PLAN DOCUMENT FOR

CALIFORNIA'S VALUED TRUST MEDICAL PLAN

BRONZE PLAN

Effective October 1, 2018

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INTRODUCTION

This document is a description of California's Valued Trust Medical Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Members against certain health expenses.

Coverage under the Plan will take effect for an eligible Subscriber and designated Family members when the Subscriber and such Family members satisfy all the eligibility requirements of the Plan.

CVT fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

For Plan Years that begin on or after January 1, 2014, to the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency limits, or restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Network Provider.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Members are limited to Covered Charges incurred before termination, amendment or elimination.

It is the intent of CVT and the Plan Administrator to comply with all applicable Federal and State laws and regulations. In the event of non-compliance with any such law or regulation, the Plan Document will be deemed amended to comply with said law or regulation as of its effective date, and the remainder of the Plan Document will remain in full force and effect. Similarly, in the event a law or regulation applicable to this Plan becomes effective after the initial effective date of this Plan Document, said law or regulation will be deemed included in this Plan Document as of its effective date and without the necessity of an amendment to this Plan Document.

This document summarizes the Plan rights and benefits for covered Subscribers and their Family members and is divided into the following parts:

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Effective Date and Termination. Explains eligibility for coverage under the Plan and when the coverage takes effect and terminates.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Member is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Member has a claim arising out of an accidental illness or injury, including but not limited to worker's compensation claims.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

SCHEDULE OF BENEFITS

Verification of Eligibility 800-442-7247

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are percentages paid by the plan and are subject to the exclusions and limitations described more fully herein including, but not limited to, the determination that: care and treatment is Medically Necessary; that charges are based on the Recognized Charges; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

This document is intended to describe the benefits provided under the Plan but, due to the number and wide variety of different medical procedures and rapid changes in treatment standards, it is impossible to describe all covered benefits and/or exclusions with specificity. Please contact the Plan Administrator if you have questions about specific supplies, treatments or procedures.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

Inpatient Hospitalizations
MRI/CAT scans
Inpatient Substance Abuse/Mental Disorder treatments
Skilled Nursing Facility stays
Home Health Care by Non-Network Providers
Certain Outpatient surgical procedures as specified by Blue Shield. Contact Blue Shield at 800-541-6652

Please see the Cost Management section in this booklet for details.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

The Plan is a plan which contains a Network Provider Organization.

PPO name: Refer to your medical identification card for the PPO name and phone number.

If the Plan generally requires or allows the designation of a primary care provider, a Member has the right to designate any primary care provider who is a Network Provider and who is available to accept the Member. For children, a Member may designate a pediatrician as the primary care provider if the pediatrician is a Network Provider and is available to accept the child as a patient. A Member does not need prior authorization from the Plan, a primary care provider, or any other person in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology and who is a Network Provider. However, the health care professional may be required to comply with certain Plan procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Therefore, when a Member uses a Network Provider, that Member will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Member‘s choice as to which Provider to use.

Blue Shield of California, an independent member of the Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

Non-Network Providers are reimbursed in accordance with the fee schedule.
The fee schedule for Hospital and Ambulatory Surgical Centers is on the following pages.
The fee schedule for Professional services is 50% of the 50th percentile of the recognized charge.
The fee schedule for outpatient Physical Therapy, Speech Therapy, Occupational Therapy, Acupuncture, and Spinal Manipulation Chiropractic will be 50% of the contracted rate with PhysMetrics.

Under the following circumstances, the Recognized Charge will be applied as shown below for certain Non-Network services:

If a Member has a Medical Emergency requiring immediate care and receives services provided by a non-network provider or at a non-network facility, the reimbursement to the non-network provider and non-network facility will be 100% of the 75th percentile of Recognized Charge. You may be liable for the difference between the maximum allowed amount and the non-network provider's charge.

If a Member has no choice of an anesthesiologist and receives services by a Non-Network anesthesiologist at a network facility, the reimbursement to the Non-Network provider will be 100% of the 75th percentile of the Recognized Charge. You may be liable for the difference between the maximum allowed amount and the non-network provider's charge.

If a Member participates in a Clinical Trial. The maximum allowed amount for services and supplies provided in connection with Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a participating provider. The Recognized Charge will be waived.

Additional information about this option, including any rules that apply to designation of a primary care provider, as well as a list of Network Providers, will be given to Plan Members, at no cost, and updated as needed. This list will include providers who specialize in obstetrics or gynecology. Contact the Network provider organization for a list of Network providers.

Authorized Referrals

In some circumstances the claims administrator may authorize participating provider cost share amounts (Deductibles or Co-Payments) to apply to a claim for a covered service you receive from a non-participating provider. In such circumstance, you or your physician must contact the claims administrator in advance of obtaining the covered service. It is your responsibility to ensure that the claims administrator has been contacted. If the claims administrator authorizes a participating provider cost share amount to apply to a covered service received from a non-participating provider, you also may still be liable for the difference between the maximum allowed amount (recognized charge) and the non-participating provider's charge. Please call the customer service telephone number on your ID card for authorized referral information or to request authorization.

Medicare as the primary payer

If Medicare is the primary payer, the maximum allowed amount does not include any charge:

(1) By a hospital, in excess of the approved amount as determined by Medicare; or

(2) By a physician who is a Network provider who accepts Medicare assignment, in excess of the approved amount as determined by Medicare; or

(3) By a physician who is a Non-Network provider or other health care provider who accepts Medicare assignment, in excess of the lesser of the maximum allowed amount, or the approved amount as determined by Medicare; or

(4) By a physician or other health care provider who does not accept Medicare assignment, in excess of the lesser of the maximum allowed amount, or the limiting charge as determined by Medicare.

UNDER NO CIRCUMSTANCES WILL THE MAXIMUM ALLOWED AMOUNT EVER EXCEED THE BILLED CHARGES.

You will always be responsible for expense incurred which is not covered under this plan.

Copayments payable by Plan Members

Copayments are dollar amounts that the Member must pay before the Plan pays.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

SCHEDULES FOR NON-NETWORK HOSPITALS/AMBULATORY SURGICAL CENTERS
SERVICE AREAS

A provider's service area is determined by the area in which the provider's principal place of business is located.

Service Area 1: Counties of Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Mono, Nevada, Placer, Plumas, Sacramento, San Benito, Shasta, Sierra, Siskiyou, Solano, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo and Yuba.

Service Area 2: Counties of Alameda, Contra Costa, Monterey, Napa and Santa Cruz.

Service Area 3: Counties of Marin, San Francisco, San Mateo and Santa Clara.

Service Area 4: Counties of Los Angeles and Riverside (City of Palm Springs only).

Service Area 5: Orange County.

Service Area 6: Counties of Kern, Riverside (except City of Palm Springs), San Bernardino, San Luis Obispo, Santa Barbara and Ventura.

Service Area 7: San Diego County.

Service Area 8: Counties of Fresno, San Joaquin, Sonoma and Stanislaus.

Service Area 9: Imperial County.

Service Area 10: Outside California.

CHARGES BY A HOSPITAL WHICH IS A NON-NETWORK PROVIDER

The maximum allowed amount for inpatient and outpatient care provided by a hospital which is a non-network provider is shown in the schedule below. The amount varies by the service area of the hospital (amounts shown are for each day).

HOSPITAL SCHEDULE

Service Area	All Conditions, Per Day
1	$540
2	$540
3	$540
4	$580
5	$540
6	$540
7	$540
8	$540
9	$540
10	$580

CHARGES BY AN AMBULATORY SURGICAL CENTER THAT IS A NON-NETWORK PROVIDER

The maximum allowed amount for outpatient surgery provided by an ambulatory surgical center which is a non-network provider is shown in the schedule below. The amount varies by the service area of the center.

AMBULATORY SURGICAL CENTER SCHEDULE

Service Area	Each Session
1	$540
2	$540
3	$540
4	$580
5	$540
6	$540
7	$540
8	$540
9	$540
10	$580

MEDICAL BENEFITS SCHEDULE

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
ANNUAL MAXIMUM BENEFIT AMOUNT	Unlimited	
DEDUCTIBLE, PER CALENDAR YEAR – the Calendar Year Deductible is combined for Network and Non-Network Providers.		
Individual	$5,000	$5,000
Family	$10,000	$10,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR – the Out-of-Pocket Maximum is combined for Network and Non-Network Providers and includes medical and prescription drugs.		
Individual	$6,350	$6,350
Family	$12,700	$12,700
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Amounts over Recognized Charges		
COVERED CHARGES		
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network providers.		
All other reimbursements – unless otherwise stated in this Document	70% after deductible	70% of fee schedule after deductible
Hospital Services		
Room and Board	70% after deductible the semiprivate room rate	70% of fee schedule after deductible the semiprivate room rate
Intensive Care Unit	70% after deductible	70% of fee schedule after deductible
Ambulatory Surgical Center	70% after deductible	70% of fee schedule after deductible
Pre-admission testing	70% after deductible	70% of fee schedule after deductible
Emergency Room Visit		
Medical Emergency	100% after deductible $250 copayment applies after deductible is satisfied Copayment waived if admitted	100% of fee schedule after deductible $250 copayment applies after deductible is satisfied Copayment waived if admitted
Professional Services	70% after deductible	70% of fee schedule after deductible
Skilled Nursing Facility	70% after deductible the facility's semiprivate room rate 100 days Calendar Year maximum	70% of fee schedule after deductible the facility's semiprivate room rate 100 days Calendar Year maximum
Urgent Care	100% after deductible $120 copayment applies after deductible is satisfied	100% of fee schedule after deductible $120 copayment applies after deductible is satisfied

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Physician Services		
Inpatient visits	70% after deductible	70% of fee schedule after deductible
Office visits	100% after $60 copayment per visit for first 3 visits deductible waived thereafter 70% after deductible	100% of fee schedule after $60 copayment per visit for first 3 visits deductible waived thereafter 70% of fee schedule after deductible
Specialty physician office visits	100% after deductible $70 copayment applies after deductible is satisfied	100% of fee schedule after deductible $70 copayment applies after deductible is satisfied
NOTE: A Specialty physician is a physician other than Family Medical, Internist, Obstetrics and Gynecology, Pediatrician, General Practitioner, Physician Assistant and Nurse Practitioner.		
Surgery	70% after deductible	70% of fee schedule after deductible
Allergy testing	70% after deductible	70% of fee schedule after deductible
Allergy serum and injections	70% after deductible	70% of fee schedule after deductible
Second Surgical Opinion	100% after $60 copayment per visit for first 3 visits deductible waived thereafter 70% after deductible	100% of fee schedule after $60 copayment per visit for first 3 visits deductible waived thereafter 70% of fee schedule after deductible
Diabetes Education	70% after deductible	70% of fee schedule after deductible
X-ray & Lab	70% after deductible	70% of fee schedule after deductible
Home Health Care	70% after deductible 100 visits Calendar Year maximum	70% of fee schedule after deductible 100 visits Calendar Year maximum
Home Infusion Therapy – for all covered services and supplies	70% after deductible	70% of fee schedule after deductible Limited to $600 maximum per day
Outpatient Hemodialysis – for all covered services and supplies	70% after deductible	70% of fee schedule after deductible
Hospice Care	100% after deductible	100% of fee schedule after deductible
Bereavement Counseling	70% after deductible	70% of fee schedule after deductible
Ambulance Service	70% after deductible	70% of fee schedule after deductible
Wig After Chemotherapy	70% after deductible $300 Calendar Year maximum	70% of fee schedule after deductible $300 Calendar Year maximum
Durable Medical Equipment	70% after deductible	70% of fee schedule after deductible
Prosthetics	70% after deductible	70% of fee schedule after deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Acupuncture	70% after deductible Limited to 12 visits Calendar Year maximum	70% of fee schedule after deductible Limited to 12 visits Calendar Year maximum
Spinal Manipulation Chiropractic	70% after deductible	70% of fee schedule after deductible Limited to 13 visits Calendar Year maximum
Mental Disorders and Substance Abuse		
Inpatient	70% after deductible	70% of fee schedule after deductible
Outpatient – facility	70% after deductible	70% of fee schedule after deductible
Outpatient – office	100% after $60 copayment per visit for first 3 visits deductible waived thereafter 70% after deductible	100% of fee schedule after $60 copayment per visit for first 3 visits deductible waived thereafter 70% of fee schedule after deductible
Preventive Care – As defined by the Patient Protection Affordable Care Act (PPACA)		
Routine Well Care – all ages	100% deductible waived	100% of fee schedule deductible waived
Bariatric Surgery	Covered as any other care based on type of service	Based on type of service per fee schedule
Organ Transplants	Covered as any other care based on type of service	Based on type of service per fee schedule
Travel expenses	100% deductible waived Limited to $10,000 per transplant	
Unrelated Donor Searches	70% after deductible Limited to $30,000 per transplant	Based on type of service per fee schedule
Gender Dysphoria	Based on type of service	Based on type of service per fee schedule
Travel expenses	100% deductible waived Limited to $10,000	
NOTE: The travel expenses maximum is per surgery or series of surgeries (if multiple surgical procedures are performed.		
Pregnancy	Covered as any other care based on type of service	Covered as any other care based on type of service
Prescription Drugs – 30-day supply		
Generic	$25 copayment after deductible	Not covered
Brand	$50 copayment after deductible	Not covered

PHYSMETRICS NETWORK OF PROVIDERS

Physical Therapy, Occupational Therapy, Speech-Language Therapy, Chiropractic and Acupuncture Schedule of Benefits

Outpatient Services	PhysMetrics NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Physical Therapy	70% after deductible	70% of fee schedule after deductible limited to 13 visits Calendar Year maximum
NOTE: Up to 24 additional visits in a year for Non-Network Providers are provided for treatment following post-neurological surgery, orthopedic surgery, cerebral vascular accident, third degree burns, head trauma or spinal cord injury. Additional visits must have prior-authorization. For all other covered conditions, up to 12 additional visits may be provided.		
Occupational Therapy	70% after deductible	70% of fee schedule after deductible
Speech-language Therapy	70% after deductible	70% of fee schedule after deductible
Chiropractic	70% after deductible	70% of fee schedule after deductible limited to 13 visits Calendar Year maximum
Acupuncture	70% after deductible limited to 12 visits Calendar Year maximum	70% of fee schedule after deductible limited to 12 visits Calendar Year maximum

- **To locate a PhysMetrics network provider for Physical Therapy, Occupational Therapy, Speech-Language Therapy, Chiropractic or Acupuncture services please visit the PhysMetrics website at www.cvt.physmetrics.com or call PhysMetrics at (844) 854-4861.**

Outpatient benefits will be provided, up to the maximum visits outlined, as long as treatment is Medically Necessary, pursuant to the provider's treatment plan, and likely to result in clinically significant progress as measured by objective and standardized tests.

- **The following protocol will apply for Physical Therapy, Occupational Therapy, Speech-Language Therapy:**
  - Benefits are provided for Medically Necessary Outpatient Therapy services when ordered by the Member's personal physician and provided by a licensed health care provider.
  - Any treatment involving more than ten (10) visits must have any and all additional visits pre-certified by the treating provider submitting a treatment plan to PhysMetrics for approval, up to the maximum visits outlined.

- **The following protocol will apply for Chiropractic and Acupuncture treatment services:**
  - Any treatment involving more than twelve (12) visits must have any and all additional visits pre-certified by the treating provider submitting a treatment plan to PhysMetrics for approval, up to the maximum visits outlined.
  - Minors (under the age of 18) require Precertification by PhysMetrics prior to treatment.
  - Massage Therapy requires Precertification by PhysMetrics prior to treatment.

EXCLUSIONS AND LIMITATIONS

The following are specifically excluded from this agreement or have specific limitations:

1. Services not documented as necessary and appropriate or classified as experimental or investigational.

2. Treatment or services for pre or post-employment physicals or vocational rehabilitation.

3. Any treatment or service caused by or arising out of the course of employment or covered under any public liability insurance.

4. Non-medical self-care or self-help, or any other self-help physical exercise training, or any other related diagnostic testing.

5. Air conditioners, humidifiers, air purifiers, therapeutic mattress supplies, or any other similar devices and appliances.

6. Vitamins, minerals, nutritional supplements or other similar products.

7. Services identified by PhysMetrics as covered by entities or third parties other than the Plan must be coordinated appropriately and will be reimbursed based on Plan responsibility.

Subject to all General Provisions, Exclusions and Limitations found in the Plan Document.

MDLIVE

Medical Consultations:

Your plan includes MDLIVE medical consultations, a 24/7/365 service where you have access to board certified doctors and pediatricians to help you anytime, anywhere about your medical care.

Services are provided either via secure, private video or telephonically through your computer or mobile device. You will be required to pay a $5 copayment for each visit. The doctor will ask you some questions to help determine your health care needs. Based on the information you provide, the advice will include general health care and pediatric care of you or your dependent's condition.

When to use MDLIVE medical services:

(1) If you are considering utilizing ER, urgent care center, or retail clinic for non-emergency medical use.

(2) Your primary care doctor is not available.

(3) Traveling and in need of medical care.

(4) During or after normal business hours, nights, weekends and holidays.

(5) To request prescriptions or get refills.

Behavioral Health Consultations:

Your plan includes MDLIVE behavioral health consultations, a service where non-Medicare members have access to board certified psychiatrists and licensed therapists and counselors.

Services are provided through secure, private video sessions with an experienced counselor or psychiatrist who is licensed in your state. You will be required to pay a $70 copayment after deductible for each visit.

Common conditions MDLIVE behavioral health can address:

(1) Depression

(2) Anxiety

(3) Life Transitions

(4) Trauma and Loss

(5) Substance Use

(6) Relationships

(7) And more

You can register by calling MDLIVE toll free at 888-632-2738 or going on the internet at mdlive.com/cvt. Be prepared to provide your name, the patient's name (if you are calling for one of your dependents under the age of 18), your medical ID number found on your ID card, your date of birth, and the patient's phone number.

Note: CVT has made arrangements to make MDLIVE available to you as a special service. It may be discontinued without notice. MDLIVE is an optional service. Remember, register to get started. MDLIVE does not guarantee patients will receive a prescription. Healthcare professionals using the platform have the right to deny care if based on professional judgment a case is inappropriate for telehealth or for misuse of services. MDLIVE operates subject to state regulation and may not be available in certain states. MDLIVE does not guarantee that a prescription will be written. MDLIVE does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. MDLIVE phone consultations are available 24/7/365, while video consultations are available during the hours of 7 am to 9 pm ET 7 days a week or by scheduled availability.

ELIGIBILITY, EFFECTIVE DATEAND TERMINATION PROVISIONS

A Plan Member should contact the Claims Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Employees. The persons described in the participation agreement are eligible to enroll as Employees.

Eligibility Requirements for Subscriber Coverage. All conditions of Eligibility shall be in accordance with the eligibility rules adopted by CVT. In the event of a discrepancy, CVT's Eligibility Policy Document will supersede the provisions of this Plan Document.

Retired Employees or their Surviving Spouses. An Employee who retires under any public retirement system may be eligible to enroll as a retired employee.

After the death of the Employee who was covered as a retired employee, coverage continues for a spouse enrolled through a participating employer until one of the following occurs:

(1) The Spouse becomes enrolled under another group health plan; or

(2) The Spouse's coverage cancels as described in **Termination of Coverage, When Family Member Coverage Terminates**.

Eligible Classes of Family Members. A Family Member is any one of the following persons:

(1) A covered Subscriber's Spouse. "Spouse" is the Subscriber's spouse under a legally valid marriage.

(2) Domestic Partner of the Subscriber.

(a) Same sex or over 62 opposite sex – state registration required;

To obtain more detailed information or to apply for this benefit, the Subscriber must contact the Plan Administrator, California's Valued Trust, 520 East Herndon Avenue, Fresno, California, 93720, 559-437-2960 or 800-288-9870.

In the event the domestic partnership is terminated, either partner is required to inform California's Valued Trust of the termination of the partnership.

The Plan Administrator may require documentation proving a legal marital and/or Domestic Partner relationship.

(3) A covered Subscriber's or domestic partner's Child(ren) under 26 years of age.

(a) Natural child – **(birth certificate is required for enrollment).**

(b) Adopted child – **(final adoption papers are required for enrollment).**

(c) Step child – **(birth certificate is required for enrollment).**

(d) Child of an eligible, covered *domestic partner* – **(birth certificate is required for enrollment).**

(e) Unmarried child under legal guardianship – A dependent child under a court ordered legal guardianship of the subscriber is eligible for coverage, provided they meet all other eligibility requirements. Please note: eligibility ends on the date of expiration of the court awarded guardianship or upon the 18th birthday of the child, whichever comes first. **(Legal guardianship papers are required for enrollment)**.

Any child of a Plan Subscriber who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Member coverage under this Plan.

The Plan Administrator may require documentation proving eligibility for Member coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(4) Permanently disabled child: A permanently disabled child who is presently covered with CVT as a family member may continue as a family member regardless of age provided the disabling condition existed before the child attained the age of 26, the disability renders the child incapable of self-sustaining employment, and the child is chiefly dependent on the Subscriber for support.

Permanently disabled dependents over the age of 26 are eligible for coverage when a new group enrolls or an existing group enrolls a new Subscriber with a permanently disabled child, if the Subscriber provides proof that the family member was an accepted and covered disabled family member on a medical plan immediately prior to requesting enrollment in CVT.

A permanently disabled family member who is married will lose their coverage at age 26; and a permanently disabled family member who is single will continue to be covered past age 26 until he or she marries, is no longer certified as permanently disabled, or no longer dependent on the Subscriber for support.

The Plan Administrator may require, at reasonable intervals, during the two years following the Family Member's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Family Member examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Family Members: other individuals living in the covered Subscriber's home, but who are not eligible as defined; divorced former Spouse of the Subscriber; any former Domestic Partner of the Subscriber; or any person who is covered under the Plan as a Subscriber.

If a person covered under this Plan changes status from Subscriber to Family Member or Family Member to Subscriber, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all amounts applied to maximums.

If both mother and father are Subscribers, their children may be covered as Family Members of both the mother and father.

Eligibility Requirements for Family Member Coverage. A family member of a Subscriber will become eligible for Family Member coverage on the first day that the Subscriber is eligible for Subscriber coverage and the family member satisfies the requirements for coverage.

At any time, the Plan may require proof that a Spouse, Domestic Partner or a Child qualifies or continues to qualify as a Family Member as defined by this Plan.

ENROLLMENT

Enrollment Requirements. A Subscriber must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization.

Enrollment Requirements for Newborn Children.

A newborn child of a subscriber, a subscriber's spouse, or a subscriber's covered domestic partner is eligible to be enrolled for coverage at the moment of birth.

A newborn child of a subscriber, a subscriber's spouse, or a subscriber's covered domestic partner will be automatically enrolled for 31 days.

An enrollment request and copy of the birth certificate must be submitted within 90 days of the date of birth. Coverage will commence on the date of birth. If a request for enrollment is not received within 90 days of the date of birth, the newborn child is not eligible to be enrolled for coverage until the annual open enrollment period or until the subscriber experiences a qualifying event.

Charges for covered nursery care will be applied toward the Plan of the covered parent. If the newborn child is not enrolled in this Plan as stated above, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Subscribers (husband and wife or Domestic Partners) are covered under the Plan and the Subscriber who is covering the Child terminates coverage, the Child's coverage may be continued by the other covered Subscriber with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Family Members who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment.

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on October 1.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If a Subscriber is declining enrollment for his or her family members (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 31 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 31 days of the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact your employer.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Individuals losing other coverage creating a Special Enrollment right.** A Subscriber or Family Member who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

(a) The Subscriber or Family Member was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Subscriber stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Subscriber or Family Member who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated.

The Subscriber or Family Member requests enrollment in this Plan not later than 31 days after the date of conditions described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Subscriber or Family Member has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

(b) The Subscriber or Family Member has a loss of eligibility as a result of legal separation, divorce, cessation of family member status (such as attaining the maximum age to be eligible as a Child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(c) The Subscriber or Family Member has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(d) The Subscriber or Family Member has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to

individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Subscriber or Family Member lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) Family Member beneficiaries. If:

(a) The Subscriber is a member under this Plan (or has met the Waiting Period applicable to becoming a member under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Family Member of the Subscriber through marriage, registration of domestic partnership, birth, adoption or placement for adoption,

then the Family Member (and if not otherwise enrolled, the Subscriber) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse or Domestic Partner of the covered Subscriber may be enrolled as a Family Member of the covered Subscriber if the Spouse or Domestic Partner is otherwise eligible for coverage. If the Subscriber is not enrolled at the time of the event, the Subscriber must enroll under this Special Enrollment Period in order for his eligible Family Members to enroll.

The Family Member Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Family Member and/or Subscriber must request enrollment during this 31-day period.

The coverage of the Family Member and/or Subscriber enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the month following the date of marriage, but only if an application to enroll the spouse has been filed within 31 days of the date of marriage, or in the case of domestic partner relationship, on the first day of the month following the date of application, but only if an application to enroll the domestic partner has been filed within 31 days following six consecutive months from the date the domestic partnership commenced; or

(b) in the case of a Family Member's birth, as of the date of birth; or

(c) in the case of a Family Member's adoption or placement for adoption, the date of the adoption or placement for adoption.

(d) in the case legal guardianship, the date of the court decree.

(e) in the case of an overage child who enters or returns to an eligible status, coverage begins on the first day of the month following the date an enrollment application is filed on their behalf.

(4) Medicaid and State Child Health Insurance Programs. A Subscriber or Family Member who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Subscriber or Family Member is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Subscriber or Family Member is terminated due to loss of eligibility for such coverage, and the Subscriber or Family Member requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Subscriber or Family Member becomes eligible for assistance with payment of Subscriber contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Subscriber or Family

Member requests enrollment in this Plan within 60 days after the date the Subscriber or Family Member is determined to be eligible for such assistance.

If a Family Member becomes eligible to enroll under this provision and the Subscriber is not then enrolled, the Subscriber must enroll in order for the Family Member to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the employer or by regulation.

EFFECTIVE DATE

The effective date of coverage is subject to the timely payment of the required monthly contributions on your behalf.

Effective Date of Subscriber Coverage. Coverage begins on the date specified in the participation agreement.

Effective Date of Family Member Coverage. A Family Member's coverage will take effect on the day that the Eligibility Requirements are met; the Subscriber is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

The Plan or your employer has the right to rescind any coverage of the Subscriber and/or Retiree and/or Family Members for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Plan or your employer may either void coverage for the Subscriber and/or covered Retirees and/or covered Family Members for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide written notice at least 31 days in advance of such action. The employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the Subscriber's and/or Retiree's and/or Family Member's paid contributions.

When Subscriber Coverage Terminates. Subscriber coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Subscriber may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated.

(2) The effective date the participation agreement between the Plan and your participating employer is canceled.

(3) The date the covered Subscriber's Eligible Class is eliminated.

(4) The day the covered Subscriber ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Subscriber. (See the section entitled Continuation Coverage Rights under COBRA.) It also includes an Employee on disability, leave of absence or other leave of absence, unless the Plan specifically provides for continuation during these periods.

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Subscriber commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Plan or employer may either void coverage for the Subscriber and covered Family Members for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided

retroactively for fraud or misrepresentation, the Plan will provide written notice at least 31 days in advance.

Continuation During Periods of Employer-Certified Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For leave of absence or layoff only: the date your employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Subscriber. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor, as well as any state employment regulations which require additional periods of leave and are applicable to the Plan.

During any leave taken under the Family and Medical Leave Act, the employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Subscriber had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Subscriber and his or her covered Family Members if the Subscriber returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated.

Rehiring a Terminated Subscriber. A terminated Subscriber who is not rehired within 26 weeks will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Subscriber is returning to work directly from COBRA coverage, this Subscriber does not have to satisfy any employment waiting period.

Subscribers on Military Leave. Subscribers going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. These rights apply only to Subscribers and their Family Members covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for 31 days or less cannot be required to pay more than the Subscriber's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

If the Subscriber wishes to elect this coverage or obtain more detailed information, contact your employer. The Subscriber may also have continuation rights under USERRA. In general, the Subscriber must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Subscriber may elect USERRA continuation coverage for the Subscriber and their Family Members. Only the Subscriber has election rights. Family Members do not have any independent right to elect USERRA health plan continuation.

When Family Member Coverage Terminates. A Family Member's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Family Member may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan or Family Member coverage under the Plan is terminated.

(2) The date that the Subscriber's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

(3) The date a covered Spouse loses coverage due to loss of eligibility status. (See the section entitled Continuation Coverage Rights under COBRA.)

(4) Coverage will end on the last day of the month in which the Child ceases to meet the applicable eligibility requirements. (See the section entitled Continuation Coverage Rights under COBRA.)

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

(6) If a Family Member commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan or the employer that he or she has become ineligible for coverage, then the Plan or your employer may either void coverage for the Family Member for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide written notice at least 31 days in advance.

OPEN ENROLLMENT

Once each Calendar Year there is an annual open enrollment period. Subscribers and their Family Members who are Late Enrollees will be able to enroll in the Plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective October 1.

Plan Members will receive detailed information regarding open enrollment from CVT and their employer.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Member for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE THRREE MONTH CARRYOVER

Covered Charges incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Member that are in excess of any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

COVERED CHARGES

Covered Charges are the Allowable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Charges for a Private Room will be limited to the semi-private room rate. The private room rate will apply if the facility only has private rooms available.

Charges for an Intensive Care Unit stay are payable.

(2) **Coverage of Pregnancy.** Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility; and

(b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(c) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Covered Charges for a Member's care in these facilities are payable as described in the Schedule of Benefits.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Allowable Charge that is allowed for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Allowable Charge for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's allowance.

(5) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

If covered charges are applied toward the Calendar Year Deductible, if applicable, and payment is not provided, those visits will be included in the visit maximum for that year.

(6) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Member's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or other covered Dependents). Bereavement services are available to the immediate family for a period of one year after the patient's death.

(7) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Surgical methods of terminating a pregnancy also called elective **abortion**.

Prescription drugs, when provided under the Food and Drug Administration (FDA) approved treatment regimen are also covered under this Plan.

(b) Charges for **acupuncture**.

If covered charges are applied toward the Calendar Year Deductible, if applicable, and payment is not provided, that visit will be included in the visit maximum for that year

(c) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled

Nursing Facility where necessary treatment can be provided unless a longer trip was Medically Necessary.

(d) **Ambulatory Surgical Center**. Services and supplies provided by an ambulatory surgical center in connection with outpatient surgery.

(e) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

Blood transfusions, including blood processing and the cost of un-replaced blood and blood products. Charges for the collection, processing and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure

(f) **Bariatric surgery.** Services and supplies in connection with medically necessary surgery for weight loss, only for morbid obesity.

(g) **Biofeedback.**

(h) **Birth Control.** Services and products for contraceptive management including, but not limited to, implants, intrauterine devices (IUDs), and birth control shots.

This does not include oral contraceptives, condoms, sponges, foam or jelly.

(i) **Clinical Trials.** Coverage is provided for services and supplies for routine patient care costs, as defined below, in connection with phase I, phase II, phase III and phase IV clinical trials, if all the following conditions are met:

(i) The treatment provided in a clinical trial must either:

(a) Involve a drug that is exempt under federal regulations from a new drug application, or

(b) Be approved by (i) one of the National Institutes of Health, (ii) the federal Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.

(ii) You must be diagnosed with cancer or another life-threatening disease or condition to be eligible for participation in these clinical trials.

(iii) Participation in such clinical trials must be recommended by your physician after determining participation has a meaningful potential to benefit the member.

(iv) For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.

Routine patient care costs means the costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the plan, including health care services which are:

(i) Typically provided absent a clinical trial.

(ii) Required solely for the provision of the investigational drug, item, device or service.

(iii) Clinically appropriate monitoring of the investigational item or service.

(iv) Prevention of complications arising from the provision of the investigational drug, item, device, or service.

(v) Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

Routine patient care costs do not include the costs associated with any of the following:

(i) Drugs or devices not approved by the federal Food and Drug Administration that are associated with the clinical trial.

(ii) Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.

(iii) Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.

(iv) Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the plan.

(v) Health care services customarily provided by the research sponsors free of charge to members enrolled in the trial.

Note: You will be financially responsible for the costs associated with non-covered services.

(j) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; and (c) in a Medical Care Facility as defined by this Plan.

(k) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(l) **Christian Science Benefits.** Benefits for the following services are provided when you receive Christian Science treatment for symptoms of a covered illness or injury:

(i) Services of a Christian Science sanatorium when you are admitted for active care of an illness or injury.

A Christian Science sanatorium is considered a hospital for purposes of this plan. The sanatorium must be accredited by the Department of Care of the First Church of Christ, Scientist; Boston, Massachusetts.

(ii) Office visits for services of a Christian Science practitioner providing treatment for a diagnosed illness or injury according to the healing practices of Christian Science. The term “physician” includes a Christian Science practitioner approved and accredited by the Mother Church, The First Church of Christ, Scientist; Boston, Massachusetts.

NO BENEFITS ARE AVAILABLE FOR SPIRITUAL REFRESHMENT. All other provisions under **PLAN EXCLUSIONS** apply equally to Christian Science benefits as to all other benefits and providers of care.

(m) Initial **contact lenses** or glasses required following cataract surgery.

(n) **Dental Care.** Medical facility, anesthesia charges or any fees associated with treatment that is determined to be medically necessary will be covered under the medical plan. Following are some examples of medical necessity:

(i) The patient is a child (up to 6 years old) with a dental condition that requires repairs of significant complexity (e.g., multiple restorations, pulpal therapy, extractions);

(ii) Patients with certain physical, intellectual or medically compromising conditions (e.g., mental retardation, cerebral palsy, epilepsy, cardiac problems, hyperactivity verified by appropriate medical documentation);

(iii) Extremely uncooperative, fearful, unmanageable, anxious or uncommunicative patients with substantial dental needs and no expectation that behavior will improve soon;

(iv) Patients with dental restorative or surgical needs for whom local anesthesia is ineffective (such as due to acute infection, anatomic variations or allergy);

(v) Patients who have sustained extensive orofacial or dental trauma, for which treatment under local anesthesia would be ineffective or compromised.

(o) **Diabetes education.** Charges for diabetes education program which:

(i) Is designed to teach a Member who is a patient and covered members of the patient's family about the disease process and the daily management of diabetic therapy;

(ii) Includes self-management training, education, and medical nutrition therapy to enable the Member to properly use the equipment, supplies, and medications necessary to manage the disease; and

(iii) Is supervised by a physician.

NOTE: Diabetic supplies are covered through the prescription drug program.

(p) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance. Repair or replacement will be covered only when required due to growth or development of a dependent child, or deterioration from normal wear and tear if recommended by the attending physician.

(q) **Foot orthotics.** Custom molded inserts. Orthotics for the prevention and treatment of diabetes-related foot complications.

(r) **Gender dysphoria (Transgender) services.** Benefits are provided for services and supplies in connection with gender transition when a Physician has diagnosed you with gender identity disorder or gender dysphoria. This coverage is provided according to the terms and conditions of this Plan that apply to all other medical conditions, including Medical Necessity requirements, utilization review, and exclusions for Cosmetic Services.

Coverage includes, but is not limited to, Medically Necessary services related to gender transition such as transgender surgery, hormone therapy, psychotherapy, and vocal training. Coverage is provided for specific services according to benefits under this Plan that apply to that type of service generally, if the Plan includes coverage for the service in question. If a specific coverage is not included, the service will not be covered. For example, transgender surgery would be covered on the same basis as any other covered, Medically Necessary surgery; hormone therapy would be covered under this Plan's Prescription Drug benefits.

Some services are subject to prior authorization in order for coverage to be provided. Please refer to "Cost Management Services" for information on how to obtain the proper reviews.

Transgender Surgery Travel Expense. Certain travel expenses incurred by the Member will be covered up to the maximum in the Schedule of Benefits. All travel expenses are limited to the maximum set forth in the Internal Revenue Code, not to exceed the maximum

specified in the Schedule of Benefits, at the time services are rendered and must be approved in advance.

Travel expenses include the following for the Member and one companion:

(i) Ground transportation to and from the approved facility when the Facility is **fifty (50)** miles or more from the Member's home. Air transportation by coach is available when the distance is **three hundred (300)** miles or more.

(ii) Lodging.

When you request reimbursement of covered travel expenses, you must submit a completed travel reimbursement form and itemized, legible copies of all applicable receipts. Credit card slips are not acceptable. Covered travel expenses are not subject to the Deductible or Copayments. Please call Customer Service at the phone number on the back of your Identification Card for further information and/or to obtain the travel reimbursement form.

Travel expenses that are not covered include, but are not limited to: meals, alcohol, tobacco, or any other non-food item; child care; mileage within the city where the approved facility is located, rental cars, buses, taxis or shuttle services, frequent flyer miles, coupons, vouchers or travel tickets; prepayments or deposits; services for a condition that is not directly related to, or a direct result of, the transgender procedure; telephone calls; laundry; postage; or entertainment.

(s) Charges for **genetic testing** when the following guidelines are met and the testing is deemed medical necessity:

(i) Diagnostic testing is covered where the patient is showing symptoms of disease, and those symptoms correspond to a medically recognized genetic disorder, or when testing is performed on the DNA of an invading virus or bacterium for the purpose of identifying and treating a specific contagious disease.

(ii) Predictive testing is covered if the patient's family history establishes him/her as at risk for a genetic disease, and once identified, there are accepted treatment alternatives for that condition.

(iii) Prenatal testing is covered when the pregnancy is categorized as high-risk, including cases where the mother is 35 years of age or older, or if the mother or father has a family history that establishes him/her as at-risk for having a hereditary genetic disorder.

(iv) Carrier testing is covered in two circumstances:

(1) The patient's family history establishes him/her as at-risk for a genetic disease, and testing is performed as a part of the pre-pregnancy family planning.

(2) The testing is part of the diagnosis of a child of the person to be tested, where the child is showing symptoms of disease, and it has been demonstrated that those symptoms may indicate a genetically based disease that could be linked through the parent.

(v) If appropriate, there should be documentation that the patient received pre-test genetic counseling from a qualified professional and gave full informed consent for the test.

In general, genetic tests for inherited disease need only be conducted once per lifetime.

It is generally accepted that unless useful medical intervention can be offered to children as a result of testing, formal testing should wait until the child is old enough to understand the

consequences of testing and make his/her own request.

Testing performed on the Member primarily for the medical management of other family members who are not covered under the plan would not be covered.

(t) Hemodialysis Treatment.

(u) Home Infusion Therapy. The following services and supplies when provided by a home infusion therapy provider in your home for the intravenous administration of your total daily nutritional intake or fluid requirements, medication related to illness or injury, chemotherapy, antibiotic therapy, aerosol therapy, tocolytic therapy, special therapy, intravenous hydration, or pain management:

(i) Medication, ancillary medical supplies and supply delivery, (not to exceed a 14-day supply); however, medication which is delivered but not administered is not covered;

(ii) Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;

(iii) Hospital and home clinical visits related to the administration of infusion therapy, including skilled nursing services including those provided for: (a) patient or alternative caregiver training; and (b) visits to monitor the therapy;

(iv) Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;

(v) Laboratory services to monitor the patient's response to therapy regimen.

(v) Laboratory studies. Covered Charges for diagnostic and preventive lab testing and services.

(w) Treatment of **Mental Disorders and Substance Abuse** are payable as shown in the Schedule of Benefits.

(x) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(y) Occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges

do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(z) **Organ transplant.** Benefits are provided for certain procedures, listed below, only if:

(i) performed at a Special Transplant Facility contracting with the Network provider,

(ii) prior authorization is obtained, in writing, and

(iii) the recipient of the transplant is a Subscriber or Family Member.

The following procedures are eligible for coverage under this provision:

(i) Human heart transplants;

(ii) Human lung transplants;

(iii) Human heart and lung transplants in combination;

(iv) Human liver transplants;

(v) Human kidney and pancreas transplants in combination;

(vi) Human bone marrow transplants, including autologous bone marrow transplantation (ABMT) or autologous peripheral stem cell transplantation used to support high-dose chemotherapy when such treatment is Medically Necessary and is not Experimental or Investigational;

(vii) Pediatric human small bowel transplants;

(viii) Pediatric and adult human small bowel and liver transplants in combination.

Benefits are provided for Services incident to obtaining the transplant material from a living donor or an organ transplant bank.

Certain travel expenses incurred in connection with an approved, specified transplant performed at a Network facility that is 75 miles or more from the recipient's or donor's place of residence are covered, provided the expenses are authorized in advance. The plan's maximum payment will not exceed the per transplant maximum in the Schedule of Benefits for the following travel expenses incurred by the recipient and one companion or the donor:

(i) Ground transportation to and from the Network facility when the Network facility is 75 miles or more from the recipient's or donor's place of residence.

(ii) Coach airfare to and from the Network facility when the designated Network facili**y** is 300 miles or more from the recipient's or donor's residence

(iii) Lodging, limited to one room, double occupancy

(iv) Other reasonable expenses. Tobacco, alcohol, drug, and meal expenses are not covered.

Note: When the member recipient is under 18 years of age, this benefit will apply to the recipient and two companions or caregivers.

The Calendar Year Deductible will not apply and no co-payments will be required for transplant travel expenses authorized in advance. The plan will provide benefits for lodging and ground transportation up to the amount shown in the Schedule of Benefits.

Expense incurred for the following is not covered: interim visits to a medical care facility while waiting for the actual transplant procedure; travel expenses for a companion and/or caregiver for a transplant donor; return visits for a transplant donor for treatment of a

condition found during the evaluation; rental cars, buses, taxis or shuttle services; and mileage within the city in which the medical transplant facility is located.

Details regarding reimbursement can be obtained by calling the customer service number on your identification card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

(aa) **Physical therapy and physical medicine.** The therapy must be administered in strict accordance with the referring Physician's orders regarding type of therapy, frequency and duration. The condition treated must also be established as one which receives substantial benefit from short-term therapy.

If covered charges are applied toward the Calendar Year Deductible, if applicable, and payment is not provided, that visit will be included in the visit maximum for that year.

Subject to PhysMetrics' prior approval, benefits for up to 24 additional visits in a year are provided when treatment follows post-neurological surgery, orthopedic surgery, cerebral vascular accident, third degree burns, head trauma or spinal cord injury. For all other covered conditions, the plan may provide for up to 12 additional visits.

If PhysMetrics determines that an additional period of physical therapy or physical medicine is medically necessary, they will authorize a specific number of additional visits.

(bb) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Additional preventive care shall be provided as required by applicable law if provided by a Network Provider. A current listing of required preventive care can be accessed at www.HealthCare.gov/center/regulations/prevention.html.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

(cc) The initial purchase, fitting and repair of fitted **prosthetic devices,** including surgical implants, which replace body parts.

(dd) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

in a manner determined in consultation with the attending Physician and the patient.

(ee) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent products.

(ff) **Speech therapy,** outpatient**.**

(gg) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C. If covered charges are applied toward the Calendar Year Deductible, if applicable, and payment is not provided, that visit will be included in the visit maximum for that year.

(hh) **Sterilization** procedures.

(ii) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(jj) Coverage of **Well Newborn Nursery**/**Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if the newborn child is an eligible Family Member and a parent (1) is a Member who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

The benefit is limited to charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

Group health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Charges for Routine Physician Care. The benefit is limited to charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

If the baby is ill, suffers an injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other eligible expense provided the child is added to the Plan and coverage is in effect.

(kk) Charges associated with the initial purchase of a **wig after chemotherapy**.

Charges for wig after chemotherapy are subject to the limits as described in the Schedule of Benefits.

(ll) Diagnostic **x-rays**.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Please refer to the Subscriber ID card for the Cost Management Services phone number.

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least five working days in advance of services being rendered or within one working day after a Medical Emergency.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Members receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Inpatient Hospitalizations
MRI/CAT scans
Inpatient Substance Abuse/Mental Disorder treatments
Skilled Nursing Facility stays
Home Health Care by Non-Network Providers
Certain Outpatient surgical procedures as specified by Blue Shield. Contact Blue Shield at 800-541-6652

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may medically necessary. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Member enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care. Precertification does not confirm or verify eligibility for coverage, nor is it a guarantee of payment. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Member. Contact the utilization review administrator at the telephone number on your ID card **at least five working days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Subscriber
- The name, subscriber identification number and address of the covered Subscriber
- The name of the employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within one working day** of the first business day after the admission.

The utilization review administrator will precertify the number of days of Medical Care Facility confinement as determined by medical necessity. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Member does not receive precertification as explained in this section, the benefit payment may be denied.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Member's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Member either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Member to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Members and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as shown in the Schedule of Benefits.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe

Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis within seven days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable as shown in the Schedule of Benefits even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

OUTPATIENT SURGERY

Certain surgical procedures can be performed safely and efficiently outside of a Hospital. Outpatient surgical facilities are equipped for many uncomplicated surgical operations, such as some biopsies, cataract surgeries, tonsillectomies and adenoidectomies, dilation and curettages, and similar procedures.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Member, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Case Manager, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Case Manager will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan. Unless specifically provided to the contrary in the Case Manager's

instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Allowable charge is a charge which is either the network Provider's reduced fee or the Recognized charge for a service or supply.

Ambulatory Surgical Center is a freestanding outpatient surgical facility. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. It must also meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations or the Accreditation Association of Ambulatory Health Care.

Authorized referral occurs when you, because of your medical needs, are referred to a non- network provider, but only when:

1. There is no network provider who practices in the appropriate specialty, which provides the required services, or which has the necessary facilities within a 50-mile radius of your residence;

2. You are referred in writing to the non- network provider by the physician who is a network provider; and

3. The referral has been authorized by the claims administrator before services are rendered.

Benefits for medically necessary and appropriate authorized referral services received from a non-network provider will be payable as shown in the **SCHEDULES FOR NON-NETWORK PROVIDERS** (benefits will be reimbursed based on Recognized Charge).

You or your physician must call the toll-free telephone number printed on your identification card prior to scheduling an admission to, or receiving the services of, a non-network provider.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year means January 1st through December 31st of the same year.

Child(ren) is the Subscriber's, Spouse's or Domestic Partner's Child as defined in the **ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS** section.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is care provided primarily to meet your personal needs. This includes help in walking, bathing or dressing. It also includes: Preparing food or special diets; feeding by utensil, tube or gastrostomy; suctioning and administration of medicine which is usually self-administered or any other care which does not require continuing services of medical personnel.

If Medically Necessary, benefits will be provided for feeding (by tube or gastrostomy) and suctioning.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

Experimental procedures are those that are mainly limited to laboratory and/or animal research.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for treatment of the Member's condition.

Family Member meets the plan's eligibility requirements for family members as outlined under **ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS**.

Family Unit is the covered Subscriber or Retiree and the family members who are covered as Dependents under the Plan.

Generic drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes as defined by the *Genetic Information Nondiscrimination Act of 2008 (GINA)*.

Home Health Care Agency is a home health care provider which is licensed according to state and local laws to provide skilled nursing and other services on a visiting basis in your home, and recognized as home health providers under Medicare and/or accredited by a recognized accrediting agency such as the Joint Commission on the Accreditation of Healthcare Organizations.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Home infusion therapy provider is a provider licensed according to state and local laws as a pharmacy, and must be either certified as a home health care provider by Medicare, or accredited as a home pharmacy by the Joint Commission on Accreditation of Health Care Organizations.

Hospice Agency is an agency or organization providing a specialized form of interdisciplinary health care that

provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and the patient's family. A hospice must be: currently licensed as a hospice pursuant to Health and Safety Code section 1747 or a licensed home health agency with federal Medicare certification pursuant to Health and Safety Code section 1726 and 1747.1. A list of hospices meeting these criteria is available upon request.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is a facility which provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of physicians. It must be licensed as a general acute care hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and meet accreditation standards of the Joint Commission on Accreditation of Health Care Organizations.

For limited purpose of inpatient care, the definition of hospital also includes: (1) psychiatric health facilities (only for the acute phase of a mental or nervous disorder or substance abuse), and (2) residential treatment centers.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Investigative procedures or medications are those that have progressed to limited use on humans, but which are not widely accepted as proven and effective within the organized medical community.

Late Enrollee means a Plan Member who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary procedures, supplies, equipment or services are those determined to be:

(1) Appropriate and necessary for the diagnosis or treatment of the medical condition;

(2) Provided for the diagnosis or direct care and treatment of the medical condition;

(3) Within standards of good medical practice within the organized medical community;

(4) Not primarily for your convenience, or for the convenience of your physician or another provider; and

(5) The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

(a) there must be valid scientific evidence demonstrating that the expected health benefit from the procedure, supply, equipment or services are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

(b) generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

(c) for hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Member is the subscriber or family member.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the patient's home.

Outpatient Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Out-of-state residents. Out-of-state residents covered under this plan means only retired subscribers, their family members and students whose permanent residence is in a state other than California.

Participating employer. A participating employer is engaged in the education industry. Specific qualifications of a participating employer are stipulated in the participation agreement and the Declaration of Trust establishing the California's Valued Trust (CVT).

Participation agreement is the agreement between California's Valued Trust (CVT) and the participating employer providing for participation of specified subscribers in this plan.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan is the set of benefits described in this plan document and in the amendments to this plan document, if any. These benefits are subject to the terms and conditions of the plan.

Plan Administrator is CVT.

Plan Member is any Member, Retiree or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Recognized Charge is the lower of:

(1) The provider's usual charge to provide a service or supply, or

(2) The charge the Claims Administrator determines to be the recognized charge percentage for the service or supply, or

(3) The charge the Claims Administrator determines to be appropriate, based on factors such as:

(a) The cost of supplying the same or similar service or supply, and

(b) The manner in which the charges for the service or supply are made.

(c) The complexity of the service or supply,

(d) The Degree of skill needed to provide it,

(e) The provider's specialty, and

(f) The Recognized Charge in other areas.

Residential treatment center is an inpatient treatment facility where the patient resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a mental or nervous disorder or substance abuse. The facility must be licensed to provide psychiatric treatment of mental or nervous disorders or rehabilitative treatment of substance abuse according to state and local laws.

Retired employee is a former full-time employee who meets the eligibility requirements described in the **ELIGIBILITY, EFFECTIVE DATE AND TERMINATION PROVISIONS**.

Service area is the area in which the provider's principal place of business is located. The counties encompassed by each service area are listed in the **SCHEDULES FOR NON-NETWORK PROVIDERS**.

Sickness is a Member's Illness, disease or Pregnancy (including complications).

Skilled Nursing Facility is an institution that provides continuous skilled nursing services. It must be licensed according to state and local laws and be recognized as a skilled nursing facility under Medicare.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Subscriber is the primary covered individual; that is, the person who is allowed to choose membership under this plan for himself or herself and his or her eligible family members.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Total Disability (Totally Disabled) means: In the case of an Active Subscriber, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. Total Disability will be determined by the employer or their designee.

In the case of a Retired Subscriber, the complete inability to perform all activities usual for persons of that age.

Total Disability (Totally Disabled) means: In the case of a Family Member, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

PLAN EXCLUSIONS

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

(1) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

(2) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(3) **Diabetic supplies.**

(4) **Educational or vocational testing.** Services for educational or vocational testing or training.

(5) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Recognized Charge.

(6) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy if covered by this Plan.

(7) **Experimental or not Medically Necessary.** Care and treatment that is either Experimental/Investigational or not Medically Necessary.

(8) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

(9) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the purpose of obtaining medical services.

(10) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This exclusion does not apply to Medicaid or when otherwise prohibited by applicable law.

(11) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

(12) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan.

(13) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(14) **Illegal acts.** Charges for services received as a result of Injury or Sickness occurring directly or indirectly, as a result of the Member's commission of or attempt to commit a Serious Illegal Act, or a riot or public disturbance. For purposes of this exclusion, the term "Serious Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(15) **Illegal drugs or medications.** Services, supplies, care or treatment to a Member for Injury or Sickness resulting from that Member's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Members other than the person using controlled substances

and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(16) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence.

(17) **Infertility.** Care, supplies, services and treatment for infertility, artificial insemination, or in vitro fertilization.

(18) **Marital or pre-marital counseling.** Care and treatment for marital or pre-marital counseling.

(19) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(20) **Non-compliance.** All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(21) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(22) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(23) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Member is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(24) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(25) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Medically Necessary charges for morbid obesity are covered.

(26) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. This exclusion may apply even if the expenses for the illness or injury are not paid by Worker's Compensation or similar employer's liability insurance.

(27) **Orthopedic Supplies.** Orthopedic shoes and shoe inserts. This exclusion does not apply to orthopedic footwear used as an integral part of a brace, shoe inserts that are custom molded to the patient, or therapeutic shoes and inserts designed to treat foot complications due to diabetes.

(28) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, over-the-counter humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments**,** scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(29) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(30) **Private duty nursing.** Charges in connection with care, treatment or services of an inpatient or outpatient private duty nurse.

(31) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Member's home or is related to the Member as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(32) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(33) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(34) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(35) **Surrogacy and surrogate mother.** All charges associated with surrogacy, a method of reproduction whereby a woman agrees to become pregnant and deliver a child for a contracted party.

(36) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance and organ transplant charges as defined as a Covered Charge.

(37) **War.** Any loss that is due to a declared or undeclared act of war.

HOW TO SUBMIT A CLAIM

When a Member has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the CVT website, www.cvtrust.org or from the Claims Administrator at www.healthcomp.com.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

HealthComp Administrators
P. O. Box 45018
Fresno, California 93718
800-442-7247

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 12 months of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Member seek a second medical opinion.

CLAIMS REVIEW

The benefits of this plan are provided only for those services that are considered medically necessary and satisfy all other terms and conditions of this plan. The fact that a physician prescribes or orders a service does not, in itself, mean that the service is medically necessary or that the service is a covered charge. Consult this benefit booklet or telephone the claims administrator at the number shown on your identification card if you have any questions regarding whether services are covered.

The claims administrator has responsibility for determining whether services are medically necessary. That determination will be made during claims review, unless reviews for medical necessity already were conducted for those services that are subject to the provisions stated under **COST MANAGEMENT SERVICES**.

When the claim is submitted for benefit payment, it is reviewed against guidelines, established by the claims administrator for medical necessity, beginning with preliminary screening against general guidelines designed to identify medically necessary services. If there is a question as to the medical necessity of the services, the claim will be further reviewed against more detailed guidelines. If the medical necessity still cannot be clearly determined, the claim will be reviewed by a physician advisor for a final determination.

Action on a Member's claim, including denial and reasons for denial, will be provided by the claims administrator to the Member in writing.

Reconsiderations

If you or your physician disagree with an initial claims review determination, or question how it was reached, reconsideration may be requested. The request may be made by you, your physician or someone chosen to represent you.

Appeals

If the reconsidered decision is not satisfactory, a request for an appeal on the reconsidered decision may be submitted in writing to the claims administrator. The request may be made by you, your physician or someone chosen to represent you.

In the event that the appeal decision still is unsatisfactory, the remedy is external review, or binding arbitration, which are explained in the next section of this benefit booklet.

How to Initiate Requests for Reconsideration or Appeals

Requests for reconsideration of claim denials or appeals of reconsidered determinations must be directed to the claims administrator at the following address:

HealthComp Administrators
CVT Customer Service Unit
Post Office Box 45018
Fresno, California 93718

Requests must be made as follows:

(1) In writing, and

(2) Within 60 days of receiving the original denial when the request is for reconsideration, or

(3) Within 30 days of receiving the reconsidered determination when the request is for an appeal.

Requests must include the following:

(1) Any medical information that supports the medical necessity of the services for which payment was denied, and any other information you or your physician feels should be considered, and

(2) A copy of the original denial.

The claims administrator must respond to the request for reconsideration or appeal within 60 days of receiving the request, except when the claims administrator indicates before the 60th day that additional time is required to review the request. In that event, the claims administrator is permitted a total of 120 days in which to respond to the request.

Voluntary Second Level Appeals

If you are dissatisfied with the first level appeal decision as described above, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External Review

If the outcome of the mandatory first level appeal is adverse to you, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the claims administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the claims administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the claims administrator's decision, can be sent between the claims administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the claims administrator at the phone number listed on your ID card and provide at least the following information:

(1) the identity of the claimant;

(2) the date (s) of the medical service;

(3) the specific medical condition or symptom;

(4) the provider's name;

(5) the service or supply for which approval of benefits was sought; and

(6) any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the claims administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

HealthComp Administrators
CVT Customer Service Unit
Post Office Box 45018
Fresno, California 93718

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws.

Requirement to file an Appeal before taking action

No legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the claims administrator's final decision on the claim or other request for benefits. If the claims administrator decides an appeal is untimely, the claims administrator's

latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the plan's internal Appeals Procedure but not including any voluntary level of appeal, before taking legal action of any kind.

The claims administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

BINDING ARBITRATION

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this plan or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort, or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute or claim within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act will govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate will apply.

The Member and CVT agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Member and CVT agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class arbitration, the Member waives any right to pursue, on a class basis, any such controversy or claim against CVT and CVT waives any right to pursue on a class basis any such controversy or claim against the Member.

The arbitration findings will be final and binding except to the extent that state or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Member making written demand on CVT. The arbitration will be conducted by Judicial Arbitration and Mediation Services (“JAMS”) according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Member and CVT, or by order of the court, if the Member and CVT cannot agree. The arbitration will be held at a time and location mutually agreeable to the Member and CVT.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Member is covered by this Plan and another plan, or the Member's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Charges.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Negotiated or Recognized Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Member does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Member used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. The Plan shall always be considered the secondary carrier regardless of the individual's election to file a claim under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a family member ("Plan B").

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Family Member of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Family Member of a laid off or Retired

Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Family Member of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(d) When a child is covered as a Family Member and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(e) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Family Member will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Family Member.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Family Member and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. If a Plan Member is Medicare entitled this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts.

(4) If a Plan Member is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Member will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Member. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

BENEFITS FOR MEDICARE ELIGIBLE MEMBERS

For Active Employees and Their Family Members

(1) If you are entitled to Medicare and receiving treatment for end-stage renal disease during the first 30 months that you are entitled to end-stage renal disease benefits under Medicare, you will receive the full benefits of this plan.

If you are receiving treatment for end-stage renal disease following the first 30 months that you are entitled to end-stage renal disease benefits under Medicare, the claims administrator will determine payment and then subtract the amount of benefits available from Medicare. The plan pays the amount that remains after subtracting Medicare's payment.

(2) If you are entitled to Medicare benefits as a disabled person and have a current employment status, as determined by Medicare rules, you will receive the full benefits of this plan.

(3) All other members entitled to Medicare will receive the full benefits of this plan.

For Retired Employees and Their Spouses

(1) If you are 65 years of age or older and eligible for Medicare Part A because you made the required number of quarterly contributions to the Social Security System, your benefits under this plan will be reduced. CVT requires that you be enrolled for both Medicare Part A and Part B benefits.

When you incur covered charges under this plan, the claims administrator will determine this plan's payment and then subtract the amount of your benefits available from Medicare Parts A and B. This plan pays the amount that remains after subtracting Medicare's benefits.

This method of payment will be applied when you are retired and eligible to enroll in Medicare Part A, whether or not you are actually enrolled in Medicare Parts A or B, and whether or not benefits to which you are entitled are actually paid by Medicare.

(2) When you incur covered charges under this plan, this plan's payment will be determined and then the amount of your benefits available from Medicare Part B will be subtracted. This plan pays the amount that remains after subtracting Medicare's benefits.

This method of payment will be applied, whether or not you are actually enrolled in Medicare Part B, and whether or not benefits to which you are entitled are actually paid by Medicare.

(3) If you are under 65 years of age and eligible for Medicare Part A because you made the required number of quarterly contributions to the Social Security System, your benefits under this plan will be reduced. CVT does not require you to enroll in Medicare Part B.

When you incur covered charges under this plan, this plan's payment will be determined and then the amount of your benefits available from Medicare Part B, if you are enrolled in Part B. This plan pays the amount that remains after subtracting Medicare's benefits.
This method of payment will be applied when you are under the age of 65, retired and actually enrolled in Medicare Part A and Part B.

For example: Say that you are billed for $100 of the maximum allowed amount, and in the absence of Medicare this plan would have paid $80. If Medicare pays $50, the claims administrator would subtract that amount from the $80 and this plan would then pay $30. The combined amount of benefits from Medicare and this plan will equal, but not exceed, what your benefit would have been from this plan alone if you were not eligible for Medicare.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Member may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party. In such circumstances, the Member may have a claim for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Member may have to Recover payments from any Third Party or any other insurer or source, including but not limited to, "first party" underinsured or uninsured motorist coverage, worker's compensation, crime victim restitution funds, medical or disability payments, homeowner's plan, renter's plan, medical malpractice plan, or any other liability plan or any other source of coverage.

This Subrogation right allows the Plan to pursue any claim which the Member has against any Third Party, or insurer, whether or not the Member chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Member whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

CVT retains sole, full and final discretionary authority to construe, apply, and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator also retains the right to delegate this discretionary authority to the Claims Administrator without notice.

The payment for benefits received by a Member under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Member as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Member, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Member to the payments of those benefits.

The Member:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Member agrees to recognize the Plan's right to Subrogation and Refund. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party or insurer to a Member relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses, even if the Member's Recovery is less than the amount claimed, and, as a result, the Member is not made whole. The Member further specifically agrees and acknowledges that the "made whole doctrine" and "common fund" doctrine are completely abrogated under this Plan, and will not affect the Plan's right to 100% Subrogation or Refund for any and all benefits paid. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interfere with or compromise in any way the Plan's equitable subrogation lien. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Member may have to recover payments from any responsible third party or insurer. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Member's Third Party Claims and/or the Member's claims under any other policy of insurance or other coverage.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Member.

When a right of Recovery exists, the Member will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Member will do nothing to prejudice the right of the Plan to Subrogate.

Failure by the Member(s) and/or his attorney to comply with any of these requirements may, at the Plan's discretion, result in forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Member(s) satisfies his or her obligation.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Member if a Member refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Member is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Member or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Member" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Member by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Member's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Subscribers and their families covered under California's Valued Trust Medical Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Members and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

The Plan is administered by CVT, 520 East Herndon Avenue, Fresno, California, 93720, 559-437-2960 or 800-288-9870. COBRA continuation coverage for the Plan is administered by CVT, 520 East Herndon Avenue, Fresno, California 93720, 800-288-9870. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to Plan Members who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Members and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active subscribers who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Subscriber, the Spouse of a covered Subscriber, or a Child of a covered Subscriber. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Subscriber during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(3) A covered Subscriber who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the employer, as is the Spouse, surviving Spouse or Child of such a covered Subscriber if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Child was a beneficiary under the Plan.

The term "covered Subscriber" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Subscriber is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

A Domestic Partner and his or her children are not Qualified Beneficiaries and do not have an independent right to elect COBRA continuation coverage. However, if a Subscriber who is a Qualified Beneficiary elects COBRA continuation coverage for himself, he may also elect to continue coverage for his Domestic Partner and Children or Qualified Dependents if they are covered under the Plan on the day before the Qualifying Event.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Subscriber during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan member would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Subscriber.

(2) The termination (other than by reason of the Subscriber's gross misconduct), or reduction of hours, of a covered Subscriber's employment.

(3) The divorce or legal separation of a covered Subscriber from the Subscriber's Spouse. If the Subscriber reduces or eliminates the Subscriber's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Subscriber's enrollment in any part of the Medicare program.

(5) A Child's ceasing to satisfy the Plan's requirements for a child (for example, attainment of the maximum age for dependency under the Plan).

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an employer from whose employment a covered Subscriber retired at any time.

If the Qualifying Event causes the covered Subscriber, or the covered Spouse or a Child of the covered Subscriber, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Subscriber, or the Spouse, or a Child of the covered Subscriber, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if a Subscriber does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Subscriber and family members will be entitled to COBRA continuation coverage even if they failed to pay the subscriber portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under

federal law. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.

Is a covered Subscriber or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Subscriber,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) entitlement of the subscriber to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Subscriber and Spouse or a Child's losing eligibility for coverage as a Child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any Spouse or Child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the COBRA Administrator.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

Mail or hand-deliver to:
California's Valued Trust
520 East Herndon Avenue
Fresno, California 93720

Fax to:
559-437-2965

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the plan or plans** under which you lost or are losing coverage,
- the **name and address of the Subscriber** covered under the plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement.**

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Subscribers may elect COBRA continuation coverage for their Spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your Spouse or Children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the employer ceases to provide any group health plan (including a successor plan) to any subscriber.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(6) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Subscriber’s enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Subscriber becomes enrolled in the Medicare program. This extension does not apply to the covered Subscriber; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Subscriber’s termination of employment or reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Subscriber during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Subscriber) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Subscriber's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered subscribers or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the employer and the entity that provides Plan benefits on the employer's behalf, the employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable

period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

CONTINUATION FOR DISABLED DISTRICT EMPLOYEES

If you become disabled as a result of a violent act directed at you while performing duties in the scope of employment as a district employee, your benefits under this plan may be continued.

Eligibility. You must be a member of the State Teachers' Retirement System or a classified school employee member of the Public Employees' Retirement System and be covered under this plan at the time of the violent act causing the disability.

Cost of Coverage. CVT requires that you pay the entire cost of your continuation coverage. This cost (called the "required monthly contribution") must be remitted to CVT each month during your continuation. CVT must receive payment of the required monthly contribution each month from you in order to maintain the coverage in force. CVT will accept the required monthly contribution only from you or your authorized representative.

When Continuation Coverage Begins. When continuation coverage is elected and the required monthly contribution is paid, coverage is reinstated back to the date you became disabled, so that no break in coverage occurs, but only if you elect to continue coverage within 60 days after your coverage terminates. For family members acquired and properly enrolled during the continuation, coverage begins according to the enrollment provisions of this plan.

When Continuation Coverage Ends. This continuation coverage ends for the subscriber on the earliest of:

(1) The date this plan terminates;

(2) The end of the period for which the required monthly contribution was last paid; or

(3) The date the maximum benefits of this plan are paid.

For family members, this continuation coverage ends according to the provisions of the section Termination of Coverage.

CONTINUATION DURING LABOR DISPUTE

If you are an enrolled member who stops working because of a labor dispute, the participating employer may arrange for coverage to continue as follows:

(1) The required monthly contribution charges are determined by CVT as stated in the participation agreement. These required monthly contribution charges becomes effective on the monthly contribution due date after work stops.

(2) The participating employer is responsible for the required monthly contributions from those enrolled subscribers who choose to continue coverage. The participating employer is also responsible for submitting that required monthly contribution to CVT on or before each due date.

(3) CVT must receive the required monthly contribution for at least 75% of the enrolled subscribers who stop work because of the labor dispute. If at any time participation falls below 75%, coverage may be canceled. This cancellation is effective ten days after written notice to the participating employer. The participating employer is responsible for notifying the enrolled subscribers.

EXTENSION OF BENEFITS

If you are totally disabled and under the treatment of a physician on the day your coverage under this plan ends, your benefits may be continued for treatment of the totally disabling condition. This extension of benefits is not available if you become covered under another group health plan that provides coverage without limitation for your disabling condition. Extension of benefits is subject to the following conditions:

(1) If you are confined as an inpatient in a hospital or skilled nursing facility, you are considered totally disabled as long as the inpatient stay is medically necessary, and no written certification of the total disability is required. If you are discharged from the hospital or skilled nursing facility, you may continue your total disability benefits by submitting written certification by your physician of the total disability within 90 days of the date of your discharge. Thereafter, the claims administrator must receive proof of your continuing total disability at least once every 90 days while benefits are extended.

(2) If you are not confined as an inpatient but wish to apply for total disability benefits, you must do so by submitting written certification by your physician of the total disability. The claims administrator must receive this certification within 90 days of the date coverage ends under this plan. At least once every 90 days while benefits are extended, the claims administrator must receive proof that your total disability is continuing.

(3) Your extension of benefits will end when any one of the following circumstances occurs:

(a) You are no longer totally disabled.

(b) The maximum benefits available to you under this plan are paid.

(c) You become covered under another group health plan that provides benefits without limitation for your disabling condition.

(d) A period of up to 12 months has passed since your extension began.

GENERAL PROVISIONS

FORCE MAJEURE. Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the employer's workforce" shall refer to all employees and other persons under the control of the employer.

(a) **Updates Required.** The employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) Certification of employer. The employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of California's Valued Trust's workforce are designated as authorized to receive Protected Health Information from California's Valued Trust Medical Plan ("the Plan") in order to perform their duties with respect to the Plan: Privacy Officer, and other individuals trained and authorized by the Privacy Officer to receive Protected Health Information.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the employer agrees to the following:

(1) The employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of employers described above.

FOR YOUR INFORMATION

STATEMENT OF RIGHTS UNDER THE NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However the plan or issuer may pay for a shorter stay if the attending *physician* (e.g., your *physician*, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a *physician* or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, please call us at the customer service telephone number listed on your ID card.

STATEMENT OF RIGHTS UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

This *plan*, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). If you have any questions about this coverage, please call us at the customer service telephone number listed on your ID card.

GET HELP IN YOUR LANGUAGE

English

You have the right to get this information and help in your language for free. Call the Customer Services number on your ID card for help (800-442-7247) or (TTY/TDD: 711)

Spanish

Tiene el derecho de obtener esta información y ayuda en su idioma en forma gratuita. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación para obtener ayuda (TTY/TDD: 711)

Arabic

مات الأعضاء الموجوديحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجانًا. اتصل برقم خد
علـى بطاقـة التعـريف الخاصـة بـك
للمساعدة) TTY/TDD.)711 :

Armenian

Դուք իրավունք ունեք Ձեր լեզվով անվճար ստանալ այս տեղեկատվությունը և ցանկացած օգնություն: Օգնություն ստանալու համար զանգահարեք Անդամների սպասարկման կենտրոն՝ Ձեր ID քարտի վրա նշված համարով: (TTY/TDD: 711)

Chinese

您有權使用您的語言免費獲得該資訊和協助。請撥打您的 ID 卡上的成員服務號碼尋求協助。(TTY/TDD: 711)

Farsi

ن اطلاعات و کمکها را به صورتی‌د که این حق را داری‌شما ا
افت کمک به‌ی‌در ی‌د. برای‌افت کن‌ی‌گان به زبان خودتان دری‌را
تان درج ی‌ی‌کارت شناسا ی‌شماره مرکز خدمات اعضاء که بر رو
دی‌ری‌شده است، تماس بگ. (TTY/TDD: 711)

Hindi

आपके पास यह जानकारी और मदद अपनी भाषा में मुफ़्त में प्राप्त करने का अधिकार है। मदद के लिए अपने ID कार्ड पर सदस्य सेवाएँ नंबर पर कॉि करें।(TTY/TDD: 711)

Hmong
Koj muaj cai tau txais qhov lus qhia no thiab kev pab hais ua koj hom lus yam tsis xam tus nqi. Hu rau tus nab npawb xov tooj lis Cov Kev Pab Cuam Rau Tswv Cuab nyob rau ntawm koj daim ID txhawm rau thov kev pab. (TTY/TDD: 711)

Japanese
この情報と支援を希望する言語で無料で受けることができます。支援を受けるには、IDカードに記載されているメンバーサービス番号に電話してください。(TTY/TDD: 711)

Khmer
អ្នកមានសិទ្ធិកនុងការទ្ទួលព័ត៌មាននេះ និងទ្ទួលជំនួយជាភាសារបស់អ្នកនោយឥតគិតថ្លៃ។ សូមនៅទូរស័ពទនៅនលខនសវាសមាជិកដែលមាននលើប័ណ្ណ ID របស់អ្នកនែើមបីទ្ទួលជំនួយ។(TTY/TDD: 711)

Korean
귀하에게는 무료로 이 정보를 얻고 귀하의 언어로 도움을 받을 권리가 있습니다. 도움을 얻으려면 귀하의 ID 카드에 있는 회원 서비스 번호로 전화하십시오. (TTY/TDD: 711)

Punjabi
ਤੁਹਾਨ ੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵ ਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵ ਿੱਚ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਵਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ ਉੱਤੇ ਮੈਂਬਰ ਸਰਵ ਵਸਜ਼ ਨੂੰਬਰ ਤੇ ਕਾਲ ਕਰੋ।(TTY/TDD: 711)

Russian
Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. (TTY/TDD: 711)

Tagalog
May karapatan kayong makuha ang impormasyon at tulong na ito sa ginagamit ninyong wika nang walang bayad. Tumawag sa numero ng Member Services na nasa inyong ID card para sa tulong. (TTY/TDD: 711)

Thai
ท่านมีสิทธิขอรับบริการสอบถามข้อมูลและความช่วยเหลือในภาษาของท่านฟรี
โทรไปที่หมายเลขฝ่ายบริการสมาชิกบนบัตรประจาตัวของท่านเพื่อขอความช่วยเหลือ(TTY/TDD: 711)

Vietnamese
Qu· vị c൬ quyền nhận miễn ph ̉ th൪ng tin nւy vւ sự trợ gi৸p bằng ng൪n ngữ của qu· vị. Hւy gọi cho số Dịch Vụ Thւnh Vi ̃n tr ̃n thẻ ID của qu· vị để được giúp đỡ. (TTY/TDD: 711)

It's important we treat you fairly

That's why we follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and information written in other languages. Interested in these services? Call the Customer Services number on your ID card for help (TTY/TDD: 711). If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our claims administrator in writing to HealthComp Administrators, P. O. Box 45018, Fresno, CA 93718. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TDD: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You can also file a complaint with CVT in writing to Kymberly Gilpin, 520 E Herndon Ave., Fresno, CA 93720.

BY THIS AGREEMENT, California's Valued Trust Medical Plan is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for California's Valued Trust on or as of the day and year first below written.

Booklet effective date: October 1, 2018

By _____
California's Valued Trust

Date _____

Witness_____

Date _____

ACCEPTANCE OF RESPONSIBILITY & CONFIRMATION OF ACCURACY

Pursuant to the terms of your agreement with HealthComp Administrators, Inc. ("HealthComp") we have assisted in the preparation of the enclosed California's Valued Trust Medical Plan. Our assistance has been based upon our understanding of what you, the Plan Sponsor, wish to have incorporated into this document. While we have undertaken to prepare this document to the best of our abilities, responsibility for the accuracy of this document remains that of the Plan Sponsor.

It is imperative that you immediately review this document in detail. You may wish to have legal counsel review this document to ensure that it reflects your plan's objectives in terms of the types and amounts of coverage afforded, exclusions, rights, and other substantive material provisions, and that it meets with all applicable regulatory requirements.

By signing below, you acknowledge your acceptance of responsibility for the contents and accuracy of this document. Please sign and return this form. If you have any questions regarding this document, please immediately contact our office.

We, the Plan Sponsor, recognize that we have full responsibility for the contents of the California's Valued Trust Medical Plan effective October 1, 2018 and that while HealthComp, its employees, agents, and/or sub-contractors may have assisted in the preparation of this document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our employee welfare plan.

Dated: _____

By: _____
Authorized Representative of
California's Valued Trust Medical Plan

Print Name: _____

Title:_____