VHP reserves the right to Coordination of Benefits Reimbursement as outlined in the Agreement. Your Benefits are limited to such an extent. As a member, you have an obligation to cooperate and assist us to coordinate Benefits by providing information to all health service providers on any other coverage you and your Dependent(s) have.
7. VHP reserves the right to seek Third Party Reimbursement as outlined in the Agreement. Your Benefits are limited to such an extent. As a Member, you have the obligation to cooperate fully in our efforts by signing any forms necessary to assist us in obtaining this recovery.
8. 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 is not a covered benefit. The appliance or device must be FDA-approved for the condition. Lifetime benefit maximum is $1290.00 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 up to 90 days after the initial fitting. The VHP medical insurance 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.

9. VHP will pay for Medically Necessary Intra-oral appliances related to TMJ up to an $800.00 maximum lifetime benefit. Intra-oral appliance and placement services which cost more than the lifetime limit of $800.00, for intra-oral positioning devices and related services, are not covered.

Principal Exclusions

The following items, procedures, benefits, services, drugs, supplies, and equipment are excluded under your Benefit Plan, except for certain medically necessary provision of services. Further exceptions can be found under the "Benefits and Cost Sharing Section":

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 Out-of-Network/Service Area Urgently Needed Services, or upon Prior Authorization by the Medical Director.
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.

6. Services which exceed the limitations or fail to meet the conditions of Covered Services contained in this Evidence of Coverage or as required by State and Federal law.
7. 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.
8. Acupuncture services except as specifically listed as a Covered Service in the "Benefits and Cost Sharing" sections.
9. Anorectics or any other drug used for the purpose of weight control, unless Medically Necessary.
10. 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 "Benefits and Cost Sharing" section under "Outpatient Services," "Facilities – Inpatient Services," "Home Health Services," and "Hospice Care." This exclusion does not apply to services deemed medically necessary for treatment of a mental health or substance use disorder.
11. Artificial Insemination - any service, procedure, or process which prepares the Member to receive conception by artificial means, such as services related to prescription drugs not on Plan Formulary, donor sperm, sperm preservation, or washing or concentration procedures. This exclusion does not apply to standard fertility preservation services when a covered treatment may directly or indirectly cause iatrogenic infertility.
12. Clinical trial services except as specifically listed as a Covered Service in the "Benefits and Cost Sharing" section under "Clinical Trial" section.
13. Chiropractic services.
14. Classes and equipment that are solely for exercise, recreation, self-help, hygiene, and beautification, except as specifically listed as a Covered Service.
15. 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.
16. Cosmetic Surgery or plastic surgery except as specified as a Covered Service in the "Definitions" and "Benefits and Cost Sharing" sections

under “Mastectomies and Lymph Node Dissections.”

17. Cosmetics, herbal products and treatments, dietary supplements, health, or beauty aids.
18. Custodial or Domiciliary Care, except as required under Hospice Care.
19. Dental services except as specified as Covered Services in the “Benefits and Cost Sharing” section.
20. Devices or appliances except Medically Necessary Diabetic, Prosthetic, 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 (1) device per year.
21. 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 “Benefits and Cost Sharing” section.
22. 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 “Benefits and Cost Sharing” section under “Health Education and Promotion Services”. This exclusion does not apply to services deemed medically necessary for treatment of a mental health or substance use disorder.
23. Emergency room services for non-emergency care.
24. Experimental or Investigational Treatment except as expressly provided as a Covered Service. Independent Medical Review of Denial of coverage by a Plan for Experimental and Investigational Treatment is available. Refer to the “Benefits and Cost Sharing” section under “Clinical Trial Services,” and in the “Access to Care” section under “Independent Medical Review.”
25. 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.

26. 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 for treatment of a mental health or substance use disorder.
27. Hearing aids, batteries, and hearing aid services, including the furnishing, fitting, installing, or replacing hearing aids.
28. Hypnotherapy, vision therapy, and sleep therapy. This exclusion does not apply to medically necessary treatment of mental health and substance use disorders
29. Human Chorionic Gonadotropin (HCG) Injections, unless Medically Necessary with the appropriate 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 Prior Authorization.
31. Services related to the diagnosis and treatment of infertility, except for treatment for iatrogenic infertility preservation.
32. Liposuction.
33. Massage therapy, except massage therapy Services that are part of a physical therapy treatment plan and covered in the “Benefits and Cost Sharing” section under “Outpatient Services,” ”Facilities – Inpatient Services,” “Home Health Services,” 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 Denial of coverage by a Plan for Experimental and Investigational Treatment is available; refer to the “Access to Care” section under “Independent Medical Review.”
35. Mental Health Services and Chemical Dependency 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 “Benefits and Cost Sharing” section.
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 intelligent

    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 Services Provided by a Psychiatrist” in the “Benefits and Cost Sharing” section

    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

    i. This exclusion does not apply to the members who determined to be medically necessary treatment of mental health and substance use disorders.

38. Oral nutrition, such as dietary supplements, herbal supplements, weigh loss aids, formulas, and food. This exclusion does not apply to the members who determined to be medically necessary treatment of mental health and substance use disorders

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 are excluded from your benefit plan.

42. Out-of-Network opinions, except as a Covered Benefit. Independent Medical Review of Denial of coverage by a Plan Provider for Experimental and Investigational Treatment is available. Refer to the

"Access to Care" section 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 Evidence of Coverage & Disclosure Form.
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 "Benefits and Cost Sharing" section".
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 operation and use of vehicles.
47. Physical exams, evaluations and reports including those for employment, insurance, licensing, school, sports, recreation, premarital purposes, or required for or by court proceedings, unless timing and scope coincide with covered periodic health appraisal exams.
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 Investigational New Drugs. Independent Medical Review of Denial of coverage by a Plan for Experimental and Investigational Treatment is available. Refer to the "Access to Care" section under "Independent Medical Review."
49. Prescription from non-Plan pharmacies, except in connection with Emergency Services, Urgently Needed Services, or upon Prior Authorization. Refer to the "Benefits and Cost Sharing" and Emergency and Urgent Care Services.
50. Private duty nursing services.
51. Reversal of voluntary sterilization or of voluntary induced infertility.
52. Routine/cosmetic foot care, including trimming of corns, calluses, and nails, unless Medically Necessary.
53. Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate.

54. Temporomandibular Joint (TMJ) Disorders Services that are not Medically Necessary.
55. 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 “Benefits and Cost Sharing” section”.
56. Vocational Rehabilitation.
57. Weight control, weight loss treatments, weight loss surgery, or related supplies unless Medically Necessary or except as specifically provided as Covered Benefits in the “Benefits and Cost Sharing” section.

Payment and Reimbursement Responsibility

Repayment Fees (Premiums)

You are responsible for submitting your monthly membership fees or Premiums to VHP.

Mail payment directly to:

County of Santa Clara Valley Health Plan
PO Box 888435
Los Angeles, CA 90088-8435

For overnight delivery Mail to:

Lockbox Services-#0138435
County of Santa Clara Valley Health Plan
3440 Flair Drive
El Monte, CA 91731

Only Members for whom VHP has received the appropriate Premiums are entitled to coverage under this Agreement, and then only for the period for which we have received payment. You must prepay the Premiums listed on the Rate Sheet, applicable to your coverage, for each month on or before the last day of the preceding month. If you have questions regarding information on the method, amount, or frequency of your Premiums, please contact VHP

Member Services at **1.888.421.8444 (toll-free)**.

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. VHP will notify Members who are in the VHP Covered California and Individual & Family Plan in writing 60 days prior to any change in Premium rates. Also, your Premiums may change when the Subscriber progresses to a new age band.

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, VHP will notify you of the change and reason(s) why.

Other Charges

When you receive medical care, you may be responsible for paying certain other charges, such as Deductibles, Coinsurance, and Copayments. Refer to the applicable “Summary of Benefits and Coverage” and “Schedule of Benefits and Coverage Matrix.

Annual Maximum Out-of-Pocket

There is a limit to the share of cost you must pay in any Calendar Year for services.

When the applicable limit has been reached, VHP will advise you. Once you have reached the Member’s share of cost limit, you will not be required to pay any additional copayments or other charges for the remainder of the Calendar Year.

If you have any questions regarding your Copayment and annual maximum limits, call a Member Services Representative at **1.888.421.8444 (toll-**

free).

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.

Premiums and Health Care Benefits Ratio

Regulations require that VHP spends on average at least 85% of Premiums on health care benefits; this requirement is known as a Medical Loss Ratio or Minimum Loss Ratio (MLR).. The bill defines “health care benefits” to include, but not be limited to, health care services that are either provided or reimbursed by the plan or its contracted providers as Covered Services; the costs of programs or activities, including training and the provision of informational materials determined through regulation to improve the provision of quality care, improve health care outcomes, or encourage the use of evidence-based medicine; disease management expenses; payments to providers as risk pool payments of pay-for-performance initiatives; plan medical advice by telephone; and, prescription drug management programs. MLR is the ratio of administrative costs vs. medical costs.

Premiums are adjusted on an annual basis. VHP spends 91% of its Premiums or MLR for the geographic area.

Provider Payments

VHP contracts with its Plan Providers to provide Covered Services to its Members. Plan Providers include clinics, urgent care centers, several community clinics, a Pharmacy Benefits Manager (PBM), Pediatric vision and dental, and a 24/7 Nurse Advice Line provider. 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 situation.

VHP's financial arrangements with our physicians and providers are reviewed and approved by the DMHC. No financial incentives are utilized for any provider.

All Plan Providers are paid based on the terms and conditions of their agreements with VHP. Plan Providers are paid 100% for Covered Services, therefore except for Deductibles, Coinsurance, and Copayments, Members do not pay any additional fees to Plan Providers.

Additional information regarding provider payments may be requested from your Plan Provider or VHP.

Reimbursement Provisions (Claims)

VHP has designed coverage in a way to minimize the need for you to file a Member medical or pharmacy claim. If for some reason, you are billed or have paid for services that are Covered Services, submit the itemized bill and/or your original receipt showing proof of payment with your request for reimbursement within 90 days after (or as soon as possible thereafter) you receive those Covered Services.

Submit medical claims to:

Valley Health Plan Claims Department
P.O. Box 26160
San Jose, CA 95159-6160

Be sure your name, the Subscriber's social security 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.

Submit pharmacy claims to:

Navitus Health Solutions Operations Division - Claims
P.O. Box 999
Appleton, WI 54912-0999

Be sure your name, specific information about the prescription, the reason you are requesting reimbursement, and any payments made by you or on

your behalf are included in your request. You must fill out the reimbursement claim form completely.

For information about reimbursements or to get a claim reimbursement form, visit 2480 N. First Street, Suite 160, San Jose, CA 95131, call Member Services at **1.888.421.8444 (toll-free)**, or go to **www.valleyhealthplan.org** under "Member Materials."

Submit pediatric vision claims to:

Vision Service Plan (VSP) Customer Service Department
P.O. Box 997100
Sacramento, CA 95899-7100

To submit a Vision Claim Form for reimbursement, you must provide specific information with the receipt, the reason you are requesting reimbursement, and any payments made by you or on your behalf. You must fill out the reimbursement claim form completely.

VHP may reimburse you or the Plan Provider, less any Coinsurance or Copayment, for the Covered Services. If a request for reimbursement is denied or partially denied, you will receive written notice specifying the reasons for the Denial.

To obtain a Vision Claim Form, go to www.vsp.com or call **1.800.877.7195 (toll-free)** 24- hours a day, seven (7) days a week. You may also visit 2480 N. First Street, Suite 160, San Jose, CA 95131, call Member Services at **1.888.421.8444 (toll-free)**, or go to **www.valleyhealthplan.org** under "Member Materials."

VHP reviews all services received outside of the Plan Network for appropriateness of care. If the services are from a non-VHP Plan Provider for either an Emergency, Out-of-Network Urgently Needed Services, or for authorized services, VHP will reimburse you or the provider for those Covered Services, less any required Coinsurance or Copayment(s). If the services from the Non-Plan Provider are non-Covered Services or you have exceeded the Benefits limits or you have not met your Deductible, VHP will not make payment/reimbursement.

In the event that VHP fails to pay a Plan Provider, you will not be liable to the Plan Provider for any amounts owed by VHP. As required by California law, every contract between VHP and a Plan Provider contains a provision to this effect. However, in the event that VHP fails to pay a Non-Plan Provider, you could be liable to the Non-Plan

Provider for the cost of services.

Liability of Subscriber or Enrollee for Payment

Plan Members are not liable for charges for Covered Services authorized by their PCP or VHP, which are covered under the Benefit Plan. A Deductible, Coinsurance, Copayment, or other charges may be required for some services. The specific Copayment or other charges for your Benefit Plan can be found in this Agreement.

If you obtain care that is not performed by your PCP or authorized by your PCP or VHP, you will be financially responsible for the cost of care provided. This does not apply if you receive Emergency Services or Out-of-Network/ Service Area Urgently Needed Services that are Covered Services and you have notified your PCP or VHP.

If you obtain care from your PCP that is a non-Covered Service or if you are referred to services of a non-VHP Provider that have not been Prior Authorized by VHP, you will be liable for such non-Covered Services. Non-Covered Services that are not covered are listed in the “Limitations and Exclusions” section and in the “Benefits and Cost Sharing” sections under “Benefits”.

Liability of Subscriber or Enrollee Receiving Advanced Premium Tax Credit (APTC)

Reinstatement Rights: Members who have paid at least one month’s premium in full, a 90-day (three months) grace period which begins on the first day of the first month allows the Member to reinstate Coverage by paying the entire outstanding amount of premium due by the last day of the third month.

Coverage during first month: Members in the 90-day grace period must be covered under their Benefit Plan only during the first month of unpaid premium.

Coverage is suspended during the second and third months of the

90-day grace period: Plans may "suspend" coverage during the second and third months of the 90-day grace period for eligible Members. Plan network providers are not obligated under their contract with the Plan to provide Covered Services to a Member while Coverage is suspended. Members may receive services from their providers but are financially responsible for the cost of those services unless their Coverage is reinstated on or before the end of the third month of the grace period.

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, Plan 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. The Plan will not duplicate coverage for such services.

When a legitimate dispute exists with a third party liability, the Plan 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 the Plan's right to recover its costs of 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 for up to the amount VHP has paid for any services rendered which duplicate such coverage. In the case of a monetary award, VHP or its Plan Providers must be reimbursed immediately after the award is received. You are responsible for notifying VHP of any duplicate 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 the Plan; 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

If you wish to release a third party from liability or settle a claim against a third party for which you receive compensation for medical care provided through VHP, you must obtain prior written consent from VHP if such acts would limit VHP's right to reimbursement.

Member Services Assistance

Member Services Representative

VHP's top priority is to provide quality service and health care to its Members. Everyone at VHP shares the responsibility for assuring your satisfaction. Our Member Services Representatives are 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 at **1.888.421.8444 (toll-free)**. For the hearing and speech impaired, call the California Relay Service (CRS) by simply dialing 711 or the 800 CRS number of your modality.

Ask our representatives how to obtain medical care, how to interpret your covered health benefits, what to do if you move, how to add dependents, how to obtain a new VHP ID Card, how to submit Member Claims or file Grievances, or to help you with any other service issues. You may also request Plan materials.

If a representative is not available, you may leave a message 24 hours a day, and your call will be returned on the next business day.
If you need to notify VHP of an emergency or urgent care situation, please leave a telephone number where you may be reached.

Open Enrollment Hours

During the open enrollment period, Member Services is available Monday through Saturday 8:00 am to 8:00 pm (Pacific Standard Time) at **1.888.421.8444 (toll-free)**.

Non-Open Enrollment Hours

During non-Open Enrollment periods, Member Services is available Monday through Friday 8:00 am to 6:00 pm (Pacific Standard Time) and Saturday 8:00 am to 5:00 pm (Pacific Standard Time) at **1.888.421.8444 (toll-free)**.

Language Assistance

If you need language assistance, VHP's Member Services offer over-the-telephone language assistance at no cost to you. Walk-in office hours are Monday through Friday 8:00 am to 5:00 pm. Valley Health Plan is located at 2480 N. First Street, Suite 160, San Jose, CA 95131. You may also visit **www.valleyhealthplan.org** for recent updates, provider listings, and general information.

Membership Records/Information

Membership records contain eligibility and other information about you and other family Members. These records are very important because they identify you as a Member and determine where you and your enrolled Dependents can receive services. Incorrect records may delay medical care, create problems in Coverage, and possibly cost you money. It is your responsibility to keep your membership records updated.

To change your membership records or to receive a new identification card with your new records, call Member Services at **1.888.421.8444 (toll-free)**.

VHP must be notified upon your death or the death of your Dependent(s), entitlement to other health coverage, or entitlement to Medicare.

Member Grievances

VHP takes pride in being a Member focused health plan. Please call our Member Services to assist you in resolving your concerns at **1.888.421.8444 (toll-free)**. For the hearing and speech impaired, call the California Relay Service (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 on your behalf 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 other VHP's language services, call Member Services at **1.888.421.8444 (toll-free)**.

Send your Grievance form to:

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

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

Pediatric Vision Grievances

To submit a Pediatric Vision Grievance, contact Vision Service Plan (VSP) at **1.800.367.9618 (toll-free)** or submit your Grievance online at **www.vsp.com**. Contact information is also located on your VHP ID card.

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 five (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 three (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 “DMHC Consumer Help-Line.”

The Plan does not have a requirement that the Member must first participate in the Plan’s Grievance process before requesting the Department to review a Grievance. Refer to the “Access to Care” section under “Independent Medical Review.”

DMHC Consumer Help-Line

“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 (toll-free)** and use your health plan’s Grievance process before contacting the Department. For the hearing and speech impaired, call the California Relay Service (CRS) by simply dialing 711 or the 800 CRS number of your modality. 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 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 also has a toll-free telephone number, **1-888-466-2219** and a TDD line, **1-877-688- 9891** for the hearing and speech impaired. The Department's internet website **http://www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online."

Public Policy Committee

You may assist VHP to establish public policy through VHP's Public Policy Committee, the VHP Advisory Board. The findings and recommendations of this Public Policy Committee or 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 VHP providers to provide services. Please contact Member Services 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 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 legal protection for your physicians if a disagreement results about following your wishes. The types are:

- Durable Power of Attorney for Health Care Decisions (DPAHCD)
- Natural Death Act Declaration

The preferred document is the DPAHCD. A VHP Member Services Representative can help you obtain one.

The policies involving your right to make medical treatment decisions may vary from facility to facility. For example, it is typical in operating rooms to 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 on carrying out Advance Health Care Directives. Provide 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 more help obtaining forms, please contact your Primary Care Physician or Member Services at **1.888.421.8444 (toll-free)**.

Termination of Coverage

Coverage will be terminated in accordance with the requirements established by the Exchange based on requirements and other applicable State and Federal laws, rules, and regulations, including, the following events:

- Before the end of the contract term, coverage may be terminated for individual Members by voluntary cancellation upon by providing at least 14-day notice. This notice may be given to VHP or Covered California.
- Coverage may be terminated for individual Members due to loss of eligibility effective as of the last day of the month following the month in which the VHP sends the notice to the Member.
- Coverage will be terminated for individual Members upon an authorized change in enrollment to another plan effective as of the last day before the effective date of coverage in the new plan.
- Coverage will be terminated for an individual Member's non-payment of premium effective as of:
    - The last day of the first month provided for nonpayment of premiums by individuals receiving advance payments of the premium tax as required under IRS Guidelines.
    - The last day of coverage established by grace periods under applicable State law, including requirements relating to Health and Safety Codes and Insurance Codes.
- Coverage will be terminated for an individual Member's non-payment of premium if the grace period is exhausted. If termination occurs outside of the regular enrollment period and the Member does not otherwise qualify for a special enrollment, the Members Coverage is terminated, and they have lost their right to reinstate Coverage.

The specific terms and conditions relating to termination of coverage, including, VHP's right to terminate in connection with the receipt of partial payments, shall be subject to further specifications set forth in the Exchange's Administrative Manual, applicable laws, rules and regulations.

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

Loss of Eligibility

VHP is responsible for enforcement of Premium payment rules at our own expense, as outlined in the terms set forth in this Combined Evidence of Coverage and Disclosure Form regarding the failure by Member to pay the Premium in a timely manner as directed by the Agreement and in accordance with applicable laws, rules and regulations.

Enforcement by VHP shall include, but not be limited to, delinquency and termination actions and notices, 30-day grace period requirements and partial payment rules. Such enforcement shall be conducted in accordance with applicable laws, rules, and regulations. VHP shall notify the Exchange in accordance with the Exchange's policies regarding a Member's failure to pay the Premium in a timely manner.

In the event VHP terminates a Member's coverage in a Qualified Health Plan (QHP) due to non-payment of Premiums, loss of eligibility, fraud or misrepresentation, change in Member's selection of QHP, decertification of VHP's QHP, and/or as otherwise authorized by regulations, VHP must include the Exchange approved appeals language in its notice of termination of coverage to the Member.

VHP acknowledges and agrees that applicable laws, rules and regulations, including the Affordable Care Act and implementing regulations specify a grace period for individuals who receive advance payments of the premium tax credit through the Exchange and that the Knox-Keene Act and Insurance Code set a grace period for other individuals with respect to delinquent payments. VHP agrees to abide by the requirements set forth in the State and Federal regulations and required under applicable laws, rules, and regulations with respect to these grace periods.

Medicare Enrollment

If you are enrolled in VHP and you or your Dependents become eligible for Medicare, you or your Dependents may not continue your Coverage under this Agreement.

If you have questions regarding Medicare enrollment and the VHP Covered California and Individual & Family Plan, please call VHP to discuss your options for continuation of coverage.

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 husband or wife 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)**.

Enlistment in Uniformed Services

VHP may terminate your membership or the membership of your Dependent(s) if you or your Dependent(s) enter full-time service in any branch of the armed forces (enlistment) and you become eligible for and become covered by other health coverage.

If you or your Dependent(s) enlist, please call Member Services at **1.888.421.8444 (toll-free)** to discuss your termination and/or your options for continuation of coverage.

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)**. For additional information, telephone numbers, or e-mail address, please refer to the "Member Services Assistance" section under "DMHC Consumer Help-Line."regulations with respect to these grace periods.

Cessation of Coverage

VHP will not cover any services or supplies provided after the effective date of termination of coverage regardless of whether you were seeing a physician or other provider for a condition or course of treatment. The only exceptions are, where applicable, the following circumstances:

- You are or your Dependent is a registered bed patient in a Plan 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 facility, whichever occurs first.
- You are or your Dependent is receiving inpatient obstetrical care in a Plan Facility at the date of termination, and there has been no default in Premiums.

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 refunded to you within 30 days. Refunds are minus any amounts due to VHP or VHP Providers. If your Coverage terminates due to fraud or deception in the use of health services or facilities or you knowingly permitted such fraud or deception by another, refunds will not be made.

Mid-Month Termination: For a termination of this Agreement that occurs

during the middle of any month, the premium for that month shall be apportioned on a pro rata basis. VHP shall be entitled to premiums from Members for the period of time prior to the date of termination and Members shall be entitled to a refund of the balance of the month.

Loss of Eligibility

VHP is responsible for enforcement of Premium payment rules at our own expense, as outlined in the terms set forth in this Combined Evidence of Coverage and Disclosure Form regarding the failure by Member to pay the Premium in a timely manner as directed by the Agreement and in accordance with applicable laws, rules and regulations.

Enforcement by VHP shall include, but not be limited to, delinquency and termination actions and notices, 30-day grace period requirements and partial payment rules. Such enforcement shall be conducted in accordance with applicable laws, rules, and regulations. VHP shall notify the Exchange in accordance with the Exchange's policies regarding a Member's failure to pay the Premium in a timely manner.

In the event VHP terminates a Member's coverage in a Qualified Health Plan (QHP) due to non-payment of Premiums, loss of eligibility, fraud or misrepresentation, change in Member's selection of QHP, decertification of VHP's QHP, and/or as otherwise authorized by regulations, VHP must include the Exchange approved appeals language in its notice of termination of coverage to the Member.

VHP acknowledges and agrees that applicable laws, rules and regulations, including the Affordable Care Act and implementing regulations specify a grace period for individuals who receive advance payments of the premium tax credit through the Exchange and that the Knox-Keene Act and Insurance Code set a grace period for other individuals with respect to delinquent payments. VHP agrees to abide by the requirements set forth in the State and Federal regulations and required under applicable laws, rules, and regulations with respect to these grace periods.

Your Rights and Responsibilites

As a Member you have the right to:

- 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.
- Be treated with dignity, respect, and consideration.
- Expect health care providers (doctors, medical professionals, and their staff) to be sensitive to your needs.
- Be provided with information about VHP, its services, and Plan Providers.
- Know the name of the Primary Care Physician who has primary responsibility for coordinating your health care and the names and professional relationships of other Plan Providers you see.
- 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.
- 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.

- 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.
- 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
- Receive complete information about your medical condition, any proposed course of treatment, and your prospects for recovery in terms that you can understand.
- Give informed consent before the start of any procedure or treatment, unless medically inadvisable.
- Refuse health care services to the extent permitted by law and to be informed of the medical consequences of that treatment, unless medically inadvisable.
- Readily accessible and ready referral to Medically Necessary Covered Services.
- A second medical opinion, when medically appropriate, from another Plan Physician within your VHP Provider Network.
- Be able to schedule appointments in a timely manner.
- Reasonable continuity of care and advance knowledge of the time and location of your appointment(s).
- Reasonable responses to any reasonable requests for Covered Services.
- 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 Physician can make informed decisions about your treatment.
- Change your Primary Care Physician.
- Review your medical records, unless medically inadvisable.

- Be informed of any charges (Copayments) associated with Covered Services.
- 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.
- Leave a Plan Facility or Hospital, even against the advice of Plan Providers.
- Be informed of continuing health care requirements following your discharge from Plan Facilities or Hospitals.
- Be informed of, and if necessary, given assistance in making a medical Advance Health Care Directive.
- Have rights extended to any person who legally may make decisions regarding medical care on your behalf.
- Know when Plan Providers are no longer under a contractual arrangement with VHP.
- Examine and receive an explanation of any bill(s) for non-Covered Services, regardless of the source(s) of payment.
- File a Grievance without discrimination through VHP or appropriate State or federal agencies.
- Know the rules and policies that apply to your conduct as a Member.
- Know Provider credentials are available by request or through the provider directory.
- Receive information regarding malpractice insurance on providers upon request.

As a Member you have responsibility to:

- Accept fiscal responsibility for any cost of share, such as Premiums, Deductibles, Coinsurance, or Copayments.
- 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).
- Adhere to behavior that is reasonably supportive of therapeutic goals

and professional supervision as specified.

- Treat healthcare providers, staff, and others with respect to prevent any interference with your Plan Provider or their ability to provide care.
- Safeguard the confidentiality of your own personal health care as well as that of other Members.
- Cooperate with VHP or a Plan Provider's third-party recovery efforts.
- 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.
- Report any changes in your name, address, telephone number, or your family's status to a Member Services Representative immediately.
- Inform your provider if you have a living will, medical power of attorney, or other directives affective care.

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 Combined Evidence of Coverage and Disclosure Form by the above regulations will bind you and VHP whether 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. Considering 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 and Protected Health Information (PHI)

VHP adheres to HIPAA and protects PHI as required by law. VHP agrees to maintain and preserve the confidentiality of any and all protected health information. VHP also requires its contracting providers to protect your PHI in your medical records and such information from Plan Providers will be kept confidential in accordance with State and federal law. PHI is health information that includes your name, Social Security number, or other information that reveals who you are.

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 consent from you or your authorized representative. However, by the terms of the Agreement, you authorize the release of information and access to any and all of your medical records. Such release of your medical records without your written consent include the purposes of utilization review, quality assurance, processing of any claim, financial audit, or any other purpose reasonably related to the provision of Coverage to VHP, its agents and employees, your Primary Care Physician, and appropriate governmental agencies.
VHP ensures members have ease of access to personal health records. As a Member, you may request a copy of VHP's Notice of Privacy Practices by contacting VHP's Member Services or view this information at **www.valleyhealthplan.org**.

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.

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.


VHP
Valley
Health Plan