

Standardized Template  
Conversion Coverage Product  
1373.6

<b>Plan Name</b> Santa Clara County dba Valley Health Plan	<b>Plan Contact Number</b> 888-421-8444 408-885-4760
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<b>Coverage Summary</b>	
Eligibility requirements	<p>An employee or member whose coverage under a group contract has been terminated by an employer is eligible for individual conversion coverage.</p> <p>Such coverage is not required to be offered under the following circumstances (*1)</p>
The premium cost of each benefit package in the service area in which the individual and eligible departments work or reside	Premium charged by plans vary age of subscribers. See "Premium Rate" tab for this plan.
When under what circumstances benefits cease	<p>Benefits cease due to:</p> <ul style="list-style-type: none"> <li>Fraud;</li> <li>Loss of eligibility;</li> <li>Failure to pay premiums;</li> <li>Failure to make only partial payment of premiums due;</li> <li>Nonpayment of any other amounts due to the Plan or Plan Provider;</li> <li>Discontinuation of a product;</li> <li>Member may terminate by written notice to plan.</li> </ul> <p>Benefits terminate for cause as follows:</p> <ul style="list-style-type: none"> <li>Fraud-upon receipt of notice;</li> <li>Loss of Eligibility-the last day of the month in which you are no longer eligible;</li> <li>Failure to pay premium due after 15-day notice;</li> <li>Payment of Partial Premium due after 15-day notice;</li> <li>Nonpayment of other charges-At least 15 days after receipt of written notice;</li> <li>Voluntary termination by member-the first of the month following adequate notice to plan.</li> </ul>
The terms under which coverage may be renewed	New sales are issued through the end of the calendar year. All accounts renew annually on January 1 <sup>st</sup> .
Other coverage that may be available if benefits under the described benefit package cease	None

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<b>Coverage Summary</b>	
The circumstances under which choice in the selection of physicians and providers is permitted	Members are encouraged to choose a Primary Care Physician (PCP) from a list of available Plan Physicians in the following specialties: Adult medicine, Obstetrics/Gynecology, Family Practice, and Pediatrics. If the member does not choose a PCP, the Plan will assign one to the member. Members may change their PCP at any time by contacting the Plan's Member Services Department.
Lifetime and annual maximums	Lifetime Maximum: None Annual maximum: Single - \$1,500 Family - \$3,000.
Deductibles	No deductibles

<b>Benefit Summary (**2) (**3)</b>		<b>Co-payments</b>	<b>Limitation</b>
Professional Services	Physician office visits, including, but not limited to preventive care, immunization, screening and diagnostic visits.		
	Doctor Office Visits	\$0.00	
	Physical Exams	\$0.00	
	Pediatric Visits	\$0.00	
	Gynecological Visits	\$0.00	
	Vision Exams	\$0.00	
	Hearing Exams	\$0.00	
	Scheduled Well Baby Visits (0 – 23 months)	\$0.00	
	Scheduled Prenatal Visit and first Post-Partum Visit	\$0.00	
	Immunizations	\$0.00	
	Family Planning	\$0.00	

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Benefit Summary (**2) (**3)		Co-payments	Limitation	
Outpatient Services	Outpatient services, including, but not limited to, surgery and treatment, and diagnostic procedures.			
	Outpatient Surgery			
	Voluntary Sterilization		\$0.00	
	Abortion		\$0.00	
	Occupational Therapy		\$0.00	
	Speech Therapy		\$0.00	
	Physical Therapy		\$0.00	
	Multidisciplinary Rehabilitation		\$0.00	
	Lab		\$0.00	
	Imaging (mamographies included)		\$0.00	
	Other Tests & Procedures		\$0.00	
	Dermatology (UV light treatment)		\$0.00	
	Health Education Classes – Individual		\$0.00	
Health Education Classes – Group		\$0.00		
Allergy Testing and Injection		\$0.00		
Hospitalization Services	Inpatient and outpatient services, including, but not limited to, room and board and supplies.			
	Inpatient-Maternity		\$0.00	
	Inpatient-Hospital (conditions other than maternity)		\$0.00	
	Inpatient-Multi-disciplinary Rehabilitation Services		\$0.00	
	(For more than one therapy, including, but not limited to therapy services provided following a stroke or spinal code injury)		\$0.00	
Emergency Health Coverage	Emergency room services at contracted and non-contracted facilities for medically necessary emergency services		\$0.00	
Ambulance Services	Emergency ambulance transport		\$0.00	

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Benefit Summary (**2) (**3)		Co-payments	Limitation
Prescription Drug Benefits	Medically necessary drugs prescribed by a physician.	\$0.00	Drugs, supplies, and supplements are covered when prescribed by a Plan Physician and in accord with our drug formulary guidelines. Certain drugs are covered only for a 30-day supply in 30-day period.
	Up to 100 Days Supply (Generic/Brand on formulary)		
Durable Medical Equipment	Home medical equipment, including, but not limited to, oxygen, parenteral and enteral nutrition, colostomy supplies corrective prosthetics and aids, and diabetic supplies.		
	Includes durable medical equipment, supplies, prosthetic devices, and braces. Other items listed above may be covered under other benefit categories. Items used during covered Hospital stay or Skilled Nursing Facilities Items used at home.	\$0.00	Durable Medical Equipment is covered in accord with our DME formulary guidelines.  See Evidence of Coverage for additional information.
Mental Health Services	Inpatient and outpatient mental health services, including, but not limited to, mental health parity services for serious mental disorders and severe emotional disturbances for children.	\$10.00 per visit \$10.00 per visit \$0.00 \$0.00	Copayment waived for Serious mental disorders and severe emotional disturbances for children
	Outpatient Outpatient-Mental Health Parity Inpatient Inpatient-Mental Health Parity		
Residential Treatment	Transitional Residential Recovery Services	\$0.00	Hospital alternative treatment services are available as authorized. Maximum 60 days per Calendar Year and 120 days in any 5 consecutive calendar years.

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Benefit Summary (**2) (**3)		Co-payments	Limitation
Chemical Dependence Services	Substance abuse treatment or rehabilitation		Maximum 60 days per Calendar Year and 120 days in any 5 consecutive calendar years.
	In the Medical Office – Individual	\$0.00	
	In the Medical Office – Group	\$0.00	
	In the Hospital Transitional Residential Recovery Services	\$0.00 \$0.00	
Home Health Services	Home Health and Hospice Care Services. (**4)		
	Hospice Care Home Health Care	\$0.00 \$0.00	
Custodial Care and Skilled Nursing Facilities	Skilled nursing care and skilled nursing facilities services Custodial Care	\$0.00 Not covered	100 days per benefit period Refer to EOC
Chiropractic Services		\$10.00 per visit	20 visits maximum per Calendar Year
Acupuncture Services		\$10.00 per visit	20 visits maximum per Calendar Year

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(\*1)

- (a) the group contract terminated and is replaced with similar coverage under another contract within 15 days of the date of termination of group coverage or the subscriber's participation;
- (b) coverage was terminated because the employee or member failed to pay amount due the plan;
- (c) the employee or member was terminated for cause as set forth in its evidence of coverage;
- (d) the employee or member knowingly furnished incorrect information or otherwise improperly obtained benefits of the plan;
- (e) the employer's insurance coverage is self-insured;
- (f) the employee or member is covered or eligible for benefits under Title XVIII of the United States Social Security Act;
- (g) the employee or member is covered by or eligible for hospital, medical or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured;
- (h) the employee or member is covered for similar benefits under an individual contract or policy;
- (i) the enrollee or member has not been continuously covered during the three-month period immediately preceding termination of coverage.

(\*\*2) This is a benefit summary. Please consult the individual plan's Evidence of Coverage for more detailed information on benefits under the plan, including any related exclusions not contained in the benefit summary.

(\*\*\*3) Percentage copayments represent a percentage of actual cost. When participating providers are compensated on a fee for service basis, the actual cost is the negotiated fee rate. In a PPO, percentage copayments for non-emergency services provided by non-participating providers are a percentage of usual, customary or reasonable rates or billed charges whichever is less and enrollees are also responsible for any excess amount.

(\*\*\*4) Hospice benefits are available through the plan. Please consult the plan's Evidence of Coverage.