October 1, 2011

PLAN 9 ($1,000/80%)

Benefit Booklet
Dear Plan Member:

This Benefit Booklet provides a complete explanation of your benefits, limitations and other plan provisions which apply to you.

Subscribers and covered family members (“members”) are referred to in this booklet as “you” and “your”.

All italicized words have specific definitions. These definitions can be found in the DEFINITIONS section of this booklet.

Please read this Benefit Booklet carefully so that you understand all the benefits your plan offers. Keep this Benefit Booklet handy in case you have any questions about your coverage.

Important: This is not an insured benefit plan. The benefits described in this Benefit Booklet or any rider or amendments hereto are funded by the plan administrator who is responsible for their payment. HealthComp Administrators provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.
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TYPES OF PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED. THE MEANINGS OF WORDS AND PHRASES IN ITALICS ARE DESCRIBED IN THE SECTION OF THIS BENEFIT BOOKLET ENTITLED DEFINITIONS.

Participating Providers. The claims administrator has established a network of various types of “Participating Providers”. These providers are called “participating” because they have agreed to participate in the claims administrator’s preferred provider organization program (PPO), which is called the Prudent Buyer Plan. Participating providers have agreed to a rate they will accept as reimbursement for covered services. The amount of benefits payable under this plan will be different for non-participating providers than for participating providers. See the definition of "Participating Providers" in the DEFINITIONS section for a complete list of the types of providers which may be participating providers.

CVT will provide you with a directory of participating providers upon request. The directory lists all participating providers in your area, including health care facilities such as hospitals and skilled nursing facilities, physicians, laboratories, and diagnostic x-ray and imaging providers. You may call the customer service number listed on your ID card and ask customer service to send you a directory. You may also search for a participating provider using the “Provider Finder” function on the claims administrator’s website at www.blueshieldca.com. The listings include the credentials of the claims administrator’s participating providers such as specialty designations and board certification.

Non-Participating Providers. Non-participating providers are providers which have not agreed to participate in the Prudent Buyer Plan network. They have not agreed to the reimbursement rates and other provisions of a Prudent Buyer Plan contract.

Contracting and Non-Contracting Hospitals. Another type of provider is the “contracting hospital.” This is different from a hospital which is a participating provider. The claims administrator has contracted with most hospitals in California to obtain certain advantages for patients covered by the plan. While only some hospitals are participating providers, all eligible California hospitals are invited to be contracting hospitals and most--over 90%--accept. For those which do not (called non-contracting hospitals), there is a significant benefit penalty in your plan.

Physicians. "Physician" means more than an M.D. Certain other practitioners are included in this term as it is used throughout the plan. This doesn't mean they can provide every service that a medical doctor could; it just means that the plan covers expense you incur from them when they're practicing within their specialty the same as it would if the care were provided by a medical doctor. As with the other terms, be sure to read the definition of "Physician" to determine which providers' services are covered. Only providers listed in the definition are covered as physicians. Please note also that certain providers’ services are covered only upon referral of an M.D. (medical doctor) or D.O. (doctor of osteopathy). Providers for whom referral is required are indicated in the definition of “physician” by an asterisk (*).

Other Health Care Providers. "Other Health Care Providers" are neither physicians nor hospitals. They are mostly free-standing facilities, or service organizations, such as ambulance companies. See the definition of "Other Health Care Providers" in the DEFINITIONS section for a complete list of those providers. Other health care providers are not part of the Prudent Buyer Plan provider network.

Reproductive Health Care Services. Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective physician or clinic, or call us at the customer service telephone number listed on your ID card to ensure that you can obtain the health care services that you need.

Centers of Medical Excellence. The claims administrator is providing access to the following separate Centers of Medical Excellence (CME) networks. The facilities included in each of these CME networks are selected to provide the following specified medical services:

- Transplant Facilities. Transplant facilities have been organized to provide services for the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Subject to any applicable co-payments or deductibles, CME have agreed to a rate they will accept as payment in full for covered services. These procedures are covered only when performed at a CME.
• **Bariatric Facilities.** Hospital facilities have been organized to provide services for bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss programs. These procedures are covered only when performed at a **CME.**

**Care Outside the United States—BlueCard Worldwide**

Prior to travel outside the United States, call the customer service telephone number listed on your ID card to find out if your plan has BlueCard Worldwide benefits. Your coverage outside the United States is limited and we recommend:

- Before you leave home, call the customer service number on your ID card for coverage details.
- Always carry your current ID card.
- In an emergency, seek medical treatment immediately.
- **The BlueCard Worldwide Service Center is available 24 hours a day, seven days a week toll-free at (800) 810-BLUE (2583) or by calling collect at (804) 673-1177.** An assistance coordinator, along with a medical professional, will arrange a physician appointment or hospitalization, if needed.

**Payment Information**

- **Participating BlueCard Worldwide hospitals.** In most cases, you should not have to pay upfront for inpatient care at participating BlueCard Worldwide hospitals except for the out-of-pocket costs you normally pay (non-covered services, deductible, copays, and coinsurance). The hospital should submit your claim on your behalf.

- **Doctors and/or non-participating hospitals.** You will have to pay upfront for outpatient services, care received from a physician, and inpatient care from a hospital that is not a participating BlueCard Worldwide hospital. Then you can complete a BlueCard Worldwide claim form and send it with the original bill(s) to the BlueCard Worldwide Service Center (the address is on the form).

**Claim Filing**

- **Participating BlueCard Worldwide hospitals will file your claim on your behalf.** You will have to pay the hospital for the out-of-pocket costs you normally pay.

- **You must file the claim** for outpatient and physician care, or inpatient hospital care not provided by a participating BlueCard Worldwide hospital. You will need to pay the health care provider and subsequently send an international claim form with the original bills to the claims administrator.

**Claim Forms**

- International claim forms are available from the claims administrator, from the BlueCard Worldwide Service Center, or online at:


  The address for submitting claims is on the form.

**Member’s Rights and Responsibilities.** The claims administrator is committed to maintaining a mutually respectful relationship with our members, and, at the same time, we expect our members to assume certain responsibilities. Your general Member Rights and Responsibilities are described below. You may refer to the claims administrator’s privacy practices related to HIPAA described in their “Notices of Privacy Practices” found on their website at [www.blueshieldca.com](http://www.blueshieldca.com) or by calling the customer services telephone number on your ID card.

**Member Rights.** You have the right to:

- Receive clear and accurate information about HealthComp Administrators, your rights and responsibilities, your health plan benefits and services, and how and when you can use them;

- Receive the names and contact information of participating doctors, hospitals, pharmacies, and other health care providers available to you;

- Be treated with courtesy, respect, and dignity;

- Your privacy and to have your personal health information be kept secure and confidential;

- Be involved with doctors and other health care professionals in decision-making regarding your health care;
• Talk over your health care needs with the health care professionals caring for you, including a clear and open discussion about appropriate or medically necessary care available for your condition, without concern for the cost or whether it is covered by your health plan benefits;

• Make a written or spoken suggestion, expression of dissatisfaction, or complaint about the care or service you received from a participating health professional or provider, or about the service you received from your health plan, and you may appeal any decision made relating to you or your health plan benefits and/or health plan services; and

• Write to HealthComp Administrators with ideas or questions about this statement on member rights and responsibilities. Your letter can be sent to HealthComp Administrators, PO Box 45018, Fresno, California 93718.

**Member Responsibilities.** To assist participating health care professionals and providers in meeting these responsibilities to you, it is your duty to:

• Give patient identification and medical information, to the best of your ability, that your health care professionals and providers need in order to care for you and for your health plan to provide services to you;

• To the best of your ability, work with your doctor to be aware of and understand your health issues so you can participate in developing mutually agreed-upon treatment goals;

• Follow the prescribed medical treatment plan and health care instructions that you have agreed upon with your doctor or other health care professional and tell him or her if you decide to take part in any health activity or program;

• Treat all health care professionals with courtesy and respect;

• Keep scheduled appointments for care and give adequate advance notice of delay or cancellation; and

• Read and understand to the best of your ability all materials concerning your health benefits or ask for clarification as needed.
SUMMARY OF MEDICAL BENEFITS

THE BENEFITS OF THIS PLAN ARE PROVIDED ONLY FOR SERVICES WHICH ARE CONSIDERED TO BE MEDICALLY NECESSARY. THE FACT THAT A PHYSICIAN PRESCRIBES OR ORDERS THE SERVICE DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY OR COVERED UNDER THIS PLAN. 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.

THIS PLAN CONTAINS MANY IMPORTANT TERMS (SUCH AS "MEDICALLY NECESSARY" AND "MAXIMUM ALLOWED AMOUNT") THAT ARE DEFINED IN THE DEFINITIONS SECTION. WHEN READING THROUGH THIS BENEFIT BOOKLET, CONSULT THE DEFINITIONS SECTION TO BE SURE THAT YOU UNDERSTAND THE MEANINGS OF THESE ITALICIZED WORDS.

For your convenience, this summary provides a brief outline of your benefits. You need to refer to the entire benefit booklet for more complete information about the benefits, conditions, limitations and exclusions of your plan.

Second Opinions. If you have a question about your condition or about a plan of treatment which your physician has recommended, you may receive a second medical opinion from another physician. This second opinion visit will be provided according to the benefits, limitations, and exclusions of this plan. If you wish to receive a second medical opinion, remember that greater benefits are provided when you choose a participating provider. You may also ask your physician to refer you to a participating provider to receive a second opinion.

Triage or Screening Services. If you have questions about a particular health condition or if you need someone to help you determine whether or not care is needed, triage or screening services are available to you by telephone. Triage or screening services are the evaluation of your health by a physician or a nurse who is trained to screen for the purpose of determining the urgency of your need for care. Please contact the 24/7 NurseLine at 1-800-977-0027, 24 hours a day, 7 days a week.

Care After Hours. If you need care after your physician's normal office hours and you do not have an emergency medical condition or need urgent care, please call your physician's office for instructions.

All benefits are subject to coordination with benefits under certain other plans. The benefits of this plan may also be subject to the REIMBURSEMENT FOR ACTS OF THIRD PARTIES section.

Important Note About Maximum Allowed Amount And Your Co-Insurance: The maximum allowed amount for non-participating providers is significantly lower than what providers customarily charge. (See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS.) You must pay all of this excess amount in addition to your Co-Insurance.
MEDICAL BENEFITS

Calendar Year Deductibles

- Individual Deductible ................................................................. $1,000
- Family Deductible ........................................................................ $3,000

Exceptions:
- The Calendar Year Deductible will not apply to covered charges incurred for Hospice Care.
- The Calendar Year Deductible will not apply to transplant travel expenses authorized by the claims administrator. See UTILIZATION REVIEW PROGRAM for information on how to obtain prior authorization.
- The Calendar Year Deductible will not apply to services under the Preventive Care benefit; and (b) the Routine Physical Exam benefit.
- The Calendar Year Deductible will not apply to services under the Adult Preventive Services benefit.
- The Calendar Year Deductible will not apply to benefits for screening blood levels in children at risk for lead poisoning.

Co-Payments and Co-Insurance

- Emergency Room Co-Payment ......................................................... $75
  - Exception: The Emergency Room Co-Payment will not apply if you are admitted as a hospital inpatient immediately following emergency room treatment.

- Co-Insurance. After you have met your Calendar Year Deductible and any applicable dollar Co-Payment, you will be responsible for 20% of the maximum allowed amount you incur.

Note: In addition to your Co-Payment and Co-Insurance, you will be required to pay any amount in excess of the maximum allowed amount for the services of an other health care provider or a non-participating provider.

Exceptions:
- No Co-Insurance will be required for covered charges incurred for Hospice Care.
- No Co-Insurance will be required for the transplant travel expenses authorized by the claims administrator. See UTILIZATION REVIEW PROGRAM.
- No Co-Insurance will be required to covered charges incurred for the following:
  a. Preventive Care
  b. Routine Physical Exam
  c. Adult Preventive Services
  d. Screening Blood Levels

Out-of-Pocket Amount. After a member has made total out-of-pocket payments for covered charges he or she incurs during a calendar year equal to $3,000, that member's Co-Insurance for the remainder of the year will be:

- Participating providers .................................................................................. No charge
- Non-participating providers or other health care providers .......................... Any amount exceeding the maximum allowed amount

Exceptions:
- Any Emergency Room Co-Payment will not be applied toward the satisfaction of your Out-of-Pocket Amount. In addition, you will be required to continue to pay the Emergency Room Co-Payment even after you have reached that amount.
– Expense which is applied toward the Calendar Year Deductibles or a dollar co-payment, which is incurred for non-covered services or supplies, or which is in excess of the amount of the maximum allowed amount will not be applied toward your Out-of-Pocket Amount and is always your responsibility to pay.

MEDICAL BENEFIT MAXIMUMS

CVT will pay for the following services and supplies, up to the maximum amounts, or for the maximum number of days or visits shown below:

**Skilled Nursing Facility**
- Covered skilled nursing facility care .................................................................................................................. **100 days** per calendar year

**Home Health Care**
- Covered home health services .......................................................................................................................... **100 visits** per calendar year

**Home Infusion Therapy**
- All covered services and supplies received during any one day ................................................................. **$600***
  *Non-participating providers only

**Outpatient Hemodialysis**
- For all covered services and supplies ............................................................................................................ **$350*** per visit
  *Non-participating providers only

**Transplant Travel Expense**
- For all authorized travel expense in connection with a specified transplant performed at a designated CME ....................................................................................................................... **$10,000** per transplant

**Unrelated Donor Searches**
- For all charges for unrelated donor searches for covered bone marrow/stem cell transplants ................. **$30,000** per transplant

**Physical Therapy and Physical Medicine**
- For covered outpatient services when provided by a non-participating provider (this includes many types of care which are customarily provided by physical therapists and osteopaths) ............................................. **13 visits** per calendar year

**Chiropractic Care**
- For covered outpatient services when provided by a non-participating provider .............................................. **13 visits** per calendar year

**Acupuncture**
- For all covered services ................................................................................................................................. **12 visits** per calendar year

**Scalp Prostheses**
- For all covered services ..................................................................................................................................... **$300** per calendar year
Bariatric Travel Expense

- For the *member* (limited to three (3) trips – one pre-surgical visit, the initial surgery and one follow-up visit)
  - For transportation to the *CME* .............................................................. up to **$130** per trip

- For the companion (limited to two (2) trips – the initial surgery and one follow-up visit)
  - For transportation to the *CME* .............................................................. up to **$130** per trip

- For the *member* and one companion (for the pre-surgical visit and the follow-up visit)
  - Hotel accommodations .............................................................. up to **$100** per day, for up to 2 days per trip, limited to one room, double occupancy

- For one companion (for the duration of the *member’s* initial surgery stay)
  - Hotel accommodations .............................................................. up to **$100** per day, for up to 4 days, limited to one room, double occupancy
  - For other reasonable expenses (excluding, tobacco, alcohol, drug and meal expenses) .............................................................. up to **$25** per day, for up to 4 days per trip
YOUR MEDICAL BENEFITS

MAXIMUM ALLOWED AMOUNT

General

This section describes the term “maximum allowed amount” as used in this Benefit Booklet, and what the term means to you when obtaining covered services under this plan. The maximum allowed amount is the total reimbursement payable under your plan for covered services you receive from participating and non-participating providers. It is the plan’s payment towards the services billed by your provider combined with any Deductible, Co-Payment, or Co-Insurance owed by you. In some cases, you may be required to pay the entire maximum allowed amount. For instance, if you have not met your Deductible under this plan, then you could be responsible for paying the entire maximum allowed amount for covered services. In addition, if these services are received from a non-participating provider, you may be billed by the provider for the difference between their charges and the maximum allowed amount. In many situations, this difference could be significant.

Provided below are two examples, which illustrate how the maximum allowed amount works. These examples are for illustration purposes only.

Example: The plan has a member Co-Payment of 30% for participating provider services after the Deductible has been met.

- The member receives services from a participating surgeon. The charge is $2,000. The maximum allowed amount under the plan for the surgery is $1,000. The member’s Co-Payment responsibility when a participating surgeon is used is 30% of $1,000, or $300. This is what the member pays. The plan pays 70% of $1,000, or $700. The participating surgeon accepts the total of $1,000 as reimbursement for the surgery regardless of the charges.

Example: The plan has a member Co-Payment of 50% for non-participating provider services after the Deductible has been met.

- The member receives services from a non-participating surgeon. The charge is $2,000. The maximum allowed amount under the plan for the surgery is $1,000. The member’s Co-Payment responsibility when a non-participating surgeon is used is 50% of $1,000, or $500. The plan pays the remaining 50% of $1,000, or $500. In addition, the non-participating surgeon could bill the member the difference between $2,000 and $1,000. So the member’s total out-of-pocket charge would be $500 plus an additional $1,000, for a total of $1,500.

When you receive covered services, the claims administrator will, to the extent applicable, apply claim processing rules to the claim submitted. The claims administrator uses these rules to evaluate the claim information and determine the accuracy and appropriateness of the procedure and diagnosis codes included in the submitted claim. Applying these rules may affect the maximum allowed amount if the claims administrator determines that the procedure and/or diagnosis codes used were inconsistent with procedure coding rules and/or reimbursement policies. For example, if your provider submits a claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed, the maximum allowed amount will be based on the single procedure code.

Provider Network Status

The maximum allowed amount may vary depending upon whether the provider is a participating provider, a non-participating provider or other health care provider.

Participating Providers and Centers of Medical Excellence (CME). For covered services performed by a participating provider or CME the maximum allowed amount for this plan will be the rate the participating provider or CME has agreed with the claims administrator to accept as reimbursement for the covered services. Because participating providers have agreed to accept the maximum allowed amount as payment in full for those covered services, they should not send you a bill or collect for amounts above the maximum allowed amount. However, you may receive a bill or be asked to pay all or a portion of the maximum allowed amount to the extent you have not met your Deductible or have a Co-Payment. Please call the customer service telephone number on your ID card for help in finding a participating provider or visit www.blueshieldca.com.

If you go to a hospital which is a participating provider, you should not assume all providers in that hospital are also participating providers. This may include, but is not limited to, anesthesiologists, pathologists, radiologists and emergency room physicians. To receive the greater benefits afforded when covered services are provided by a participating provider, you should request that all your provider services be performed by participating providers whenever you enter a hospital.
If you are planning to have outpatient surgery, you should first find out if the facility where the surgery is to be performed is an ambulatory surgical center. An ambulatory surgical center is licensed as a separate facility even though it may be located on the same grounds as a hospital (although this is not always the case). If the center is licensed separately, you should find out if the facility is a participating provider before undergoing the surgery.

Non-Participating Providers.* The maximum allowed amount for services provided by a non-participating provider will always be the lesser of the billed charge or the scheduled amount. See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS, and the definition of "Scheduled Amount" in the DEFINITIONS section. You will be responsible for any billed charge which exceeds the scheduled amount for services provided by a non-participating provider.

Other Health Care Providers.* For covered services you receive from an other health care provider the maximum allowed amount will be based on the applicable non-participating provider rate or fee schedule for this plan, an amount negotiated by the claims administrator or a third party vendor which has been agreed to by the non-participating provider, an amount derived from the total charges billed by the non-participating provider, or an amount based on information provided by a third party vendor.

Unlike participating providers, non-participating providers and other health care providers may send you a bill and collect for the amount of the non-participating provider's or other health care provider's charge that exceeds the maximum allowed amount under this plan. You may be responsible for paying the difference between the maximum allowed amount and the amount the non-participating provider or other health care provider charges. This amount can be significant. Choosing a participating provider will likely result in lower out of pocket costs to you. Please call the customer service number on your ID card for help in finding a participating provider or visit the website at www.blueshieldca.com. Customer service is also available to assist you in determining this plan's maximum allowed amount for a particular covered service from a non-participating provider or other health care provider.

Please see the “Out Of Area Services” provision in the section entitled GENERAL PROVISIONS for additional information.

*Exceptions:

- **Emergency Services Provided by Non-Participating Providers**
  
  For emergency services provided by non-participating providers or at non-contracting hospitals, reimbursement is based on the reasonable and customary value. You will not be responsible for any amounts in excess of the reasonable and customary value for emergency services rendered within California.

- **Cancer Clinical Trials.** The maximum allowed amount for services and supplies provided in connection with Cancer Clinical Trials will be the lesser of the billed charge or the amount that ordinarily applies when services are provided by a participating provider.

- **If Medicare is the primary payor:**
  1. The maximum allowed amount for inpatient hospital stays is the rate participating provider hospitals have agreed with the claims administrator to accept as reimbursement for covered services, or the lesser of the billed charge or the scheduled amount for non-participating provider hospitals.
  2. The maximum allowed amount for all other covered services is limited as follows:

    a. When a participating provider accepts Medicare assignment of benefits, the maximum allowed amount will be Medicare’s approved amount or the rate participating providers have agreed with the claims administrator to accept as reimbursement for covered services, whichever is less.

    b. When a non-participating provider accepts Medicare assignment of benefits, the maximum allowed amount will be Medicare’s approved amount, or the lesser of the billed charge or the scheduled amount, whichever is less.

    c. When a participating provider does not accept Medicare assignment of benefits, the maximum allowed amount will not exceed the rate participating providers have agreed with the claims administrator to accept as reimbursement for covered services.

    d. When a non-participating provider does not accept Medicare assignment of benefits, the maximum allowed amount will not exceed the lesser of the billed charge or the scheduled amount.

**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.
MEMBER COST SHARE

For certain covered services, and depending on your plan design, you may be required to pay all or a part of the maximum allowed amount as your cost share amount (Deductibles or Co-Payments). Your cost share amount and the Out-Of-Pocket Amounts may be different depending on whether you received covered services from a participating provider or non-participating provider. Specifically, you may be required to pay higher cost-sharing amounts or may have limits on your benefits when using non-participating providers. Please see the SUMMARY OF BENEFITS section for your cost share responsibilities and limitations, or call the customer service telephone number on your ID card to learn how this plan’s benefits or cost share amount may vary by the type of provider you use.

The claims administrator will not provide any reimbursement for non-covered services. You may be responsible for the total amount billed by your provider for non-covered services, regardless of whether such services are performed by a participating provider or non-participating provider. Non-covered services include services specifically excluded from coverage by the terms of your plan and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, Medical Benefit Maximums or day/visit limits.

In some instances you may only be asked to pay the lower participating provider cost share percentage when you use a non-participating provider. For example, if you go to a participating hospital or facility and receive covered services from a non-participating provider such as a radiologist, anesthesiologist or pathologist providing services at the hospital or facility, you will pay the participating provider cost share percentage of the maximum allowed amount for those covered services. However, you also may be liable for the difference between the maximum allowed amount and the non-participating provider’s charge.

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 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.

DEDUCTIBLES, CO-PAYMENTS, CO-INSURANCE, OUT-OF-POCKET AMOUNT AND MEDICAL BENEFIT MAXIMUMS

After subtracting any applicable Deductible and your Co-Payment and/or Co-Insurance, the benefits of this plan will be paid up to the maximum allowed amount, (or the reasonable and customary value for emergency services provided by a non-participating provider), not to exceed the applicable Medical Benefit Maximum. The Deductible amounts, Co-Payments, Co-Insurance, Out-of-Pocket Amount, and Medical Benefit Maximums are set forth in the SUMMARY OF BENEFITS.

CALENDAR YEAR DEDUCTIBLES. Each year, you will be responsible for satisfying the Individual Calendar Year Deductible before the benefits of the plan will be paid. Only the covered charges that make up the maximum allowed amount (or the reasonable and customary value for emergency services provided by a non-participating provider) will apply toward satisfaction of the deductible.

If enrolled members of a family pay deductible expense in a year equal to the Family Deductible, but not more than the Individual Deductible for any one member, the Calendar Year Deductible for all members in that family will be considered to have been met. Once the Family Deductible is satisfied, no further Calendar Year Deductible expense will be required for any enrolled member of that family.

Any covered charges incurred from October 1 through December 31 and applied to your Calendar Year Deductible for that year will also be applied toward your Calendar Year Deductible for the next year.

Prior Plan Calendar Year Deductibles. If you were covered under the prior plan, any amount applied, during the same calendar year, toward your calendar year deductible under the prior plan, will be applied toward your Calendar Year Deductible under this plan, provided that such charges would be covered under this plan.
CO-PAYMENTS, CO-INSURANCE AND OUT-OF-POCKET AMOUNT

After you have satisfied any applicable deductible, your Co-Payment and/or Co-Insurance will be subtracted from the maximum allowed amount remaining (or from the amount of reasonable and customary value remaining for emergency services provided by a non-participating provider).

Emergency Room Co-Payment. Each time you visit an emergency room for treatment, you will be responsible for paying the Emergency Room Co-Payment. However, this Co-Payment will not apply if you are admitted as a hospital inpatient from the emergency room immediately following emergency room treatment.

Co-Insurance. The claims administrator will apply the applicable percentage to the maximum allowed amount remaining after any deductible or dollar co-payment has been subtracted. This will determine the dollar amount of your Co-Insurance.

Out-of-Pocket Amount. If you pay Co-Insurance equal to the Out-of-Pocket Amount per member during a calendar year, you will no longer be required to pay Co-Insurance for any additional covered services or supplies during the remainder of that year.

Charges Which Do Not Apply Toward the Out-of-Pocket Amount. The following charges will not be applied toward satisfaction of an Out-of-Pocket Amount:

- Charges for services or supplies not covered under this plan;
- Charges which exceed the maximum allowed amount; and
- Any expense applied to a deductible or dollar co-payment.

MEDICAL BENEFIT MAXIMUMS

CVT does not make benefit payments for any member in excess of any of the Medical Benefit Maximums.

Prior Plan Maximum Benefits. If you were covered under the prior plan, any benefits paid to you under the prior plan will reduce any maximum amounts you are eligible for under this plan which apply to the same benefit.

CONDITIONS OF COVERAGE

The following conditions of coverage must be met for expense incurred for services or supplies to be covered under this plan.

1. You must incur this expense while you are covered under this plan. Expense is incurred on the date you receive the service or supply for which the charge is made.

2. The expense must be for a medical service or supply furnished to you as a result of illness or injury or pregnancy, unless a specific exception is made.

3. The expense must be for a medical service or supply included in MEDICAL CARE THAT IS COVERED. Additional limits on covered charges are included under specific benefits and in the SUMMARY OF BENEFITS.

4. The expense must not be for a medical service or supply listed in MEDICAL CARE THAT IS NOT COVERED. If the service or supply is partially excluded, then only that portion which is not excluded will be covered under this plan.

5. The expense must not exceed any of the maximum benefits or limitations of this plan.

6. Any services received must be those which are regularly provided and billed by the provider. In addition, those services must be consistent with the illness, injury, degree of disability and your medical needs. Benefits are provided only for the number of days required to treat your illness or injury.

7. All services and supplies must be ordered by a physician.
SCHEDULES FOR NON-PARTICIPATING PROVIDERS

This section explains how the claims administrator determines the scheduled amount (the maximum allowed amount for non-participating providers) and is, subject to the maximums, conditions, exclusions and limitations of this plan.

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.

**Important Note:** The claims administrator has the right to adjust, without notice, all schedules found in this section in order to maintain the relationship between these scheduled amounts for non-participating providers and the fee schedule negotiated by the claims administrator with participating providers. Benefits are determined based on the schedule in effect at the time the claim is paid.

CHARGES BY A PHYSICIAN WHO IS A NON-PARTICIPATING PROVIDER

1. Charges for services of a physician who is a non-participating provider are determined by multiplying the "Unit Value" of the service (listed in the Unit Value Schedule) by the appropriate "Unit Allowance" listed in the Unit Allowance Schedule. The "Unit Allowance" varies according to the service area of the provider.

2. For any procedure not listed in the Unit Value Schedule, CVT provides a benefit on the basis of comparable service.

3. The Unit Value Schedule listed in this benefit booklet is only a partial listing.

For services provided by a physician who is a non-participating provider, the maximum allowed amount will not exceed the amount determined by the following process. First, the claims administrator determines the appropriate "Unit Allowance" for the service by determining in which service area the physician performed the service. Then the "Unit Value" of that service is multiplied by the appropriate "Unit Allowance". The resulting amount is the maximum allowed amount for that service under the plan.

The claims administrator has developed a Unit Value Schedule for covered services. An excerpt of this Schedule is set forth in this section. Notice that for each service listed in the Schedule, there is a "Procedure Code" and a "Unit Value". Physicians use these Procedure Codes to identify their services for billing purposes. These codes are published by the American Medical Association and are widely used throughout the medical profession.

Your physician should be able to identify for you which "Procedure Code(s)" applies to the service(s) to be performed. Remember, the maximum allowed amount may be less than the physician's charge for such services. You are
responsible for paying any amount by which this charge exceeds the maximum allowed amount, in addition to any Co-Payment and/or Co-Insurance required under this plan.

If you want assistance in determining the maximum allowed amount for services provided by a physician who is a non-participating provider, you may telephone the claims administrator at the number shown on your identification card.

Remember, if you obtain your health care services from a participating provider, you will be able to determine the amount of your financial responsibility more simply. Participating providers have agreed to accept the maximum allowed amount as payment in full for covered services. They should not send you a bill or collect for amounts above the maximum allowed amount, leaving you only the amount of your Co-Payment and/or Co-Insurance described in the SUMMARY OF BENEFITS.

### UNIT ALLOWANCE SCHEDULE

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Surgery</th>
<th>Anesthesia</th>
<th>Medicine</th>
<th>Radiology</th>
<th>Pathology</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$110.00</td>
<td>$25.00</td>
<td>$4.80</td>
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<td>$1.05</td>
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<td>25.00</td>
<td>4.80</td>
<td>9.50</td>
<td>1.05</td>
</tr>
<tr>
<td>3</td>
<td>120.00</td>
<td>26.00</td>
<td>5.10</td>
<td>10.50</td>
<td>1.15</td>
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<tr>
<td>4</td>
<td>120.00</td>
<td>26.00</td>
<td>5.10</td>
<td>10.50</td>
<td>1.15</td>
</tr>
<tr>
<td>5</td>
<td>120.00</td>
<td>26.00</td>
<td>5.10</td>
<td>10.50</td>
<td>1.15</td>
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<td>6</td>
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<td>4.80</td>
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<td>5.10</td>
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<td>1.15</td>
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### UNIT VALUE SCHEDULE

(Partial Listing)

<table>
<thead>
<tr>
<th>PROC CODE</th>
<th>SURGICAL PROCEDURE</th>
<th>UNIT VALUE</th>
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</thead>
<tbody>
<tr>
<td>10060</td>
<td>Incision and drainage of abscess</td>
<td>0.58</td>
</tr>
<tr>
<td>11100</td>
<td>Biopsy of skin, including closure</td>
<td>0.43</td>
</tr>
<tr>
<td>11770</td>
<td>Excision of pilonidal cyst or sinus</td>
<td>1.59</td>
</tr>
<tr>
<td>19120</td>
<td>Excision of breast tumor, unilateral</td>
<td>2.80</td>
</tr>
<tr>
<td>19200</td>
<td>Radical mastectomy, including pectoral muscles and axillary nodes</td>
<td>7.25</td>
</tr>
<tr>
<td>21315</td>
<td>Nasal, simple, closed reduction</td>
<td>1.16</td>
</tr>
<tr>
<td>25565</td>
<td>Closed radial and ulnar shafts, manipulative reduction</td>
<td>3.71</td>
</tr>
<tr>
<td>27232</td>
<td>Femur and neck, manipulative reduction, including traction</td>
<td>5.63</td>
</tr>
<tr>
<td>33400</td>
<td>Aortic valvuloplasty, with bypass</td>
<td>14.79</td>
</tr>
<tr>
<td>33420</td>
<td>Valvotomy, mitral valve, closed</td>
<td>11.04</td>
</tr>
<tr>
<td>42650</td>
<td>Dilation, salivary duct</td>
<td>0.42</td>
</tr>
<tr>
<td>42820</td>
<td>Tonsillectomy and adenoidectomy, under 12 years</td>
<td>2.64</td>
</tr>
<tr>
<td>43620</td>
<td>Total gastrectomy</td>
<td>10.25</td>
</tr>
<tr>
<td>44950</td>
<td>Appendectomy</td>
<td>3.96</td>
</tr>
<tr>
<td>47600</td>
<td>Cholecystectomy</td>
<td>5.67</td>
</tr>
</tbody>
</table>
Rectum
- 46200 Fissurectomy ............................................................................................................................ 2.01
- 46250 Hemorrhoidectomy, external, complete .................................................................................. 2.48

Male
- 55801 Prostatectomy, perineal (sub-total) ....................................................................................... 8.16

Female
- 58180 Supracervical (sub-total) hysterectomy with or without tubes or ovaries ........................... 7.15

Maternity
- 59510 Cesarean section, including antepartum and postpartum care ............................................. 11.98

Thyroid
- 60200 Local excision of cyst of thyroid ............................................................................................. 4.54
- 60240 Thyroidectomy, total or complete ............................................................................................ 7.89

Ear
- 69420 Myringotomy .......................................................................................................................... 0.75
- 69501 Transmastoid antrotomy .......................................................................................................... 5.17

SURGERY (two or more surgical procedures). When two or more surgical procedures are performed during the same operative session, the maximum allowed amount for all of the services combined will be calculated by adding:
- The maximum allowed amount for the services with the highest scheduled amount; plus
- A reduced percentage of what the scheduled amount would have been for each of the additional surgical services if these services had been performed alone.

SURGERY (assistant surgeon). The Unit Value for the services of an assistant surgeon will be a reduced percentage of the scheduled amount for the primary surgeon.

ANESTHESIA (anesthesiologist or anesthetist). The total Unit Value for the services of an anesthesiologist or anesthetist is the basic anesthesia value for that procedure and a Unit Value for the actual time spent administering anesthesia.

PROC CODE BASIC ANESTHESIA UNIT VALUE
- 01400 Knee joint .................................................................................................................................. 3.0
- 01462 Lower leg, ankle, or foot ........................................................................................................... 3.0
- 00566 Direct coronary artery bypass grafting without pump oxygenator ........................................ 12.0
- 00740 Upper gastrointestinal endoscopic ......................................................................................... 4.0
- 00940 Vaginal ....................................................................................................................................... 3.0
- 01961 Cesarean delivery ..................................................................................................................... 5.6

MEDICINE UNIT VALUE
- 99205 Office Visit -- initial comprehensive exam ............................................................................... 19.44
- 99212 Office Visit -- problem-focused examination evaluation, and/or treatment .......................... 4.61
- 99231 Hospital Visit -- problem-focused examination, evaluation, and/or treatment, same illness .... 5.27
- 99241 Consultation -- problem-focused examination and/or evaluation ............................................ 10.59
RADIOLOGY UNIT VALUE

Diagnostic
70210 Sinuses and paranasal, limited .......................................................... 2.75
70250 Skull, limited ................................................................................. 3.03
74241 Upper gastrointestinal tract ......................................................... 7.71
74415 Nephrotomography ..................................................................... 8.95

Therapeutic
77261 Therapeutic radiology treatment planning, simple.................... 6.55

Nuclear Medicine
78000 Thyroid uptake ........................................................................... 4.00
79000 Hyperthyroidism, initial evaluation .......................................... 15.88

PATHOLOGY UNIT VALUE
81000 Urinalysis, routine, complete ..................................................... 4.32
87081 Microbiology - culture, bacterial screening ............................. 10.58

CHARGES BY A HOSPITAL WHICH IS A NON-PARTICIPATING PROVIDER

1. The maximum allowed amount for outpatient care provided by a hospital which is a non-participating provider is the amount determined under YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

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

INPATIENT HOSPITAL SCHEDULE

<table>
<thead>
<tr>
<th>Service Area</th>
<th>All Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$540</td>
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<td>2</td>
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<td>9</td>
<td>540</td>
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<tr>
<td>10</td>
<td>580</td>
</tr>
</tbody>
</table>
CHARGES BY AN AMBULATORY SURGICAL CENTER WHICH IS A NON-PARTICIPATING PROVIDER

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

**AMBULATORY SURGICAL CENTER SCHEDULE**

<table>
<thead>
<tr>
<th>Service Area</th>
<th>Each Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$540</td>
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<tr>
<td>2</td>
<td>$540</td>
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<td>9</td>
<td>$540</td>
</tr>
<tr>
<td>10</td>
<td>$580</td>
</tr>
</tbody>
</table>
MEDICAL CARE THAT IS COVERED

Subject to the Medical Benefit Maximums in the SUMMARY OF BENEFITS, the requirements set forth under CONDITIONS OF COVERAGE and the exclusions or limitations listed under MEDICAL CARE THAT IS NOT COVERED, benefits will be provided for the following services and supplies:

Hospital

1. Inpatient services and supplies, provided by a hospital. The maximum allowed amount will not include charges in excess of the hospital's prevailing two-bed room rate unless there is a negotiated per diem rate with the hospital, or unless your physician orders, and the plan authorizes, a private room as medically necessary.

2. Services in special care units.

3. Outpatient services and supplies provided by a hospital, including outpatient surgery.

4. Routine radiology and laboratory exams received within seven days prior to a scheduled surgery. The exams must be provided and billed by the hospital where the surgery is to take place.

The maximum allowed amount includes take home drugs dispensed by the hospital's pharmacy at the time you are discharged from the hospital.

Emergency room care must be for the first treatment of a medical emergency and emergency room care for an accidental injury must be received within 72 hours of the injury date.

Hospital services are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

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

Ambulatory surgical center services are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

Skilled Nursing Facility. Inpatient services and supplies provided by a skilled nursing facility, for up to 100 days per calendar year. The amount by which your room charge exceeds the prevailing two-bed room rate of the skilled nursing facility is not considered covered under this plan.

Skilled nursing facility services and supplies are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.

If covered charges are applied toward the Calendar Year Deductible, if applicable, and payment is not provided, those days will be included in the 100 days for that year.

Home Health Care. The following services provided by a home health agency:

1. Services of a registered nurse or licensed vocational nurse under the supervision of a registered nurse or a physician.

2. Services of a licensed therapist for physical therapy, occupational therapy, speech therapy, or respiratory therapy.

3. Services of a medical social service worker.

4. Services of a health aide who is employed by (or who contracts with) a home health agency. Services must be ordered and supervised by a registered nurse employed by the home health agency as professional coordinator. These services are covered only if you are also receiving the services listed in 1 or 2 above.

5. Medically necessary supplies provided by the home health agency.

In no event will benefits exceed 100 visits during a calendar year. A visit of four hours or less by a home health aide shall be considered as one home health visit.

If covered charges are applied toward the Calendar Year Deductible, if applicable, and payment is not provided, those days will be included in the 100 days for that year.
Home health care services are subject to pre-service review to determine medical necessity. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.
Home health care services are not covered if received while you are receiving benefits under the "Hospice Care" provision of this section.

**Hospice Care.** The services and supplies listed below are covered when provided by a hospice for the palliative treatment of pain and other symptoms associated with a terminal disease. You must be suffering from a terminal illness as certified by your physician and submitted to the claims administrator. Covered services are available on a 24-hour basis for the management of your condition.

1. Interdisciplinary team care with the development and maintenance of an appropriate plan of care.
2. Short-term inpatient hospital care when required in periods of crisis or as respite care. Coverage of inpatient respite care is provided on an occasional basis and is limited to a maximum of five consecutive days per admission.
3. Skilled nursing services provided by or under the supervision of a registered nurse. Certified home health aide services and homemaker services provided under the supervision of a registered nurse.
4. Social services and counseling services provided by a qualified social worker.
5. Dietary and nutritional guidance. Nutritional support such as intravenous feeding or hyperalimentation.
6. Physical therapy, occupational therapy, speech therapy, and respiratory therapy provided by a licensed therapist.
7. Volunteer services provided by trained hospice volunteers under the direction of a hospice staff member.
8. Pharmaceuticals, medical equipment, and supplies necessary for the management of your condition. Oxygen and related respiratory therapy supplies.
9. Bereavement services, including assessment of the needs of the bereaved family and development of a care plan to meet those needs, both prior to and following the subscriber's or the family member's death. Bereavement services are available to surviving members of the immediate family for a period of one year after the death. Your immediate family means your spouse, children, step-children, parents, and siblings.
10. Palliative care (care which controls pain and relieves symptoms, but does not cure) which is appropriate for the illness.

Your physician must consent to your care by the hospice and must be consulted in the development of your treatment plan. The hospice must submit a written treatment plan to the claims administrator every 30 days.

**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:

1. 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;
2. Pharmacy compounding and dispensing services (including pharmacy support) for intravenous solutions and medications;
3. 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;
4. Rental and purchase charges for durable medical equipment (as shown below); maintenance and repair charges for such equipment;
5. Laboratory services to monitor the patient's response to therapy regimen.

The maximum payment will not exceed $600 for the services or supplies received during any one day when provided by a home infusion therapy provider which is not a participating provider.

Home infusion therapy provider services are subject to pre-service review to determine medical necessity. See UTILIZATION REVIEW PROGRAM for details.
Professional Services

1. Services of a physician.
2. Services of an anesthetist (M.D. or C.R.N.A.).

Telemedicine. Diagnosis, consultation, treatment, transfer of medical data and medical education through the use of electronic media such as interactive audio, video or other electronic media. This does not include services performed during a telephone or facsimile machine.

Reconstructive Surgery. Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance. This includes medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. “Cleft palate” means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Ambulance. The following ambulance services:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a hospital.
2. Emergency services or transportation services that are provided to you by a licensed ambulance company as a result of a “911” emergency response system* request for assistance if you believe you have an emergency medical condition requiring such assistance.
3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest hospital where appropriate treatment is provided if, and only if, such services are medically necessary and ground ambulance service is inadequate. Pre-service review is required for air ambulance in a non-medical emergency. Please refer to UTILIZATION REVIEW PROGRAM for information on how to obtain the proper reviews.
4. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

* If you have an emergency medical condition that requires an emergency response, please call the “911” emergency response system if you are in an area where the system is established and operating.

Diagnostic Services. Outpatient diagnostic imaging and laboratory services. Imaging procedures, including, but not limited to, Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography, and nuclear cardiac imaging are subject to pre-service review to determine medical necessity. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review. See UTILIZATION REVIEW PROGRAM for details.

Radiation Therapy

Chemotherapy

Hemodialysis Treatment. Outpatient hemodialysis treatment provided by a non-participating provider is limited to $350 per visit.

Prosthetic Devices

1. Breast prostheses following a mastectomy.
2. Prosthetic devices to restore a method of speaking when required as a result of a covered medically necessary laryngectomy.
3. Other medically necessary prosthetic devices, including:
   a. Surgical implants;
   b. Artificial limbs or eyes; and
c. The first pair of contact lenses or eye glasses when required as a result of a covered medically necessary eye surgery.

d. Therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications.

**Durable Medical Equipment.** Rental or purchase of dialysis equipment; dialysis supplies. Rental or purchase of other medical equipment and supplies which are:

1. Of no further use when medical needs end;
2. For the exclusive use of the patient;
3. Not primarily for comfort or hygiene;
4. Not for environmental control or for exercise; and
5. Manufactured specifically for medical use.

Rental charges that exceed the reasonable purchase price of the equipment are not covered. The claims administrator will determine whether the item satisfies the conditions above.

The rental or purchase of durable medical equipment over $1,000 is subject to pre-service review to determine medical necessity. See UTILIZATION REVIEW PROGRAM for details.

**Blood.** Blood transfusions, including blood processing and the cost of unreplaced 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.

**Dental Care**

1. **Admissions for Dental Care.** Listed inpatient hospital services for up to three days during a hospital stay, when such stay is required for dental treatment and has been ordered by a physician (M.D.) and a dentist (D.D.S. or D.M.D.). The claims administrator will make the final determination as to whether the dental treatment could have been safely rendered in another setting due to the nature of the procedure or your medical condition. Hospital stays for the purpose of administering general anesthesia are not considered necessary and are not covered.

2. **Dental Injury.** Services of a physician (M.D.) or dentist (D.D.S. or D.M.D.) solely to treat an accidental injury to sound natural teeth. Coverage shall be limited to only such services that are medically necessary to repair the damage done by accidental injury and/or restore function lost as a direct result of the accidental injury. Damage to natural teeth due to chewing or biting is not accidental injury. Dental implants are not covered.

3. **Cleft Palate.** Medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures. “Cleft palate” means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

**Important:** If you decide to receive dental services that are not covered under this plan, a participating provider who is a dentist may charge you his or her usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about the dental services that are covered under this plan, please call the customer service telephone number listed on your ID card. To fully understand your coverage under this plan, please carefully review this benefit booklet document.

**Pregnancy and Maternity Care**

1. All medical benefits when provided for pregnancy or maternity care, including diagnosis of genetic disorders in cases of high-risk pregnancy. Inpatient hospital benefits in connection with childbirth will be provided for at least 48 hours following a normal delivery or 96 hours following a cesarean section, unless the mother and her physician decide on an earlier discharge.

2. Medical hospital benefits for routine nursery care of a newborn child, if the child’s natural mother is enrolled under the plan.

**Transplant Services.** Services and supplies provided in connection with a non-investigative organ or tissue transplant, if you are:

1. The recipient; or
2. The donor.

If you are the recipient, an organ or tissue donor who is not an enrolled member is also eligible for services as described. Benefits are reduced by any amounts paid or payable by that donor's own coverage. The maximum allowed amount for a donor, including donor testing and donor search, is limited to expense incurred for medically necessary medical services only. The maximum allowed amount for services incident to obtaining the transplanted material from a living donor or a human organ transplant bank will be covered. Such charges, including complications from the donor procedure for up to six weeks from the date of procurement, are covered. Services for treatment of a condition that is not directly related to, or a direct result of, the transplant are not covered. The plan's payment for unrelated donor searches for bone marrow/stem cell transplants will not exceed $30,000 per transplant.

Covered services are subject to any applicable deductibles, co-payments and medical benefit maximums set forth in the SUMMARY OF BENEFITS. The maximum allowed amount does not include charges for services received without first obtaining prior authorization or which are provided at a facility other than a transplant center approved by the claims administrator. See UTILIZATION REVIEW PROGRAM for details.

Specified Transplants

You must obtain the claims administrator's prior authorization for all services including, but not limited to, preoperative tests and postoperative care related to the following specified transplants: heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures. Specified transplants must be performed at Centers of Medical Excellence (CME). Charges for services provided for or in connection with a specified transplant performed at a facility other than a CME will not be covered. Call the toll-free telephone number for pre-service review on your identification card if your physician recommends a specified transplant for your medical care. A case manager transplant coordinator will assist in facilitating your access to a CME. See UTILIZATION REVIEW PROGRAM for details.

Transplant Travel Expense

Certain travel expenses incurred in connection with an approved, specified transplant (heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney, or bone marrow/stem cell and similar procedures) performed at a designated CME that is 75 miles or more from the recipient's or donor's place of residence are covered, provided the expenses are authorized by the claims administrator in advance. The plan's maximum payment will not exceed $10,000 per transplant for the following travel expenses incurred by the recipient and one companion* or the donor:

- Ground transportation to and from the CME when the designated CME is 75 miles or more from the recipient's or donor's place of residence.
- Coach airfare to and from the CME when the designated CME is 300 miles or more from the recipient's or donor's residence
- Lodging, limited to one room, double occupancy
- Other reasonable expenses. Tobacco, alcohol, drug, and meal expenses, are excluded.

*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 by the claims administrator. The plan will provide benefits for lodging and ground transportation up to the current limits set forth in the Internal Revenue Code.

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.

Bariatric Surgery. Services and supplies in connection with medically necessary surgery for weight loss, only for morbid obesity and only when performed at a designated CME facility. See UTILIZATION REVIEW PROGRAM for details.
You must obtain pre-service review for all bariatric surgical procedures. **Charges for services provided for or in connection with a bariatric surgical procedure performed at a facility other than a CME will not be covered.**

**Bariatric Travel Expense.** The following travel expense benefits will be provided in connection with an approved bariatric surgical procedure only when the member’s place of residence is fifty (50) miles or more from the nearest bariatric CME. All travel expenses must be approved by the claims administrator in advance. The fifty (50) mile radius around the CME will be determined by the bariatric CME coverage area (See DEFINITIONS).

- Transportation for the member to and from the CME up to $130 per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion to and from the CME up to $130 per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the member and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as medically necessary. Limited to one room, double occupancy.
- Hotel accommodations for one companion not to exceed $100 per day for the duration of the member’s initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed $25 per day, up to four (4) days per trip. Tobacco, alcohol, drug and meal expenses are excluded from coverage.

Customer service will confirm if the “Bariatric Travel Expense” benefit is available in connection with access to the selected bariatric CME. Details regarding reimbursement can be obtained by calling the customer service number on your I.D. card. A travel reimbursement form will be provided for submission of legible copies of all applicable receipts in order to obtain reimbursement.

**Mental or Nervous Disorders or Substance Abuse.** Covered services shown below for the medically necessary treatment of mental or nervous disorders or substance abuse.

1. Inpatient hospital services as stated in the “Hospital” provision of this section, services from a residential treatment center, and visits to a day treatment center.
2. Physician visits during a covered inpatient stay.
3. Physician visits for outpatient psychotherapy or psychological testing or outpatient rehabilitative care (such as physical therapy, occupational therapy, or speech therapy) for the treatment of mental or nervous disorders or substance abuse. Outpatient physician visits will require pre-service review after the first 12 visits. No benefits are payable if pre-service review is not obtained for visits after the 12th visit. (See UTILIZATION REVIEW PROGRAM.)

Treatment for substance abuse does not include smoking cessation programs, nor treatment for nicotine dependency or tobacco use.

(Note: The maximum allowed amount for non-participating providers will not exceed the scheduled amount. See the SCHEDULES FOR NON-PARTICIPATING PROVIDERS.)

**Preventive Care (Dependent Children Only).** The plan will cover the preventive care services shown below. The calendar year deductible will not apply to these services. No copayment will apply to these services.

1. Physician’s services for routine physical examinations.
2. Immunizations given as standard medical practice.
3. Radiology and laboratory services in connection with routine physical examinations. This includes human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

See the definition of “Preventive Care Services” in the DEFINITIONS section for more information about services that are covered by this plan as preventive services.

**Screening For Blood Lead Levels.** Services and supplies provided in connection with screening for blood lead levels if your dependent child is at risk for lead poisoning, as determined by your physician, when the screening is prescribed by your physician. This is considered to be a preventive care service. The calendar year deductible will not apply to these services. No copayment will apply to these services.
Routine Physical Exam (Subscriber and Spouse only). In addition to any preventive services specified elsewhere in the benefit booklet, the plan will pay for the following services when provided for a subscriber or spouse. The calendar year deductible will not apply to these services. No copayment will apply to these services.

1. A physician’s services for routine physical examinations.
2. Radiology and laboratory services and tests ordered by the examining physician in connection with a routine physical examination.
3. Immunizations given as standard medical practice.
4. Preventive counseling and risk factor reduction intervention services in connection with tobacco use and tobacco use-related diseases.

See the definition of “Preventive Care Services” in the DEFINITIONS section for more information about services that are covered by this plan as preventive services.

Adult Preventive Services. Services and supplies in connection with all generally medically accepted cancer screening tests including FDA-approved cancer screenings for cervical cancer, and human papillomavirus (HPV) screening, mammography testing and appropriate screening for breast cancer, prostate cancer screenings, colorectal cancer screenings, and the office visit related to those services. Also included is human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis. The Calendar Year Deductible will not apply to these services. Adult Preventive Services are considered to be preventive care services. No copayment will apply to these services.

Breast Cancer. Services and supplies provided in connection with the screening for, diagnosis of, and treatment for breast cancer whether due to illness or injury, including:

1. Diagnostic mammogram examinations for the treatment of a diagnosed illness or injury. Routine mammograms will be covered initially with Adult Preventive Services benefits (see “Adult Preventive Services”).
2. Mastectomy and lymph node dissection; complications from a mastectomy including lymphedema.
3. Reconstructive surgery performed to restore and achieve symmetry following a medically necessary mastectomy.
4. Breast prostheses following a mastectomy (see “Prosthetic Devices”).

This coverage is provided according to the terms and conditions of this plan that apply to all other medical conditions.

Cancer 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 cancer clinical trials, if all the following conditions are met:

1. 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.
2. You must be diagnosed with cancer to be eligible for participation in these clinical trials.
3. Participation in such clinical trials must be recommended by your physician after determining participation has a meaningful potential to benefit the member.
4. 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:

1. Typically provided absent a clinical trial.
2. Required solely for the provision of the investigational drug, item, device or service.
3. Clinically appropriate monitoring of the investigational item or service.
4. Prevention of complications arising from the provision of the investigational drug, item, device, or service.

5. 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:

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

2. 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.

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

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

5. 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.

Physical Therapy and Physical Medicine. The following services provided by a physician under a treatment plan are covered:

Physical therapy and physical medicine provided on an outpatient basis for the treatment of illness or injury including the therapeutic use of heat, cold, exercise, electricity, ultra violet radiation, manipulation of the spine, or massage for the purpose of improving circulation, strengthening muscles, or encouraging the return of motion. (This includes many types of care which are customarily provided by physical therapists and osteopaths.)

For the services of a non-participating provider only, visits are limited to not more than 13 visits per calendar year.

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 (13 visits) for that year.

Subject to the claims administrator’s 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 the claims administrator determines that an additional period of physical therapy or physical medicine is medically necessary, the claims administrator will authorize a specific number of additional visits.

Important Notes:

Additional visits are not payable if pre-service review is not obtained. See UTILIZATION REVIEW PROGRAM for details.

Benefits are not payable for care provided to relieve general soreness or for conditions that may be expected to improve without treatment. For the purposes of this benefit, the term “visit” shall include any visit by a physician in that physician’s office, or in any other outpatient setting, during which one or more of the services covered under this limited benefit are rendered, even if other services are provided during the same visit.

Chiropractic Care. The plan will pay for services of a physician for manual manipulation of the spine to correct subluxation demonstrated by physician-read x-ray, including:

1. Diagnostic services, other than diagnostic scanning, when provided during an initial examination or re-examination;

2. Adjustments;

3. Radiological x-rays and laboratory tests; and

4. Medically necessary therapy when provided in conjunction with the visit specifically for spinal or joint adjustment.

For the services of non-participating providers only, visits are limited to not more than 13 visits per calendar year.

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 (13 visits) for that year.
Outpatient Speech Therapy. Outpatient speech therapy following injury or organic disease.

Christian Science Benefits

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

1. 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.

2. 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 MEDICAL CARE THAT IS NOT COVERED apply equally to Christian Science benefits as to all other benefits and providers of care.

Diabetes. The following services and supplies provided for the treatment of diabetes:

1. The following equipment and supplies for the treatment of diabetes are covered under your plan’s benefits for durable medical equipment (see “Durable Medical Equipment”):
   
   a. Disposable pen delivery systems for insulin administration. Charges for insulin, insulin syringes, and other prescriptive medications are not covered.
   
   b. Testing strips and lancets. Charges for alcohol swabs are not covered.

2. Diabetes education program which:
   
   a. 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;
   
   b. 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
   
   c. Is supervised by a physician.

   Diabetes education services are covered under plan benefits for office visits to physicians.

Injectable Drugs and Implants for Birth Control. Injectable drugs and implants for birth control administered in a physician’s office if medically necessary.

Acupuncture. The services of a physician for acupuncture treatment to treat a disease, illness or injury, including a patient history visit, physical examination, treatment planning and treatment evaluation, electroacupuncture, cupping and moxibustion. This plan will pay for up to 12 visits during a calendar year.

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 (13 visits) for that year.

Prescription Drug for Abortion. Mifepristone is covered when provided under the Food and Drug Administration (FDA) approved treatment regimen.

Scalp hair prostheses. Scalp hair prostheses, including wigs or any form of hair replacement, limited to $300 per calendar year.
MEDICAL CARE THAT IS NOT COVERED

No payment will be made under this plan for expenses incurred for or in connection with any of the items below. (The titles given to these exclusions and limitations are for ease of reference only; they are not meant to be an integral part of the exclusions and limitations and do not modify their meaning.)

Not Medically Necessary. Services or supplies that are not medically necessary, as defined.

Experimental or Investigative. Any experimental or investigative procedure or medication. But, if you are denied benefits because it is determined that the requested treatment is experimental or investigative, you may request an independent medical review.

Crime or Nuclear Energy. Conditions that result from: (1) your commission of or attempt to commit a felony; or (2) any release of nuclear energy, whether or not the result of war, when government funds are available for treatment of illness or injury arising from such release of nuclear energy.

Not Covered. Services received before your effective date or after your coverage ends, except as specifically stated under EXTENSION OF BENEFITS.

Non-Licensed Providers. Treatment or services rendered by non-licensed health care providers and treatment or services for which the provider of services is not required to be licensed. This includes treatment or services from a non-licensed provider under the supervision of a licensed physician, except as specifically provided or arranged by the claims administrator.

Excess Amounts. Any amounts in excess of maximum allowed amounts or any Medical Benefit Maximum.

Work-Related. Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.

If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits will be provided subject to the right of recovery and reimbursement under California Labor Code Section 4903, and as described in REIMBURSEMENT FOR ACTS OF THIRD PARTIES.

Government Treatment. Any services actually given to you by a local, state or federal government agency, except when payment under this plan is expressly required by federal or state law. The plan will not cover payment for these services if you are not required to pay for them or they are given to you for free.

Services of Relatives. Professional services received from a person who lives in your home or who is related to you by blood or marriage.

Voluntary Payment. Services for which you have no legal obligation to pay, or for which no charge would be made in the absence of insurance coverage or other health plan coverage, except services received at a non-governmental charitable research hospital. Such a hospital must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research;
2. At least 10% of its yearly budget must be spent on research not directly related to patient care;
3. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;
4. It must accept patients who are unable to pay; and
5. Two-thirds of its patients must have conditions directly related to the hospital's research.

Not Specifically Listed. Services not specifically listed in this plan as covered services.

Private Contracts. Services or supplies provided pursuant to a private contract between the member and a provider, for which reimbursement under the Medicare program is prohibited, as specified in Section 1802 (42 U.S.C. 1395a) of Title XVIII of the Social Security Act.

Inpatient Diagnostic Tests. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.
Mental or Nervous Disorders or Substance Abuse. Academic or educational testing, counseling, and remediation. Mental or nervous disorders or substance abuse, including rehabilitative care in relation to these conditions, except as specifically stated in the "Mental or Nervous Disorders" or "Substance Abuse" provisions of MEDICAL CARE THAT IS COVERED. Any educational treatment or any services that are educational, vocational, or training in nature except as specifically provided or arranged by the claims administrator.

Nicotine Use. Smoking cessation programs or treatment of nicotine or tobacco use. Smoking cessation drugs.

Orthodontia. Braces and other orthodontic appliances or services, except as specifically stated in the “Reconstructive Surgery” or “Dental Care” provisions of MEDICAL CARE THAT IS COVERED.

Dental Services or Supplies. For dental treatment, regardless of origin or cause, except as specified below. “Dental treatment” includes but is not limited to preventative care and fluoride treatments; dental x rays, supplies, appliances, dental implants and all associated expenses; diagnosis and treatment related to the teeth, jawbones or gums, including but not limited to:

- Extraction, restoration, and replacement of teeth;
- Services to improve dental clinical outcomes.

This exclusion does not apply to the following:

- Services which the claims administrator is required by law to cover;
- Services specified as covered in this plan;
- Dental services to prepare the mouth for radiation therapy to treat head and/or neck cancer.

Hearing Aids or Tests. Hearing aids. Routine hearing tests.

Optometric Services or Supplies. Optometric services, eye exercises including orthoptics. Routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated in the "Prosthetic Devices" provision of MEDICAL CARE THAT IS COVERED.

Outpatient Occupational Therapy. Outpatient occupational therapy, except by a home health agency, hospice or home infusion therapy provider as specifically stated in the "Home Health Care", "Hospice Care", or "Home Infusion Therapy" provisions of MEDICAL CARE THAT IS COVERED.

Outpatient Speech Therapy. Outpatient speech therapy except as stated in the "Outpatient Speech Therapy" provision of MEDICAL CARE THAT IS COVERED.

Cosmetic Surgery. Cosmetic surgery or other services performed solely for beautification or to alter or reshape normal (including aged) structures or tissues of the body to improve appearance. This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following a mastectomy. Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons.

Commercial Weight Loss Programs. Weight loss programs, whether or not they are pursued under medical or physician supervision, unless specifically listed as covered in this plan.

This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

This exclusion does not apply to medically necessary treatments for morbid obesity or dietary evaluations and counseling, and behavioral modification programs for the treatment of anorexia nervosa or bulimia nervosa. Surgical treatment for morbid obesity is covered as stated in the “Bariatric Surgery” provision of MEDICAL CARE THAT IS COVERED.

Sex Transformation. Procedures or treatments to change characteristics of the body to those of the opposite sex.

Sterilization Reversal. Reversal of sterilization.

Infertility Treatment. Any services or supplies furnished in connection with the diagnosis and treatment of infertility, including, but not limited to, diagnostic tests, medication, surgery, artificial insemination, in vitro fertilization, sterilization reversal, and gamete intrafallopian transfer.
Surrogate Mother Services. For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).

Orthopedic Supplies. Orthopedic shoes (other than shoes joined to braces) or non-custom molded and cast shoe inserts, except for therapeutic shoes and inserts for the prevention and treatment of diabetes-related foot complications as specifically stated in the “Prosthetic Devices” provision of MEDICAL CARE THAT IS COVERED.

Air Conditioners. Air purifiers, air conditioners, or humidifiers.

Custodial Care or Rest Cures. Inpatient room and board charges in connection with a hospital stay primarily for environmental change or physical therapy. Custodial care, rest cures, or treatment of chronic pain, except as specifically provided under the “Hospice Care” or “Home Infusion Therapy” provisions of MEDICAL CARE THAT IS COVERED. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a skilled nursing facility, except as specifically stated in the “Skilled Nursing Facility” provision of MEDICAL CARE THAT IS COVERED.

Health Club Memberships. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.

Personal Items. Any supplies for comfort, hygiene or beautification.

Telephone and Facsimile Machine Consultations. Consultations provided by telephone or facsimile machine.

Routine Exams or Tests. Routine physical exams or tests which do not directly treat an actual illness, injury or condition, including those required by employment, government authority, military, sports related activities or life insurance, except as specifically stated in the “Preventive Care”, “Screening For Blood Lead Levels”, “Routine Physical Exam”, “Cervical Cancer Screening”, "Breast Cancer", or “Prostate Cancer Screening” provisions of MEDICAL CARE THAT IS COVERED.

Immunizations. Immunizations for foreign travel. Immunizations, except as specifically stated in the “Preventive Care” and “Routine Physical Exam” provisions of MEDICAL CARE THAT IS COVERED.

Acupuncture. Acupuncture treatment except as specifically stated in the "Acupuncture" provision of MEDICAL CARE THAT IS COVERED. Acupressure or massage to control pain, treat illness, or promote health by applying pressure to one or more specific areas of the body based on dermatomes or acupuncture points.

Eye Surgery for Refractive Defects. Any eye surgery solely or primarily for the purpose of correcting refractive defects of the eye such as nearsightedness (myopia) and/or astigmatism. Contact lenses and eyeglasses required as a result of this surgery.

Chiropractic Services. Chiropractic services, except as specifically stated in the “Chiropractic Care” provision of MEDICAL CARE THAT IS COVERED.

Outpatient Prescription Drugs and Medications. Outpatient prescription drugs or medications and insulin, except as specifically stated in the "Home Infusion Therapy" and "Prescription Drug for Abortion provisions of MEDICAL CARE THAT IS COVERED. Non-prescription, over-the-counter patent or proprietary drugs or medicines. Cosmetics, dietary supplements, health or beauty aids.

Specialty Drugs. Specialty drugs that must be obtained from the physician, but, which are obtained from a retail pharmacy are not covered by this plan. You will have to pay the full cost of the specialty drugs you get from a retail pharmacy that should have been obtained from your physician.

Contraceptive Devices. Contraceptive devices prescribed for birth control except as specifically stated in “Injectable Drugs and Implants for Birth Control” provision in MEDICAL CARE THAT IS COVERED.

Private Duty Nursing. Inpatient or outpatient services of a private duty nurse.

Clinical Trials. Services and supplies in connection with clinical trials, except as specifically stated in the “Cancer Clinical Trials” provision under the section MEDICAL CARE THAT IS COVERED.
SUBROGATION AND REIMBURSEMENT

These provisions apply when CVT pays benefits as a result of injuries or illnesses you sustained and you have a right to a Recovery or have received a Recovery from any source. A “Recovery” includes, but is not limited to, monies received from any person or party, any person’s or party’s liability insurance, uninsured/underinsured motorist proceeds, worker’s compensation insurance or fund, “no-fault” insurance and/or automobile medical payments coverage, whether by lawsuit, settlement or otherwise. Regardless of how you or your representative or any agreements characterize the money you receive as a Recovery, it shall be subject to these provisions.

SUBROGATION

CVT has the right to recover payments they make on your behalf from any party responsible for compensating you for your illnesses or injuries. The following apply:

1. CVT has first priority from any Recovery for the full amount of benefits they have paid regardless of whether you are fully compensated, and regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

2. You and your legal representative must do whatever is necessary to enable CVT to exercise their rights and do nothing to prejudice those rights.

3. In the event that you or your legal representative fail to do whatever is necessary to enable CVT to exercise their subrogation rights, CVT shall be entitled to deduct the amount CVT paid from any future benefits under the plan.

4. CVT has the right to take whatever legal action it sees fit against any person, party or entity to recover the benefits paid under the plan.

5. To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full CVT’s subrogation claim and any claim held by you, CVT’s subrogation claim shall be first satisfied before any part of a Recovery is applied to your claim, your attorney fees, other expenses or costs.

6. CVT is not responsible for any attorney fees, attorney liens, other expenses or costs you incur without CVT’s prior written consent. The “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the plan.

REIMBURSEMENT

If you obtain a Recovery and CVT has not been repaid for the benefits the plan paid on your behalf, CVT shall have a right to be repaid from the Recovery in the amount of the benefits paid on your behalf and the following provisions will apply:

1. You must reimburse CVT from any Recovery to the extent of benefits the plan paid on your behalf regardless of whether the payments you receive make you whole for your losses, illnesses and/or injuries.

2. Notwithstanding any allocation or designation of your Recovery (e.g., pain and suffering) made in a settlement agreement or court order, CVT shall have a right of full recovery, in first priority, against any Recovery. Further, CVT’s rights will not be reduced due to your negligence.

3. You and your legal representative must hold in trust for CVT the proceeds of the gross Recovery (i.e., the total amount of your Recovery before attorney fees, other expenses or costs) to be paid to CVT immediately upon your receipt of the Recovery. You must reimburse CVT, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered by any attorney you hire regardless of whether funds recovered are used to repay benefits paid by the plan.

4. If you fail to repay CVT, CVT shall be entitled to deduct any of the unsatisfied portion of the amount of benefits the plan has paid or the amount of your Recovery whichever is less, from any future benefit under the plan if:
   a. The amount CVT paid on your behalf is not repaid or otherwise recovered by CVT; or
   b. You fail to cooperate.

5. In the event that you fail to disclose the amount of your settlement to CVT, CVT shall be entitled to deduct the amount of CVT’s lien from any future benefit under the plan.
6. CVT shall also be entitled to recover any of the unsatisfied portion of the amount the plan has paid or the amount of your Recovery, whichever is less, directly from the providers to whom the plan has made payments on your behalf. In such a circumstance, it may then be your obligation to pay the provider the full billed amount, and CVT will not have any obligation to pay the provider or reimburse you.

7. CVT is entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate you or make you whole.

YOUR DUTIES

1. You must notify CVT promptly of how, when and where an accident or incident resulting in personal injury or illness to you occurred and all information regarding the parties involved.

2. You must cooperate with CVT in the investigation, settlement and protection of CVT's rights. In the event that you or your legal representative fail to do whatever is necessary to enable CVT to exercise its subrogation or reimbursement rights, CVT shall be entitled to deduct the amount CVT paid from any future benefits under the plan.

3. You must not do anything to prejudice CVT's rights.

4. You must send CVT copies of all police reports, notices or other papers received in connection with the accident or incident resulting in personal injury or illness to you.

5. You must promptly notify CVT if you retain an attorney or if a lawsuit is filed on your behalf.

CVT has sole discretion to interpret the terms of the Subrogation and Reimbursement provision of this plan in its entirety and reserves the right to make changes as it deems necessary.

If the member is a minor, any amount recovered by the member, the member's trustee, guardian, parent, or other representative, shall be subject to this provision. Likewise, if the member's relatives, heirs, and/or assignees make any Recovery because of injuries sustained by the member, that Recovery shall be subject to this provision.

CVT shall be secondary in coverage to any medical payments provision, no-fault automobile insurance policy or personal injury protection policy regardless of any election made by you to the contrary. CVT shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

CVT is entitled to recover its attorney's fees and costs incurred in enforcing this provision.
COORDINATION OF BENEFITS

If you are covered by more than one group health plan, your benefits under This Plan will be coordinated with the benefits of those Other Plans. These coordination provisions apply separately to each member, per calendar year, and are largely determined by California law. Any coverage you have for medical or dental benefits, will be coordinated as shown below.

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will be capitalized. When you see these capitalized words, you should refer to this Definitions provision.

Allowable Expense is any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan. For the purposes of determining This Plan’s payment, the total value of Allowable Expense as provided under This Plan and all Other Plans will not exceed the greater of: (1) the amount which the plan would determine to be eligible expense, if you were covered under This Plan only; or (2) the amount any Other Plan would determine to be eligible expenses in the absence of other coverage.

Other Plan is any of the following:
1. Group, blanket or franchise insurance coverage;
2. Group service plan contract, group practice, group individual practice and other group prepayment coverages;
3. Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans.

The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract, or arrangement which reserves the right to take the services or benefits of other plans into consideration in determining benefits.

Principal Plan is the plan which will have its benefits determined first.
This Plan is that portion of this plan which provides benefits subject to this provision.

EFFECT ON BENEFITS

1. If This Plan is the Principal Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
2. If This Plan is not the Principal Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed Allowable Expense.
3. If the Principal Plan for a family member is an HMO plan, This Plan will pay for out-of-pocket expenses such as copayments, deductibles and other services not available through the HMO provider.
4. If the Principal Plan for a family member is an HMO plan but the family member is treated by a non-HMO provider when those services are available through the HMO provider, This Plan will not make any payment as secondary payer.
5. The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if you were covered under This Plan only.

ORDER OF BENEFITS DETERMINATION

The following rules determine the order in which benefits are payable:
1. A plan which has no Coordination of Benefits provision pays before a plan which has a Coordination of Benefits provision. This includes Medicare in all cases except when the law requires that This Plan pays before Medicare.
2. A plan which covers you as an employee pays before a plan which covers you as a dependent. But, if you are a Medicare beneficiary and also a dependent of an employee with current employment status under another plan, this rule might change. If, according to Medicare’s rules, Medicare pays after that plan which covers you as a dependent, then the plan which covers you as a dependent pays before the plan which covers you as an employee.
For example: You are covered as a retired employee under this plan and a Medicare beneficiary (Medicare would pay first, this plan would pay second). You are also covered as a dependent of an active employee under another plan provided by an employer group of 20 or more employees (then, according to Medicare’s rules, Medicare would pay second). In this situation, the plan which covers you as a dependent of an active employee will pay first and the plan which covers you as a retired employee will pay last, after Medicare.

3. For a dependent child covered under plans of two parents, the plan of the parent whose birthday falls earlier in the calendar year pays before the plan of the parent whose birthday falls later in the calendar year. However, if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

Exception to rule 3: For a dependent child of parents who are divorced or separated, the following rules will be used in place of Rule 3:

a. If the parent with custody of that child for whom a claim has been made has not remarried, then the plan of the parent with custody that covers that child as a dependent pays first.

b. If the parent with custody of that child for whom a claim has been made has remarried, then the order in which benefits are paid will be as follows:
   i. The plan which covers that child as a dependent of the parent with custody.
   ii. The plan which covers that child as a dependent of the stepparent (married to the parent with custody).
   iii. The plan which covers that child as a dependent of the parent without custody.
   iv. The plan which covers that child as a dependent of the stepparent (married to the parent without custody).

c. Regardless of a and b above, if there is a court decree which establishes a parent’s financial responsibility for that child’s health care coverage, a plan which covers that child as a dependent of that parent pays first.

4. The plan covering you as a laid-off or retired employee or as a dependent of a laid-off or retired employee pays after a plan covering you as other than a laid-off or retired employee or the dependent of such a person. But, if either plan does not have a provision regarding laid-off or retired employee, provision 6 applies.

5. The plan covering you under a continuation of coverage provision in accordance with state or federal law pays after a plan covering you as an employee, a dependent or otherwise, but not under a continuation of coverage provision in accordance with state or federal law. If the order of benefit determination provisions of the Other Plan do not agree under these circumstances with the Order of Benefit Determination provisions of This Plan, this rule will not apply.

6. When the above rules do not establish the order of payment, the plan on which you have been enrolled the longest pays first unless two of the plans have the same effective date. In this case, Allowable Expense is split equally between the two plans.

In no event will you be entitled to benefits from this plan in excess of those which you would have received if no Other Plan benefits were available.

OUR RIGHTS UNDER THIS PROVISION

Responsibility For Timely Notice. CVT is not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision. Such timely information must include an Explanation of Benefits statement (EOB) from the Other Plan.

Reasonable Cash Value. If any Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and CVT’s liability reduced accordingly.

Facility of Payment. If payments which should have been made under This Plan have been made under any Other Plan, CVT has the right to pay that Other Plan any amount CVT determines to be warranted to satisfy the intent of this provision. Any such amount will be considered a benefit paid under This Plan, and such payment will fully satisfy CVT’s liability under this provision.

Right of Recovery. If payments made under This Plan exceed the maximum payment necessary to satisfy the intent of this provision, CVT has the right to recover that excess amount from any persons or organizations to or for whom those payments were made, or from any insurance company or service plan.
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.

If you incur covered charges under this plan, the claims administrator will determine this plan’s payment and then subtract the amount of benefits from Medicare Parts A and B. This plan will pay the amount that remains after subtracting Medicare's benefit. Please note, this plan will not pay any benefit when Medicare’s payment is equal to or more than the amount which would have been paid under this plan in the absence of Medicare.

This method of payment will be applied when you are 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. 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. If you are 65 years of age or older and not eligible for Medicare Part A, CVT requires you still be enrolled for Medicare Part B benefits.

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.
UTILIZATION REVIEW PROGRAM

Benefits are provided only for medically necessary and appropriate services. Utilization Review is designed to work together with you and your provider to ensure you receive appropriate medical care and avoid unexpected out of pocket expense.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and requirements of this plan.

Important: The Utilization Review Program requirements described in this section do not apply when coverage under this plan is secondary to another plan providing benefits for you or your family members.

The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your physician are advised if it has been determined that services can be safely provided in an outpatient setting, or if an inpatient stay is recommended. Services that are medically necessary and appropriate are certified by the claims administrator and monitored so that you know when it is no longer medically necessary and appropriate to continue those services.

It is your responsibility to determine whether a particular service requires pre-service authorization. Please read the following information that follows to assist you in this determination and please feel free to call the toll-free number for pre-service printed on your identification card if you have any questions about making this determination.

It is also your responsibility to see that your physician starts the utilization review process before scheduling you for any service subject to the utilization review program. If you receive any such service, and do not follow the procedures set forth in this section, your benefits will be reduced as shown in the "Effect on Benefits".

UTILIZATION REVIEW REQUIREMENTS

Utilization reviews are conducted for the following services:

- All inpatient hospital stays and residential treatment center admissions.
- Specific outpatient services, including diagnostic treatment and other services.
- Specific outpatient surgeries performed in an outpatient facility or a doctor’s office.
- Facility-based care for the treatment of mental or nervous disorders and substance abuse.
- Transplant services.
- Air ambulance in a non-medical emergency.
- Home infusion therapy.
- Admissions to a skilled nursing facility.
- Additional visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy and Physical Medicine" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
- Home health care.
- Rental or purchase of Durable Medical Equipment over $1,000.
- Bariatric surgical services performed at a Centers of Medical Excellence (CME) facility.
- Specific diagnostic procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and Nuclear Cardiac Imaging. You may call the toll-free customer service telephone number on your identification card to find out if an imaging procedure requires pre-service review.
- Outpatient visits to a physician for the treatment of mental or nervous disorders or substance abuse after the first 12 visit in a year.
Exceptions: Utilization review is not required for inpatient hospital stays for the following services:

- Maternity care of 48 hours or less for a normal delivery or 96 hours or less for a cesarean section; and
- Mastectomy and lymph node dissection.

The stages of utilization review are:

1. **Pre-service review** determines in advance the medical necessity and appropriateness of certain procedures or admissions and the appropriate length of stay, if applicable. Pre-service review is required for the following services:
   - Scheduled, non-emergency inpatient hospital stays and residential treatment center admissions (except inpatient stays for maternity care or mastectomy and lymph node dissection).
   - Specific, non-emergency outpatient services, including diagnostic treatment and other services.
   - Specific outpatient surgeries performed in an outpatient facility or a doctor’s office.
   - Facility-based care for the treatment of mental or nervous disorders and substance abuse.
   - Transplant services.
   - Air ambulance in a non-medical emergency.
   - Home infusion therapy.
   - Admissions to a skilled nursing facility.
   - Additional visits for physical therapy, physical medicine and occupational therapy beyond those described under the "Physical Therapy and Physical Medicine" provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.
   - Home health care.
   - Rental or purchase of Durable Medical Equipment over $1,000.
   - Bariatric surgical services performed at a CME facility.
   - Specific diagnostic procedures, including but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scan), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and Nuclear Cardiac Imaging.
   - Outpatient visits to a physician for the treatment of mental or nervous disorders or substance abuse starting with the thirteenth visit in a year.

2. **Concurrent review** determines whether services are medically necessary and appropriate when the claims administrator is notified while service is ongoing, for example, an emergency admission to the hospital.

3. **Retrospective review** is performed to review services that have already been provided. This applies in cases when pre-service or concurrent review was not completed, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

**EFFECT ON BENEFITS**

In order for the full benefits of this plan to be payable, the following criteria must be met:

1. The appropriate utilization reviews must be performed in accordance with this plan. When pre-service review is performed and the admission, procedure or service is determined to be medically necessary and appropriate, benefits will be provided for the following:
   - Scheduled, non-emergency inpatient hospital stays and residential treatment center admissions.
   - Specific, non-emergency outpatient services, including diagnostic treatment and other services.
   - Specific outpatient surgeries performed in an outpatient facility or a doctor’s office.
• **Facility-based care** for the treatment of *mental or nervous disorders* and substance abuse.

• Transplant services as follows:
  a. For bone, skin or cornea transplants, if the *physicians* on the surgical team and the facility in which the transplant is to take place are approved for the transplant requested.
  b. For transplantation of heart, liver, lung, combination heart-lung, kidney, pancreas, simultaneous pancreas-kidney or bone marrow/stem cell and similar procedures, if the providers of the related preoperative and postoperative services are approved and the transplant will be performed at a *Centers of Medical Excellence (CME)* facility.

• Air ambulance in a non-medical *emergency*.

• Services of a home infusion therapy provider if the attending *physician* has submitted both a prescription and a plan of treatment before services are rendered.

• Services provided in a *skilled nursing facility* if you require daily skilled nursing or rehabilitation, as certified by your attending *physician*.

• A specified number of additional visits for physical therapy, physical medicine and occupational therapy if you need more visits than is provided under the “Physical Therapy and Physical Medicine” provision of YOUR MEDICAL BENEFITS: MEDICAL CARE THAT IS COVERED.

• Home health care services if:
  a. The services can be safely provided in your home, as certified by your attending *physician*;
  b. Your attending *physician* manages and directs your medical care at home; and
  c. Your attending *physician* has established a definitive treatment plan which must be consistent with your medical needs and lists the services to be provided by the *home health agency*.

• Rental or purchase of durable medical equipment over $1,000 if your attending *physician* has submitted both a prescription and a plan of treatment prior to services or supplies being rendered.

• Bariatric surgical procedures, such as gastric bypass and other surgical procedures for weight loss if:
  a. The services are to be performed for the treatment of morbid obesity;
  b. The *physicians* on the surgical team and the facility in which the surgical procedure is to take place are approved for the surgical procedure requested; and
  c. The bariatric surgical procedure will be performed at a *CME* facility.

• Specific diagnostic procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computerized Axial Tomography (CAT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography and Nuclear Cardiac Imaging.

• Outpatient visits to a *physician* for the treatment of *mental or nervous disorders* or substance abuse after the first 12 visit in a *year*.

If you proceed with any services that have been determined to be not *medically necessary* and appropriate at any stage of the utilization review process, benefits will not be provided for those services.

2. Services that are not reviewed prior to or during service delivery will be reviewed retrospectively when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not *medically necessary* and appropriate, benefits will not be paid for those services. Remaining benefits will be subject to previously noted reductions that apply when the required reviews are not obtained.
HOW TO OBTAIN UTILIZATION REVIEWS

Remember, it is always your responsibility to confirm that the review has been performed. If the review is not performed your benefits will be reduced as shown in the “Effect on Benefits”.

Pre-service Reviews. Penalties will result for failure to obtain pre-service review, before receiving scheduled services, as follows:

1. For all scheduled services that are subject to utilization review, you or your physician must initiate the pre-service review at least five working days prior to when you are scheduled to receive services.

2. You must tell your physician that this plan requires pre-service review. Physicians who are participating providers will initiate the review on your behalf. A non-participating provider may initiate the review for you, or you may call the toll-free number printed on your identification card directly.

3. If you do not receive the certified service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

4. Services that are medically necessary and appropriate will be certified. For inpatient hospital and residential treatment center stays, a specific length of stay for approved services will be certified, if appropriate. For facility-based care for the treatment of mental or nervous disorders and substance abuse, the type and level of services, as well as their duration, will be certified, if appropriate. You, your physician and the provider of the service will receive a written confirmation showing this information.

Concurrent Reviews

1. If pre-service review was not performed, you, your physician or the provider of the service must contact the claims administrator for concurrent review. For an emergency admission or procedure, the claims administrator must be notified within one working day of the admission or procedure, unless extraordinary circumstances* prevent such notification within that time period.

2. When participating providers have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a non-participating provider to call the toll free number printed on your identification card, or you may call directly.

3. When the service is determined medically necessary and appropriate, depending upon the type of treatment or procedure, the service will be certified for a period of time that is medically appropriate. The medically appropriate setting will be determined also.

4. If the service is determined not medically necessary and appropriate, your physician will be notified by telephone no later than 24 hours following the claims administrator’s decision. The claims administrator will send written notice to you and your physician within two business days following the claims administrator’s decision. However, care will not be discontinued until your physician has been notified and a plan of care that is appropriate for your needs has been agreed upon.

*Extraordinary Circumstances. In determining “extraordinary circumstances”, the claims administrator may take into account whether or not your condition was severe enough to prevent you from notifying the claims administrator, or whether or not a member of your family was available to notify the claims administrator for you. You may have to prove that such “extraordinary circumstances” were present at the time of the emergency.

Retrospective Reviews

1. Retrospective review is performed when the claims administrator has not been notified of the service you received, and therefore has been unable to perform the appropriate review prior to your discharge from the hospital or completion of outpatient treatment. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified.

   It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-service or concurrent review was performed.

2. Such services which have been retrospectively determined to not be medically necessary and appropriate will be retrospectively denied certification.
THE MEDICAL NECESSITY REVIEW PROCESS

The claims administrator works with you and your health care providers to cover medically necessary and appropriate care and services. While the types of services requiring review and the timing of the reviews may vary, they are committed to ensuring that reviews are performed in a timely and professional manner. The following information explains the review process.

1. A decision on the medical necessity of a pre-service request will be made no later than 5 business days from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition.

2. A decision on the medical necessity of a concurrent request will be made no later than one business day from receipt of the information reasonably necessary to make the decision, and based on the nature of your medical condition. However, care will not be discontinued until your physician has been notified and a plan of care that is appropriate for your needs has been agreed upon.

3. A decision on the medical necessity of a retrospective review will be made and communicated in writing no later than 30 days from receipt of the information necessary to make the decision to your and your physician.

4. If the claims administrator does not have the needed information, they will make every attempt to obtain that information from you or your physician. If they are unsuccessful, and a delay is anticipated, you and your physician will be notified of the delay and what is needed to make a decision. You will also be informed of when a decision can be expected following receipt of the needed information.

5. All pre-service, concurrent and retrospective reviews for medical necessity are screened by clinically experienced, licensed personnel (called “Review Coordinators”) using pre-established criteria and the claims administrator’s Medical Policy. These criteria and policies are developed and approved by practicing providers not employed by the claims administrator, and are evaluated at least annually and updated as standards of practice or technology changes. Requests satisfying these criteria are certified as medically necessary. Review Coordinators are able to approve most requests.

6. A written confirmation including the specific service determined to be medically necessary will be sent to you and your provider no later than 2 business days after the decision, and your provider will be initially notified by telephone within 24 hours of the decision for pre-service and concurrent reviews.

7. If the request fails to satisfy these criteria or medical policy, the request is referred to a Peer Clinical Reviewer. Peer Clinical Reviewers are health professionals clinically competent to evaluate the specific clinical aspects of the request and render an opinion specific to the medical condition, procedure and/or treatment under review. Peer Clinical Reviewers are licensed in California with the same license category as the requesting provider. When the Peer Clinical Reviewer is unable to certify the service, the requesting physician is contacted by telephone for a discussion of the case. In many cases, services can be certified after this discussion. If the Peer Clinical Reviewer is still unable to certify the service, your provider will be given the option of having the request reviewed by a different Peer Clinical Reviewer.

8. Only the Peer Clinical Reviewer may determine that the proposed services are not medically necessary and appropriate. Your physician will be notified by telephone within 24 hours of a decision not to certify and will be informed at that time of how to request reconsideration. Written notice will be sent to you and the requesting provider within two business days of the decision. This written notice will include:
   • an explanation of the reason for the decision,
   • reference of the criteria used in the decision to modify or not certify the request,
   • the name and phone number of the Peer Clinical Reviewer making the decision to modify or not certify the request,
   • how to request reconsideration if you or your provider disagree with the decision.

9. Reviewers may be plan employees or an independent third party the claims administrator chooses at their sole and absolute discretion.

10. You or your physician may request copies of specific criteria and/or medical policy by writing to the address shown on your plan identification card. The claims administrator discloses the medical necessity review procedures to health care providers through provider manuals and newsletters.
A determination of medical necessity does not guarantee payment or coverage. The determination that services are medically necessary is based on the clinical information provided. Payment is based on the terms of your coverage at the time of service. These terms include certain exclusions, limitations, and other conditions. Payment of benefits could be limited for a number of reasons, including:

- The information submitted with the claim differs from that given by phone;
- The service is excluded from coverage; or
- You are not eligible for coverage when the service is actually provided.

PERSONAL CASE MANAGEMENT

The personal case management program enables you to obtain medically appropriate care in a more economical, cost-effective and coordinated manner during prolonged periods of intensive medical care. The claims administrator, through a case manager, may recommend an alternative plan of treatment which may include services not covered under this plan. It is not your right to receive personal case management, nor does the plan have an obligation to provide it. The plan provides these services at CVT’s sole and absolute discretion.

HOW PERSONAL CASE MANAGEMENT WORKS

You may be identified for possible personal case management through the plan’s utilization review procedures, by the attending physician, hospital staff, or the claims administrator’s claims reports. You or your family may also call the claims administrator.

Benefits for personal case management will be considered only when all of the following criteria are met:

1. You require extensive long-term treatment;
2. The claims administrator anticipates that such treatment utilizing services or supplies covered under this plan will result in considerable cost;
3. A cost-benefit analysis determines that the benefits payable under this plan for the alternative plan of treatment can be provided at a lower overall cost than the benefits you would otherwise receive under this plan while maintaining the same standards of care; and
4. You (or your legal guardian) and your physician agree, in a letter of agreement, with the claims administrator’s recommended substitution of benefits and with the specific terms and conditions under which the alternative benefits are to be provided.

Alternative Treatment Plan. If the claims administrator determines that your needs could be met more efficiently, an alternative treatment plan may be recommended. This may include providing benefits not otherwise covered under this plan. A case manager will review the medical records and discuss your treatment with the attending physician, you, and your family.

The claims administrator makes treatment recommendations only; any decision regarding treatment belong to you and your physician. CVT will not compromise your freedom to make such decisions.

EFFECT ON BENEFITS

1. Benefits are provided for an alternative treatment plan on a case-by-case basis only. CVT and the claims administrator have absolute discretion in deciding whether or not to authorize services in lieu of benefits for any member, which alternatives may be offered and the terms of the offer.
2. The authorization of services in lieu of benefits in a particular case in no way commits the plan to do so in another case or for another member.
3. The personal case management program does not prevent the claims administrator from strictly applying the expressed benefits, exclusions and limitations of this plan at any other time or for any other member.

Note: The claims administrator reserves the right to use the services of one or more third parties in the performance of the services outlined in the letter of agreement. No other assignment of any rights or delegation of any duties by either party is valid without the prior written consent of the other party.
DISAGREEMENTS WITH MEDICAL MANAGEMENT DECISIONS

1. If you or your physician disagree with a decision, or question how it was reached, you or your physician may request reconsideration. Requests for reconsideration (either by telephone or in writing) must be directed to the reviewer making the determination. The address and the telephone number of the reviewer are included on your written notice of determination. Written requests must include medical information that supports the medical necessity of the services.

2. If you, your representative, or your physician acting on your behalf, find the reconsidered decision still unsatisfactory, a request for an appeal of a reconsidered decision may be submitted in writing to the claims administrator.

3. If the appeal decision is still unsatisfactory, your remedy is binding arbitration. (See BINDING ARBITRATION.)

QUALITY ASSURANCE

Utilization review programs are monitored, evaluated, and improved on an ongoing basis to ensure consistency of application of screening criteria and medical policy, consistency and reliability of decisions by reviewers, and compliance with policy and procedure including but not limited to timeframes for decision making, notification and written confirmation. The claims administrator’s Board of Directors is responsible for medical necessity review processes through its oversight committees including the Strategic Planning Committee, Quality Management Committee, and Physician Relations Committee. Oversight includes approval of policies and procedures, review and approval of self-audit tools, procedures, and results. Monthly process audits measure the performance of reviewers and Peer Clinical Reviewers against approved written policies, procedures, and timeframes. Quarterly reports of audit results and, when needed, corrective action plans are reviewed and approved through the committee structure.
HOW COVERAGE BEGINS AND ENDS

HOW COVERAGE BEGINS

ELIGIBLE STATUS

1. **Subscribers.** The persons described in the participation agreement are eligible to enroll as subscribers.

2. **Family Members.** The following are eligible to enroll as family members: (a) Either the subscriber's spouse or domestic partner; and (b) A child.

Definition of Family Member

1. **Spouse** is the subscriber's spouse under a legally valid marriage.

2. **Domestic partner** is the subscriber's domestic partner, subject to the following. The subscriber and the subscriber's domestic partner will provide CVT with a signed Declaration of Domestic Partnership form certifying, under penalty of perjury, that:
   a. They are both 18 years of age or older;
   b. They have an intimate, committed relationship of mutual caring;
   c. They have been living together as a couple in the same household for at least six consecutive months, currently share the same principal residence(s), and intend to continue residing together;
   d. They agree to be responsible for each other's basic living expenses during their domestic partnership; and also agree that anyone who is owed these expenses can collect from either of them;
   e. Neither of them is legally married;
   f. Neither of them has a different domestic partner now, nor has had a spouse or different domestic partner in the last six months;
   g. They are not so closely related by blood that legal marriage would otherwise be prohibited; and
   h. If living in a city or county providing for such registration, they have registered as domestic partners with a California city or county or the State of California and have provided CVT with a copy of the Certificate of Domestic Partnership.

3. **Child** is the subscriber's, spouse's or domestic partner's natural child stepchild, legally adopted child, or a child for whom the subscriber, spouse or domestic partner has been appointed legal guardian by a court of law, subject to the following:
   a. A child is under 26 years of age.
   b. An unmarried child 26 years of age or older and: (i) was covered under the prior plan, (ii) was covered as a family member of the subscriber, spouse or domestic partner under another plan or has six months of other creditable coverage, (iii) is chiefly dependent on the subscriber, spouse or domestic partner for support and maintenance, and (iv) is incapable of self-sustaining employment due to a physical or mental condition. A physician must certify the disability in writing. CVT must receive this certification, at your own expense, within 60 days of the date the child qualifies as a family member. Further, the following conditions must be met:
      -- Subscribers who are new hires must furnish CVT with evidence that the child was covered as a family member under the subscriber's former group plan immediately prior to the date of application for coverage under this plan.
      -- Subscribers who were covered under a prior plan must furnish CVT with evidence that the child was covered as a family member under the prior plan.
      -- CVT may request proof of continuing dependency and disability.

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 SUPERCEDE THE PROVISIONS OF THIS BENEFIT BOOKLET.
ENROLLMENT
To enroll as a subscriber, or to enroll family members, the subscriber must properly file an application. An application is considered properly filed only if it is personally signed, dated, and given to CVT within 31 days from your eligibility date. If your application is filed after 31 days, your coverage may be denied.

EFFECTIVE DATE
Your effective date of coverage is subject to the timely payment of the required monthly contributions on your behalf. If this condition has been met, the date you become covered is determined as indicated below.

Timely Enrollment: If you enroll for coverage before, on, or within 31 days after your eligibility date, then your coverage will begin as follows:

1. Subscriber’s Effective Date
   Your coverage begins on the date specified in the participation agreement.

2. Family Member’s Effective Date
   a. If the application of a person enrolling as a subscriber includes application for an eligible spouse, domestic partner or child, coverage for that spouse, domestic partner or child begins on the subscriber’s effective date.
   b. For a new spouse of a subscriber who is already enrolled under the plan, coverage begins on 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.
   c. For a newly acquired child of an enrolled subscriber, other than a newborn or newly adopted child or a child for whom the subscriber is legal guardian, coverage begins on the first day of the month after acquiring the child, but only if an application to enroll the child has been filed within 31 days of acquiring the child.
   d. For a child born to an enrolled subscriber, coverage begins at the moment of birth. This coverage ends on the day following 31 days from the date of birth if CVT does not receive an application to enroll the child and any additional required monthly contributions due.
   e. For a child being adopted by an enrolled subscriber, coverage begins on the date the child is placed in the physical custody of the subscriber. This coverage ends on the day following 31 days from the date of physical custody if CVT does not receive an application to enroll the child and any additional required monthly contributions due.
   f. For a child for whom the enrolled subscriber is legal guardian, coverage begins on the date of the court decree. CVT must receive an application to enroll the child and legal evidence of the decree.
   g. For 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.
   h. For a new domestic partner of a subscriber who is already enrolled under the plan, coverage begins 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.

Late Enrollees/Disenrollees
For any eligible person who is not enrolled within the time limits stated above under ENROLLMENT, or who is permitted to decline coverage and voluntarily chooses to disenroll from coverage under this plan but later reapplies, you must wait until the next Open Enrollment Period, or experience a qualifying event as outlined in CVT’s Eligibility Policy, to enroll.

EXCEPTIONS. If you are a late enrollee or disenrollee, you may enroll without waiting for the next Open Enrollment Period if you are otherwise eligible under any one of CVT’s qualifying events. Please call CVT Member Services at (800) 288-9870 for a listing of qualifying events.

OPEN ENROLLMENT PERIOD
There is an Open Enrollment Period once each calendar year. During that time, an individual who meets the eligibility requirements as a subscriber under this plan may enroll. A subscriber may also enroll any eligible family members at that time. Persons eligible to enroll as family members may enroll only under the subscriber’s plan.
For anyone so enrolling, coverage under this plan will begin on the first day of October following the end of the Open Enrollment Period. Coverage under the former plan ends when coverage under this plan begins.

HOW COVERAGE ENDS

Your coverage ends without notice as provided below:

1. On the effective date the participation agreement between CVT and your participating employer is canceled.

2. If the plan terminates, your coverage ends at the same time. This plan may be canceled or changed without notice to you.

3. If CVT no longer provides coverage for the class of members to which you belong, your coverage ends on the effective date of that change. If this plan is amended to delete coverage for family members, a family member’s coverage ends on the effective date of that change.

4. Coverage for family members ends when the subscriber’s coverage ends.

5. Coverage ends at the end of the period for which the required monthly contribution has been paid on your behalf when the required monthly contribution for the next period is not paid.

6. If you no longer meet the requirements set forth in the “Eligible Status” provision of HOW COVERAGE BEGINS, your coverage ends as of the due date for the required monthly contribution coinciding with or following the date you cease to meet such requirements.

Exceptions to item 6:

a. Leave of Absence. If you are an employee and the required monthly contributions are paid, your coverage may continue during an approved leave of absence.

b. Disabled Children: If a child reaches the age limits shown in the “Eligible Status” provision of this section, the child will continue to qualify as a family member if he or she is (i) covered under this plan, (ii) still financially dependent on the subscriber, and (iii) incapable of self-sustaining employment due to a physical or mental disability. A physician must certify this disability in writing.

   CVT must receive the certification, within 60 days of the date the child otherwise becomes ineligible. CVT may request proof of continuing dependency and disability. This exception will last until the child is no longer disabled or dependent on the subscriber for financial support.

Note: If a domestic partnership terminates, the subscriber must notify CVT by providing a signed copy of the Notification of Termination of Domestic Partnership within 10 days of the termination. A new domestic partner may not be enrolled under this plan, until at least six months after the Notification of Termination has been filed.

You may be entitled to continued benefits under terms which are specified elsewhere under CONTINUATION OF COVERAGE, CONTINUATION FOR DISABLED DISTRICT EMPLOYEES, COVERAGE FOR RETIRED EMPLOYEES OR THEIR SURVIVING SPOUSES, EXTENSION OF BENEFITS and HIPAA COVERAGE AND CONVERSION.
CONTINUATION OF COVERAGE

DEFINITIONS

The meanings of key terms used in this section are shown below. Whenever any of the key terms shown below appear in these provisions, the first letter of each word will appear in capital letters. When you see these capitalized words, you should refer to this “Definitions” provision.

Initial Enrollment Period is the period of time following the original Qualifying Event, as indicated in the “Terms of COBRA Continuation” provisions below.

Qualified Beneficiary means: (a) a person enrolled for this COBRA continuation coverage who, on the day before the Qualifying Event, was covered under this plan as either a subscriber or family member; and (b) a child who is born to or placed for adoption with the subscriber during the COBRA continuation period. Qualified Beneficiary does not include any person who was not enrolled during the Initial Enrollment Period, including any family members acquired during the COBRA continuation period, with the exception of newborns and adoptees as specified above. It does not include domestic partners if they are eligible under HOW COVERAGE BEGINS AND ENDS.

Qualifying Event means any one of the following circumstances which would otherwise result in the termination of your coverage under the plan. The events will be referred to throughout this section by number.

1. For Subscribers and Family Members:
   a. The subscriber's termination of employment, for any reason other than gross misconduct; or
   b. A reduction in the subscriber's work hours.

2. For Retired Employees and their Family Members. Cancellation or a substantial reduction of benefits under the plan for retired employees and their family members due to filing for Chapter 11 bankruptcy by the participating employer from whose employment the subscriber retired.

   Such cancellation or reduction of benefits occurs within one year before or after your participating employer’s filing for bankruptcy.

3. For Family Members:
   a. The death of the subscriber;
   b. The spouse’s divorce from the subscriber;
   c. The end of a child's status as a dependent child, as defined by the plan; or
   d. The subscriber's entitlement to Medicare.

ELIGIBILITY FOR COBRA CONTINUATION

A subscriber or family member may choose to continue coverage under the plan if your coverage would otherwise end due to a Qualifying Event.

TERMS OF COBRA CONTINUATION

Notice. The participating employer, CVT or its administrator (Blue Shield is not the administrator), will notify either the subscriber or family member of the right to continue coverage under COBRA, as provided below:

1. For Qualifying Events 1, or 2, CVT will notify the subscriber of the right to continue coverage.
2. For Qualifying Events 3(a) or 3(d) above, a family member will be notified of the COBRA continuation right.
3. You must inform the participating employer within 60 days of Qualifying Events 3(b) or 3(c) above if you wish to continue coverage. The participating employer, in turn, must also notify CVT, who will promptly give you official notice of the COBRA continuation right.
If you choose to continue coverage you must notify CVT within 60 days of the date you receive notice of your COBRA continuation right. The COBRA continuation coverage may be chosen for all members within a family, or only for selected members.

If you fail to elect the COBRA continuation during the Initial Enrollment Period, you may not elect the COBRA continuation at a later date.

Notice of continued coverage, along with the initial required monthly contribution, must be delivered by you to CVT within 45 days after you elect COBRA continuation coverage.

**Additional Family Members.** A spouse or child acquired during the COBRA continuation period is eligible to be enrolled as a family member. The standard enrollment provisions of the plan apply to enrollees during the COBRA continuation period.

**Cost of Coverage.** CVT may require that you pay the entire cost of your COBRA continuation coverage. This cost, called the "required monthly contribution", must be remitted to CVT each month during the COBRA continuation period. CVT must receive payment of the required monthly contribution in order to maintain the coverage in force.

Besides applying to the subscriber, the subscriber's rate also applies to:

1. A spouse whose COBRA continuation began due to divorce or death of the subscriber;
2. A child if neither the subscriber nor the spouse has enrolled for this COBRA continuation coverage (if more than one child is so enrolled, the subscription charge will be the two-party or three-party rate depending on the number of children enrolled); and
3. A child whose COBRA continuation began due to the person no longer meeting the dependent child definition.

**Subsequent Qualifying Events.** Once covered under the COBRA continuation, it’s possible for a second Qualifying Event to occur. If that happens, your family members, who are Qualified Beneficiaries, may be entitled to an extended COBRA continuation period. This period will in no event continue beyond 36 months from the date of the first Qualifying Event.

For example, a child may have been originally eligible for COBRA continuation due to termination of the subscriber's employment, and enrolled for this COBRA continuation as a Qualified Beneficiary. If, during the COBRA continuation period, the child reaches the upper age limit of the plan, the child is eligible for an extended continuation period which would end no later than 36 months from the date of the original Qualifying Event (the termination of employment).

**When COBRA Continuation Coverage Begins.** When COBRA continuation coverage is elected during the Initial Enrollment Period and the required monthly contribution is paid, coverage is reinstated back to the date of the original Qualifying Event, so that no break in coverage occurs.

For family members properly enrolled during the COBRA continuation, coverage begins according to the enrollment provisions of the plan.

**When the COBRA Continuation Ends.** This COBRA continuation will end on the earliest of:

1. The end of 18 months from the Qualifying Event, if the Qualifying Event was termination of employment or reduction in work hours.*
2. The end of 36 months from the Qualifying Event, if the Qualifying Event was the death of the subscriber, divorce, or the end of dependent child status.*
3. The end of 36 months from the date the subscriber became entitled to Medicare, if the Qualifying Event was the subscriber's entitlement to Medicare. If entitlement to Medicare does not result in coverage terminating and Qualifying Event 1 occurs within 18 months after Medicare entitlement, coverage for Qualified Beneficiaries other than the subscriber will end 36 months from the date the subscriber became entitled to Medicare.
4. The date the plan terminates.
5. The end of the period for which required monthly contributions are last paid.
6. The date, following the election of COBRA continuation coverage, the member first becomes covered under any other group health plan. However, if the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the member, this COBRA continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied.
7. The date, following the election of COBRA continuation coverage, the member first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

*For a member whose COBRA continuation coverage began under a prior plan, this term will be dated from the time of the Qualifying Event under that prior plan. Additional note: If your COBRA continuation under this plan began on or after January 1, 2003 and ends in accordance with item 1, you may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. Please see CALCOBRA CONTINUATION OF COVERAGE in this booklet for more information.

Subject to the plan remaining in effect, a retired employee whose COBRA continuation coverage began due to Qualifying Event 2 may be covered for the remainder of his or her life; that person's covered family members may continue coverage for 36 months after the subscriber's death. But coverage could terminate prior to such time for either the subscriber or family member in accordance with items 4, 5 or 6 above.

If your COBRA continuation under this plan ends in accordance with items 1 or 2, you are eligible for medical conversion coverage as long as CVT offers such coverage. CVT will provide notice of this conversion right within 180 days prior to such termination date.

EXTENSION OF CONTINUATION DURING TOTAL DISABILITY

If at the time of termination of employment or reduction in hours, or at any time during the first 60 days of the COBRA continuation, the subscriber or a covered family member is determined to be disabled for Social Security purposes, all covered members may be entitled to up to 29 months of continuation coverage after the original Qualifying Event.

Eligibility for Extension. To continue coverage for up to 29 months from the date of the original Qualifying Event, the disabled member must: (1) Satisfy the legal requirements for being totally and permanently disabled under the Social Security Act; and (2) Be determined and certified to be so disabled by the Social Security Administration.

Notice. The member must furnish CVT with proof of the Social Security Administration's determination of disability during the first 18 months of the COBRA continuation period and no later than 60 days after the later of the following events:

1. The date of the Social Security Administration's determination of the disability;
2. The date on which the original Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses coverage; or
4. The date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice.

Cost of Coverage. For the 19th through 29th months that the member continues to be totally disabled, the cost (called the "required monthly contribution") shall be subject to the following conditions:

1. This charge shall be 150% of the usual COBRA rate, and must be remitted to CVT each month during the period of extended continuation coverage. CVT must receive timely payment of the required monthly contribution each month from you in order to maintain the extended coverage in force.
2. CVT requires that you pay the entire cost of the extended continuation coverage.

If a second Qualifying Event occurs during this extended continuation, the total COBRA continuation may continue up to 36 months from the date of the first Qualifying Event. The required monthly contribution charge shall then be 150% of the applicable rate for the 19th through 36th months.

When The Extension Ends. This extension will end at the earlier of:

1. The end of the month following a period of 30 days after the Social Security Administration's final determination that you are no longer totally disabled.
2. The end of 29 months from the Qualifying Event.
3. The date the plan terminates.
4. The end of the period for which required monthly contributions are last paid.
5. The date, following the election of COBRA continuation, the *member* first becomes covered under any other group health plan. However, if the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the *member*, this COBRA extension will end at the end of the period for which the pre-existing condition exclusion or limitation applied.

6. The date, following the election of COBRA continuation, the *member* first becomes entitled to Medicare. However, entitlement to Medicare will not preclude a person from continuing coverage which the person became eligible for due to Qualifying Event 2.

You must inform the *group* within 30 days of a final determination by the Social Security Administration that you are no longer totally disabled.

*Note: If your COBRA continuation under this *plan* began on or after January 1, 2003 and ends in accordance with item 2, you may further elect to continue coverage for medical benefits only under CalCOBRA for the balance of 36 months (COBRA and CalCOBRA combined). All COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. Please see **CALCOBRA CONTINUATION OF COVERAGE** in this booklet for more information.*

**CALCOBRA CONTINUATION OF COVERAGE**

If your continuation coverage under federal COBRA began on or after January 1, 2003, you have the option to further continue coverage under CalCOBRA for medical benefits only if your federal COBRA ended following:

1. 18 months after the qualifying event, if the qualifying event was termination of employment or reduction in work hours; or

2. 29 months after the qualifying event, if you qualified for the extension of COBRA continuation during total disability.

All federal COBRA eligibility must be exhausted before you are eligible to further continue coverage under CalCOBRA. You are not eligible to further continue coverage under CalCOBRA if you (a) are entitled to Medicare; (b) have other coverage or become covered under another group plan, as long as you are not subject to a pre-existing condition limitation under that coverage; or (c) are eligible for or covered under federal COBRA. Coverage under CalCOBRA is available for medical benefits only.

**TERMS OF CALCOBRA CONTINUATION**

**Notice.** Within 180 days prior to the date federal COBRA ends, CVT will notify you of your right to further elect coverage under CalCOBRA. If you choose to elect CalCOBRA coverage, you must notify CVT in writing within 60 days of the date your coverage under federal COBRA ends or when you are notified of your right to continue coverage under CalCOBRA, whichever is later.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in higher cost or you could be denied coverage entirely.

**Additional Family Members.** A dependent acquired during the CalCOBRA continuation period is eligible to be enrolled as a *family member*. The standard enrollment provisions of the *plan* apply to enrollees during the CalCOBRA continuation period.

**Cost of Coverage.** You will be required to pay the entire cost of your CalCOBRA continuation coverage (this is the "required monthly contribution"). This cost will be:

1. 110% of the applicable group rate if your coverage under federal COBRA ended after 18 months; or

2. 150% of the applicable group rate if your coverage under federal COBRA ended after 29 months.

You must make payment to CVT each month during the CalCOBRA continuation period to maintain your coverage in force.

**CalCOBRA Continuation Coverage Under the Prior Plan.** If you were covered through CalCOBRA continuation under the *prior plan*, your coverage may continue under this *plan* for the balance of the continuation period. However your coverage shall terminate if you do not comply with the enrollment requirements and required monthly contribution payment requirements of this *plan* within 30 days of receiving notice that your continuation coverage under the *prior plan* will end.
When CalCOBRA Continuation Coverage Begins. When you elect CalCOBRA continuation coverage and pay the required monthly contribution, coverage is reinstated back to the date federal COBRA ended, so that no break in coverage occurs.

For family members properly enrolled during the CalCOBRA continuation, coverage begins according to the enrollment provisions of the plan.

When the CalCOBRA Continuation Ends. This CalCOBRA continuation will end on the earliest of:

1. The date that is 36 months after the date of your qualifying event under federal COBRA*;
2. The date the plan terminates;
3. The end of the period for which required monthly contribution is last paid;
4. The date you become covered under any other health plan, unless the other health plan contains an exclusion or limitation relating to a pre-existing condition that you have. In this case, this continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied;
5. The date you become entitled to Medicare; or
6. The date you become covered under a federal COBRA continuation.

CalCOBRA continuation will also end if you move out of CVT’s service area or if you commit fraud.

*If your CalCOBRA continuation coverage began under a prior plan, this term will be dated from the time of the qualifying event under that prior plan.

If your CalCOBRA continuation under this plan ends in accordance with item 1, you may be eligible for medical conversion coverage. If your CalCOBRA continuation under this plan ends in accordance with items 1 or 2, you may be eligible for HIPAA coverage. You will receive notice of these options within 180 days prior to your CalCOBRA termination date. Please see HIPAA COVERAGE AND CONVERSION in this booklet for more information.

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 entitled HOW COVERAGE BEGINS AND ENDS.
COVERAGE FOR RETIRED EMPLOYEES OR THEIR SURVIVING SPOUSES

1. An subscriber who retires under any public retirement system may be eligible to enroll as a retired employee under the participation agreement.

2. After the death of the subscriber who was covered as a retired employee, coverage continues for a spouse enrolled through a participating employer until one of the following occurs:
   a. The spouse becomes enrolled under another group health plan; or
   b. The spouse’s coverage cancels as described under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE ENDS.

CONTINUATION DURING LABOR DISPUTE

If you are an enrolled subscriber 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.

4. Coverage during a labor dispute may continue up to six months. After six months, coverage is canceled automatically without notice from CVT.

CONTINUATION FOR DOMESTIC PARTNERS AND THEIR CHILDREN

An enrolled domestic partner and the enrolled child of the domestic partner, who is not a child of the subscriber, may be eligible to continue coverage under this plan if coverage would otherwise end due to either: (1) the subscriber’s termination of employment or a reduction in the subscriber’s work hours, and the subscriber elects to continue benefits as specified under CONTINUATION OF COVERAGE (COBRA); or (2) the death of the subscriber.

CVT or its administrator (Blue Shield is not the administrator) will notify the subscriber, or the domestic partner following the death of the subscriber, of the right to continue coverage. If you choose to continue coverage, you must notify CVT within 60 days of the date you receive notice of your continuation right. This continuation may be chosen for both a domestic partner and child or only for selected members. If you fail to elect the continuation during this period, you may not elect the continuation at a later date. Notice of continued coverage, along with the initial required monthly contribution, must be delivered by you to CVT. Any new family members acquired during this continuation period may not be added.

The cost of your continuation coverage, called the “required monthly contribution”, must be remitted to CVT each month during the continuation period. CVT must receive payment of the required monthly contribution each month in order to maintain the coverage in force.

This continuation will end on the earliest of:

1. The date the subscriber’s COBRA coverage terminates.

2. The end of 36 months from the death of the subscriber. If the subscriber dies while covered under COBRA, this 36 month continuation for an enrolled domestic partner and/or child of the domestic partner begins on the date of the subscriber’s Qualifying Event for COBRA (i.e., termination of employment).

3. The date the domestic partnership terminates, except in the event of the subscriber’s death.
4. The date the group cancels coverage for domestic partners under the “Eligible Status” provision of HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

5. The date the member first becomes entitled to Medicare, unless eligibility for Medicare is solely as a result of end-stage renal disease.

6. The date the member first becomes covered under any other group health plan, unless the other group health plan contains an exclusion or limitation relating to a pre-existing condition of the member, in which case this continuation will end at the end of the period for which the pre-existing condition exclusion or limitation applied.

7. The date the maximum benefits of this plan are paid.

8. The end of the period for which required monthly contributions are last paid on the member's behalf.

9. The date the plan terminates.

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.

HIPAA COVERAGE AND CONVERSION

If your coverage for medical benefits under this plan ends, you may be eligible to enroll for coverage with any carrier or health plan that offers individual medical coverage. HIPAA coverage and conversion coverage are available upon request if you meet the requirements stated below. Both HIPAA coverage and conversion are available for medical benefits only. Please note that the benefits and cost of these plans will differ from your current employer’s plan.

HIPAA Coverage

The Health Insurance Portability and Accountability Act (HIPAA) is a federal law that provides an option for individual coverage when coverage under the plan ends. To be eligible for HIPAA coverage, you must meet all of the following requirements:

1. You must have a minimum of 18 months of continuous health coverage, most recently under a group health plan, and have had coverage within the last 63 days.

2. Your most recent coverage was not terminated due to nonpayment of premium charges or fraud.

3. If continuation of coverage under the plan was available under COBRA, CalCOBRA, or a similar state program, such coverage must have been elected and exhausted.
4. You must not be eligible for Medicare, Medi-Cal, or any group medical coverage and cannot have other medical coverage.

You must apply for HIPAA coverage within 63 days of the date your coverage under the plan ends. Any carrier or health plan that offers individual medical coverage must make HIPAA coverage available to qualified persons without regard to health status. If you decide to enroll in HIPAA coverage, you will no longer qualify for conversion coverage.

**Conversion Coverage**

To apply for a conversion plan, you must submit an application to the claims administrator and pay the first required monthly contribution within 63 days of the date your coverage ends. Under certain circumstances you are not eligible for a conversion plan. They are:

1. Your coverage ends because the participation agreement between CVT and the participating employer terminates and is replaced by another group plan within 15 days.
2. Your coverage under this plan ends because required monthly contributions are not paid when due because you (or the subscriber who enrolled you as a family member) did not contribute your part, if any.
3. You are eligible for health coverage under another group plan when your coverage ends.
4. You are eligible for Medicare coverage when coverage under the plan ends, whether or not you have actually enrolled in Medicare.
5. You are covered under an individual health plan.
6. You were not covered for medical benefits under the plan for three consecutive months immediately prior to the termination of your coverage.

If you decide to enroll in a conversion plan, you will no longer qualify for HIPAA coverage.

**Important:** The intention of conversion coverage is not to replace the coverage you have under this plan, but to make available to you a specified amount of coverage for medical benefits until you can find a replacement. The conversion plan provides lesser benefits than this plan and the provisions and rates differ.

When coverage under the plan ends, you will receive more information about how to apply for HIPAA coverage or conversion, including a postcard for requesting an application and a telephone number to call if you have any questions.
GENERAL PROVISIONS

Benefit Booklet. This benefit booklet is not a participation agreement. It does not change the coverage under the participation agreement in any way. This benefit booklet, which is evidence of coverage under the participation agreement, is subject to all of the terms and conditions of that Agreement.

Providing of Care. CVT is not responsible for providing any type of hospital, medical or similar care, nor is CVT responsible for the quality of such care received.

Independent Contractors. The relationship between CVT and the providers is that of an independent contractor. Physicians, and other health care professionals, hospitals, skilled nursing facilities and other community agencies are not agents of CVT nor is CVT or any of CVT’s employees, an employee or agent of any hospital, medical group or medical care provider of any type. CVT is not liable for any claim or demand for damages connected with any injury resulting from any treatment.

Non-Regulation of Providers. The benefits of this plan do not regulate the amounts charged by providers of medical care, except to the extent that rates for covered services are regulated with participating providers.

Out-of-Area Services. The claims administrator has a variety of relationships with other Blue Shield Association Licensees referred to generally as “Inter-Plan Programs”. Whenever you obtain healthcare services outside of our service area, the claims for these services may be processed through one of these Inter-Plan Programs, which include the BlueCard® Program and may include negotiated National Account arrangements available between us and other Blue Shield Licensees. If you are outside of California and require medical care or treatment, you may use a local Blue Shield provider. If you use one of these providers, your out-of-pocket expenses may be lower than those incurred when using a provider that does not participate in the BlueCard Program. The rules for the BlueCard Program, including those described below, are set by The Blue Shield Association. In order for you to receive access to whatever discounts may be available, the plan must abide by those rules.

Typically, when accessing care outside the claims administrator’s service area, you may obtain care from healthcare providers that have a contractual agreement (i.e., are “participating providers”) with the local Blue Cross and/or Blue Shield Licensee in that other geographic area (“Host Blue”). In some instances, you may obtain care from non-participating healthcare providers. The claims administrator’s payment practices in both instances are described below.

Under the BlueCard® Program, when you access covered healthcare services within the geographic area served by a Host Blue, the claims administrator will remain responsible for fulfilling their contractual obligations. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

Whenever you access covered healthcare services outside the claims administrator’s service area and the claim is processed through the BlueCard® Program, the amount you pay for covered healthcare services is usually calculated based on the lower of:

- The billed charges for your covered services, or
- The negotiated price that the Host Blue makes available to the claims administrator.

Often, the “negotiated price” will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past prices for the types of transaction modifications noted above. However such adjustments will not affect the price the claims administrator uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, the claims administrator would then calculate your liability for any covered healthcare services according to applicable law.

Providers available to you through the BlueCard Program have not entered into contracts with the claims administrator. If you have any questions or complaints about the BlueCard Program, please call the customer service telephone number listed on your ID card.
Terms of Coverage

1. In order for you to be entitled to benefits under the plan, both the participation agreement and your coverage under the plan must be in effect on the date the expense giving rise to a claim for benefits is incurred.

2. The benefits to which you may be entitled will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date you receive the service or supply for which the charge is made.

3. The plan is subject to amendment, modification or termination according to the provisions of the participation agreement and the Declaration of Trust establishing the California’s Valued Trust without your consent or concurrence.

Protection of Coverage. CVT does not have the right to cancel your coverage under this plan while: (1) this plan is in effect; (2) you are eligible; and (3) your required monthly contributions are paid according to the terms of the plan.

Free Choice of Provider. This plan in no way interferes with your right as a member entitled to hospital benefits to select a hospital. You may choose any physician who holds a valid physician and surgeon’s certificate and who is a member of, or acceptable to, the attending staff and board of directors of the hospital where services are received. You may also choose any other health care professional or facility which provides care covered under this plan, and is properly licensed according to appropriate state and local laws. However, your choice may affect the benefits payable according to this plan.

Provider Reimbursement. Physicians and other professional providers are paid on a fee-for-service basis, according to an agreed schedule. A participating physician may, after notice from the claims administrator, be subject to a reduced negotiated rate in the event the participating physician fails to make routine referrals to participating providers, except as otherwise allowed (such as for emergency services). Hospitals and other health care facilities may be paid either a fixed fee or on a discounted fee-for-service basis.

Medical Necessity. The benefits of this plan are provided only for services which the claims administrator determines to be medically necessary. The services must be ordered by the attending physician for the direct care and treatment of a covered condition. They must be standard medical practice where received for the condition being treated and must be legal in the United States. The process used to authorize or deny health care services under this plan is available to you upon request.

Expense in Excess of Benefits. CVT is not liable for any expense you incur in excess of the benefits of this plan.

Benefits Not Transferable. Only the member is entitled to receive benefits under this plan. The right to benefits cannot be transferred.

Notice of Claim. You or the provider of service must send properly and fully completed claim forms to the claims administrator within 12 months of the date you receive the service or supply for which a claim is made. Services received and charges for the services must be itemized, and clearly and accurately described. CVT is not liable for the benefits of the plan if you do not file claims within the required time period. Claim forms must be used; canceled checks or receipts are not acceptable.

Payment to Providers. The benefits of this plan will be paid directly to participating hospitals, participating providers and medical transportation providers. Also, non-participating hospitals and other providers of service will be paid directly when you assign benefits in writing. If you or one of your family members receive services from non-participating hospitals or non-participating providers, payment will be made directly to the subscriber and you will be responsible for payment to the provider. The plan will pay non-participating hospitals and other providers of service directly when emergency services and care are provided to you or one of your family members. The plan will continue such direct payment until the emergency care results in stabilization.

If you are a MediCal beneficiary and you assign benefits in writing to the State Department of Health Services, benefits of this plan will be paid to the State Department of Health Services. These payments will fulfill CVT’s obligation to you for those covered services.

Right of Recovery. Whenever payment has been made in error, the claims administrator will have the right to recover such payment from you or, if applicable, the provider, in accordance with applicable laws and regulations. In the event the claims administrator recovers a payment made in error from the provider, except in cases of fraud or misrepresentation on the part of the provider, the claims administrator will only recover such payment from the provider within 365 days of the date the claims administrator made the payment on a claim submitted by the provider. The claims administrator reserves the right to deduct or offset any amounts paid in error from any pending or future claim.
Under certain circumstances, if the claims administrator pays your healthcare provider amounts that are your responsibility, such as deductibles, co-payments or co-insurance, the claims administrator may collect such amounts directly from you. You agree that the claims administrator has the right to recover such amounts from you.

The claims administrator has oversight responsibility for compliance with provider and vendor and subcontractor contracts. The claims administrator may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a provider, vendor, or subcontractor resulting from these audits if the return of the overpayment is not feasible.

The claims administrator has established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses, and whether to settle or compromise recovery amounts. The claims administrator will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. The claims administrator may not provide you with notice of overpayments made by them or you if the recovery method makes providing such notice administratively burdensome.

Workers’ Compensation Insurance. The plan does not affect any requirement for coverage by workers’ compensation insurance. It also does not replace that insurance.

Prepayment Fees. Your participating employer may require that you contribute all or part of the costs of these required monthly contributions. Please consult your participating employer for details.

Liability of Subscriber to Pay Providers. In the event that the plan does not pay a provider who has provided benefits to you, you will be required to pay that provider any amounts not paid to them by the plan.

Area of Service. The benefits of this plan are provided for covered services received anywhere in the world.

Renewal Provisions. The plan is subject to renewal at certain intervals. The required monthly contribution or other terms of the plan may be changed from time to time.

Financial Arrangements with Providers. The claims administrator or an affiliate has contracts with certain health care providers and suppliers (hereafter referred to together as “Providers”) for the provision of and payment for health care services rendered to its members and insured persons entitled to health care benefits under individual certificates and group policies or contracts to which the claims administrator or an affiliate is a party, including all persons covered under the plan.

Under the above-referenced contracts between Providers and the claims administrator or an affiliate, the negotiated rates paid for certain medical services provided to persons covered under the plan may differ from the rates paid for persons covered by other types of products or programs offered by the claims administrator or an affiliate for the same medical services. In negotiating the terms of the plan, CVT was aware that the claims administrator or its affiliates offer several types of products and programs. The subscribers, family members and CVT are entitled to receive the benefits of only those discounts, payments, settlements, incentives, adjustments and/or allowances specifically set forth in the plan.

Certificate of Creditable Coverage. Certificates of creditable coverage are issued automatically when your coverage under this plan ends. We will also provide a certificate of creditable coverage in response to your request, or to a request made on your behalf, at any time while you are covered under this plan and up to 24 months after your coverage under this plan ends. The certificate of creditable coverage documents your coverage under this plan. To request a certificate of creditable coverage, please call the customer service telephone number listed on your ID card.

Transition Assistance for New Members: Transition Assistance is a process that allows for completion of covered services for new members receiving services from a non-participating provider. If you are a new member, you may request Transition Assistance if any one of the following conditions applies:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the claims administrator in consultation with you and the non-participating provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the time you enroll in this plan.
3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

5. The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the time the child enrolls in this plan.

6. Performance of a surgery or other procedure that the claims administrator has authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the time you enroll in this plan.

Please contact customer service at the telephone number listed on your ID card to request Transition Assistance or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Transition Assistance does not provide coverage for services not otherwise covered under the plan.

You will be notified by telephone, and the provider by telephone and fax, as to whether or not your request for Transition Assistance is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the plan. Financial arrangements with non-participating providers are negotiated on a case-by-case basis. The non-participating provider will be asked to agree to accept reimbursement and contractual requirements that apply to participating providers, including payment terms. If the non-participating provider does not agree to accept said reimbursement and contractual requirements, the non-participating provider’s services will not be continued. If you do not meet the criteria for Transition Assistance, you are afforded due process including having a physician review the request.

Continuity of Care after Termination of Provider: Subject to the terms and conditions set forth below, benefits will be provided at the participating provider level for covered services (subject to applicable copayments, coinsurance, deductibles and other terms) received from a provider at the time the provider’s contract with the claims administrator terminates (unless the provider’s contract terminates for reasons of medical disciplinary cause or reason, fraud, or other criminal activity).

You must be under the care of the participating provider at the time the provider’s contract terminates. The terminated provider must agree in writing to provide services to you in accordance with the terms and conditions of his or her agreement with the claims administrator prior to termination. The provider must also agree in writing to accept the terms and reimbursement rates under his or her agreement with the claims administrator prior to termination. If the provider does not agree with these contractual terms and conditions, the provider’s services will not be continued beyond the contract termination date.

Benefits for the completion of covered services by a terminated provider will be provided only for the following conditions:

1. An acute condition. An acute condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the acute condition.

2. A serious chronic condition. A serious chronic condition is a medical condition caused by a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services shall be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by the claims administrator in consultation with you and the terminated provider and consistent with good professional practice. Completion of covered services shall not exceed twelve (12) months from the date the provider's contract terminates.

3. A pregnancy. A pregnancy is the three trimesters of pregnancy and the immediate postpartum period. Completion of covered services shall be provided for the duration of the pregnancy.

4. A terminal illness. A terminal illness is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of covered services shall be provided for the duration of the terminal illness.

5. The care of a newborn child between birth and age thirty-six (36) months. Completion of covered services shall not exceed twelve (12) months from the date the provider’s contract terminates.
6. Performance of a surgery or other procedure that the claims administrator has authorized as part of a documented course of treatment and that has been recommended and documented by the provider to occur within 180 days of the date the provider’s contract terminates.

Such benefits will not apply to providers who have been terminated due to medical disciplinary cause or reason, fraud, or other criminal activity.

Please contact customer service at the telephone number listed on your ID card to request continuity of care or to obtain a copy of the written policy. Eligibility is based on your clinical condition and is not determined by diagnostic classifications. Continuity of care does not provide coverage for services not otherwise covered under the plan.

You will be notified by telephone, and the provider by telephone and fax, as to whether or not your request for continuity of care is approved. If approved, you will be financially responsible only for applicable deductibles, coinsurance, and copayments under the plan. Financial arrangements with terminated providers are negotiated on a case-by-case basis. The terminated provider will be asked to agree to accept reimbursement and contractual requirements that apply to participating providers, including payment terms. If the terminated provider does not agree to accept the same reimbursement and contractual requirements, that provider’s services will not be continued. If you disagree with the determination regarding continuity of care, you may file complaint as described in the COMPLAINT NOTICE.
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 UTILIZATION REVIEW PROGRAM.

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 binding arbitration, which is 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 a 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:

- the identity of the claimant;
- the date (s) of the medical service;
- the specific medical condition or symptom;
- the provider's name;
- the service or supply for which approval of benefits was sought; and
- 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 or ERISA (if applicable).

Requirement to file an Appeal before filing a lawsuit

No lawsuit or 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 filing a lawsuit or taking other 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.
DEFINITIONS

The meanings of key terms used in this benefit booklet are shown below. Whenever any of the key terms shown below appear, it will appear in italicized letters. When any of the terms below are italicized in this benefit booklet, you should refer to this section.

Accidental injury is physical harm or disability which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

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-participating provider, but only when:

1. There is no participating 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-participating provider by the physician who is a participating 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-participating provider will be payable as shown in the SCHEDULES FOR NON-PARTICIPATING PROVIDERS: NON-PARTICIPATING PROVIDER EXCEPTIONS.

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-participating provider.

Such authorized referrals are not available to bariatric surgical services. These services are only covered when performed at a designated bariatric CME.

Bariatric CME Coverage Area is the area within the 50-mile radius surrounding a designated bariatric CME.

Benefit booklet is this written description of the benefits provided under the plan.

Centers of Medical Excellence (CME) are health care providers designated by the claims administrator as a selected facility for specified medical services. A provider participating in a CME network has an agreement in effect with Blue Shield of California, an affiliate of the claims administrator, or through the claims administrator's relationship with the Blue Shield Association, at the time services are rendered. CME agrees to accept the maximum allowed amount as payment in full for covered services.

Child meets the plan's eligibility requirements for children as outlined under HOW COVERAGE BEGINS AND ENDS.

Claims administrator refers to HealthComp Administrators. On behalf of CVT, HealthComp Administrators shall perform all administrative services in connection with the processing of claims under the plan.

Contracting hospital is a hospital which has a Standard Hospital Contract in effect with the claims administrator to provide care to members. A contracting hospital is not necessarily a participating provider. A list of contracting hospitals will be sent on request.

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.

CVT is the California's Valued Trust.
Day treatment center is an outpatient psychiatric facility which is licensed according to state and local laws to provide outpatient programs and treatment of mental or nervous disorders or substance abuse under the supervision of physicians.

Domestic partner meets the plan’s eligibility requirements for domestic partners as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

Effective date is the date your coverage begins under this plan.

Emergency is a sudden, serious, and unexpected acute illness, injury, or condition (including without limitation sudden and unexpected severe pain), or a psychiatric emergency medical condition, which the member reasonably perceives could permanently endanger health if medical treatment is not received immediately. Final determination as to whether services were rendered in connection with an emergency will rest solely with the claims administrator.

Emergency services are services provided in connection with the initial treatment of an emergency.

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

Facility-based care is care provided in a hospital, psychiatric health facility, residential treatment center or day treatment center for the treatment of mental or nervous disorders or substance abuse.

Family member meets the plan’s eligibility requirements for family members as outlined under HOW COVERAGE BEGINS AND ENDS: HOW COVERAGE BEGINS.

Home health agencies are home health care providers which are 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 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 is an agency or organization primarily engaged in providing palliative care (pain control and symptom relief) to terminally ill persons and supportive care to those persons and their families to help them cope with terminal illness. This care may be provided in the home or on an inpatient basis. A hospice must be: (1) certified by Medicare as a hospice; (2) recognized by Medicare as a hospice demonstration site; or (3) accredited as a hospice by the Joint Commission on Accreditation of Hospitals. A list of hospices meeting these criteria is available upon request.

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 the 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.

Infertility is: (1) the presence of a condition recognized by a physician as a cause of infertility; or (2) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception.

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.

Maximum allowed amount is the maximum amount of reimbursement the claims administrator will allow for covered medical services and supplies under this plan. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Medically necessary procedures, equipment, services or supplies are those considered 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 benefits from the procedure, supply, equipment or service 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.

Member is the subscriber or family member.

Mental or nervous disorders, for the purposes of this plan, are conditions that affect thinking and the ability to figure things out, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (e.g., seeing or hearing things that are not there), moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior. Mental or nervous disorders include severe mental disorders as defined in this plan (see definition of “severe mental disorders”).

Any condition meeting this definition is a mental or nervous disorder no matter what the cause of the condition may be.

Non-contracting hospital is a hospital which does not have a Standard Hospital Contract in effect with the claims administrator at the time services are rendered.

Non-participating provider is one of the following providers which does NOT have a Prudent Buyer Plan Participating Provider Agreement in effect with the claims administrator at the time services are rendered:

1. A hospital;
2. A physician;
3. An ambulatory surgical center;
4. A home health agency;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A skilled nursing facility;
8. A clinical laboratory;
9. A home infusion therapy provider; or
10. A hospice.

They are not participating providers. Remember that the maximum allowed amount may only represent a portion of the amount which a non-participating provider charges for services. See YOUR MEDICAL BENEFITS: MAXIMUM ALLOWED AMOUNT.

Other health care provider is one of the following providers:

1. A certified registered nurse anesthetist;
2. A blood bank; or
3. A licensed ambulance company.

The provider must be licensed according to state and local laws to provide covered medical services.

Out-of-state residents. Out-of-state residents covered under this plan means only retired employees, 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).

Participating provider is one of the following providers which has a Prudent Buyer Plan Participating Provider Agreement in effect with the claims administrator at the time services are rendered:

1. A hospital;
2. A physician;
3. An ambulatory surgical center;
4. A home health agency;
5. A facility which provides diagnostic imaging services;
6. A durable medical equipment outlet;
7. A skilled nursing facility;
8. A clinical laboratory;
9. A home infusion therapy provider; or
10. A hospice.

Participating providers agree to accept the maximum allowed amount as payment for covered services. A directory of participating providers is available upon request.

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

Physician means:

1. A doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, is rendering a service within the scope of that license and such license is required to render that service, is providing a service for which benefits are specified in this benefit booklet, and when benefits would be payable if the services were provided by a physician as defined above:
   a. A dentist (D.D.S. or D.M.D.)
   b. An optometrist (O.D.)
   c. A dispensing optician
   d. A podiatrist or chiropodist (D.P.M., D.S.P. or D.S.C.)
   e. A licensed clinical psychologist
   f. A clinical social worker (L.C.S.W.)
   g. A marriage and family therapist (M.F.T.)
   h. A physical therapist (P.T. or R.P.T.)*
   i. A speech pathologist*
   j. An audiologist*
   k. An occupational therapist (O.T.R.)*
   l. A respiratory care practitioner (R.C.P.)*
   m. A psychiatric mental health nurse (R.N.)*
   n. A licensed midwife**
   o. A chiropractor (D.C.)
   p. A licensed acupuncturist (A.C.)

*Note: The providers indicated by asterisks (*) are covered only by referral of a physician as defined in 1 above.

**If there is no nurse midwife who is a participating provider in your area, you may call the Customer Service telephone number on your ID card for a referral to an OB/GYN.
Plan is the set of benefits described in this benefit booklet and in the amendments to this benefit booklet, if any. These benefits are subject to the terms and conditions of the plan. If changes are made to the plan, an amendment or revised benefit booklet will be issued to each subscriber affected by the change.

Preventive Care Services include routine examinations, screenings, tests, education, and immunizations administered with the intent of preventing future disease, illness, or injury. Services are considered preventive if you have no current symptoms or prior history of a medical condition associated with that screening or service. These services shall meet requirements as determined by federal and state law. Sources for determining which services are recommended include the following:

1. Services with an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF);
2. Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
3. Preventive Care and screening for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. Additional preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

Please call us at the customer service number listed on your ID card for additional information about services that are covered by this plan as preventive care services. You may also refer to the following websites that are maintained by the U.S. Department of Health & Human Services.

http://www.healthcare.gov/center/regulations/prevention.html
http://www.ahrq.gov/clinic/uspreventfix.htm
http://www.cdc.gov/vaccines/recs/acip/

Prior plan is a plan sponsored by CVT which was replaced by this plan within 60 days. You are considered covered under the prior plan if you: (1) were covered under the prior plan on the date that plan terminated; (2) properly enrolled for coverage within 31 days of this plan’s Effective Date; and (3) had coverage terminate solely due to the prior plan’s termination.

Prosthetic devices are appliances which replace all or part of a function of a permanently inoperative, absent or malfunctioning body part. The term "prosthetic devices" includes orthotic devices, rigid or semi-supportive devices which restrict or eliminate motion of a weak or diseased part of the body.

Psychiatric emergency medical condition is a mental or nervous disorder that manifests itself by acute symptoms of sufficient severity that the patient is either (1) an immediate danger to himself or herself or to others, or (2) immediately unable to provide for or utilize food, shelter, or clothing due to the mental or nervous disorder.

Psychiatric health facility is an acute 24-hour facility as defined in California Health and Safety Code 1250.2. It must be:

1. Licensed by the California Department of Health Services;
2. Qualified to provide short-term inpatient treatment according to state law;
3. Accredited by the Joint Commission on Accreditation of Health Care Organizations; and
4. Staffed by an organized medical or professional staff which includes a physician as medical director.

Benefits provided for treatment in a psychiatric health facility which does not have a Standard Hospital Contract in effect with the claims administrator will be subject to the non-contracting hospital penalty in effect at the time of service.

Psychiatric mental health nurse is a registered nurse (R.N.) who has a master’s degree in psychiatric mental health nursing, and is registered as a psychiatric mental health nurse with the state board of registered nurses.

Reasonable and customary value is (1) for professional non-participating providers, the reasonable and customary value is determined by using a percentile of billed charges from a database of a third-party that takes into consideration various factors, such as the amounts billed for same or similar services, and the geographic locations in which the services were rendered; and (2) for facility non-participating providers and non-contracting hospitals, the reasonable and customary value is determined by using a percentile of billed charges from a database of the claims administrator’s
actual claims experience, subject to certain thresholds based on each provider’s cost-to-charge ratio as reported by the provider to a California governmental agency and the actual claim submitted to the claims administrator.

**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 "Eligible Status" provision in **HOW COVERAGE BEGINS AND ENDS**.

**Scheduled amount** is determined according to the SCHEDULES FOR NON-PARTICIPATING PROVIDERS. Any amount by which a non-participating provider’s charge exceeds this schedule and the maximum allowed amount will not be covered under this plan. **You are responsible for paying any such excess amount.**

**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-PARTICIPATING PROVIDERS.

**Severe mental disorders** include the following psychiatric diagnoses specified in California Health and Safety Code section 1374.72: schizophrenia, schizoaffective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia, and bulimia.

“Severe mental disorders” also includes serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the child’s age according to expected developmental norms. The child must also meet one or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being removed from the home or has already been removed from the home or the mental disorder has been present for more than six months or is likely to continue for more than one year without treatment.

2. The child is psychotic, suicidal, or potentially violent.

3. The child meets special education eligibility requirements under California law (Government Code Section 7570).

**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.

**Specialty drugs** are high-cost, injectable, infused, oral or inhaled medications that generally require close supervision and monitoring of their effect on the patient by a medical professional. These drugs which often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail pharmacies.

**Special care units** are special areas of a hospital which have highly skilled personnel and special equipment for acute conditions that require constant treatment and observation.

**Spouse** meets the plan’s eligibility requirements for spouses as outlined under **HOW COVERAGE BEGINS AND ENDS**.

**Stay** is inpatient confinement which begins when you are admitted to a facility and ends when you are discharged from that facility.

**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** means those conditions, not including those covered as **mental or nervous disorders**. These conditions include, but are not limited to: (1) psychoactive substance abuse induced **mental or nervous disorders**; (2) psychoactive substance abuse dependence; and (3) psychoactive substance use abuse. Substance abuse does not include addiction to, or dependency on, tobacco or food substances (or dependency on items not ingested).

**Telemedicine** means the use of interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. The term does not include services performed using a telephone or facsimile machine.
**Totally disabled subscribers** are *subscribers* who, because of illness or injury, are unable to work for income in any job for which they are qualified or for which they become qualified by training or experience, and who are in fact unemployed.

**Totally disabled family members** are *family members* who are unable to perform all activities usual for persons of that age.

**Totally disabled retired employees** are *retired employees* who are unable to perform all activities usual for persons of that age.

**Unit Value Schedule** lists the unit values of medical services. For any procedure not listed in the schedule, the *claims administrator* provides a benefit on the basis of comparable service. Benefits are determined based on the schedule in effect at the time the claim is paid. The unit value schedule listed in this Benefit Booklet is only a partial listing.

**Urgent care** is the services received for a sudden, serious, or unexpected illness, injury or condition, other than one which is life threatening, which requires immediate care for the relief of severe pain or diagnosis and treatment of such condition.

**Year** or **calendar year** is a 12 month period starting January 1 at 12:01 a.m. Pacific Standard Time.

**You (your)** refers to the *subscriber and family members* who are enrolled for benefits under this *plan*. 
FOR YOUR INFORMATION

LANGUAGE ASSISTANCE PROGRAM

HealthComp Administrators is able to provide certain written translation and oral interpretation services to California members with limited English proficiency.

The Language Assistance Program makes it possible for you to access oral interpretation services and certain written materials vital to understanding your health coverage at no additional cost to you.

Written materials available for translation include grievance and appeal letters, consent forms, claim denial letters, and explanations of benefits. These materials are available in the following languages:

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Oral interpretation services are available in additional languages.

To requesting a written or oral translation, please contact customer service by calling the phone number on your ID card to update your language preference to receive future translated documents or to request interpretation assistance.
COMPLAINT NOTICE

All complaints and disputes relating to coverage under this Plan must be resolved in accordance with the Plan’s grievance procedures. Grievances may be made by telephone (please call the number described on your Identification Card) or in writing (write to HealthComp Administrators, Post Office Box 45018, Fresno, California 93718-5018 marked to the attention of the CVT Customer Service Unit). If you wish, the Claims Administrator will provide a Complaint Form which you may use to explain the matter.

All grievances received under the Plan will be acknowledged in writing, together with a description of how the Plan proposes to resolve the grievance. Grievances that cannot be resolved by this procedure shall be submitted to arbitration.

Claims Administered by:

HealthComp Administrators

on behalf of

California’s Valued Trust